

2026

Humana Dual Integrated (HMO D-SNP) in Michigan Provider Manual

Humana®

849804 MIHMU4NEN

Contents

Welcome 7
- About this manual 7
- Manual updates and changes 8

Chapter 1: Introduction 9
- Humana mission statement 9
- About Humana 9
- About the Michigan Dual Integrated (HMO D-SNP) 9
- Compliance and ethics 10
- Provider websites 11
- Availity Essentials provider portal 12
- Humana provider relations representatives 13
- How to join our network 13
- Accreditation 15

Chapter 2: Enrollee enrollment 16
- Enrollee enrollment 16
- Verifying enrollee enrollment 16
- Enrollee ID cards 16
- New enrollee kits 17
- Enrollee disenrollment 17
- Deeming period 18
- Disenrollment for cause 18
- Out of area 19

Chapter 3: Enrollee rights and responsibilities 20
- Enrollee rights 20
- Enrollee responsibilities 21

Chapter 4: Provider rights and responsibilities 23
- Overview 23
- Liability insurance 23
- CMS requirements 23
- Provider rights 25
- Provider responsibilities 25
- Emergency services responsibilities 29
- Americans with Disabilities Act (ADA) 29
- HIPAA compliance 30
  - Personally identifiable information and PHI 30
  - Enrollee privacy 30
  - Enrollee consent to share health information 31
  - Enrollee data 31
  - Confidentiality statement 31
- Advance directives 31
- PCP responsibilities 32
- PCP changes 32
- Appointment wait times and access standards and requirements 32
- Provider-based marketing activities 33
- Notification of demographic changes 35
- Provider training 36
  - Provider orientation 37

Chapter 5: Enrollee abuse, neglect and exploitation 38

Definitions of enrollee abuse, neglect and exploitation 38

Abuse 38

Neglect 39

Exploitation 40

Indicators of enrollee abuse, neglect, and exploitation 41

Physical 41

Behavioral 43

Neglect 44

Exploitation 44

Requirements for reporting abuse, neglect or exploitation 45

Types of critical incidents 45

Who can report critical incidents 46

Mandated reporters 46

General reporting questions 46

Reporting suspected abuse, neglect, and/or exploitation 47

Reporting adverse events 47

Reporting critical incidents 47

Chapter 6: Cultural humility, health equity and implicit bias 48

Importance of health equity and cultural humility in care delivery 48

Cultural competency 48

Cultural humility 50

Provide culturally appropriate decision aids 51

Implicit bias 52

Health equity 53

Factors affecting health equity 53

Linguistic services 54

Interpreter services 54

Chapter 7: Covered services 56

Providing covered services through our provider network 56

Covered services 56

Scope of benefits 57

Mandatory supplemental benefits and enhanced value added benefits 72

Emergency services 75

Transplant services 76

Go365 by Humana wellness and rewards program 77

Getting started 77

Humana Wellness Coaching 78

Services not covered 78

Chapter 8: Behavioral health 80

Behavioral health overview 80

Emergency care 81

Provider coordination for behavioral health 81

Referral procedures 81

Primary care provider expectations 82

Chapter 9: Care coordination 83

Our approach to care coordination 83

Model of care 83

Humana care coordinator responsibilities 84

Humana care coordinator qualifications 86

Care coordinator assignments and change requests 86

Continuity of care requirements 87

Disease management programs 88

Enrollee assessments 89
Individualized care plans 90
Enrollee reassessments 90
Care coordination risk stratification .. 91
Low-risk enrollees 91
Moderate-risk enrollees 91
High-risk/complex enrollees 91

Chapter 10: Quality Assessment and Performance Improvement 93
Quality improvement program overview 93
Quality Improvement Committee 94
Quality measures 95
HEDIS and other performance measures 95
CAHPS 96
Health disparities analysis 96
Access to care audits 96
Provider and enrollee satisfaction surveys 97
Peer review 97
Provider participation in the QAPI Program 98
Evaluation of the QAPI Program 98
Medical record standards 98
Medical record confidentiality requirements 99
Medical record storage requirements 100
Enrollee rights related to medical records ... 100
Preventive guidelines and clinical practice guidelines 102

Chapter 11: Utilization management 104
Utilization management program overview 104
Access to UM staff 104
Referrals 105
Prior authorizations 105
Services that do not require prior authorization 106
Required information for prior authorization requests 107
Timeliness of prior authorization decisions 108
Prior authorization for hospital admissions 108
Prior authorization in continuity of care 109
Prior authorizations for outpatient surgery 109
Discharge planning 109
Retrospective review 109
Concurrent review 110
Retrospective determinations 110
Medical necessity criteria and reviews 111
Obtaining clinical criteria and rationale used in making UM determinations 112
Peer-to-peer review 112
Second opinions 113
Out-of-network services 113
Claim status 114
Post-stabilization services 114
Special requirements for hospitals ... 115
Hospital Discharge Rights for HIDE-SNP Enrollees: 115

Special requirements for skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities.. 116

Notice of Medicare Non-Coverage (NOMNC):..... 116

Right to appeal a NOMNC (Fast-track Appeal):..... 117

Chapter 12: Claims submission protocols and standards..... 119

Overview..... 119

Claim payment..... 119

Submitting an electronic claim 119

Timely provider payments..... 120

NPI and TIN..... 120

Location of provider NPI, TIN and enrollee ID number..... 121

Service encounter submission accuracy..... 121

Provider portal 122

EFT/ERA enrollment through Humana..... 122

Code sets 122

Common errors and reasons for denial or rejection..... 123

Code editing and payment policies .. 123

Claim acknowledgment..... 125

Claim processing 125

Clean claim criteria..... 126

Claims overpayment..... 126

Out-of-network claims..... 127

Third-party liability 127

Enrollee billing 127

Suspension of provider payments ... 128

Chapter 13: Provider appeals..... 129

Overview..... 129

Process and timelines 129

Provider appeal Q&A 130

Medicaid covered services..... 130

Binding arbitration..... 131

Chapter 14: Enrollee grievances, appeals and state fair hearings..... 132

Process and timelines 132

Filing a grievance or appeal 132

Requesting a grievance..... 133

Requesting an appeal 133

Requesting an expedited appeal 134

Medicaid state fair hearing process 134

Continuation of benefits 135

Chapter 15: Credentialing and recredentialing 136

Overview..... 136

Provider recruitment and nondiscriminatory credentialing policy 136

Provider background checks 137

Individual provider credentialing.... 137

Facility/organizational/ancillary providers..... 138

Required information for organizational provider credentialing 138

Managed HCBS/LTSS providers..... 138

Required information for providers offering Community-Based MLTSS services..... 138

Credentialing/assessment and recredentialing/reassessment overview 139
Practitioners 139
Organizational providers 143
HCBS/LTSS providers 145
Helpful tips for providers 146
Recredentialing process 147
Credentials Committee 147
Provider rights in the credentialing and recredentialing process 148
Provider responsibilities in the credentialing and recredentialing process 148
Reconsideration of credentialing/recredentialing decisions 148
Ongoing provider monitoring 149
Delegation of credentialing/recredentialing 149

Chapter 16: Fraud, waste and abuse (FWA) 151
Overview 151
Reporting FWA 152
Key features of methods for direct reporting to Humana 152

Chapter 17: Pharmacy 153
Pharmacy Overview: 153
Requesting coverage determinations 153
Pharmacy and Therapeutics Committee 154
Coverage limitations 154
Prescription drug formulary 154
Formulary updates 155
Medications administered in the provider setting 155
Medication Therapy Management 155

Chapter 18: Long-term services and supports 156
Humana and the Detroit Area Agency on Aging 156
Overview 156
Covered services 157
Care coordination and service authorization 157
LTSS claims 158
LTSS provider responsibilities 158
Level-of-care assessment and reassessment processes 158
Needs assessment service planning requirements 159
HCBS 159
Policies related to LTSS authorization 160
Service plan timeline requirements 161

Appendices 164
Phonebook 164
Definitions 169
Acronyms 181
Benefit grids 184
LTSS covered services 184

Welcome

Thank you for your participation with Humana Dual Integrated (HMO D-SNP) in Michigan, where our goal is to provide high quality services to Michigan Dual Eligible Medicare-Medicaid enrollees.

Within this manual, key points are highlighted related to Humana's policies and procedures. This manual is intended to inform both you and your staff of requirements for the Michigan Dual Integrated (HMO D-SNP)), what Humana 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 enrollees.

You will be notified of updates to this manual via fax or mail. If you require further information about anything covered within this manual, please reach out to your provider relations representative.

On behalf of everyone at Humana, 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 enrollees. Throughout the manual, all instances of "us," "we" or "our" refer to Humana 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.

Please see the **Linked resources** section of this manual for complete URLs referenced within.

Color coding and font variations are used to denote different information throughout this provider manual as follows:

- **Internal references** to other parts of this provider manual are denoted in bold eggplant font and are linked to the relevant section of the manual.
- **Contact information** is denoted in bold teal font and is linked to the relevant details in this manual's **phonebook**.
  - NOTE: After following links to the phonebook or other parts of this provider manual, simply click the Alt key and the left arrow key together to navigate back to the section you were reading.
- **Hyperlinks** to external resources are denoted in bold, underlined, navy font.

This manual furnishes you and your office staff with important information concerning Humana's policies and procedures, claim submission and adjudication requirements, and other guidelines used to administer our health plans. A paper copy of this manual can be obtained at any time upon request to your local Humana 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 constate revisions to Humana's 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 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's policies and procedures.

Manual updates and changes

A current electronic copy of our provider manual can be found via the Humana provider website. Updates to this manual as permitted by the provider contract are posted on **Humana.com/HealthyMI.** A notice is sent to providers at least 30 days in advance of implementing any policy or procedure changes in the provider manual. Notification is sent via U.S. mail and/or fax.

Chapter 1: Introduction

Humana mission statement

We offer a whole-person approach to delivering healthcare to dual eligible (Medicare and Medicaid) enrollees in Michigan aiming to help improve the health and well-being of enrollees across the state, while helping you provide quality care.

About Humana

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.

About the Michigan Dual Integrated (HMO D-SNP)

Effective January 1, 2026, the Michigan Department of Health and Human Services (MDHHS) has transitioned from the Michigan Health Link program to Michigan Coordinated Health. Humana is honored to participate in this program where we will offer a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). A HIDE-SNP is a type of Medicare Advantage (MA) plan designed for individuals who are eligible for both Medicare and Medicaid benefits. HIDE-SNPs provide integrated benefits and care coordination for enrollees, offering a higher level of integration between Medicare and Medicaid services than standard dual eligible SNPs.

Humana offers 1 HIDE-SNP plan in Michigan: Humana Dual Integrated H0963-001-000 (HMO D-SNP) which serves enrollees in Macomb and Wayne counties for Plan Year 2026.

This plan is referred to as HIDE-SNP throughout the rest of this manual.

The HIDE-SNP will offer all Medicare and most Medicaid benefits, including long-term services and supports and Medicaid behavioral health benefits not provided by the regional pre-paid inpatient health plans (PIHPs), through a single health plan to low-income seniors and individuals with disabilities who are eligible for both Medicare and Medicaid.

HIDE-SNPs offer many benefits to individuals who are eligible for both Medicaid and Medicare to facilitate their ability to navigate complex health insurance systems and receive the services and supports they need to thrive and live healthy lives. By more closely aligning Medicare and Medicaid for dually eligible individuals, MDHHS aims for the HIDE-SNP program to accomplish the following:

- Foster integration and continuity;
- Reduce racial disparities;
- Improve care delivery;
- Promote self-determination; and
- Build a culture of quality

Covered populations include individuals who meet all the following eligibility requirements:

- Aged 21 or older at the time of enrollment including individuals aged 21 and older served by the Children's Special Health Care Services (CSHCS) program
- Entitled to Medicare Part A, Medicare Part B and Medicare Part D
- Receive full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility, including those who have a monthly patient pay amount)
- Reside in one of the Medicaid regions where this program is available, Macomb and Wayne counties

There are several other types of SNP products, as defined by CMS, which target different populations and enrollee needs. This manual applies only to providers in Humana's Medicare HMO network or Humana's Medicaid network who are serving a HIDE-SNP enrollee.

Home and Community Based Services (HCBS) providers should use the Detroit Area Agency on Aging(DAAA) provider manual. All other SNP products are out of scope for this manual, including all Humana Gold Plus plans. If you are serving an enrollee in another plan, and need more information, please refer to Humana's Medicare Manual on our website at **Humana.com/Publications**.

Compliance and ethics

Humana is responsible for complying with applicable state and federal regulations, along with applicable 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, enrollees 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 enrollees 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 relations representative or call Provider Services at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time. To report any ethics or compliance concerns, please contact Ethics Helpline at **877-5-THE-KEY (877-584-3539)**.

Provider websites

Providers can obtain plan information from **Humana.com/Publications**. This information includes:

- Health and wellness programs
- Provider publications (including provider manual, newsletters and program updates)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

Providers can obtain specific plan information by visiting **Humana.com/HealthyMI**. 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 lookup
- Value-based care report

Michigan-specific educational resources are also available at **Humana.com/HealthyMI**. These resources include the following:

- Annual training information
- Communications and network notices
- COVID-19 coverage and resources
- Documents and forms
- Educational materials
- Pharmacy materials
- Quality resources

For help or more information regarding web-based tools, please call Provider Services at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Availity Essentials provider portal

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

- Certificates of coverage
- Claim submission and status
- Appeals
- Eligibility and benefits
- Electronic remittance advice (ERA)/electronic funds transfer (EFT) enrollment
- Humana-specific applications, resources and news
- Medical record requests
- Enrollee summary
- Overpayment management
- Plan of care
- Provider directory
- Referrals and authorizations
- Remittance advice
- Status of prior authorization and referral requests

Humana provider relations representatives

To contracted providers, we offer provider relations representatives who support direct engagement and relationship oversight and specialize in the following:

- Assisting 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
- Instructing resolution processes and assisting with escalated issues
- Communicating important information with the provider network via meetings, newsletters, network notices and emails

Your provider relations representative will conduct on-site visits to provider offices upon request to ensure compliance with and provide education on many requirements, including but not limited to:

- Access and availability standards
- Care coordination programs
- Cultural humility, health equity and implicit bias
- Encounter submissions
- Grievance and appeals processes
- Health Insurance Portability and Accountability Act (HIPAA) policies and procedures
- Enrollee disenrollment processes
- Patient rights and responsibilities
- Privacy practices
- Provider resources

More information about your assigned provider relations representative is available at **Humana.com/HealthyMI**. If you are unable to determine who your provider relations representative is, please contact Provider Services at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Claims-related inquiries can be sent to provider relations at **MIProviderRelations@humana.com**. Please copy your provider relations representative on the inquiry.

How to join our network

We are committed to offering accessible and high-quality care to our enrollees. We would be honored to partner with you. Typical providers must first be enrolled with Michigan Medicaid via the Community Health Automated Medicaid Processing System (CHAMPS) and obtain a National Provider Identifier (NPI) before enrolling with Humana. Please see guidelines below:

Typical providers deliver medical or health services as defined by federal law (42 U.S.C. 1395). They must enroll in CHAMPS and obtain an NPI before enrolling with Humana.

Typical Providers include but are not limited to:

- Institutional providers: hospitals, nursing homes, etc.
- Professional providers: practitioners, prescribers, pharmacies, dentists, hearing centers, etc.

Atypical providers do not provide direct medical services and may or may not be enrolled in CHAMPS or Bridges. These providers do not qualify for an NPI but may submit HIPPA transactions.

Atypical providers include but are not limited to:

- Home-help services
- Non-emergency medical transportation (NEMT)
- Adult foster care (AFC)

Enrollment limitations for atypical providers: fiscal intermediaries (FI's) and providers offering services requiring electronic visit verification (EVV) (e.g., state plan personal care, respite) can enroll in CHAMPS.

For additional information, HIDE-SNPs can reference the **MDHHS Provider Enrollment Webpage** to determine provider enrollment requirements and to learn more about CHAMPS. CHAMPS can be accessed through the **MiLogin web portal**.

If you are not yet participating in our HIDE-SNP network but are interested in joining, please reach out to us using the contact information below or fill out the online form at **Humana National Request to Join Portal**:

Area	Representative	Contact information
Physical health providers (physician group, facility, ancillary, FQHC, RHC)	Humana Provider Contracting	**MichiganMarket@humana.com**
Behavioral health providers	Humana Behavioral Health Contracting	**MIBHMedicaid@humana.com**
HCBS	Detroit Area Agency on Aging	**contractmgt@daaa1a.org**
Vision providers	EyeMed	**888-289-0595** Monday – Saturday, 7:30 a.m. – 11:00 p.m., Eastern Time, and Sunday, 11:00 a.m. - 8:00 p.m., Eastern Time
Hearing providers	TruHearing	**855-286-0550** Monday – Friday, 6:00 a.m. – 6:00 p.m., Mountain Time
NEMT	SafeRide	**Humana** Provider Services at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time
Pharmacy	Humana Pharmacy Contracting	**PharmacyContracting@humana.com**

Accreditation

We hold a strong commitment to quality, demonstrating our commitment through programs based on national standards, when applicable. Providers must agree to comply with Humana quality assurance, quality investigation and peer review process, quality improvement (QI), accreditation, risk management, utilization review, utilization management (UM), clinical trial and other administrative policies and procedures established and revised by Humana.

The National Committee for Quality Assurance (NCQA) review process examines Humana's quality improvement program structure, tests quality improvement processes and looks for evidence that quality improvement activities have resulted in measurable improvement in Humana's performance in both clinical and service areas. The NCQA Healthcare Effectiveness and Data Information Set (HEDIS®) is designed to measure plan and provider performance on a number of measures to produce a consumer report card. The information collected from managed care plans is published to assist consumers in choosing a healthcare plan, physicians and other healthcare providers. Specific HEDIS measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts.

Humana prepares information for NCQA based on data obtained from participating providers in the form of claims or encounter records. In addition to gathering HEDIS data administratively via claims and encounters, Humana also encourages submission of supplemental data. For example, one HEDIS measure is to determine if enrollees with diabetes receive an annual dilated eye examination. The percent of diabetic enrollees who meet HEDIS criteria and have an encounter reported for a dilated retinal eye examination is reported. If there is no report of such an examination, the enrollee is identified as needing an examination. Humana may remind enrollees of the importance of the examination, assist in scheduling an appointment or help overcome their barriers to receiving the examination. The type of outreach the enrollee receives is based upon consumer insights and history of completing a dilated eye examination. Periodically, the Humana quality management department may visit provider offices to review medical records of enrollees and to collect data.

URAC (originally known as Utilization Review Accreditation Commission) is a nonprofit organization founded in 1990 to establish standards for the healthcare industry by providing a method of evaluation and accreditation for a variety of healthcare organizations, including health plans, utilization management organizations, pharmacy benefit managers and others. There are more than 20 accreditation and certification programs—some that review the entire organization, such as the health plan standards, and some that focus on a single functional area in an organization, such as case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs and provider groups, can seek accreditation.

Chapter 2: Enrollee enrollment

Enrollee enrollment

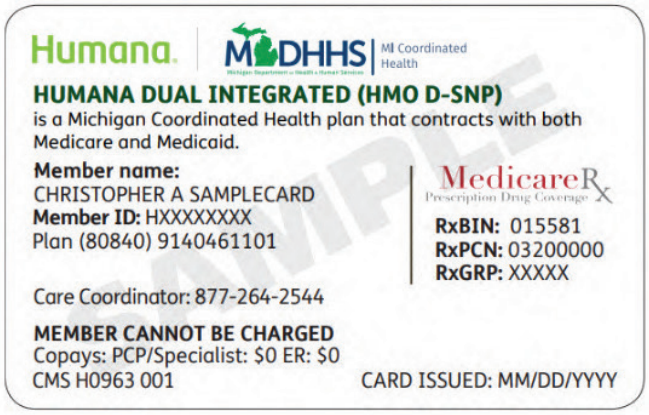
Centers for Medicare & Medicaid Services (CMS) and MDHHS are solely responsible for determining an individual's eligibility. Once an individual is determined to be eligible for Medicare and Medicaid, they may choose to enroll in a Michigan HIDE-SNP. Once they choose to enroll in a HIDE-SNP, the enrollee must choose a plan. Medicare Advantage agents, brokers, or other third-party representatives may assist individuals in selecting a Medicare Advantage plan. If Humana utilizes agents, brokers, or other third parties to market or enroll beneficiaries in its Michigan HIDE-SNP, it will comply with all applicable federal regulations and Michigan state laws. Humana will also ensure that brokers receive training specific to long-term services and supports (LTSS), in accordance with applicable CMS guidance. Humana's Dual Integrated in Michigan is available to these enrolled individuals residing in Wayne and Macomb counties for plan year 2026, offering aligned enrollment that integrates their Medicare and Medicaid benefit under one plan.

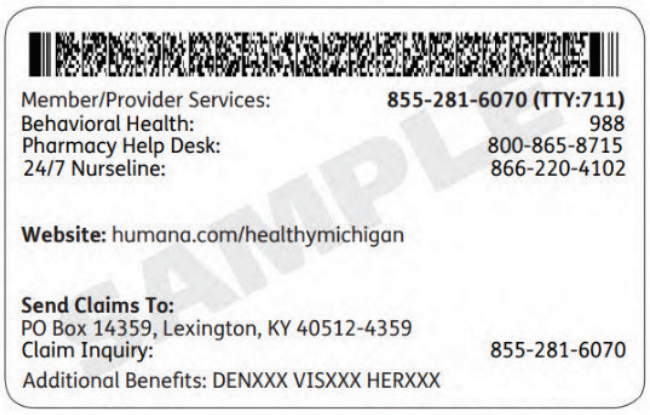
Verifying enrollee enrollment

Humana is available to assist providers in verifying that enrollees are enrolled in our HIDE-SNP plan. Before providing all non-emergency services, you must verify enrollee enrollment in our plan. You should ask enrollees to present an identification (ID) card each time services are rendered. If you are not familiar with the enrollee seeking care and cannot verify the person as a Humana enrollee, you should ask to see photo ID. Enrollment can be verified through **Availity Essentials** → Patient Registration → Eligibility and Benefits Inquiry, by calling **800-282-4548** Monday – Friday 8 a.m. to 8 p.m., Eastern time, or through CHAMPS via the **MiLogin web portal**.

Enrollee ID cards

All new Humana enrollees receive an enrollee 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 enrollee ID card is used to identify a Humana enrollee but does not guarantee eligibility or benefits coverage because enrollees may disenroll from Humana or lose HIDE-SNP eligibility at any time. Therefore, it is important to verify enrollee eligibility prior to rendering any service.





New enrollee kits

Each new enrollee receives a new enrollee kit and an ID card for each person in the family joining Humana. New enrollee kits are mailed separately from the ID card. The new enrollee kit contains:

- A welcome guide
- A welcome letter
- State-required and Humana forms and documents with a postage paid return envelope (e.g., Continuity of Care, Appointment of Representative, Disclosure to Exchange Information Form, etc.)
- Information on how to obtain a one-time hard copy request of important plan documents (e.g., summary of benefits, evidence of coverage, provider/pharmacy directory, formulary, etc.)

Enrollee disenrollment

Enrollees may be disenrolled from **Humana** only for specific reasons as defined by Federal law (42 CFR § 422.74). These reasons include:

- Any monthly basic and supplementary beneficiary premiums are not paid on a timely basis, subject to the grace period for late payment (if applicable)
- The individual has engaged in disruptive behavior, which is specifically defined by federal law
- The individual provides fraudulent information on their election form or permits abuse of their enrollment card
- The individual no longer resides in our service area
- The individual loses entitlement to Part A or Part B benefits
- The individual no longer meets the Medicare Medical Savings Account's (MSA's) eligibility criteria
- Death of the individual
- The individual is not lawfully present in the United States

Deeming period

If an enrollee experiences changes to their Medicaid eligibility level or loses Medicaid eligibility, the enrollee is placed into the deeming period. Enrollees who lose Medicaid eligibility have a six-month deeming period of continued enrollment in the HIDE-SNP to minimize risks and maximize continuity of care during periods of temporary Medicaid eligibility loss, in accordance with § 422.52(d). During the deeming period, the enrollee's Medicare HIDE-SNP benefits and primary care provider (PCP) remain the same; however, the enrollee does not have any Medicaid benefits. The amount applied to cost share will be paid under the Humana Medicare plan. Enrollees have six months to regain qualifying Medicaid eligibility and remain in the HIDE-SNP. If the enrollee does not regain qualifying Medicaid eligibility during those six months, they will be disenrolled from the HIDE-SNP. As a reminder, you are encouraged to verify a patient's eligibility via Availity Essentials before providing services.

Please notify Provider Services at **855-281-607** Monday – Friday, 8 a.m. – 8 p.m., Eastern time if you become aware of one or more situations described above.

Disenrollment for cause

CMS guidelines allow a PCP to request an enrollee's disenrollment "for cause" only if the enrollee's behavior is disruptive, unruly, abusive, threatening or uncooperative to the extent that his/her continued membership would substantially impair the provider's ability to provide health services to that particular enrollee or other patients. An enrollee also may be disenrolled for other reasons including, but not limited to, if he/she fails to qualify for Medicare benefits or fraudulently permits others to use his/her enrollee ID card for services. An enrollee cannot be disenrolled based on the enrollee's utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a provider regarding treatment decisions, or as retaliation for an enrollee's complaint, appeal or grievance. Before initiating a request to disenroll an enrollee for cause, the provider and Humana must make a serious effort to resolve the problems, such as encouraging the enrollee to change his/her behavior, and must document the result of this action. If the behavioral problems are not resolved, the provider may initiate a request to disenroll the enrollee by submitting the Request for Disenrollment for Cause form to the local Humana market office. The form is available through the local Humana market office.

CMS requires Humana to notify a HIDE-SNP enrollee that the consequences of continued disruptive behavior could include disenrollment from the plan. The health plan and provider must reasonably demonstrate that the enrollee's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition or use (or lack of use) of the provider's medical services.

Out of area

When an enrollee is temporarily out of the service area (for up to six months), coverage is limited to urgently needed, emergency care, post-stabilization services following an emergency and renal dialysis until the enrollee returns to the service area or the effective date of disenrollment. HIDE-SNP enrollees may receive participating benefits from any participating provider, nationwide, as well as out-of-network benefits.

Disenrollment outside of the service area: An enrollee must notify a customer care representative when they permanently move out of the service area. A permanent move is an absence of more than six months.

Chapter 3: Enrollee rights and responsibilities

As a Humana provider, you are required to respect the rights of our enrollees, who are informed of their rights and responsibilities via their **enrollee handbook.** We have also included the list of enrollee rights and responsibilities below for your reference. Humana complies with any applicable federal and state laws that pertain to enrollee rights and ensures that its employees and contracted providers observe and protect those rights.

Enrollee rights

All enrollees are encouraged to take an active and participatory role in their own health and the health of their family.

Enrollees 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.
- Exercise their rights, and that the exercise of those rights does not adversely affect the way Humana and its network providers or MDHHS treat the enrollee.
- Have advance directives explained and to establish them, if the enrollee so desires, in accordance with 42 CFR §§489.100, and 489.102.
- Receive reasonable advance notice in writing of any transfer to another treatment setting and the justification for the transfer.
- Receive medical and non-medical care from a team that meets the enrollee's needs, presented in a manner that is sensitive to the enrollee's language and culture, and in an appropriate care setting, including the home and community.
- 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 enrollee.

- 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 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, including access to an adequate network of primary and specialty providers who are capable of meeting enrollee needs with respect to physical access, communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
- 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 to the Humana enrollee 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, its services, its providers, and enrollee rights and responsibilities.
- Receive information in accordance with 42 C.F.R 438.10.
- Take an active part in discussions about the enrollee's healthcare unless it is not in their best interest.
- Voice complaints or appeals about the plan or the care it provides.
- Have a voice in the governance and operation of the integrated system, provider or health plan

Enrollee responsibilities

Enrollees 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 PCP 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 enrollee and their healthcare provider agree upon.
- Participate in the plan of treatment they have agreed to, when possible, and make available an informal caregiver to 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.

Chapter 4: Provider rights and responsibilities

Overview

To comply with the requirements of accrediting and regulatory agencies, Humana has adopted certain responsibilities for providers serving HIDE-SNP enrollees in Michigan that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and the provider agreement.

Liability insurance

Upon request, all providers must provide Humana with evidence of insurance coverage in accordance with their agreement's requirements.

CMS requirements

Humana is responsible for including certain CMS Medicare Advantage-related provisions in the policies and procedures distributed to the providers that constitute Humana's health services delivery network. The following table summarizes these provisions, which can be accessed online by visiting the **Code of Federal Regulations on the U.S. Government Printing Office website**.

Summary of CMS requirements	CFR42 (section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" enrollees to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, 7 days week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)

Summary of CMS requirements	CFR42 (section)
Maintain procedures to inform enrollees of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place of an individual's medical record if that individual has executed an advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a) 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all enrollees affected by the termination of a provider contract 45 calendar days for PCP/BH and 30 days for other specialties before their termination by plan or provider	422.111(e)
Submit data and medical records and certify completeness and truthfulness	422.310(d)(3)-(4) 422.310(e) 422.504(d)-(e) 422.504(i)(3)-(4) 422.504(l)(3)
Comply with medical policy, quality improvement and medical management	422.202(b) 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits regarding disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Notify providers in writing for reason of denial, suspension and/or termination	422.202(d)(1)
Provide 60-day notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

Provider rights

Providers, including PCPs, have the right:

- To not be prohibited from acting within the lawful scope of their practice when advising or advocating on behalf of a Humana enrollee for the following:
- The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the enrollee needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The enrollee's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- To receive information on the grievance, appeals and fair hearing procedures.
- To have access to Humana's policies and procedures covering the authorization of services.
- To be notified of any decision by Humana to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- To challenge, on behalf of Humana enrollees, the denial of coverage of, or payment for, medical assistance.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who acts within the scope of their license or certification under applicable state law, solely on the basis of that license or certification.

Provider responsibilities

Providers, including PCPs, have the responsibilities to:

- Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid enrollees.
- Submit a claim on behalf of the enrollee in accordance with timely filing laws, rules, regulations and policies.
- Not bill Humana enrollees for missed appointments in compliance with federal and state requirements.
- Inform enrollees regarding follow-up care or provide training in self-care.
- Not discriminate against enrollees as a result of their participation as enrollees, their source of payment, age, race, color, national origin, religion, sex, sexual preference, gender identity, health status or disability.
- Not discriminate in any manner between Humana enrollees and non-Humana enrollees.
- Provide services in a culturally competent manner (e.g., removing all language barriers; arranging and paying for interpretation services for limited English proficient (LEP) and the deaf and hard of hearing or blind or partially sighted) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient.

- Provide or arrange for continued treatment to all enrollees including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Provide access to healthcare benefits for all plan enrollees in a manner consistent with CMS requirements for any Humana HIDE-SNP enrollees.
- Treat all enrollee records and information confidentially and not release such information without the written consent of the enrollee, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Admit enrollees only to participating network hospitals, skilled nursing facilities (SNFs) and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- For enrollees who have end stage renal disease (ESRD), complete the Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security office when the provider becomes aware of the disease. The form must be completed and returned to the Social Security office and the ESRD Network.

  Send the form by one of the following ways:

  – Fax: 502-508-3450

  – Mail: Humana

  Attn: Medicare Reconciliation Department – ESRD Unit Waterside Building 101 Main St., Louisville, KY 40202
- Assure the availability of physician services to enrollees 24 hours a day, seven days a week (required for HMO PCPs and all MA providers).
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA providers).
- Refer Humana enrollees with problems outside of the physician's normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer enrollees only to participating providers, except in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana enrollee other than for copayments, deductibles, coinsurance, other fees that are the enrollee's responsibility under the terms of their benefit plan, or fees for noncovered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare, or services excluded in the enrollee's plan.
- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.
- Be credentialed by Humana and meet all credentialing and recredentialing criteria as required.
- Not be on the HHS Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) or the General Service Administration's System of Award Management (SAM) debarment list

- Not be in the CMS preclusion list or excluded from participating in Medicare.
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable, and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Inform Humana in writing within 24 hours of any revocation or suspension of their Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of their license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing him/her to practice in any state in which the provider is licensed.
- Inform Humana immediately of changes in licensure status, tax identification numbers, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect their participation status with Humana.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if they make plan-enrollee rounds and have no record of hospital privileges having been reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Retain all agreements, books, documents, papers and medical records related to the provision of services to enrollees as required by state and federal laws and in accordance with relevant Humana policies.
- Agree to comply with Humana's quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, UM, clinical trial and other administrative policies and procedures established and revised by Humana.
- Upon request of Humana, provide an electronic, automated means, at no cost, for Humana and all Humana-affiliated vendors acting on behalf of Humana to access enrollee clinical information including, but not limited to, medical records, for all payer responsibilities including, but not limited to, care coordination, UM, claims review and audit and claims adjudication.
- Treat all enrollee records and information confidentially and not release such information without the written consent of the enrollee, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Transfer copies of medical records for the purpose of continuity of care to other Humana providers upon request and at no charge to Humana, the enrollee or the requesting party, unless otherwise agreed upon.
- Provide copies and access for Humana or its designee to examine the provider's office books, records and operations of any related organization or entity involving transactions related to health services provided to enrollees. A related organization or entity is defined as having:
  - Influence, ownership or control and

  - Either a financial relationship or a relationship for rendering services to the primary care office.
- Submit a report of an encounter for each visit when the enrollee is seen by the provider. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form and submitted according to the time frame listed in the agreement.
- Meet the requirements of all applicable state and federal laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Perform services under the agreement consistently and in compliance with Humana's contractual obligations under its Medicare Advantage contract(s). Physician agrees to cooperate with and assist Humana in its efforts to comply with its Medicare Advantage contract(s) and/ or Medicare Advantage rules and regulations and to assist Humana in complying with corrective action plans necessary for Humana to comply with such rules and regulations.
- Understand and agree that provider performance data can be used by Humana.
- Notify Humana of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Humana of any material change in provider's performance of delegated functions, if applicable.
- Notify Humana of their termination 60 days prior to the effective date of termination, or as otherwise outlined in provider's agreement with Humana. Not be excluded from participating in Medicare.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial enrollees, Medicare enrollees in an MA plan and Medicaid enrollees. Respond expeditiously to Humana's request for medical records or any other documents to comply with regulatory requirements and to provide any additional information about a case in which an enrollee has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Humana plan(s) with which the provider is contracted, including Humana's.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and enrollees regarding an enrollee's medical condition or available treatment options or to dictate medical judgment
- For providers who participate in Medicare Advantage networks and who participate in Original Medicare, abide by the guidelines set out in Humana's Rules of Participation for MA Networks, which are available here. A paper copy can be obtained upon request.
- For providers who have downstream agreement(s) with physicians or other providers who provide services to Humana enrollees, agree to provide a copy of said agreement(s) to Humana upon request (financial information is not requested).
- Agree to pay court costs and/or legal fee incurred by Humana or the enrollee to enforce the terms of this provision.

- CMS requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries, including HIDE-SNP plan enrollees who are hospital inpatients. Please see the **Special requirements for hospitals** section for more information.
- CMS requires that physicians and other healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to HIDE-SNP health plan enrollees at least two days prior to termination of SNF, home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Please see the **Special requirements for skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities** section of this manual for more information.

Emergency services responsibilities

Participating providers are required to ensure adequate accessibility for healthcare 24 hours a day, seven days a week. An after-hours telephone number must be available to enrollees. Voicemail alone is not acceptable. If the enrollee is treated and stabilized during an emergency visit, and the treating provider recommends continued treatment, the enrollee is instructed to call their Humana PCP and any other specialty providers to which the enrollee was referred to for outpatient follow-up care. Enrollees who suffer an emergency while away from home are instructed to go to the nearest emergency room (ER) or setting. In such situations, the enrollee's PCP should be contacted as soon as possible.

Americans with Disabilities Act (ADA)

Humana and all Humana-contracted healthcare providers must comply with the ADA, as well as all applicable state and/or federal laws, rules and regulations. Humana reasonably accommodates persons and ensures that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. You must provide physical access, reasonable accommodations, and accessible equipment for HIDE-SNP enrollees with physical or mental disabilities.

More details are available in your provider contract under Compliance with Regulatory Requirements. Providers must accommodate enrollees' physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities. Humana accommodates enrollees and ensures that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities. We develop individualized care plans (ICPs) that consider enrollees' special and unique needs. Enrollees in need of interpretation services can call the number on the back of their enrollee ID card or call Member Customer Service at **855-281-6070** available 7 days a week, Oct 1st to March 31st and Monday – Friday, April 1st to September 30th, 8 a.m. – 8 p.m., Eastern time to schedule interpretation services at least 48 hours prior to an appointment. 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 enrollees.

If your patient requires interpretive services, you may contact **Communication Assistance, Interpreters, and** Alternative Formats at **877-320-2233** or **email ADAservices@humana.com**.

You will need to include the date, time, your phone number and the appointment location. If you have Humana enrollees who require interpretation, you can reach out to Member Customer Service at **855-281-6070** available 7 days a week, Oct 1st to March 31st and Monday – Friday, April 1st to September 30th, 8 a.m. – 8 p.m., Eastern time.

HIPAA compliance

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of patient information. If a Humana-covered enrollee changes their PCP for any reason, you must transfer a copy of the patient's medical record to the patient's new PCP at the request of the plan or the patient. 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-covered patients and Humana.

Personally identifiable information and PHI

In the day-to-day business of patient treatment, payment and healthcare operations, Humana and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that 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.

Enrollee 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.

Enrollee consent to share health information

Consent is the enrollee's written permission to share their information. Not all disclosures require the enrollee'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 (SUD/0 patient records: 42 C.F.R Part 2 pertains to federal requirements that apply to all states. While all enrollee data is protected under the HIPAA Privacy Rules, 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 displays all enrollee 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 an enrollee does not consent to share this information, a message displays on the provider portal to indicate that all the enrollee's health information may not be available to all providers.

Enrollee data

Providers must be enrolled with and actively submit enrollee data to the Michigan Care Improvement Registry (MCIR). For more information or to access MCIR, please refer to the **Michigan Care Improvement Registry Website.**

Confidentiality statement

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

Advance directives

Providers have the responsibility to discuss advance medical directives with enrollees aged 18 or older who are of sound mind at the first medical appointment, admission or enrollment. The discussion should be charted in the enrollee's permanent medical record. A copy of the advance directives should be included in the enrollee's medical record inclusive of other mental health directives. Providers will not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive.

The provider should discuss potential medical emergencies with the enrollee and document that discussion in the enrollee's medical record.

PCP responsibilities

PCPs have the following responsibilities:

- Refer enrollees only to participating providers, except in an emergency.
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA providers).
- Submit complete enrollee referral information when applicable and in a timely manner to Humana via electronic means or telephone.
- Ensure that physician services are available to enrollees 24 hours a day, seven days a week, through their assigned PCP.

All Humana enrollees choose or are assigned to a PCP on enrollment in the plan. This means PCPs help coordinate healthcare for the enrollee and provide additional health options to the enrollee for self-care or care from community partners. PCPs also are required to know how to screen and refer enrollees for behavioral health conditions. Please refer to the **Behavioral Health** section of this provider manual for more information.

PCP changes

Enrollees can change their PCP as often as needed. Enrollees initiate the change by calling Member Customer Service at **855-281-6070** available 7 days a week, Oct 1st to March 31st and Monday – Friday, April 1st to September 30th, 8 a.m. – 8 p.m., Eastern time. PCP changes are effective on the first day of the month following the requested change. When enrollees change PCPs, the medical records or copies of medical records should be forwarded to the new PCP. The PCP is required to have enrollees sign a release of medical records before a medical record transfer occurs.

Appointment wait times and access standards and requirements

Humana requires its network providers that are serving HIDE-SNP enrollees to meet CMS and MDHHS standards for timely access to care and services, taking into account the urgency of the need for services, as well as the appointment wait times, specified in 42 CFR §438.68(e). We have adopted service standards regarding the availability of participating provider services. You are expected to maintain these standards as outlined in your contract.

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours a day, seven days a week. An after-hours telephone number must be available to enrollees (voicemail is not permitted). The after-hours coverage must be accessible using the medical office's daytime telephone number. 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, seven days a week coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The PCP must arrange for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services.

The enrollee should have access to care for PCP services and the PCP (or specialists) should submit referrals to the plan so the enrollee can see specialists for medical and behavioral health services available on a timely basis.

Timely access standards

Provider type	Time to appointment standard
Non-urgent symptomatic care	Within 7 business days of request
Routine outpatient mental health and SUD, adult and pediatric	Within 10 business days of request
Routine primary care, adult and pediatric	Within 15 business days of request
Routine obstetrics and gynecological	Within 15 business days of request
Routine specialty care, such as vision and hearing	Within 6 weeks of request
Acute specialty care, such as vision and hearing	Within 5 business days of request
Emergency dental services	Immediately, 24 hours per day, 7 days a week
Urgent dental care	Within 48 hours of request
Routine dental care	Within 21 business days of request
Preventive dental services	Within 6 weeks of request
Initial dental appointment	Within 8 weeks of request

Compliance with availability and accessibility standards is monitored regularly through random appointment availability surveys, review of enrollee grievances and appeals data, and network performance data to ensure enrollees have reasonable access to providers and services.

Provider-based marketing activities

Marketing and promotional activities, including provider promotional activities, must comply with all relevant federal and state laws, including, when applicable, the antikickback statute, which is a civil monetary penalty prohibiting inducements to enrollees.

For purposes of this manual, the term "HIDE-SNP marketing and communication" includes any information, whether oral or written, intended to promote or educate prospective or current Humana HIDE-SNP enrollees about Humana or its HIDE-SNP plans, products or services. This includes, but is not limited to, any and all promotional materials used at provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations and announcements that use Humana's name.

HIDE-SNP marketing and communication must be approved through the Humana corporate review process prior to a provider conducting any HIDE-SNP marketing and communication activity. The Humana corporate review process includes review by legal and regulatory compliance and filing through Humana's HIDE-SNP product compliance department and CMS (as applicable), in accordance with CMS guidelines.

To obtain approved HIDE-SNP marketing or communication materials, contact your Humana representative or to arrange for a provider-sponsored activity, contact the regional HIDE-SNP sales director or physician marketing contact. Any joint (provider and plan) communication or marketing activity must also comply with Humana policies and procedures, as well as federal and state regulations. For applicable Humana policies, please see Humana's compliance policy. Any misrepresentation of a Humana HIDE-SNP product or service, intentional or not, is a serious violation of Humana's agreements with CMS.

You may announce new or continuing affiliations for specific sponsors of HIDE-SNP through direct mail, email, telephone or advertisement using Humana-approved templates. You may not create your own communications for this purpose or alter the templates in any way unless approved through the Humana corporate review process. Humana must review the communication prior to you sending it to ensure that it adheres to the approved template or that the communication has been approved through the Humana corporate review process. The announcement must clearly state that you also may contract with other plans/ Part D sponsors. Any affiliation materials that describe plan benefits, premiums or cost sharing must be approved by Humana and CMS prior to use and may not be mailed by providers, as these would be considered marketing materials for a plan.

Our providers must remain aware of and in compliance with the following requirements:

- You may display health-plan-specific materials in your own offices. You are permitted to make available and/or distribute Humana marketing materials as long as you and/or your facility distribute or make available marketing materials for all managed care plans with which you participate.
- If you agree to make available and/or distribute Humana marketing materials, you should do so knowing you must accept future requests from other plans with whom you participate.
- You also are permitted to display posters or other materials in common areas such as the waiting room.
- Long-term care (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 their needs and potential options to meet those needs, you may do so. You may engage in discussions with enrollees should an enrollee 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 enrollees 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.
- For Humana, 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 enrollees are referred to the Enrollee Services section of the health plan or the state.
- You may refer your enrollees 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 enrollees from the state or CMS website.

You must not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade enrollees to enroll in a particular plan 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/enrollees 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 MI HIDE-SNP enrollees or the membership of any managed care plan to Humana or any other MCO with which you contract.
- Furnish lists of other health plans' membership lists to Humana; nor can you assist with health plan enrollment.

Notification of demographic changes

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

Demographic updates to provider data or group (e.g., service, mailing, billing address changes and demographic updates or providers roster changes)

To initiate demographic or roster updates, please visit the **Humana Provider Application** link via our online form, which includes a list of required documents.

After submission, a confirmation email and tracking number will be provided. A contracting representative will follow up to assist with next steps.

Immediate notification is required for:

- Demographic changes (e.g., telephone, fax, email, or administrative staff changes)
- Name and ownership change (35-day notice)
- New enrollee indicator
- Physical address change
- Tax identification/billing address change (W-9 required)
- Provider added to existing group (The new provider still needs to follow the Join our network process. For more information, please see the **How to join our network** section of this manual.)

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 enrollees, please notify your provider relations representative immediately.

Provider training

As a Humana provider, you are required to complete all necessary training identified within your contract during your initial Humana orientation. 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, as required by Section 6032 of the Federal Deficit Reduction Act of 2005, Humana's contract with the state and/or our compliance program:

- General compliance
- Combating fraud, waste and abuse
- Michigan HIDE-SNP provider orientation training
- Cultural humility, health equity and implicit bias
- Health, safety and welfare (abuse, neglect and exploitation) of enrollees

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 as required by § 6032 of the Federal Deficit Reduction Act of 2005.

Providers and authorized users can access these online training modules 24 hours a day, 7 days a week via **Availity Essentials**. Sign into **Availity Essentials** using your existing user ID and password. If you do not already have access to **Availity Essentials**, your organization's administrator may create a new user for this purpose. Within **Availity Essentials**, the administrator should:

- Once logged into Availity Essentials, click on Payer Spaces → Humana→ Humana Learning Center
- Select the category: Compliance trainings
- Search for the current year training in Michigan (or any state(s) in which you are contracted).

Additional education and trainings are available to you at **Humana.com/HealthyMI** and through our continuing education (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 enrollee 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 health-related social needs (HRSN) of enrollees. This resource guide is available to network providers on the compliance training materials section of the **Humana.com/HealthyMI**, and is designed to support network providers to:

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

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

Provider orientation

The provider relations team will provide you with an initial orientation after you have completed the credentialing process. To ensure you are aware of potential changes in policies and procedures, providers are required to complete provider orientation training annually thereafter. Available provider orientation training sessions will be posted at **Humana.com/HealthyMI**. Please check the link regularly to register you and your staff for available training sessions.

Chapter 5: Enrollee abuse, neglect and exploitation

Definitions of enrollee abuse, neglect and exploitation

According to CMS, abuse occurs when another person does something on purpose that causes another individual mental or physical harm or pain[1]. Neglect occurs when a caretaker does not give a person they care for the goods or services required to avoid harm or illness[2]. Exploitation is the illegal or improper use of an incapacitated or dependent adult or that adult's resources for another's profit or advantage[3]. Please see the Health, Safety and Welfare training on **Humana.com/HealthyMI** 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 enrollee or any other person. Abuse can also include active encouragement by a relative, caregiver or household enrollee 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 an enrollee 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

1. Centers for Medicare & Medicaid Services. (2024). Glossary. **https://www.cms.gov/glossary?term=abuse&items_per_page=10&viewmode=grid**
2. Ibid, **https://www.cms.gov/glossary?term=neglect&items_per_page=10&viewmode=grid**
3. U. S. Department of Justice. (2022). Elder abuse and elder financial exploitation statutes. 22 M.R.S. § 3472. **https://www.justice.gov/elderjustice/prosecutors/statutes#:~:text=%C2%A7%203472.,for%20another%27s%20profit%20or%20advantage**.

- Sexual:
  - Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with a child, an adult with disabilities or any other person.
  - This 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. It may also include ridicule, coercion and threats.
  - 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 enrollee
  - 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 of the necessities of life including, but not limited to, food, clothing, shelter or medical care.

Exploitation

Exploitation refers to the act of utilizing someone or something for personal gain, often in an unfair or unethical manner such as:

- obtains control over the person's funds, assets or property,
- deprives the person of the use, benefit or possession of funds, assets or property (temporary or permanent), or
- uses the person's funds, assets or property for the benefit of someone other than the disabled adult or elderly person.[1]

Exploitation includes:

- Financial exploitation
  - The misuse of or withholding of an individual's funds or assets to the disadvantage of the individual to whom the funds or assets belong or the profit or advantage of a person other than the person to whom the funds or assets belong
- Labor exploitation
  - The forcing an individual to work under unfair conditions or without proper compensation
- Social exploitation:
  - The manipulation or abuse of vulnerable individuals or groups for economic or social benefit, often seen in contexts such as human trafficking or child labor
- Exploitation of older adults or adults with disabilities:
  - The illegal use of assets or resources of an adult with disabilities includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in a manner contrary to law. 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 uses an enrollee's property or funds for the benefit of an individual or individuals other than the enrollee.

1. U. S. Department of Justice. (2022). Elder abuse and elder financial exploitation statutes. 22 M.R.S. § 3472. **https://www.justice.gov/elderjustice/prosecutors/statutes#:~:text=%C2%A7%203472.,for%20another%27s%20profit%20or%20advantage**.

Indicators of enrollee abuse, neglect, and exploitation

Physical

Physical indicator	Description
Unexplained bruises or welts	Bilateral (e.g., matching) bruises on both arms that may indicate the enrollee 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 (e.g., presence of old and new bruises at the same time)
	Wrap-around bruises encircling the enrollee'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, 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 enrollee being brought to different medical facilities for treatment to prevent medical providers from observing patterns Delays between onset of injury and seeking of medical care Inconsistent or conflicting information from family members about how injuries were sustained Injuries healing through secondary intention that indicate the enrollee 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 enrollee's explanation
Other	Abrasions on arms, legs or torse 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 evidence 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	Description
Destructive behavior of victim	Assaults others Destroys belongings of others or themselves Threatens self-harm or suicide Inappropriately displays rage in public Steals without an apparent need for the things stolen Recent or sudden changes in behavior or attitudes
Other behavior of victim	Afraid of being alone Suspicious of other people and extremely afraid others will harm them Shows symptoms of withdrawal, severe hopelessness, helplessness Constantly moves from place to place Frightened of caregiver Overly quiet, passive, timid Denial of problems
Behavior of family or caregiver	Marital or family discord Striking, shoving, beating, name-calling, scapegoating Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible Denial of problems Recent family crisis Inability to handle stress Recent loss of spouse, family member or close friend Alcohol abuse or drug use by family Withholds food, medication Isolates individual from others in the household Lack of physical, facial, eye contact with individual Changes doctor frequently without specific cause History of similar incidents Resentment, jealousy Unrealistic expectations of individual

Neglect

Neglect indicator
Weight loss that cannot be explained by other causes
Lack of toileting that causes incontinence Enrollee 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 enrollee to sign documents the enrollee does not understand
Unpaid bills (despite adequate financial resources, bills remain unpaid by the caregiver or other party)
Lack of affordable amenities for the enrollee, such as personal grooming items or appropriate clothing
New “best friends” who take an interest in the enrollee’s finances
Legal documents, such as powers of attorney, which the enrollee did not understand at the time they signed them
Unusual activity in the enrollee’s bank accounts, including large, unexplained withdrawals, frequent transfers between accounts or other activity the enrollee cannot explain
Caregiver expresses excessive interest in the amount of money being spent on the enrollee
Missing belongings or property
Suspicious signatures on checks or other documents (including signatures not matching the enrollee’s and signatures and other writing by an enrollee who cannot write)
Absence of documentation about financial arrangements
Implausible explanations about the enrollee’s finances from the enrollee or the caregiver
Enrollee 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 enrollee to speak for themselves
See others who could impact an enrollee’s situation without the presence of the enrollee
Have an attitude of indifference or anger toward the enrollee
Blame the enrollee for the enrollee’s condition
Show aggressive behavior toward the enrollee (threaten, insult, harass)

Requirements for reporting abuse, neglect or exploitation

Although the law[4] 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
- Human Rights Advocacy Committee (HRAC) and Long-Term-Care Ombudsman Council (LTCOC) enrollees
- Banks, savings and loan, or credit union officers, trustees or employees

Types of critical incidents

Critical incidents involve any situation that poses a significant risk of serious harm to the physical or mental health, safety or well-being of the enrollee.

Critical incident types are defined below:

- Exploitation is when a person who stands in a position of trust and confidence with an enrollee and knowingly, by deception, intimidation or force uses an enrollee's property or funds for the benefit of an individual or individuals other than the enrollee.
- Illegal activity in the home is any illegal activity in the home that puts the enrollee or the providers coming into the home at risk.
- Neglect is the failure to provide or willful withholding of necessary care, assistance, or supervision or other necessities of life, including, but not limited to, food, clothing, shelter or medical care to an individual, leading to harm or risk of harm.
- Physical abuse is inflicting physical pain or injury, such as hitting, slapping or burning.
- Use of restraints, seclusions or restrictive interventions includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).
- Provider no-show are instances when a provider is scheduled to be at an enrollees home but does not come and a back-up service plan is either not put into effect or fails to get an individual to the enrollee's home in a timely manner.
- Sexual abuse is any sexual contact or behavior, including unwanted touching, fondling, sexual threats and sexually inappropriate remarks, with someone who did not and/or cannot consent.
- Theft is when a person intentionally and fraudulently takes the personal property of another without permission.
- Verbal abuse refers to the intentional verbal infliction of harm, injury or suffering on another person.
- Worker consuming drugs or alcohol on the job is the use of any drugs or alcohol that would affect the abilities of the worker to do his or her job.
- Suspicious or unexpected death is when an enrollees life ends which does not occur as a natural outcome.

4. Laws vary by state.

- Suicide attempt is when the enrollee attempts to end their life.
- Medication errors occur when the wrong medication, wrong dosage, double dosage, or missed dosage is given to an enrollee which resulted in death or loss of limb or function or the risk thereof.

Who can report critical incidents

Critical incidents can be reported by the following:

- Enrollees
- Family members, guardians or friends
- Service provider agencies or vendors
- Care coordinators
- State officials
- Concerned third parties

Mandated reporters

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[5]. 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[6]. The court can then release confidential information without penalty[7].

General reporting questions[8]

- 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 enrollees 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, phone number? (Reporters can report anonymously.)

5. Laws vary by state.
6. Laws vary by state.
7. Laws vary by state.
8. Reporting requirements vary by state.

1. You must also report suspected abuse, neglect or exploitation to the care coordinator participating on the enrollee's interdisciplinary care team.
2. Care coordinators also must report the suspected abuse, neglect or exploitation to Market Compliance for review and applicable state reporting.
3. Care coordinators must follow internal Humana associate reporting procedures as well.

Reporting suspected abuse, neglect, and/or exploitation

Suspected cases of abuse, neglect and/or exploitation must be reported to MDHHS' 24-hour abuse and neglect hotline at **855-444-3911**, which has the responsibility for investigating allegations of abuse, neglect and exploitation. You must also report suspected abuse, neglect or exploitation to the care coordinator participating on the enrollee's interdisciplinary care team. Care coordinators also must report the suspected abuse, neglect or exploitation to the appropriate state agency. Care coordinators must follow internal Humana associate reporting procedures.

Reporting adverse events

Humana's Risk Management Program includes adverse event reporting. An adverse event is an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient, also referred to as a Serious Reportable Event. If you identify an adverse event, you should:

- Report the adverse event to the appropriate entity (e.g., police, adult protective services, etc.).
- Call 911 if the enrollee is in immediate danger.
- Report the adverse event within 24 hours to Humana.
- Report suspected abuse, neglect and exploitation of an enrollee immediately.

Reporting critical incidents

Humana's Risk Management Program also includes a management system for critical incidents that negatively impact the health, safety or welfare of our enrollees. A critical incident is defined as any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of an enrollee, including Adverse Events and Serious Reportable Events as defined by the National Quality Forum. If you determine an enrollee meets the criteria for a critical incident, it must be reported immediately to the enrollee's care coordinator. This could be a Humana associate or one of our contracted vendors or delegates. Once the enrollee's care coordinator is notified of the critical incident, the care coordinator must report it to Humana's risk management department for review and reporting.

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 and SNFs need to report abuse, neglect or exploitation incidents to Humana. Critical incidents involving abuse, neglect or exploitation also must be reported by you to Humana and MDHHS.

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

Chapter 6: Cultural humility, health equity and implicit bias

Importance of health equity and cultural humility in care delivery

In the pursuit of delivering high-quality healthcare, it is essential to recognize and address the diverse cultural backgrounds, experiences, and needs of our enrollees. This chapter focuses on three critical concepts: cultural humility, health equity and implicit bias. Understanding and integrating these principles into care delivery will help provide more equitable and effective care to all enrollees.

Humana recognizes cultural differences and the influence that race, ethnicity, language, gender identity, sexual orientation, disability status, pregnancy status, 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 enrollees and providers. Some disparities may be attributed to miscommunication between providers and enrollees, 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 enrollees.

Cultural competency

Humana supports efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identify; and sex stereotypes. We actively collaborate with MDHHS and our provider partners to develop programs and strategies to implement these goals.

Cultural competency refers to a set of interpersonal skills that promote the delivery of services in a culturally competent manner to all enrollees—including those with LEP, sexual orientation, gender identity, disability status, pregnant, 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 enrollees (as required by 42 C.F.R §438.206).

Subculture is a term that describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture also is an important aspect of cross-culture healthcare.

Our providers are expected to provide services in a culturally competent manner, which includes but is not limited to removing all language barriers to service and accommodating the special needs of the ethnic, cultural, sexual orientation, gender identity, disability status, pregnancy status , and social circumstances of each enrollee. Providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA and the Rehabilitation Act of 1973.

Humana recognizes cultural differences and the influence that race, ethnicity, language, sexual orientation, gender identity, disability status, pregnant status, and socioeconomic status have upon the enrollee 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. Data across 64 measures show significant differences in health outcomes and access to care between people of color and White individuals. The Commonwealth Fund 2024 State Health Disparities Report found that Black enrollees received worse care than White enrollees 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 enrollees and their providers. Some disparities may be attributed to miscommunication between enrollees 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 enrollees.

We offer several initiatives to deliver services to all enrollees regardless of ethnicity, socioeconomic status, sexual orientation, gender identity, disability status, pregnant 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.

To request a printed copy of our cultural humility, health equity and implicit bias plan at no charge, please contact Humana **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time. You may also review your market's cultural competency training via **Humana.com/HealthyMI.**

Cultural competence in a hospital or care system produces numerous benefits for the organization, enrollees and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from enrollees, 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 enrollees understand that cultural factors influence enrollees' 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 enrollees during shared decision making.

Cultural humility

Cultural humility is an ongoing process of self-reflection and self-critique that involves recognizing and addressing power imbalances in healthcare interactions. Unlike cultural competence, which implies a finite level of knowledge, cultural humility emphasizes lifelong learning and openness to understanding different cultural perspectives.

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. 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.

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 brings 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.
- 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 amongst 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

Key practices for cultural humility:

1. **Active listening:** Engage in active listening to understand the unique experiences and needs of each enrollee. This builds trust and fosters effective communication

2. **Self-reflection:** Regularly reflect on your own cultural beliefs, biases, and assumptions. This helps in recognizing how they may impact your interactions with enrollees
3. **Mutual respect:** Approach each interaction with respect for the enrollee's cultural background and lived experiences. This includes being open to learning from the enrollee and valuing their input
   - Learn how to interact with enrollees with varied cultural experiences. Keep an open mind. Remember that each enrollee has a unique set of beliefs and values, and enrollees may not share yours.
   - Ask enrollees 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 enrollees.

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 enrollees 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 enrollees' cultures.

Know what you don't know. You won't be able to learn about every aspect of every enrollee's culture. Don't be afraid to let your enrollees 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 enrollees about their learning preferences so you can present information better during shared decision making. Find out if your enrollees prefer for you to offer materials in print, video or audio format. Ask your enrollees 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 enrollees want you to present information in a variety of ways.

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

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

Implicit bias

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

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

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

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

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

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

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

- Having a basic understanding of the cultures from which your enrollees come.
- Avoid stereotyping your enrollees; individuate them.
- Understanding and respecting the magnitude of unconscious bias.
- Recognizing situations that magnify stereotyping and bias.
- Knowing the national standards for culturally and linguistically appropriate services (CLAS) in health and healthcare (see the **Think Cultural Health website**).
- Performing "teach back" (e.g., the National Patient Safety Foundation's Ask Me 3® educational program).
- Assiduously practicing evidence-based medicine.
- Using techniques to debias enrollee care, which include training (including cultural competency training offered through Humana), intergroup contact, perspective-taking, emotional expression and counter- stereotypical exemplars.

Health equity

Health equity is the elimination of unjust, avoidable and unnecessary barriers in health and healthcare. According to the AHA Institute for Diversity and Health Equity, health equity ensures that every individual has a fair and just chance to attain their best possible health[9]. 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

SDOH are the conditions in the places people live, learn, work, play and worship that can negatively affect health outcomes. Long-standing inequities in six key areas influence a wide range of health and quality-of-life risks and outcomes[10]. 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: Includes 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: Includes 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.
- 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.

9. AHA Institute for Diversity and Health Equity. (2024). Glossary of health equity terms. **https://equity.aha.org/glossary**
10. Healthy People 2030. (2023). Social determinants of health. Office of Disease Prevention and Health Promotion. **https://health.gov/healthypeople/priority-areas/social-determinants-health**

Strategies to promote health equity:

- **Address HRSN:** Identify and address factors such as socioeconomic status, education and access to healthcare that impact health outcomes
- **Community engagement:** Collaborate with community organizations and leaders to understand and address the specific needs of different populations
- **Policy advocacy:** Advocate for policies that promote health equity and reduce disparities. This includes supporting initiatives that improve access to care for underserved communities

Linguistic services

Humana offers several initiatives to deliver services to all enrollees regardless of ethnicity, gender identity, sexual orientation, socioeconomic status, culture and primary language. These include:

- Language assistance services
- Race and ethnicity data collection and analysis
- Internal staff training on cultural humility, health equity, health literacy and implicit bias. All of our clinical associates complete cultural humility and implicit bias training.
- 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 enrollee by calling **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

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

All of our clinical associates complete cultural humility and implicit bias training.

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

Interpreter services

If you are assisting an enrollee who needs interpretive services, please be aware that we provide the following communication services at no cost when the enrollee is interacting with us. You can connect Humana enrollees via the following:

- Over-the-phone interpretation available in 150 languages at all Humana touchpoints
- American Sign Language interpreters (in person or via video)—Call **877-320-2233** to schedule at least 48 hours in advance
- Linguistically trained interpreters for visually impaired customers—Call **877-320-2233** to schedule at least 48 hours in advance

- TTY services—This is voice to text provided by the federal relay service (and no special instructions) and is available at all touchpoints
- Written materials available in languages other than English, and in alternative formats including Braille, audio, large print and accessible PDF, can be requested by you or the enrollee by calling **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time

Chapter 7: Covered services

Providing covered services through our provider network

Humana maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. The full range of covered services include preventive, primary care and specialty services, behavioral health services, other specialty services, and all other services required in 42 CFR §§422.112, 423.120, and 438.206, Medicaid Provider Manual, HIDE-SNP 1915 (b) and (c) waiver applications, and other services as indicated. Through our contracted providers, Humana arranges for medically necessary services for each enrollee. When providing covered services to enrollees, you must adhere to applicable plan coverage provisions and all applicable state and federal laws.

Covered services

Humana provides covered services under current administrative regulations. The scope of services may be enhanced with approval of MDHHS and as necessary to comply with federal mandates and state laws. Humana Dual Integrated offers all Medicare and most Medicaid benefits, including long-term services and supports and Medicaid behavioral health benefits not provided by the regional PIHPs.

As the payer of last resort, Michigan Medicaid only pays for covered services not covered by Medicare or covered in a greater amount, duration, or scope than Medicare. Humana provides an integrated Medicare-Medicaid benefit package to the greatest extent possible. We provide enrollees with a comprehensive, single summary of benefits pursuant to MDHHS guidelines describing all Medicare and Medicaid benefits that enrollees may be eligible to receive upon enrollment in the plan.

In this section, you will find a brief summary of the benefits and services covered by Humana's HIDE-SNP in Michigan for our HIDE-SNP enrollees. This is not a comprehensive list of all services covered for HIDE-SNP enrollees. For a comprehensive list of all services covered, you can check benefits at **Availity Essentials** or call Humana Provider Services at **855-281-6070**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Scope of benefits

Covered service	Limitations, exceptions and additional benefit information
Abdominal aortic aneurysm screening	Humana covers a one-time ultrasound screening for people at risk. Our plan only covers this screening if the enrollee has certain risk factors and if they get a referral for it from their physician, physician assistant, nurse practitioner, or clinical nurse specialist. Prior authorization requirements may apply.
Acupuncture	Humana covers up to 20 visits per calendar year if an enrollee has chronic low back pain, defined as: • Lasting 12 weeks or longer; • Not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory or infectious disease) • Not associated with surgery; and • Not associated with pregnancy Enrollees may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if the enrollee doesn't get better or if they get worse.
Adaptive medical equipment and supplies	Humana covers devices, controls, or appliances that enable enrollees to increase their ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Services might include: • Automated/telephone or watches that assist with medication reminders • Bath aids such as long handle scrubbers • Bath lifts/room lifts • Button hooks or zipper pulls • Exercise items and other therapy items • Heating pads • Jar openers • Lift chairs • Modified eating utensils • Modified grooming tools • Modified oral hygiene aids • Nutritional supplements such as Ensure • Raised toilet seats • Reachers

Covered service	Limitations, exceptions and additional benefit information
	• Sharps containers • Shower chairs/benches • Swivel discs • Telephone aids • Transfer seats • Voice output blood pressure monitor
Alcohol misuse screening and counseling	Humana pays for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If an enrollee screens positive for alcohol misuse, enrollees can get up to 4 brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified PCP or practitioner in a primary care setting.
Ambulance services and other emergency medical transportation	Ambulance services for other cases (non-emergent) must be approved by Humana. In cases that are not emergencies, Humana may pay for an ambulance. The enrollees' condition must be serious enough that other ways of getting to a place of care could risk their life or health. Prior authorization requirements may apply.
Annual Wellness Visit	Enrollees can get an annual preventive visit to establish or update a personalized care plan based on current risk factors. Humana will pay for this once every 12 months and is allowed only after 12 months from "Welcome to Medicare" visit.
Bone mass measurement	Bone mass measurement procedures are covered for eligible patients, typically those at risk for bone loss or osteoporosis. These diagnostic services assess bone mass, bone loss, or bone quality, and are reimbursed once every 24 months, or more frequently if medically necessary. Interpretation by a physician is also covered. Prior authorization requirements may apply.
Breast cancer screening (mammograms)	Humana pay for the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months

Covered service	Limitations, exceptions and additional benefit information
Breast pumps (Medicaid)	**Hospital-grade electric breast pumps** are available through rental only. These are covered for enrollees whose infant is in the neonatal intensive care unit (NICU) for up to 3 months. Coverage also applies if the baby experiences significant feeding difficulties or if either the mother or infant is hospitalized and cannot be together. Extension of coverage beyond the initial 3 months requires submission of additional documentation. **Personal use double electric breast pumps** are covered for purchase once every five years, provided the enrollee meets required criteria. **Manual breast pumps** are covered for purchase once per birth, subject to clinical criteria. In cases of multiple births, only one manual pump will be provided per delivery.
Cardiac rehabilitation services	Humana covers cardiac rehabilitation services such as exercise, education and counseling. Enrollees must meet certain conditions and prior authorization requirements may apply.
Cardiovascular screenings	Humana covers cardiovascular screenings once every five years.
Care coordination services	Care coordination services are provided to all Humana HIDE-SNP enrollees. Care coordination provides a more intensive level of service if the enrollee's health requires it.
Certified nurse-midwife (CNM) services (Medicaid)	Humana covers a wide range of women's and reproductive health services. These services include but are not limited to maternity care, newborn care, gynecological and family planning services.
Cervical and vaginal cancer screening	Coverage includes routine cervical and vaginal cancer screening services: • All women are eligible for a Pap test and pelvic exam every 24 months. • Women at high risk for cervical or vaginal cancer are eligible for one Pap test every 12 months. • Women of childbearing age who have had an abnormal Pap test in the last three years are eligible for one Pap test every 12 months. **Cervical and vaginal cancer screening (Medicaid)** Humana covers outpatient screening services are included as part of or as follow-up to family planning visits. This includes Pap tests and treatment for precancerous conditions, especially those related to sexually transmitted infections (STIs).

Covered service	Limitations, exceptions and additional benefit information
Chiropractic services	Humana covers adjustments of the spine to correct alignment. Prior authorization requirements may apply. **Chiropractic services (Medicaid)** Humana covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. Prior authorization requirements may apply. • Up to 18 chiropractic visits per year; • 1 set of spinal x-rays per year (Subluxation must be demonstratable on x-rays).
Chronic pain management and treatment services	Humana covers monthly services for people living with choric pain (persistent or recurring pain lasting longer than 3 months). Cost sharing for this service will vary depending on individual services provided under the course of treatment.
Colorectal cancer screening	Humana covers a colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at a high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. Computer tomography colonography, flexible sigmoidoscopy, screening fecal-occult blood tests, multitarget stool DNA, blood-based biomarker tests are also covered with certain requirements.
Community Health Worker (CHW) services	CHW's are non-licensed public health providers who facilitate access to needed health and social services for enrollees. CHW services must be recommended by a licensed provider. Conditions that may define an enrollee's eligibility for CHW services include the following: • Diagnosis of one or more chronic health conditions including behavioral health; • Suspected or documented unmet health-related social needs; or • Pregnancy and postpartum.

Covered service	Limitations, exceptions and additional benefit information
Dental services	Humana provides a full range of dental care for both children and adults through DentaQuest, its Medicaid and Medicare Dental Benefits Administrator. Contact **844-870-3977** for information or visit **Dentaquest.com**. Prior authorization requirements may apply. **Dental services (Medicaid)** • Apicoectomy: Covered after at least one root canal procedure and re-treatment has no be successful or is not possible • Complete and partial dentures: 1 every 5 years • Crowns covered once per 5 years on the same tooth • Full mouth debridement: 1 every 365 days – Cannot be done on the same date of service as a comprehensive periodontal evaluation or prophylaxis • Oral prophylaxis: 1 every 6 months – Includes routine scaling and debridement, stain removal and polishing of tooths surface • Periodontal maintenance: 1 every 6 months • Relines or duplications of dentures: Covered after the initial 6 months, once within a 2-year period • Root canals: No limit • Re-treatment of root canals: 1 per tooth per lifetime • Sealants: 1 every 3 years • Includes repair and replacement of the sealant for 3 years • Stainless steels crowns: 1 every 2 years
Depression screening	Humana covers one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.
Diabetes prevention program, screening and self-management training	For all enrollees who have diabetes (insulin and non-insulin users) to help increase healthy behavior. This includes long-term dietary change, increased physical activity and ways to maintain weight loss and a healthy lifestyle. Prior authorization requirements may apply.
Doula services	Humana covers community-based doula services to address many of the drivers of poor maternal and child health outcomes.

Covered service	Limitations, exceptions and additional benefit information
Durable medical equipment and related supplies	Humana covers the following items: • Bone stimulator • Cervical traction (over the door) • Crutches • Dialysis care equipment • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Nebulizers • Oxygen equipment and supplies • Powered mattress systems • Speech generating devices • Standard curved handle or quad cane and replacement supplies • Walkers • Wheelchairs Other items may be covered. Prior authorization requirements may apply.
Emergency care services	Enrollees may use any emergency room if they reasonably believe they need emergency care. They do not need prior authorization, and the hospital does not have to be in-network. If an enrollee receives emergency care at an out-of-network hospital and need inpatient care after their emergency is stabilized, they must move to a network hospital for their care to continue to be paid for. Enrollees can stay in the out-of-network hospital for their inpatient care only if our plan approves their stay. Enrollees are covered for emergency care world-wide. If they have an emergency outside of the U.S. and its territories, enrollees will be responsible to pay for the services rendered upfront.
End Stage Renal Disease (ESRD) services	This benefit is for enrollees who have been diagnosed with ESRD.
Family planning services	Family planning services provide individuals and families with essential healthcare options to delay or prevent pregnancy, ensuring they can make informed reproductive choices. Prior authorization is required for infertility and genetic testing.

Covered service	Limitations, exceptions and additional benefit information
Gender affirmation services (Medicaid)	Humana covers gender affirmation/confirming medical, surgical, and pharmacologic treatments and procedures. Services must be medically necessary for the treatment of clinically diagnosed gender dysphoria.
Group prenatal care services	Humana will pay for group prenatal care services if you have a low-risk pregnancy that doesn't require individual monitoring. You'll be educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception. Group sessions are facilitated by a trained healthcare provider and include others in similar stages of pregnancy. The plan may cover up to 12 total in-person group sessions per pregnancy in addition to the required individual professional maternity visit, if: • The group session is in addition to but doesn't replace the individual prenatal physical assessment visit. • The group session is at least 60 minutes. • The time spent in the group session is documented. One of the 12 group sessions may relate to the postpartum professional visit. Childbirth and Parenting Education (Medicaid) Childbirth and parenting education classes are provided in a group classroom situation. In unusual circumstances (beneficiary entered prenatal care late or is homebound due to a medical condition) education may be provided in the enrollee's home.
Health education	These programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. This plan offers online and printed health education materials and tools, nutrition counseling, and disease management programs

Covered service	Limitations, exceptions and additional benefit information
Hearing services	For Medicare Hearing benefit, see description in the **Mandatory supplemental benefits and enhanced value added benefits** section. **Hearing services (Medicaid)** Humana covers the following hearing services: • Hearing aids are covered when the enrollee has not received a Medicaid covered hearing aid(s) within the last 5 years. A manufacturer's warranty of 24 months covering parts and labor and a 12-month warranty covering loss or damage are included. • Hearing aid repairs and modifications • Replacement earmolds: Once every 12 months; after the 90-day dispensing period • Hearing aid supplies and accessories • Replacement of hearing aid batteries: Up to 36 batteries per hearing aid per date of services. Maximum of 72 batteries per aid per year • Assistive listening devices (ALDs): Covered when Medicaid has not covered any hearing aid(s) or ALD dispensed to the enrollee within the last 3 years • Cochlear implants: Covered for enrollees with pre or post-lingual deafness who meet the implantation criteria • Bone anchored hearing devices (BAHD): Implantable or non-implantable BAHDs when there is no other suitable aid
HIV screening	Humana covers one HIV screening exam every 12 months for people who ask for an HIV screening or are at increased risk for HIV infection.
Home and community-based (HCBS) services (Medicaid)	Humana covers HCBS. Prior authorization and/or referral may be required. Waiver may be required. For more information, please see the **LTSS covered services** section of this manual.
Home health agency care	Humana covers home health services, including nursing care, rehabilitation therapies and home aide services. Prior to receiving home health services, a provider must certify that the enrollee needs home health services and will order home health services to be provided by a home health agency. The enrollee must be homebound. Prior authorization requirements may apply.
Hospice care	Enrollees have the right to elect hospice if a provider and hospice medical director determine an enrollee has a terminal prognosis. Enrollees can get care from any hospice program certified by Medicare.

Covered service	Limitations, exceptions and additional benefit information
Housing assistance (Medicaid)	Humana covers up to $500 per enrollee per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water or gas (late payment notice required) • Trailer Park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority
Immunizations	Humana covers the following vaccines but not limited to pneumonia vaccine, flu/influenza shots, hepatitis B vaccine if an enrollee are at high or intermediate risk of getting hepatitis B, COVID-19 vaccine, other vaccines if they are at risk and they meet Medicare Part B coverage rules and other vaccines that meet the Medicare Part D coverage rules. Medicaid vaccines and immunizations are covered when given according to Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations. **Vaccines and Immunizations (Medicaid)** Humana covers vaccines and immunizations when given according to the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations. This includes ACIP recommendations based on risk due to health condition, occupation, and travel. Vaccines and immunizations can be administered by providers and/or pharmacists.
Inpatient hospital care	Humana covers semi-private rooms, meals, general nursing, drugs (including methadone to treat an opioid use disorder), and other hospital services and supplies as part of the enrollee's inpatient treatment. Prior authorization requirements may apply.
Inpatient services in a psychiatric hospital	Humana covers inpatient hospital care for psychiatric care in inpatient psychiatric facilities. Humana covers other mental health care services not covered by PIHPs that require a hospital stay. Prior authorization requirements may apply.
Intermittent or short-term restorative or rehabilitative services, in a nursing facility	Humana may cover respite care services on a short-term, intermittent basis to relieve family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Prior authorization and/or referral may be required. Waiver may be required.

Covered service	Limitations, exceptions and additional benefit information
Kidney disease services and supplies	Generally, Humana covers 3 dialysis treatments (or equivalent continuous ambulatory peritoneal dialysis) per week if an enrollee has end-stage renal disease (ESRD). This includes renal dialysis drugs and biological products, laboratory tests, home dialysis training, support services, equipment and supplies. Prior authorization requirements may apply.
Lung cancer screening with low dose computed tomography (LDCT)	Our plan pays for lung cancer screening every 12 months if an enrollee: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years Prior authorization requirements may apply.
Long-term acute care hospital services (LTACH) (Medicaid)	Long-term acute care hospital services (LTACH) generally provide services like (but not limited to) respiratory therapy, head trauma treatment, and pain management. Enrollee must meet level of care requirements. .
Maternal and Infant Health Program (MIHP) services (Medicaid)	MIHP services are available for enrollees up to 12 months postpartum. • Psychosocial and nutritional assessments • Plan of care development • Professional intervention services • Maternal and infant health and nutrition education • Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments • Referral to community services (e.g., mental health, substance abuse) • Coordination with other medical care providers • Family Planning education and referral • Coordinating or providing childbirth or parenting education classes • Lactation support services

Covered service	Limitations, exceptions and additional benefit information
Meals – Day trip reimbursement/ allowance (Medicaid)	Humana covers medically necessary overnight stays that include meals and lodging. • Covered for up to 14 consecutive nights (medically necessary stays beyond limits need prior approval) • 1 medically necessary attendant • Meals must meet one of the following: – For breakfast: The vehicle must depart before 6:00 AM and must return after 8:30 AM. – For lunch: The vehicle must depart before 11:30 AM and must return after 2:00 PM. – For dinner: The vehicle must depart before 5:30 PM and must return after 8:00 PM. • Meal reimbursement requires itemized, unaltered receipts which must include the business name, address, date, time, and itemized list of items purchased with cost of each item. • Meals must be purchased and consumed on the day and within the time of travel
Medical nutrition therapy	This benefit is for enrollees who have diabetes or kidney disease, or if they had a kidney transplant in the last 36 months and a doctor refers them for services.
Medicare Part B drugs	Part B drugs include drugs given in a provider's office, some oral cancer drugs and some drugs used with certain medical equipment. Please see the **pharmacy** section of this manual for more information.
Michigan Diabetes Prevention Program (MiDPP)	Humana covers 28 structured health behavior change on-hour sessions provided by a Medicaid-enrolled lifestyle coach for enrollees who are: • Overweight or obese as defined by body mass index (BMI) and has one of the following: – Elevated blood glucose levels according to CDC standards for blood glucose level requirements – History of gestational diabetes mellitus – Score at "high risk" on the CDC prediabetes risk test – An enrollee with previously diagnosed type 1 or type 2 diabetes or who's currently pregnant can't enroll in MiDPP

Covered service	Limitations, exceptions and additional benefit information
Non-emergency medical transportation (NEMT)	For Medicare NEMT benefit, see description in **Mandatory supplements benefits and enhanced value added benefits** section of this manual. **Non-emergency medical transportation (NEMT) (Medicaid)** Enrollees are covered for 48 one-way, non-emergency trips to plan-approved locations within the plan service area per calendar year. There is a maximum allowed travel distance of 50 miles per trip. Please contact Member Services for information on how to arrange transportation. Member Services will confirm their benefits and guide them to the transportation provider to plan an enrollee's trip. Enrollees must schedule trips with the transportation provider at least 72 hours (3 business days) in advance of their appointment.
Nursing facility care	Humana provides coverage for nursing home care including custodial care, skilled nursing and rehabilitation services and mental health monitoring. Prior authorization requirements may apply. **Nursing facility mental health monitoring (Medicaid)** Humana covers follow-up treatment in response to emerging problems or needs of a nursing facility resident. This service is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the enrollee. **Nursing facility services – Institutions for mental diseases (Medicaid)** Covered for enrollees age 65 and older. • Bed and board, including a private room, if medically necessary, and special dietary services • Nursing care, other medical services related to nursing care, and use of equipment that is owned by the facility and is ordinarily provided in the care and treatment of the patient • Specialized nursing services for patients who have been determined to be mentally ill and have other infirmities requiring nursing care • Routine physical therapy, occupational therapy and speech pathology consisting of repetitive services required to maintain function

Covered service	Limitations, exceptions and additional benefit information
Obesity screening and therapy	Humana covers weight management counseling. Counseling must be given in a primary care setting. **Weight reduction services (Medicaid)** Weight loss surgery will be covered for the treatment of obesity in enrollees with a Body Mass Index (BMI) greater than 40 kg/m², or a BMI 35 kg/m² and 40 kg/m² with at least one co-morbid condition. Treatment for obesity includes but is not limited to: • Physician office visits • Pharmacotherapy • Laboratory • Behavioral health • Surgical interventions – Gastric bypass, gastric bond, sleeve gastrectomy, removal, revision, and/or replacement of adjustable gastric restrictive devices, and subcutaneous port components and repeat procedures
Outpatient diagnostic procedures, labs, tests, imaging, surgery, including observation	Unless the provider has written an order to admit the enrollee as an inpatient to the hospital, the enrollee is an outpatient. Even if the enrollee stays in the hospital overnight, they might still be considered an outpatient. Prior authorization requirements may apply.
Outpatient rehabilitation services	Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices and CORFs. Prior authorization requirements may apply.
Outpatient substance use disorder services	Humana covers Opioid Treatment Program services.
Out-of-state services	Humana covers out-of-state services that are authorized by Humana. Prior authorization requirements may apply.
Partial hospitalization services	Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. Medicaid specialty behavioral health services are provided by regional PIHPs or community mental health services providers (CMHSPs)
Personal care services	Humana will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) but only when there's also a need for an ADL.

Covered service	Limitations, exceptions and additional benefit information
Preventive care	There is no coinsurance, copayment or deductible for enrollees eligible for Medicare-covered preventive services. Humana also covers preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS. Prior authorization requirements may apply.
Podiatry services	Humana covers yearly foot exams or treatment. Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for enrollees with certain medical conditions affecting the lower limbs Prior authorization requirements may apply. **Podiatry services (Medicaid)** • Routine foot care when medically necessary • Debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection Prior authorization requirements may apply.
Prostate cancer screening exams	For men aged 50 and over, Humana covers for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test
Prosthetic and orthotic devices and related supplies	Humana covers some supplies related to prosthetic and orthotic devices. Humana also covers to repair or replace prosthetic and orthotic devices. Prosthetic devices that replace all or part of a body part or function. Prior authorization requirements may apply.
Respite care	Enrollees might be eligible for respite care services on a short-term intermittent basis. Prior authorization requirements may apply.
Service animal stipend (Medicaid)	Humana will pay up to $20 per month for maintenance costs of a service animal if: • An enrollee is receiving personal care services, and • An enrollee is certified as disabled due to a specific condition defined by the ADA, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, and • The service animal is trained to meet an enrollee's specific needs relative to their disability, and • The enrollee's service plan must document that the service animal will be used primarily to meet their personal care needs.

Covered service	Limitations, exceptions and additional benefit information
Sexually transmitted infections (STIs) screening and counseling	Prior authorization and criteria requirements may apply. **Sexually transmitted infections treatment (Medicaid)** Outpatient services that include but are not limited to: • Diagnostic procedures, drugs, and follow-up visits to treat an STI or STI-related disorder • PAP screens and treatment for pre-cancerous conditions which commonly originate from a sexually transmitted infection (STI) Family planning-related preventive services recommended by the United States Preventive Services Task Force (USPSTF), and vaccines to prevent STIs
Skilled nursing facility (SNF) care	Humana provides coverage for skilled and intermediate nursing facility care. Enrollees are covered for up to 100 medically necessary days per benefit period.
Smoking and tobacco use cessation	Humana covers 2 quit attempts in a 12-month period as a preventive service. **Tobacco cessation counseling (Medicaid)** Individual tobacco cessation counseling/coaching in conjunction with tobacco cessation, medication or without medication. • 4 counseling sessions per quit attempt; • 2 quit attempts per 12 month period (8 per year); • No limitations for pregnant women. • Non-nicotine prescription medications • Prescription inhalers and nasal sprays • The following over-the-counter agents: – Patch – Gum – Lozenge • Combination therapy – the use of a combination of medications, including but not limited to the following combinations: – Long-term (14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray) • Nicotine patch and inhaler • Nicotine patch and bupropion SR

Covered service	Limitations, exceptions and additional benefit information
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	Humana covers SET for enrollees with symptomatic PAD who have a referral for PAD from the physician responsible for PAD treatment.
Therapies (speech, language, physical, occupational, family, individual, group, and therapies to support activities of daily living)	Humana covers therapies (speech, language, physical, occupational, family, individual, group, and therapies to support activities of daily living) excluding therapies billed through PIHPs, including therapy provided to persons with intellectual and/or development disabilities (I/DD) or provided by Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts
Transplant services	In some cases, Humana covers the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. Prior authorization requirements may apply.
Urgent care	Urgently needed services are not emergency care. Enrollees do not need prior authorization and the urgent care center does not have to be in-network.
"Welcome to Medicare" Preventive Visit	Humana covers the Welcome to Medicare preventive visit only within the first 12 months the enrollee has Medicare Part B. The visit includes a review of an enrollees medical and social history related to their health. It also includes education and counseling about preventive services, including certain screenings, shots or vaccines (like flu, pneumococcal, and other recommended shots or vaccines), and referrals for other care, if needed.
Wheelchairs, crutches, walkers, nebulizers, oxygen equipment and supplies	Humana provides coverage for wheelchairs, crutches and walkers, as well as a wide range of other DME items. DME coverage is based on medical necessity and has no maximum benefit limits. Humana covers all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for the enrollee. The most recent list of suppliers is available on our website at **Humana.com/FindADoctor**. Prior authorization requirements may apply.

Mandatory supplemental benefits and enhanced value added benefits

In addition to covered services, Humana Medicare-enrolled enrollees have access to mandatory supplemental benefits and Humana Medicaid-enrolled enrollees have access to enhanced value added benefits. HIDE-SNP enrollees have access to both enhanced value added benefits and

mandatory supplemental benefits. Humana offers enrollees extra benefits and tools (at no cost to the enrollee) that are not otherwise covered or that exceed limits outlined by the MDHHS. These supplemental and enhanced benefits are more than the amount, duration and scope of covered benefits listed in this manual. Supplemental benefits included in Humana's Medicare Advantage plan that overlap with Medicaid state plan or waiver benefits are first adjudicated by Humana as claims for services under the Medicare supplemental benefit before treating such services as Medicaid-covered. In instances when the Medicaid limit for a service exceeds the Medicare limit for the same service, Humana covers the service up to the Medicaid limit.

For a full list of the enhanced benefits and mandatory supplemental benefits offered to Humana HIDE-SNP enrollees, call Humana Provider Services at **855-281-6070**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

For a list of some of the enhanced benefits and mandatory supplemental benefits offered to Humana HIDE-SNP enrollees, please see the table below. Please note that this may not be an exhaustive list.

Benefit	Covered by	Description
Dental services	Medicare	In addition, to the covered dental services, Humana covers mandatory supplemental dental benefits which include preventive and diagnostic services. Contact **844-870-3977** for information or visit **Dentaquest.com**.
Fall prevention kit	Medicaid clinical program	Enrollees who are at risk for falls may receive a fall prevention kit once per lifetime. Enrollees must reside in a home and/or community-based setting and Humana care coordinator approval required.
Go365 by Humana	Medicare	Please see **Go365** section of this manual for more information.
Hearing services	Medicare	Humana will cover routine hearing exams up to 1 per year and follow-up provider visits up to unlimited per year. Up to 2 TruHearing-branded prescription hearing aids every 3 years (1 per ear every 3 years). Benefit is limited to the TruHearing Advanced prescription hearing aids, which come in various styles and colors. Note: Includes 80 batteries per aid and 3 year warranty. Enrollees must see a TruHearing provider to use this benefit. Enrollees should visit **https://www.truhearing.com/Humana/** for more information.
HMO Travel Benefit	Medicare	Covered services must be provided by providers within the national Medicare HMO or SNP network. If an enrollee is planning to travel outside of their service area and anticipates needing to use the HMO Travel Benefit, it is recommended that they notify their PCP.

Benefit	Covered by	Description
Housing assistance	Medicaid	Up to $500 per enrollee per year (unused allowance does not roll over to the next year) to assist with specified housing expenses. For more information about the eligibility requirements, please contact Humana Provider Services at **855-281-6070**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.
Medicare benefit: Meal benefit	Medicare	**Medicare benefit:** Humana Well Dine® meal program. After enrollee's inpatient stay in either a hospital or a nursing facility, enrollees may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 days of discharge from your inpatient stay. Limited to 4 times per year. Enrollees must use Mom's Meals for this service. If they choose to use another provider for meals, they are responsible for all charges.
Medically tailored meals	Medicaid clinical program	Up to 3 home-delivered meals per day for 12 weeks for enrollees living with congestive heart failure and/or diabetes. Humana care coordinator approval required. **Note:** The Medicare benefit must be exhausted before the enrollee can use the Medicaid benefit.
Medicare benefit: non-emergency medical transportation	Medicare	**Medicare benefit:** For plan approved location up to 48 one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle. • This benefit is not to exceed 50 miles per trip. For plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for enrollees with a chronic kidney disease (CKD), ESRD or cancer diagnosis. • This benefit is not to exceed 50 miles per trip.
Non-medical transportation	Medicaid	Up to 15 round trips (or 30 one-way trips) up to 30 miles for non-medical 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 enrollees such as community and neighborhood centers, parks, recreation areas and churches.

Benefit	Covered by	Description
Over the counter (OTC) + Healthy Options Allowance	Medicare	$245 monthly allowance on a prepaid spending card. All plan enrollees receive this amount to buy approved OTC health and wellness products at participating retailers or through the plan's approved OTC mail order vendor. Plus, enrollees may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria. Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first.
Personal Emergency Response System (PERS)	Medicaid clinical program	$0 copayment for a personal help button. Enrollees must be at a high risk for falls. Enrollees must reside in a home and/or community-based setting and Humana care coordinator approval required.
SilverSneakers® fitness program	Medicare	Basic fitness center membership including in-person and digital fitness classes. Enrollees can go to **SilverSneakers.com** to learn more about their benefit.
Smoking Cessation (additional benefit)	Medicare	Additional sessions of smoking and tobacco cessation counseling up to 4 per year. The in-network provider must be used for this service. If enrollees choose to use another provider for this benefit, they are responsible for all charges.
Vision services	Medicare	• Routine vision exam up to 1 per year. • $400 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.
Wigs (related to chemotherapy treatment)	Medicare	Humana covers wigs (for hair loss related to chemotherapy) up to a $500 maximum benefit per year.

Emergency services

Humana covers and pays for emergency services until an enrollee is stabilized regardless of whether the provider that furnishes the service is in or out-of-network. Humana covers out of area emergency services. Humana providers are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. If an enrollee is experiencing an emergency, they should call 911 for help or go

to the closest ER or any other emergency setting when they are experiencing an emergency medical condition such as acute symptoms of sufficient severity (including severe pain).

Humana will not deny payment when a Humana representative instructs an enrollee to seek emergency services or when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified by the definition of "emergency medical condition." If the ER physician treating the enrollee determines that the visit is not an emergency, the enrollee will be given the choice to stay and receive medical treatment. Humana will cover the emergency up until the attending emergency physician, or the provider treating the enrollee, is sufficiently stabilized for transfer or discharge.

The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on Humana if:

- Such transfer or discharge order is consistent with generally accepted principles of professional medical practice
- Is a covered service

Humana does not:

- Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms
- Refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the enrollee's PCP, Humana, or MDHHS of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the enrollee.

Transplant services

Humana covers appropriate cost sharing for Medicare-covered costs associated with transplant surgery and care. Related care may include, but is not limited to:

d. Organ procurement
e. Donor searching and typing
f. Harvesting of organs
g. Related donor medical costs

Humana also covers appropriate cost sharing for Medicare-covered extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, small bowel, and bone marrow including allogenic, autologous, and peripheral stem cell harvesting) on a patient-specific basis when determined to be medically necessary according to currently accepted standards of care. If a transplant service is not covered by Medicare but is covered by Medicaid, Medicaid will be the primary payer.

Go365 by Humana wellness and rewards program

Go365 by Humana® is a well-being and rewards program available to our HIDE-SNP enrollees. Go365 rewards enrollees for completing healthy activities, including getting preventive screenings, staying active and participating in community events. Rewards can be redeemed for gift cards in the Go365 Mall to help with everyday living expenses and other well-being related purchases. Enrollees also have access to our libraries of expert-led online courses and podcasts on topics such as nutrition and cooking, heart health, diabetes management and on-demand fitness classes.*

Getting started

Enrollees with a **MyHumana account** can use the same information to log in to **Go365.com**. If an account is not currently set up, they can activate their profile at **MyHumana.com**. Once logged in to Go365, they'll see eligible activities they can complete to earn rewards, and details on how to track their actions.

Please view the chart below for a complete list of rewards.

Preventive activities	**Reward value**
Annual wellness visit	$25
Bone density screening	$20
Colorectal screening	$55
Diabetic bundle: (complete all 4 screenings for reward) Kidney urine test, kidney blood test, hemoglobin HbA1c test, diabetic eye exam	$40
Flu vaccination	$5
Health Risk Assessment (HRA)	$10
Mammogram	$30
Medication usage survey	$10
Connect and learn activities	**Reward value**
Enroll and onboard for new enrollees and returning enrollees who register online for the first time, attend Humana QMAC meeting, or update communication preferences	$5 per activity, $10 annual maximum
Complete a health education course provided by Go365 or an external provider (e.g. elder care, fall prevention, diabetes, preventive screenings, addiction/sobriety)	
Complete a mental health activity on **Go365.com**	

Exercise and fitness activities	Reward value
Complete a minimum of 12 activities per month via compatible tracker or fitness device. Includes mobility exercises, strength training, steps, Zumba, yoga, stretching.	$5 once per month, 12 times per year, $60 annual maximum

If enrollees have questions about the Go365 program, they can call the number on the back of their Humana ID card. If an enrollee disenrolls from a Humana HIDE-SNP and enrolls with another MCO, their Go365 rewards will be forfeited. If an enrollee leaves a Humana HIDE-SNP and enrolls with a Humana Medicaid plan that includes Go365, they can call the number on the back of their Humana ID card within 90 days of their plan end date to redeem any remaining rewards.

Humana Wellness Coaching

Humana's Wellness Coaching program provides enrollees with 1:1 support to achieve their health and well-being goals. Participants choose an area of focus and work with their coach to create a personalized action plan to achieve their goal. Areas of focus may include quitting tobacco, managing weight, eating better and reducing stress.

Our National Board-Certified Health and Wellness Coaches are experts in helping people who want to improve their lives and are ready to get started on a path to better health.

More information is available on **Go365.com**. Or, to get started, enrollees can call **877-240-4588 (TTY: 711)** Monday – Friday, 8 a.m. - 7 p.m., Eastern time.

Services not covered

Certain services are excluded from Humana's HIDE-SNP. These include:

- Behavioral health, intellectual/developmental disabilities services and supports, and substance use services covered by the PIHP and services set forth in Section 3.13. are excluded under this plan. Humana will coordinate Medicaid behavioral health services with other covered services and you may be asked to participate in an enrollee's interdisciplinary care team.
- Community transition services (CTS) are excluded from our HIDE-SNP. Humana is responsible for making referrals to the CTS program when an enrollee meets program criteria as defined in the CTS.

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 Michigan providers in the delivery of these services to enrollees. You may access information related to these excluded service programs from MDHHS to aid in the coordination of services.

The following services are excluded under Medicaid:

- Elective cosmetic surgery
- Services for treatment of infertility

- Experimental/investigational drugs, biological agents, procedures devices or equipment
- Elective abortions and related services
- Abortions may be covered if 1 of the following conditions are met:
  - A physician certifies that the abortion is medically necessary to save the life of the mother
  - The pregnancy is a result of rape or incest
  - Treatment is for medical complications occurring as a result of an elective abortion
  - Treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy
  - All appropriate forms relating to abortion must be completed by the designated party and Humana must retain these forms for 10 years. The appropriate forms must also be submitted to MDHHS annually and prior to reimbursement.
- Behavioral health, intellectual/developmental disabilities services and supports, and substance use services covered by the PIHP
  - Humana is responsible for coordinating Medicaid behavioral health services with other covered services and participation in the interdisciplinary care team.
  - Humana provides all behavioral health services not provided by the PIHPs.
  - Humana may provide services through contracts with PIHPs, CMHSP providers, or contracts with other appropriate Medicaid Network Providers.
  - Medicaid specialty services including behavioral health, intellectual/developmental disabilities services and supports, and substance use services must be provided by the PIHP.
  - Humana is responsible for making referrals to the CTS program when an enrollee meets program criteria as defined in the CTS chapter of the Michigan Medicaid Provider Manual.

Chapter 8: Behavioral health

Behavioral health overview

Under Michigan's HIDE-SNP program, behavioral health and SUD services are managed through a combination of PIHPs and Humana. PIHPs manage Medicaid specialty services consistent with Michigan's 1115 Behavioral Health Waiver, which include mental health and substance use services for Medicaid-eligible individuals who have a need for behavioral health, intellectual/developmental disabilities services, and supports and substance use services. Humana is responsible for covering all covered behavioral health services not provided by PIHPs.

To help providers, health plans and enrollees understand these benefits, MDHHS provides a benefit grid, the **Medicaid Behavioral Health and SUD Authorization and Payment Responsibility Grid**, that includes details about the types of covered services and who is responsible for reimbursement of the services.

The Medicaid Behavioral Health and SUD Authorization and Payment Responsibility Grid currently delineates coverage responsibilities based on the setting in which the service is provided but will be modified to delineate responsibility based on enrollees' needs. The following provides a summary of the information found in this Grid but please consult the Grid for the most current and accurate information.

Humana's responsibility: In general, services provided in outpatient offices (FQHCs/RHCs/THCs, physician offices, psychiatrists, psychologists, social workers). Services provided in medical emergency departments are Humana's responsibility or responsibility is mixed between Humana or MDHHS through FFS reimbursement.

PIHP responsibility: Services provided in mental health crisis centers, outpatient behavioral health (crisis) residential centers, outpatient substance abuse office, residential substance abuse center or sub-acute detox center including OTPs. In addition, inpatient psychiatric hospital services (excluding state psychiatric hospital services) are generally reimbursed by PIHPs.

Services provided in nursing facilities may be reimbursed by PIHPs or Humana dependent upon factors such as enrollment and the Preadmission Screening and Annual Resident Review results.

Emergency care

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

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

Provider coordination for behavioral health

Humana and Michigan's PIHPs such as Detroit Wayne Integrated Health Network (DWIHN). are responsible for coordinating enrollees' behavioral health care for mutually served enrollees. Shared responsibilities will include:

- Collaborate with enrollees' PCPs
- Participate in integrated care teams (ICTs)
- Referrals

Network providers are required to coordinate care when Humana enrollees are experiencing behavioral health conditions that require ongoing care. In the best interest of our enrollees and to promote positive healthcare outcomes, Humana supports and encourages continuity of care and coordination of care between medical and behavioral health providers. Providers may contact Humana to refer enrollees in need of behavioral health SUD care coordination assistance by calling Care Coordination at **877-264-2547** Monday – Friday, 9 a.m. –6 p.m., Eastern time.

Referral procedures

Humana and the PIHPs have agreed to processes for referrals. These include:

- The PIHP shall exercise reasonable efforts to assist mutually served enrollees in understanding the role of Humana and how to contact Humana.
- Humana shall exercise reasonable efforts to assist mutually served enrollees in understanding the role of the PIHP and how to contact the PIHP.
- PIHPs and Humana shall both encourage and maintain plan-to-plan and plan-to-PCP communications and collaborations.
- Humana and PIHPs will exercise reasonable efforts to rapidly determine and provide the appropriate type, amount, scope, and duration of medically necessary services.
- Humana will make a referral to the PIHP for an assessment for SUD, behavioral health needs, or I/DD needs, as quickly as the mutually served enrollee's needs require, and no longer than within 5 calendar days from the date the need for an assessment was identified and in accordance with the requirements of Humana's contract with MDHHS.

- The PIHP must make best efforts to conduct necessary behavioral health assessments, as quickly as the mutually served enrollee's needs require, in accordance with the requirements of the PIHP's contract with MDHHS, and no longer than within 15 calendar days of receiving a referral from a HIDE-SNP.
- When making a referral to a PIHP or it's subcontractor(s), Humana will communicate with the PIHP who is receiving the referral to let them know they are about to refer the mutually served enrollee. The PIHP team should be supplied with the relevant background information, including any SDOH screening, and should have the necessary expertise to assist the mutually served enrollee.
- Humana and PIHPs agree to track referrals and conduct further outreach to mutually served enrollees, and/or Humana and the PIHP, or their contracted behavioral health providers, if necessary.
- Humana and the PIHP shall develop, provide, and update specific written behavioral health referral processes and contacts. Humana and PIHPs shall develop and maintain processes for multi-lateral referral tracking and service access metrics.

If you have questions regarding these processes, please contact Provider Services at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Primary care provider expectations

PCPs are required to:

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

Humana assists with referrals, scheduling appointments and coordinating an integrated approach to the enrollee's health and well-being by coordinating care between behavioral health providers, PCPs and specialists.

Chapter 9: Care coordination

Our approach to care coordination

Humana's care coordination 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 HRSN. We implement an integrated, personal approach, supporting enrollees from their initial assessment through the continuum of care with the goal of enrollees taking an active part in their healthcare and making healthy lifestyle decisions. We take a person-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 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 care coordination 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. You can do this by accepting and attending invitations to participate in ICT meetings. We believe communication and coordination are integral to ensure the best care for our enrollees. Please contact Care Coordination at **877-264-2547** Monday – Friday, 9 a.m. –6 p.m., Eastern time for care coordination referrals and assistance with enrollee needs.

Model of care

Humana's model of care includes, but is not limited to, the following elements:

- Provide the full scope of care coordination services for all enrollees and care coordination for select populations as defined by MDHHS and other enrollees identified by Humana based on their level of need and risk
- Identify, assess, and stratify enrollees with ongoing, emerging and changing needs for care coordination at various intensity levels
- Include comprehensive health risk assessments, individualized care planning, and interdisciplinary care team involvement for enrollees receiving care coordination services
- Integrate physical health, behavioral health, pharmacy, LTSS and social service needs into the approach to the provision of care coordination services

- Be responsive to the enrollee's needs and preferences and take into account the enrollee's health, safety and welfare
- Include staff and provider network training (in conjunction with MDHHS whenever possible) on the model of care to ensure enrollees receive person-centered, culturally competent care through trained care coordinators
- Include processes and systems of care that engage enrollees and family members in person-centered, culturally competent care and ensure seamless transitions between levels of care and care settings, addressing all barriers to accessing appropriate services to support enrollee health.

As provided under section 1859(f)(7) of the Social Security Act, every SNP, including HIDE-SNPs, must have a model of care (MOC) approved by the NCQA. The MOC provides the basic framework under which each SNP will meet patient needs. It serves as the foundation for promoting SNP quality, care management and care coordination processes.

- Humana's MOC has four goals:
  - To improve enrollee outcomes by coordinating care and ensuring care transitions
  - To improve enrollee access to and utilization of services and benefits
  - To increase enrollees' satisfaction with their healthcare experience and health status
  - To ensure cost-effective service delivery
- Humana achieves these goals by:
  - Conducting HRAs to identify risk needs
  - Developing a plan of care to address identified needs
  - Providing access to an interdisciplinary care team

All contracted providers serving HIDE-SNP enrollees must review and attest to our HIDE-SNP Training for Physicians, which includes information on our MOC. To access the training and obtain additional information about the model, please refer to **Humana.com/ProviderCompliance.** More information about our Michigan HIDE-SNP model of care is also provided throughout this chapter.

Humana care coordinator responsibilities

All enrollees are eligible for care coordination and have an assigned care coordinator based on level of needs and risk as well as enrollee preference. Humana care coordinator responsibilities include conducting the HRA, assuring the person-centered planning process is completed, preparing the individualized care plan, coordinating care transitions, and leading the ICT. Humana care coordinators are also responsible for the following activities, which may not be delegated to other individuals unless specified. For activities that may be delegated, the Humana care coordinator supervises the activity and is informed of the activity for the purpose of enrollee and provider communications, including ICT discussions. Activities include:

- Support an ongoing person-centered planning process
- Assess clinical risk and needs including HRSN and the impact of SDOH by conducting an

assessment process that includes a HRA and completion of or referral for additional assessments (as appropriate)

- Facilitate timely access to all Medicare- and Medicaid-covered services including, but not limited to, primary care, specialty care, LTSS, behavioral health, SUD, and I/DD services, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers or referrals to the PIHP (scheduling appointments or transportation may be delegated)
- Make referrals to address any physical or cognitive barriers or referrals to the PIHP
- Create and maintain an electronic enrollee health record for each enrollee to manage communication and information regarding referrals, transitions, and care delivery
- Facilitate communication among the enrollee's providers through the use of the Care Coordination Platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence (may be delegated)
- Ensure that the ICT is notified of the enrollee's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable
- Facilitate face-to-face and in-person meetings, conference calls, and other activities of the ICT as needed or requested by the enrollee
- Facilitate direct communication between the provider and the enrollee or the enrollee's authorized representative and/or family or informal supports as appropriate (may be delegated)
- Facilitate enrollee and family education
- Coordinate and communicate, as applicable, with First Tier Downstream and Related Entities (FDR) and other external entities that provide services and supports to the enrollee to ensure timely, non-duplicative supports and services are provided
- Develop, with the enrollee and ICT, following the person-centered planning process, an ICP specific to individual needs and preferences, and monitor and update the ICP at least annually or following a significant change in needs or other factors
- Facilitate referrals to community resources (e.g., housing, food, energy assistance programs) to meet ICP goals (may be delegated)
- Perform ongoing care coordination
- Monitor the implementation of the ICP with the enrollee, including facilitating the enrollee's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up
- Advocate with or on behalf of the enrollee as needed, to ensure successful implementation of the ICP
- Support transitions in care when the enrollee moves between care settings (please see the **Discharge planning** section of this provider manual for additional details)

- Engage in other activities or services needed to assist the enrollee in optimizing their health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status
- Assist with the timely completion of the Medicaid eligibility redetermination process to prevent the loss of benefits (may be delegated)
- Ensure appropriate assessments are conducted for enrollees with identified LTSS needs and collaborate with the applicable PIHP coordinator or identified behavioral health representative
- If the enrollee has need of LTSS, collaborate with the enrollee's chosen LTSS representative(s), as applicable, when the enrollee has received LTSS within the last 12 months or a new enrollee request or is identified as having potential need for LTSS

Humana care coordinator qualifications

Humana care coordinators are culturally competent and have the experience, qualifications and training, including MDHHS-required training, appropriate to the needs of the enrollee. Care coordinators may be a Michigan:

- Licensed registered nurse
- Licensed nurse practitioner
- Licensed physician's assistant
- Licensed Bachelor's prepared social worker
- Limited license Master's prepared social worker
- Licensed Master's prepared social worker
- Limited license Bachelor's prepared social worker
- Clinical nurse specialist

Care coordinator assignments and change requests

Humana allows enrollees or their authorized representative a choice in their Humana care coordinator. We ensure every enrollee has a Humana care coordinator with the appropriate experience and qualifications based on their assigned risk level and individual needs (e.g., communication, cognitive, or other barriers). We also ensure appropriate assignment of Humana care coordinators to align with the enrollee's known or expressed cultural, religious, linguistic, and ethnic preferences by considering the knowledge and experience of the Humana care coordinator. Humana provides a timely written notice, within two weeks of the reassignment, to an enrollee or their authorized representative when there is a change in their Humana care coordinator. An enrollee or their authorized representative may request a change in their Humana care coordinator at any time.

Continuity of care requirements

To avoid disruptions in care and services as enrollees transition between managed care entities and Humana, we collaborate with our internal programs and external entities. Humana maintains an enrollee's current providers and amount, scope and duration of services at the time of enrollment. This includes prescription drugs and providers which are not part of Humana's network. Transition requirements vary based on the service and population, in accordance with the requirements and timelines set forth below. For enrollees receiving services from the Habilitation Supports Waiver (HSW) and/or through the PIHP under the Michigan 1115 Behavioral Health Demonstration, the following continuity of care requirements apply to Humana services.

Provider type	Humana Transition Requirement for HSW and enrollees Receiving services through the PIHP under the Michigan 1115 Behavioral Health Demonstration
Physician/other practitioners	Maintain current provider at the time of enrollment for 180 calendar days. (Humana must honor existing plans of care and prior authorizations (prior authorizations) until the authorization ends or 180 calendar days from enrollment, whichever is sooner
DME	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity
Scheduled surgeries	Must honor specified provider and prior authorizations for surgeries scheduled within 180 calendar days of enrollment
Chemotherapy/ radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, bone marrow, hematopoietic stem cell transplant	Must honor specified provider, prior authorizations and plans of care
Dialysis treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days
Vision and dental	Must honor prior authorizations when an item has not been delivered
Home health	Maintain current level of service and same provider at the time of enrollment for 180 calendar days
State plan personal care	Maintain current provider and level of services at the time of enrollment for 180 calendar days. The ICP must be reviewed and updated and providers secured within 180 calendar days of enrollment. If Humana fails to meet this requirement, the continuity of care period must remain in place until the requirement is met. Humana can increase or reduce the amount of services during the continuity of care period if a reassessment is conducted utilizing the personal care assessment and the ICP is reviewed and updated with enrollee approval.

Transition Requirements	Humana Transition Requirements for All Other Enrollees
Physician/other practitioners	Maintain current provider at the time of enrollment for 90 calendar days. (Humana honors existing plans of care and prior authorizations until the authorization ends or 180 calendar days from enrollment, whichever is sooner)
DME	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity
Scheduled surgeries	Must honor specified provider and prior authorizations for surgeries scheduled within 180 calendar days of enrollment
Chemotherapy/ radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, bone marrow, hematopoietic stem cell transplant	Must honor specified provider, prior authorizations and plans of care
Dialysis treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days
Vision and dental	Must honor prior authorizations when an item has not been delivered
Home health	Maintain current level of service and same provider at the time of enrollment for 90 calendar days
Medicaid nursing Facility services	Enrollee may remain at the facility through contract with Humana or via single case agreements or on an out-of-network basis until the enrollee chooses to relocate.
Waiver services	Maintain current providers and level of services at the time of enrollment 90 calendar days unless changed during the person- centered planning process for services provided by the HIDE-SNP HBCS waiver.
State plan personal care	Maintain current provider and level of services at the time of enrollment for 90 calendar days. The ICP must be reviewed and updated and providers secured within 90 calendar days of enrollment. If Humana fails to meet this requirement, the continuity of care period must remain in place until the requirement is met. Humana can increase or reduce the amount of services during the continuity of care period if a reassessment is conducted utilizing the Personal Care Assessment and the ICP is reviewed and updated with enrollee approval.

Disease management programs

Humana enrollees with emerging conditions and those with chronic conditions are eligible for enrollment in our disease management programs. Enrollees 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. Enrollees identified as high risk are assigned a medical or behavioral

health clinician who helps educate, coordinate and provide resources to the enrollee to optimize their overall health.

Chronic and emerging conditions include, but are not limited to:

- Asthma
- Chronic Obstructive Pulmonary Disorder (COPD)
- Heart disease
- Diabetes
- Obesity
- Cancer
- Enrollees with special healthcare needs
- And others as determined by Humana

If you have Humana-covered patients with any of these chronic conditions, and you believe they would benefit from this program, please contact **Care Coordination** at **877-264-2547** Monday – Friday, 9 a.m. –6 p.m., Eastern time.

Enrollee assessments

Each enrollee must receive, and be an active participant in, a timely HRA of medical, behavioral health, psychosocial, SDOH, HRSN, and LTSS needs completed by a Humana care coordinator, using the standardized HRA Tool required by MDHHS, unless an enrollee chooses to decline an assessment. Should that occur, Humana honors and documents the enrollee's decision. Humana uses the results of the HRA to confirm the appropriate acuity or risk stratification level for enrollee care coordination assignments and to determine the need for an additional assessment. HRAs will be completed within 90 calendar days of enrollment.

Additional assessments will be conducted by appropriately trained and knowledgeable licensed health professionals who have experience working with individuals who have HCBS, or LTSS service needs. Humana ensures that the following additional assessments are conducted as appropriate for enrollees based on needs identified during the HRA:

- InterRAI home care assessment (interRAI HC/iHC) for enrollees needing waiver services (interRAI HC data must be electronically transmitted to the State as directed by MDHHS).
- The Personal Care Assessment for enrollees demonstrating ADL needs identified in the HRA, enrollees transitioning from the Home Help program, enrollees with personal care flag in CareConnect360, enrollees with identified personal care need in other MDHHS data exchange, or enrollees with a history of personal care services from another HIDE-SNP.
- Nursing Facility Level of Care Determination for enrollees demonstrating nursing facility level of care needs, including HCBS waiver service needs identified during the HRA to determine eligibility for those services as well as Medicaid Nursing Facility services.
- Other assessments as may be approved by MDHHS.

If you think your Humana-covered patients may benefit from specialized behavioral health or LTSS services, please reach out to Care Coordination at **877-264-2547** Monday – Friday, 9 a.m. –6 p.m., Eastern time.

Individualized care plans

The Humana care coordinator, the enrollee, their family, caregiver or authorized representative, providers, and other ICT members develop a comprehensive, person-centered, written ICP for each enrollee. Unless the enrollee refuses, the meeting to develop the ICP is conducted in-person at a time and location convenient to the enrollee. If the enrollee refuses the ICP, at a minimum, the Humana care coordinator provides their contact information to the enrollee and re-visits the refusal at the time of reassessment or a change of condition.

The initial ICP is completed within 90 calendar days of enrollment. Existing person-centered service plans or plans of care can be incorporated into the ICP. Humana attempts to reach the enrollee at least three times within the first 90 days of enrollment to complete the ICP. If the enrollee is unable to be reached or unwilling to participate in the ICP development, then Humana creates an ICP using pertinent available information. All refusals are documented in the enrollee's health record.

Humana reviews the adopted plan with the enrollee to determine if revisions are necessary to address the enrollee's prioritized goals and meet the enrollee's needs. The ICP is signed by the enrollee and the enrollee's assigned Humana care coordinator. The ICP is contained in the enrollee health record and shared with the enrollee and the ICT.

The enrollee's ICP is available to view in the provider portal. The care coordinator shares updates or changes to the ICP with the enrollee's chosen ICT via the provider portal, enrollee portal or other ICT preferred methods to request feedback and input. This feedback is shared with the enrollee prior to ICP finalization. The Humana care coordinator will contact providers to request enrollee information or ask for your participation in ICT conversations. Your role is to cooperate and engage with our care coordination team.

Enrollee reassessments

The care coordinator evaluates the ICP on a risk level (High- 30 days, moderate- 90 days, low- 180 days) to confirm that the services contained within are meeting the enrollee's needs and that the enrollee 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 enrollee's condition may signal that the services on the ICP are not sufficient to meet the enrollee'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.

Care coordination risk stratification

Low-risk enrollees

Low-risk enrollees are those who have minimal risk factors who require only intermittent support. Outreach is done biannually and focuses on short term needs, such as assisting with HRSN. Humana reviews ICPs of low-risk enrollees with the enrollee at least every 180 calendar days.

Moderate-risk enrollees

Moderate-risk enrollees typically demonstrate rising risk and need focused attention to support their clinical care needs and to address HRSN. Focus is on interventions targeted at the enrollee's specific problems and aims to improve overall health and prevent further illness/disease progression or increase in risk. These enrollees have, at a minimum, quarterly telephonic outreach and plan of care updates. Humana review ICPs of moderate-risk enrollees with the enrollee at least every 90 calendar days. At minimum, at least every other ICP review will be an in-person visit with the enrollee. The other quarterly ICP reviews may be conducted as an in-person, telephonic or telepresence visit with the enrollee.

High-risk/complex enrollees

High-risk enrollees in intensive care coordination are those enrollees who require the intensive, highly focused attention to support their clinical needs. Enrollees with multiple or complex illnesses with long-term needs that often include psychosocial concerns or barriers, as well as enrollees transitioning between care settings or systems that require intensive, proactive care coordination. Outreach is done at least once a month. Humana reviews ICPs of high-risk enrollees with the enrollee at least every 30 calendar days. For enrollees who have been designated high-risk, the Humana care coordinator will complete an in-person visit with the enrollee to review the ICP at least quarterly. The other monthly ICP reviews during each quarter may be conducted as an in-person, telephonic or face-to-face visit with the enrollee. There is a subset of high-risk enrollees that are considered complex enrollees.

The following populations, at a minimum, are automatically stratified as high-risk:

- Enrollees receiving services in the HSW
- Enrollees receiving services in the HIDE-SNP HCBS waiver
- Enrollees transitioning to Humana from the Michigan Choice waiver
- Enrollees transitioning to Humana from PACE
- Enrollees who are within their first 90 days in Humana after transitioning from Home Help
- Enrollees who are transitioning from a nursing facility to the community
- Enrollees who are receiving personal care services and meet nursing facility level of care (NFLOC) but are not enrolled in the HIDE-SNP HCBS waiver

- Enrollees with unmet needs due to low or no access to needed resources such as caregiver support, housing, food, transportation, and shelter
- Enrollees who have had five or more hospitalizations in the last 12 months related to uncontrolled conditions
- Enrollees who have had six or more emergency department visits within the last 12 months
- Enrollees who had a hospitalization or emergency department visit with a primary diagnosis related to behavioral health within the last 12 months, until the condition(s) has stabilized

Chapter 10: Quality Assessment and Performance Improvement

Quality improvement program overview

Humana's Quality Assessment and Performance Improvement (QAPI) Program is a comprehensive quality improvement program that encompasses clinical care, preventive care, SDOH and HRSN experienced by enrollees, population health management and Humana's administrative functions. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral health services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, the QAPI Program 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

QAPI Program activities include monitoring clinical indicators or outcomes, quality studies, HEDIS measures, CAHPS program, Healthcare Outcomes Survey results and medical record audits. The quality improvement committee (QIC) is delegated by Humana's 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 QIC is accountable to Humana's executive management team.

The goals of the QAPI Program 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 enrollee access and availability to healthcare services.
- Providing a mechanism where enrollees, practitioners and providers can express concerns to Humana regarding care and service.
- Providing effective customer service for enrollee and provider needs and requests.
- Monitoring coordination and integration of enrollee care across provider sites.

- Monitoring, evaluating and improving the quality and appropriateness of care and service delivery to enrollees through peer review, performance improvement projects (PIPs), medical/case record audits, performance measures, surveys and related activities.
- Providing a comprehensive strategy for population health management that addresses enrollee needs across the continuum of care.
- Providing mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.
- Providing mechanisms to detect both underutilization and overutilization.
- Providing mechanisms where enrollees with complex needs and multiple chronic conditions can achieve optimal health outcomes.
- Guiding enrollees to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs.
- Identifying and addressing disparities to help enrollees achieve their goals and improve health outcomes.
- 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 enrollees, practitioners, providers and associates.
- Promoting improved clinician experience for providers and all clinicians to promote enrollee safety, provider satisfaction and provider retention.

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

Quality Improvement Committee

The Humana QIC directs the quality activities of the plan. The QIC meets quarterly and reports to the corporate quality improvement committee. Humana's Chief Medical Officer chairs the committee with active involvement from key areas across the health plan such as behavioral health, long-term support services, and UM. Other partners, such as external medical and behavioral health providers, LTSS providers and subcontractors are included as appropriate. The QIC 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 enrollee service and well-being.

The QIC is responsible for the following:

- Reviewing and approving any changes to the QAPI 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 PIP initiatives

- Reviewing, recommending, 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
- Directing and analyzing UM reviews of enrollees' service utilization patterns

Quality measures

Humana 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 enrollees, including enrollees enrolled in specialty plans with special healthcare needs and enrollees involved in LTSS services, 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 enrollee record documentation standards.
Peer reviews	Peer reviews are reviews of the provider's practice methods, patterns and appropriateness of care.
PIPs	PIPs 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 enrollee satisfaction.
Performance measures	Performance measures include data collected on enrollee outcomes, as defined by the HEDIS or otherwise defined by the state.
Surveys	Survey measures include the CAHPS, provider satisfaction surveys, and the Health Outcomes Survey.

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 enrollees transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. The CMS Adult Core Set is a standardized group of measures used to ascertain the quality of care delivered to HIDE-SNP beneficiaries and improve quality and health outcomes. Humana may conduct medical record reviews to validate HEDIS and Adult Core Set measures. In addition to medical record reviews, information for performance measures is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data:

- Nonstandard supplemental data involves directly submitted, scanned images (e.g., PDF documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary 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 or population health tool and is submitted to Humana via either secure email or file transfer process transmission. Humana also accepts lab data files in the same way. Humana partners with various electronic medical records to provide enrollee summaries and detail reports and to automatically retrieve scanned charts.

CAHPS

The CAHPS survey includes measures that reflect enrollee satisfaction with your care and service. Each year, surveys are sent to our enrollees that ask multiple questions about how you and Humana are performing. Humana monitors and evaluates your quality, appropriateness of care and service delivery to enrollees using this measure along with other measures of your satisfaction, behavioral health surveys and special surveys implemented to support quality/performance improvement initiatives.

Health disparities analysis

Humana leverages HEDIS data as well as enrollee demographics, including race, language, age, disability, and gender to complete an annual health disparities analysis. Disparities are analyzed using clinical performance data and enrollee experience surveys such as CAHPS. The evaluation process incorporates the National Quality Forum's principles for disparities-sensitive measures, assessing prevalence, impact, quality gaps, and feasibility of improvement. Humana's processes for disparities analysis enable actionable strategies to improve health outcomes for underserved populations.

Access to care audits

The quality improvement program includes evaluation of the availability, accessibility and acceptability of services rendered to enrollees by participating providers.

Please keep in mind the following access standards for differing levels of care. Humana requires its network providers that are serving HIDE-SNP enrollees to have procedures in place to see enrollees within these time frames and to offer office hours to their Humana-covered patients that are at least the equivalent of those offered to all other patients. Humana will monitor appointment time compliance using surveys in accordance with contractual requirements.

Enrollees should be triaged and provided appointments for care within the time frames outlined below.

Provider type	Time to appointment standard
Non-urgent symptomatic care	Within 7 business days of request
Routine outpatient mental health and SUD, adult and pediatric	Within 10 business days of request
Routine primary care, adult and pediatric	Within 15 business days of request
Routine obstetrics and gynecological	Within 15 business days of request
Routine specialty care, such as vision and hearing	Within 6 weeks of request
Acute specialty care, such as vision and hearing	Within 5 business days of request
Emergency dental services	Immediately, 24 hours a day, 7 days a week
Urgent dental care	Within 48 hours of request
Routine dental care	Within 21 business days of request
Preventive dental services	Within 6 weeks of request
Initial dental appointment	Within 8 weeks of request

An enrollee should be seen as expeditiously as the enrollee's condition warrants based on severity of symptoms. If you are unable to see the enrollee within the appropriate time frame, then Humana facilitates an appointment with a participating provider or a nonparticipating provider when necessary.

Provider and enrollee satisfaction surveys

Humana 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 and respond to the survey as the results are analyzed and used to develop provider-related QI initiatives.

Compliance with availability and access standards are monitored regularly through random sampling, review of enrollee concerns, and enrollee satisfaction surveys to ensure enrollees 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.

Provider participation in the QAPI Program

Network providers are contractually required to comply with Humana's QAPI Program, which includes providing enrollee records for assessing quality of care and external quality review organization activities. In addition, the HIPAA Privacy Rule of 45 C.F.R 164.506 and rules and regulations promulgated thereunder (45 C.F.R Parts 160, 162 and 164) permit a covered entity (provider) to use and disclose PHI to health plans without enrollee authorization for treatment, payment and healthcare operations activities. Healthcare operations include but are not limited to the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care coordination and care coordination. You also must allow Humana to use your performance data.

Evaluation of the QAPI Program

Humana evaluates the effectiveness of the QAPI Program on an annual basis. The annual report reviews completed and continuing QAPI activities, assesses the progress in meeting goals, addresses the quality of clinical care and service, trends measure 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 QAPI Program. Information regarding the QAPI Program is available upon request.

Medical record standards

Humana ensures that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards. For each enrollee, the provider should maintain detailed and legible medical records that include:.

- The enrollee's identifying information including name, enrollee ID, date of birth, sex and details of legal guardianship.
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications.
- A description of chief complaint or purpose of visit, the objective diagnosis and medical findings of provider impressions.
- Identification of any studies ordered and any referral reports.
- Identification of any therapies administered and prescribed.
- Name and profession of the provider rendering services, including the signature or provider initials.
- Enrollee disposition, recommendations and instructions and evidence of any follow-up and service outcomes.
- Immunization history.

- Information relating to the enrollee's use of tobacco products and alcohol/substance use.
- Summaries of emergency services, care and hospital discharges with appropriate follow-up
- Documentation of referral services and enrollee medical records
- All services provided by provider (e.g., family planning services, preventive services, etc.)
- Primary language spoken by the enrollee and any enrollee translation needs
- Information indicating an enrollee's need of communication assistance in the delivery of healthcare services
- Documentation enrollee was provided written enrollee rights information including details on advance directives and confirmation enrollee has received the advance directive information

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

Confidentiality of enrollee 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, the state and/or its designee within the time frame identified in the request and contain all information necessary for each Humana enrollee. You must have procedures in place to permit the timely access and submission of health records to Humana on request. Failure to submit records in a timely manner may result in additional action and follow-up.

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

Medical record confidentiality requirements

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

The enrollee 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 the privacy and security provisions of HIPAA and 42 C.F.R, Part 431, Subpart F.

Humana and providers must agree to maintain the confidentiality of information contained in their records regarding healthcare services rendered to enrollees as required by state or federal law, rule, or regulation, including without limitation 42 C.F.R, Part 431, Subpart F, 42 C.F.R § 438.224, and HIPAA privacy and security requirements in 45 C.F.R Parts 160 and 164.

For medical records and any other health and enrollment information that identifies a particular enrollee, Humana uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these

requirements are applicable. Humana trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within Humana as outlined in 45 CFR §164.530. Humana has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.

Humana designates a privacy official who is responsible for the development and implementation of our policies and procedures. Humana designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520.

Medical record storage requirements

Confidentiality of enrollee 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, 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 upon request. Information from the health records review may be used in the recredentialing process as well as quality activities.

Enrollee rights related to medical records

Humana enrollees 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 that their health records be changed or corrected if needed. Records should be retained for 10 years or longer as required by federal law. Enrollees also have the right to say yes or no to having their information given out unless Humana 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 HIDE-SNP 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 the HIDE-SNP recipient records and any other information that cannot be separated from HIDE-SNP-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 enrollees and as 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's contract with the state.

In addition to record retention requirements for your licensure, subcontractors are required to retain, as applicable, the following information in accordance with 42 C.F.R 438.3.(u):

- Enrollee grievance and appeal records (42 C.F.R 438.416),
- Base data (42 C.F.R 438.5(c),
- MLR reports (42 C.F.R 438.8(k)), and
- Data, information, and documentation (42 C.F.R 438.604, 42 C.F.R 438.606, 42 C.F.R 438.608, and 42 C.F.R 438.610)

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 if the subcontract is continuous (42 C.F.R 438.3(h)).

Humana requires that each enrollee or their representative is entitled to one free copy of their medical record. Additional copies are made available to enrollees at cost.

Medical records should be preserved and maintained by you for a minimum of 10 years unless federal requirements mandate a longer retention period (e.g., 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 periodically requests enrollee medical records as part of our provider monitoring as described in the **Medical record reviews** section of this provider manual. Humana realizes that supplying medical records for review requires your staff's valuable time; your cooperation with our requests and associated timelines is appreciated.

Humana offers the following suggestions to ensure complete and accurate documentation of enrollee 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 front and back of every page of the medical record.
- 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.

Preventive guidelines and clinical practice guidelines

Humana's clinical practice guidelines are available for both affiliated and non-affiliated providers. The guidelines incorporate relevant evidence-based medical and behavioral health guidelines from recognized sources such as professional medical associations, voluntary health organizations, NIH centers and the United States Preventive Services Task Force (USPSTF). Humana considers the needs of our enrollees when adopting guidelines. Humana reviews newly adopted and updated clinical practice guidelines in its Clinical Practice Guideline Physician Committee under the direction of the medical director and participation of contracted network providers. The committee's recommendations are presented to the Corporate Quality Improvement Committee for final approval before being posted to **Humana.com**. The guidelines can serve as a reference regarding the management of specific clinical conditions. 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

We encourage you to consider and refer to these guidelines as applicable. You remain responsible for determining the applicable treatment for each individual. Humana monitors your adherence to guidelines using claim, pharmacy and utilization data. Education is provided via Humana's Provider Newsletter, highlighting guidelines that are identified as outliers. The newsletter includes links to the identified guidelines.

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

You also can receive preventive health and clinical practice guidelines through your provider relations representative. Clinical practice guidelines also are available to providers, enrollees and the public at **https://provider.Humana.com/patient-care/guidelines**.

Chapter 11: Utilization management

Utilization management program overview

Our Utilization management (UM) Program is designed to ensure Humana enrollees receive access to the right care in the right place at the right time. Our goal is to optimize the enrollee's benefits by facilitating quality healthcare services that meet professionally recognized standards of care; are a covered benefit, medically necessary and appropriate for the individual enrollee's condition; and are provided at the most appropriate level of care.

Services are provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) in accordance with generally accepted standards of medical practice;
- (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, 14 injury or disease;
- (c) not primarily for the convenience of the patient, hospital or other health care provider, and not more costly than the alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, hospital specialty society recommendations and the views of hospitals practicing in relevant clinical areas. Humana does not reward doctors, other individuals or Humana employees for denying coverage or encourage underuse of services.

Humana completes an annual assessment of satisfaction with the UM process to identify areas for improvement.

Access to UM staff

The UM department performs all UM activities, including prior authorization, concurrent review, and discharge planning. Providers may send an email to the UM staff with any UM questions.

- Medical health inquiries can be directed to **855-281-6070** Monday – Friday, 6 a.m. – 7 p.m., Central time.
- Behavioral health inquiries can be directed to **855-281-6070** Monday – Friday, 6 a.m. – 7 p.m., Central time.

Please keep the following in mind when contacting UM staff:

- Staff are available Monday – Friday, 6 a.m. – 7 p.m., Central time.
- Staff can receive inbound 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 enrollees and to promote positive healthcare outcomes, Humana supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Referrals

If an enrollee requires specialized treatment beyond the scope of a PCP, the enrollee may see an in-network specialist for consultation and/or treatment without a referral from their PCP. For enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, Humana allows enrollees to directly access a specialist without a referral as well.

After the patient has been treated, the specialist's findings, diagnosis and recommendation for treatment should be sent to the patient's PCP. The specialist also must submit claim/encounter data to Humana.

Humana provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

For behavioral health referrals, please refer to the **Behavioral health** section of this provider manual for more information. For long-term services and supports referrals, please refer to the **Long-term services and supports** section of this provider manual for more information.

Prior authorizations

All services that require prior authorization from Humana should be authorized before the service is delivered. Humana is not able to pay claims for services in which prior authorization is required but not obtained by you. To determine which services require preauthorization, please access our Preauthorization and Notification List at **Humana.com/PAL** under the Medicare tab or call **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time to request a copy. It is important to request prior authorization as soon as you know that a Humana-covered patient requires a service on the Preauthorization Notification List. The enrollee, their PCP or treating provider is responsible for initiating a request for services. Online requests are encouraged through Availity Essentials, our secure, payer-agnostic provider portal, but prior authorizations can be requested through any of the following methods:

- Sign in to Availity Essentials at **Availity.com** (registration required). For select services, you can answer a series of questions when requesting the preauthorization. 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 business to business or batch Health Care Services Review and Response transaction (278) via EDI.
- Use our interactive voice response system (IVR) by calling **800-523-0023**.
- Call the number for preauthorization on the back of the patient's Humana ID card.
- Call **800-523-0023** if a request needs to be expedited due the seriousness of a patient's condition.

If an enrollee requires medically necessary services from a nonparticipating provider, you may need to call Clinical Intake Team at **855-281-6070** Monday – Friday, 6 a.m. – 7 p.m., Central time to obtain prior authorization. You can view the status of your prior authorization requests by visiting **Availity Essentials**.

When prior authorization is requested for a service rendered in the same month, enrollee enrollment is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent on enrollee eligibility on the date of service. You must verify enrollment on the date the service is to be rendered. Humana is not able to pay claims for services provided to ineligible enrollees.

For behavioral health prior authorizations, please refer to the **Behavioral health** section of this provider manual for more information. For long-term services and supports prior authorizations, please refer to the **Long-term services and supports** section of this provider manual for more information.

Services that do not require prior authorization

Humana does not require prior authorization for the following services:

- Any services for emergency medical conditions as defined in 42C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care)
- Urgent care sought outside of the service area
- Urgent care under unusual or extraordinary circumstances provided in the service area when the contracted medical provider is unavailable or inaccessible
- Family planning services
- Out-of-area renal dialysis services
- Prescription drugs
- Tobacco cessation treatment
- Treatment services for communicable diseases from local health departments
- Vaccines and immunizations provided to enrollees at local health departments

Required information for prior authorization requests

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

- Enrollee's ID number and date of birth
- Relationship to subscriber
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- Procedure codes, up to a maximum of 10 per authorization request
- Date of proposed procedure, if applicable
- ICD Diagnosis codes (primary and secondary), up to a maximum of 6 per authorization request
- Service location
- Type of authorization—inpatient or outpatient
- Tax ID Number (TIN) and National Provider Identifier (NPI) number of requesting provider
- TIN and NPI of treatment facility where service is being rendered
- TIN and NPI of the provider performing the service
- Name and telephone number of all providers indicated
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate a quicker determination. If Humana requires additional clinical information, a Humana representative will request the specific information needed to complete the authorization process. Humana makes Utilization Management determinations within federal, state and accreditation timeframes, as applicable Prior authorization request review process

Humana ensures that a Humana representative and a behavioral health provider are available 24 hours a day for timely authorization of medically necessary services, including, if necessary, the transfer of the enrollee who presented to an emergency department with an emergency medical condition that has been stabilized.

Humana consults with the requesting provider for medical services when appropriate. If additional clinical or other information is needed to determine medical necessity, Humana will request the relevant information via telephonic outreach and/or fax. The request will clearly indicate what additional information is required to complete the prior authorization request. Humana 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.

Timeliness of prior authorization decisions

For standard prior authorization decisions, Humana provides notice to you as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days following authorization request date. The time frame for a standard authorization request may be extended up to 14 calendar days if you or the enrollee requests an extension, or if Humana justifies, in writing, to MDHHS a need for additional information and how the extension is in the enrollee's best interest. Written notice of the extension will be provided to the enrollee and will include the reason for the extension and the enrollee's right to file a grievance. If Humana fails to respond to a prior authorization request not pertaining to medications within 14 calendar days of receiving the necessary documentation, the authorization is considered granted.

For cases in which you indicate, or Humana determines, that following the standard time frame could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function, Humana will complete an expedited authorization decision within 72 hours and provide notice as expeditiously as the enrollee's health condition requires. The enrollee or the enrollee's provider may request an extension up to 14 calendar days. Humana 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 enrollee. Written notice of the extension is provided to the enrollee and includes the reason for the extension and the enrollee's right to file a grievance. Please specify in **Availity Essentials** or on the authorization fax request cover if you believe the request needs to be expedited.

Prior authorization for hospital admissions

For hospital admissions, you must use **Availity Essentials** or call the number for preauthorization listed on the back of the enrollee's ID card. Information required for a preauthorization request or notification may include:

- Enrollee's Humana ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes, up to 10 maximum per preauthorization request
- Date of proposed procedure, if applicable
- Diagnosis codes, primary and secondary, up to 6 maximum per authorization request
- Service location
- Inpatient location (e.g., acute hospital, skilled nursing, hospice)
- OP location (e.g., telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center)
- Referral (e.g., office, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center, other)
- Tax Identification Number (TIN) and National Provider Identifier (NPI) of treatment facility where service is rendered

- TIN and NPI of the provider performing the service
- Caller/requestor's name and telephone number
- Attending provider's telephone number
- Relevant clinical information
- Discharge plans

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

For urgent prior authorizations or notifications, you should call our Clinical Intake Team, at 800-523-0023. Representatives are available Monday through Friday, 6 a.m. – 7 p.m., Central time, (excluding major holidays). Press "0" or say "representative" for live help and have your NPI available.

Prior authorization in continuity of care

For information about prior authorization during continuity of care, please consult the **Continuity of care requirements** section of this provider manual.

Prior authorizations for outpatient surgery

If the prior authorization request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Discharge planning

The hospital's UM and discharge planning departments and the patient's attending physician/PCP are responsible for establishing the discharge plan. The Humana UM team is available to assist with complex discharge planning, when needed. Hospitals should provide Humana with discharge dates and discharge plans of Humana discharged enrollees each day to assist with post-discharge follow-up, coordination of care and referrals to other clinical programs that may be available to the enrollee.

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 the care, service or benefit. Humana requires prior authorization to ensure covered patients receive medically necessary and appropriate services.

On request, Humana only allows for a retrospective authorization submission after the date of service when a prior authorization is required but not obtained. When submitting a retroactive authorization request, please include the following documentation:

- Patient name and Humana ID number

- Authorization number of the previously authorized service for the related request
- Clinical information supporting the service

When retrospective review is required, providers must include clinical information to perform a medical necessity review. Elective ambulatory or inpatient services on Humana's Preauthorization and Notification List for which precertification did not occur before providing the service are not eligible for retrospective review.

A retrospective review request for inpatient and outpatient services can be submitted via **Availity Essentials** or by contacting Availity Essentials directly.

For requests submitted via Availity Essentials or by fax, you can check the status online on via **Availity Essentials**. You can see the authorization status along with the authorization number associated with the request. Some outpatient authorization requests may auto-approve if the procedure code is not listed on our online prior authorization list (PAL). Written notification for approved service requests is not provided unless requested. Requests for written notification can be included when clinical information is submitted or by calling **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Exceptions to this policy apply if enrollee is in the pharmacy lock-in program.

Concurrent review

Concurrent reviews are those in which the enrollee is in the process of receiving the requested medical care or services, even if Humana did not previously approve the earlier care. Notice of decision is provided as expeditiously as the enrollee's health condition requires but no later than 72 hours. The UM department performs concurrent reviews.

Retrospective determinations

Humana will provide a notice of decision within 14 business days of receipt of the retrospective request. Humana will not retroactively deny authorization for the continuation of care unless the provider submitted the authorization untimely.

For authorizations originally approved by Humana, if we deny the continuation of services with the skilled nursing facility or long-term attendant care, we must provide at least 10 business days of coverage for the services from the date of the notice of denial, to ensure the safe discharge of the enrollee. This requirement does not apply for authorizations submitted untimely by the provider.

For requests related to HCBS, Humana will make an expedited authorization decision and issue notice to the enrollee no later than 72 hours after receipt of the request for service. An extension of the 72-hour time period by up to 14 calendar days can be completed at the request of the enrollee or if the plan justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

When there are any decisions to terminate, suspend or reduce previously authorized covered services because of probable enrollee fraud verified by the state Office of Inspector General or the attorney general, Humana will provide notice 5 days before the date the indicated service would be terminated, suspended or reduced.

Humana 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. For adverse benefit determinations (ABDs), Humana will notify the enrollee by letter with a copy to you at the address on file.

Medical necessity criteria and reviews

All decisions are based on eligibility, coverage and medical necessity criteria. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials are rendered by board-certified or board- eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which must be rendered by a qualified psychologist.

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 enrollee's needs
- Be consistent with generally accepted professional medical standards as determined by the HIDE-SNP 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

Humana specifies what constitutes "medically necessary services" in a manner that:

- Is no more restrictive than that used by the MDHHS Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes and regulations, the state plan, and other MDHHS policy and procedures
- Addresses the extent to which Humana is responsible for covering services that address:
  - The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.
  - The ability for an enrollee to achieve age-appropriate growth and development.
  - The ability for an enrollee to attain, maintain, or regain functional capacity.

  - The opportunity for an enrollee receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.
- Complies with the requirements for demonstrating parity for treatment limitations between mental health and SUD and medical/surgical inpatient, outpatient and pharmacy benefits
- Is no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and SUD services.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, 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.

Obtaining clinical criteria and rationale used in making UM determinations

Enrollee health is always Humana's top priority. Provider reviewers from Humana are available to discuss individual cases with attending providers upon request. Clinical criteria and clinical rationale used in making UM determinations are available at **Medical and Pharmacy Coverage Policies**, in the 'Humana Physician News' newsletter, and upon request by emailing one of the following UM departments:

- Medical health inquiries can be directed to **855-281-6070.**
- Behavioral health inquiries can be directed to **855-281-6070**.

Upon request and at no cost to you, Humana supplies all documents, records and other information relevant to an adverse payment or coverage determination.

Peer-to-peer review

Prior to the time an adverse determination is communicated, providers may be given an opportunity to discuss the services being requested for the enrollee and the clinical basis for treatment with a medical director or other appropriate reviewer.

A participating provider may submit a pre-claim dispute prior to submitting a claim under the following circumstances:

- Physician/provider is contracted with Humana
- Humana's adverse determination was based on lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service
- A peer-to-peer discussion had not previously occurred.

Second opinions

Humana provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee. Enrollees have a right to receive a second opinion from a qualified provider in or out of the Humana network. Humana arranges for out-of-network care when an in-network provider is unable to provide with necessary covered services. This includes second opinions related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions.

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

- The provider must be enrolled with the state.
- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider. The provider must not be affiliated with the enrollee's PCP or the specialist practice group from which the first opinion was obtained.
- The provider 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

For reimbursement of out-of-network emergency services or urgent care services, you are required to accept as payment in full by Humana the amounts you could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS. Humana covers applicable Medicare cost sharing for such out-of-network emergency or urgent care services. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 CFR §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies Humana in writing that it is billing an amount less than such amount.

On notification of authorization from a referring provider, Humana will arrange out-of-network care if we are unable to provide necessary covered services or ensure the second opinion of an in-network provider. Humana may authorize other out-of-network services to promote access to services and continuity of care. When out-of-network services are authorized and where the service would traditionally be covered under Medicare FFS, Humana pays out-of-network health care professionals and section 1861(u) providers of services the amount that providers could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 CFR §§412.105(g) and 413.76 for section 1861(u) providers), regardless of the setting and type of care. Humana covers applicable Medicare cost sharing for such out-of-network authorized services. When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, Humana pays out-of-network providers at established MDHHS Medicaid fees in effect on the date of service.

Enrollees maintain improper billing protections. If Michigan Medicaid has not established a specific rate for the covered service, Humana follows Medicaid policy for the determination of the correct payment amount. Nothing in the preceding provisions must restrict the right of the provider and Humana to negotiate a lower rate of payment.

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 18 months. Within 3 business days you can search by:

- Enrollee - need provider tax ID, enrollee ID (either H or MCD), DOB and Service Dates
- Claim Number - Provider tax ID, and claim number
- Service Dates - Provider tax ID and service dates
- HIPPA Standard

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

Post-stabilization services

Post-stabilization care services are covered services related to an emergency medical condition that are provided after an enrollee is stabilized following an emergency to maintain, improve or resolve the enrollee's condition. Post-stabilization services are covered in or out of network.

Humana covers post-stabilization care services obtained within or outside the Humana network that are not pre-approved by a plan provider or other Humana representative but are administered to maintain, improve, or resolve the enrollee's stabilized condition under the following circumstances:

- The services are administered to maintain the enrollee's stabilized condition within one hour of a request to Humana for pre-approval of further post-stabilization care services
- Humana does not respond to a request for pre-approval within 1 hour
- Humana cannot be contacted
- The Humana representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, Humana will give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.

Humana is financially responsible for post-stabilization care services obtained within or outside the HIDE-SNP that are pre-approved by a plan provider or other Humana representative.

Post-stabilization services that Humana has not pre-approved will no longer be covered by Humana when a plan physician with privileges at the treating hospital takes over the enrollee's care, a plan physician takes responsibility for the enrollee's care through transfer, the Humana representative and the treating physician agree on the enrollee's care plan, or when the enrollee is discharged from the facility.

Special requirements for hospitals

Hospital Discharge Rights for HIDE-SNP Enrollees:

CMS requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries, including HIDE-SNP plan enrollees who are hospital inpatients. Hospitals are required to provide the IM to the HIDE-SNP enrollee upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM are on the CMS website at **Beneficiary Notices Initiative (BNI) | CMS**.

The IM informs hospitalized HIDE-SNP beneficiaries about their hospital discharge appeal rights. HIDE-SNP enrollees who are hospital inpatients have the statutory right to request an "immediate review" by a quality improvement organization (QIO) when Humana, along with the hospital and physician, determines that inpatient care is no longer necessary.

Guidelines for IM notification by telephone:

If the hospital staff is unable to personally deliver the IM to the patient or his/her representative, then the hospital staff should telephone the patient or representative to advise him/her of an enrollee's rights as a hospital patient, including the right to appeal a discharge decision. At a minimum, the telephone notification should include:

- The name and telephone number of a contact at the hospital
- The beneficiary's planned discharge date and the date when the beneficiary's liability begins
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged
- A description of the steps for filing an appeal
- When (by what time/date) the appeal must be filed to take advantage of the liability protections
- To whom to appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires to receive the appeal in a timely fashion

Note: The date that the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

The hospital is required to:

- Confirm the telephone contact by written notice mailed to the enrollee's authorized representative on that same date.

- Place a dated copy of the notice in the enrollee's medical file and document the telephone contact with either the enrollee or his/her representative on either the notice itself or in a separate entry in the enrollee's file.
- Ensure the documentation indicates the staff person told the enrollee or representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal.
- Ensure the documentation includes the name of the staff person initiating the contact, the name of the enrollee or representative contacted by phone, the date and time of telephone contact and the telephone number called.

When direct phone contact with an enrollee or an enrollee's representative cannot be made, the hospital must:

- Send the notice to the enrollee or representative by certified mail (return receipt requested) or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the enrollee's medical file and document the attempted telephone contact to the enrollee or representative.
- Ensure that the documentation includes:
  - The name of the staff person initiating the contact
  - The name of the enrollee or enrollee's representative 18
  - The date and time of the attempted call
  - The telephone number called

Special requirements for skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities

Notice of Medicare Non-Coverage (NOMNC):

CMS requires that physicians and other healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to HIDE-SNP health plan enrollees at least two days prior to termination of SNF, home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the enrollee's SNF services are expected to be fewer than two calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs enrollees how to request an expedited determination from their QIO if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at **Beneficiary Notices Initiative (BNI) | CMS**.

Practitioners also can contact their quality improvement organizations (QIO) for forms or additional information. Forms also can be obtained from Humana's local health services Utilization Management department. No modification of the text on the CMS NOMNC is allowed.

For the NOMNC to be valid:

- The enrollee must be able to comprehend and fully understand the notice contents
- The enrollee or his/her authorized representative must sign and date the notice as proof of receipt
- The notice must be the standardized CMS NOMNC form

If an enrollee refuses to sign the NOMNC, the enrollee's refusal to sign, the date, time, name of person who witnessed the refusal and his/her signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented. If an enrollee is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the enrollee's behalf; in such cases, the representative, in addition to the enrollee, must receive all required notifications. The following specific information is required to be given when contacting an enrollee's representative of the NOMNC by phone:

- The enrollee's last day of covered services and the date when the beneficiary's liability is expected to begin
- The enrollee's right to appeal a coverage termination decision
- A description of how to request an appeal by a QIO
- The deadline to request a review, as well as what to do if the deadline is missed
- The telephone number of the QIO to request the appeal

The date when the information is verbally communicated is considered the NOMNC's receipt date. Practitioners must document the telephone contact with the enrollee's representative on the NOMNC on the day that it is made, indicating that all the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called

A dated copy of the annotated NOMNC must be placed in the enrollee's medical file, mailed to the representative the same day as the telephone contact and faxed to the practitioner's local Humana health services Utilization Management department.

Right to appeal a NOMNC (Fast-track Appeal):

CMS offers fast-track appeal procedures to HIDE-SNP enrollees, including HIDE-SNP enrollees, when coverage of their SNF, HHA or CORF services will soon end. CMS contracts with QIOs to conduct these fast-track appeals. When notified by Humana or the QIO that the enrollee has requested a fast-track appeal, SNFs, HHAs and CORFs must:

- Provide medical records and documentation to Humana and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.
- Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by Humana (or that is delegated to the practitioner to complete) to enrollee or their authorized representatives no later than close of the calendar day on which they are notified, including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

For more information about notification of termination requirements, practitioners can visit the CMS website at: **Beneficiary Notices Initiative (BNI) | CMS**.

Chapter 12: Claims submission protocols and standards

Overview

As part of our commitment to achieve operational excellence and comply with established standards for the timeliness of claims, Humana has implemented a 'Pay It Right the First Time' strategy. Our HIDE-SNP providers are able to submit a claim for services rendered, which Humana will process through our Claims Adjudication System. Within our claims system, we align enrollees' plan benefits and existing coverage. This means we process claims seamlessly, producing a single remittance, reflecting the enrollee's specific coverage with Humana. We generate a Provider Explanation of Remittance for both electronic and paper distribution, providing comprehensive remittance advice for clear understanding.

Humana maintains and complies with HIPAA standards for the submission and adjudication of claims. This section will provide information regarding submission and payment process. If you have questions or would like training regarding submitting claims, please contact your Humana Provider Relations Representative. For more information on LTSS claims, please see the **LTSS claims** section of this manual.

Claim payment

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

Submitting an electronic claim

Healthcare providers can use Availity Essentials and EDI services as no-cost solutions for submitting claims electronically. To register for Availity Essentials or to learn more about Availity Essentials claims solutions, visit **Availity Essentials**.

Healthcare providers also can file a claim by EDI through the clearinghouse of their choice. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for information.

If submitting a claim to a clearinghouse, use the following payer IDs for Humana:

- Claims: 61101 (for fee-for-service claims/non-capitated)
- Encounters: 61102 (capitated)

Paper claims should be submitted to the address listed on the back of the enrollee's ID card or to the appropriate address listed below:

Claims	Encounters
Humana Claims Office	Humana Claims Office
P.O. Box 14359	P.O. Box14055
Lexington, KY 40512-4359	Lexington, KY 40512-4055

Timely provider payments

For claim payment inquiries or complaints, please call **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time or contact your network management consultant.

To learn more about Humana's payment policies, please visit **Humana.com**

You are required to file your claims/encounters for all services rendered to HIDE-SNP enrollees in a timely manner. Timely filing is an essential component reflected in Humana's HEDIS reporting and ultimately can affect how a health plan and its providers are measured in enrollee preventive care and screening compliance.

Humana makes provider payments on a timely basis consistent with the claims payment procedure described in 42 U.S.C. § 1396a(a)(37)(A).Payment complaints or disputes for the provision of services are subject to Humana's provider dispute process.

Humana pays 95% of all clean covered provider service claims within 30 days of submission receipt. Humana pays 99% of all clean covered provider service claims within 90 days of submission receipt.

Humana pays hospitals' clean claims within 45 days after receipt. Humana provides hospitals with a denial or written request for additional information within 30 days after receipt of an inaccurate or insufficient claim. Humana may either deny the claim or make payment in full to a hospital within 30 days on a "corrected" claim.

For enrollee admission to a nursing facility or LTSS, a clean claim means that the admission is reflected on the patient's credit file that Humana receives from the state. Humana pays 99% of these claims within 14 calendar days after receipt and 100% are paid within 30 calendar days after receipt.

NPI and TIN

Your NPI and TIN are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., FQHC, RHC and/ or primary care center), using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered. Atypical providers are not required to have NPIs.

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

Location of provider NPI, TIN and enrollee ID number

Humana 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:

- 2010AA loop—BILLING PROVIDER TAX IDENTIFICATION
- 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 76

The Humana enrollee ID number should go on:

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

Service encounter submission accuracy

You are required to submit timely, complete and accurate encounter claims in accordance with contract requirements and applicable regulations. Accurate and complete encounter data is critical to Humana's success. 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 HIDE-SNP managed care program and in demonstrating its

responsibility and stewardship. The state has the right to audit all encounter data at its choosing. This often includes validating the information on the encounter against providers' medical records. In the event of an encounter data validation review, you may be asked for your medical records in support of the encounters submitted.

Provider portal

Humana partners with **Availity Essentials** to allow you to reference enrollee 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 **800-282-4548** Monday – Friday 8 a.m. to 8 p.m., Eastern time or visit Availity Essentials online.

EFT/ERA enrollment through Humana

Get paid faster and reduce administrative paperwork with EFT and ERA.

You can use the Humana ERA/EFT enrollment tool on the **Availity Essentials** provider portal. To access this tool:

Sign in to **Availity Essentials** (registration required).

4. From the Payer Spaces menu, select Humana.
5. 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 claim payments are deposited directly in the bank account(s) of your choice.

Code sets

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

Code set	Details
ICD-10-CM	Available online: **https://www.cdc.gov/nchs/icd/Comprehensive-Listing-of-ICD-10-CM-Files.htm**
ICD-10-PCS	Available online: **https://www.cms.gov/medicare/coding/icd10**
CPT	Available online: **https://www.ama-assn.org/practice-management/cpt**
HCPCS Level II	Available online: **https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update**

Code set	Details
National Drug Codes (NDC)	Available online: **https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directoryhttps://www.fda.gov/**

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

Please note: Humana 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.

Common errors and reasons for denial or rejection

Common reasons for rejected or denied claims include the following:

- Enrollee or patient not found
- Duplicate claim submission
- Missing or incorrect information
- Providers submitting with incorrect NPI/ZIP code/taxonomy/address/NPI type
- Missing provider NPI/ZIP code/taxonomy
- Rendering provider data missing for provider organizations
- Invalid ICD10 Diagnosis/HCPCS/Revenue code submitted
- Billing/rendering/attending NPIs not enrolled/registered for Medicaid with the state
- NPI's not enrolled/registered in CHAMPS
- No prior authorization obtained for a service that requires one

You can avoid these common errors by doing the following:

- Confirming that enrollee 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 enrollee ID for the billing/rendering/attending NPIs and taxonomies submitted on claims exactly matching the applicable active PML record.

Code editing and payment policies

Humana processes accurate and complete provider claims in accordance with Humana normal claims processing procedures, including, but not limited to, **claims processing edits, claims 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 claims processing procedures is dependent upon the factors reported on each claim. Examples of the most commonly used factors are:

- 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 enrollee
- Whether services can be billed as a complete set of services under one billing code

Humana 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:

- MDHHS 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) Current Procedural Terminology (CPT®) and associated AMA publications and services
- CMS' Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services
- International Classification of Diseases (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
- Food and Drug Administration (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 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 at **Provider.Humana.com**.

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 of any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, see the **Provider appeals** section of this manual.

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

Humana 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 acknowledgment

Humana acknowledges all electronically submitted claims for services within 24 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 ensures the following time frames:

- Within 3 business dates 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.

Claim processing

You have 1 year from the date of service or discharge to submit a claim. If the claim is submitted after the applicable timely filing term, the claim will be denied for timely filing.

If you do not agree with the decision on a processed claim, you have 60 days from receipt of notification that payment for a submitted claim has been reduced or denied to submit an appeal.

If you indicate that a claim was not paid at your contracted rate, you may submit a dispute which must be received by Humana within 60 days of the original claim adjudication date.

If the claim appeal is not submitted in the required time frame, the claim is not considered, and the appeal is denied.

Abortion, sterilization and hysterectomy procedures and initial hospice claims submissions must have consent forms attached. The **Certification for Induced Abortion** and **Consent for Sterilization MSA-1959** forms are available online. (**Link to all forms**)

Claims indicating that an enrollee's diagnosis was caused by the enrollee's employment are not to be paid. You will be advised to submit the charges to Workers' Compensation for reimbursement.

Home health providers are required to bill the electronic HIPAA standard institutional claim transaction (837), or you can bill a paper form CMS-1450, also known as the UB-04. These claims are processed according to the claim guidelines and processing.

You are required to report provider-preventable and healthcare-acquired conditions associated with claims for payment or treatments for which payment would otherwise be made. Claims indicating these conditions are not to be paid. If not submitting a claim, you must report the condition in writing to MDHHS.

Clean claim criteria

Clean claims refer to claims that can be processed without obtaining additional information from the provider of the service or from a third party.

Claims overpayment

You must report to Humana all service claim overpayments for medical services rendered within 60 days of identification of the overpayment, when you have received an overpayment within 60 days after the date on which the overpayment was identified. You must notify Humana in writing of the reason for the overpayment as required by 42 CFR 438.608.

Refund checks for overpayments can be mailed to:

Humana Healthcare Plans

P.O. Box 931655

Atlanta, GA 31193-1655

Humana implements and maintains arrangements or procedures for reporting within 30 calendar days of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to MDHHS-OIG. Humana will report all overpayments to MDHHS. These reports include all unsolicited provider refunds.

Humana follows the retention policies for the treatment of recoveries of all overpayments from Humana to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste or abuse. Humana complies with the process, time frames, and documentation for reporting the recovery of all overpayments, including the required annual report to MDHHS. Humana complies with the process, time frames, and documentation required for payment of recoveries of overpayments to the State in situations where Humana is not permitted to

retain some or all of the recoveries of overpayments. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

You should not refund money paid to an enrollee by a third party. When Humana 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 will ensure that this does not prevent an enrollee from receiving medically necessary services in a timely manner. If Humana is unable to establish that an enrollee has other insurance, Humana 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.

Out-of-network claims

Humana requires out-of-network providers to coordinate with Humana for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network. For additional information, please review the **Out-of-network services** section of this provider manual.

Third-party liability

Humana's plans allow claims for healthcare services provided due to automobile and workplace injuries. However, you must make all reasonable efforts to determine whether there is other coverage for an automobile or workplace injury, such as under automobile or workers' compensation insurance, and must promptly report as described below, in claims submitted to Humana and any such other coverage that is identified.

Additionally, you must bill an enrollee's automobile or workplace injury insurance plan, if applicable, before billing the enrollee's Humana plan. Finally, you must promptly forward to Humana any determination by an automobile or workplace insurance plan made with respect to a claim for a Humana enrollee's injury. Your failure to promptly fulfill any requirement could affect Humana disposition of a claim after initial receipt and/or after initial adjudication.

If you identify automobile insurance, you must include the information below when submitting a paper claim to Humana or equivalent information when submitting an electronic claim to Humana.

Enrollee billing

State requirements and federal regulations prohibit you from billing Humana enrollees for medically necessary covered services except under extremely limited circumstances. Providers who knowingly and willfully bill an enrollee 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.

Humana monitors this billing policy activity based on complaints of billing from enrollees. Failure to comply with regulations after intervention may result in both criminal charges and termination of your contract with Humana.

Government regulations stipulate you must hold enrollees harmless in the event Humana does not pay for a covered service performed by you. Enrollees cannot be billed for services that are administratively denied. The only exception is if a Humana enrollee agrees in advance, in writing, to pay for a non-Medicaid covered service. This contract must be completed prior to providing the service and the enrollee must sign and date the contract acknowledging their financial responsibility. The form or type of contract must specifically state the services or procedures that are not covered by Medicaid.

You should call **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time for guidance before billing enrollees for services.

Suspension of provider payments

Your claim payments are subject to suspension when the state determines that there is a credible allegation of fraud and notifies Humana.

Chapter 13: Provider appeals

Overview

Humana's policies and procedures for provider claim appeals are aligned with the Code of Federal Regulations. All providers and subcontractors agree to be fully compliant with all federal and state laws, regulations, and policies governing provider appeals.

If you disagree with the determination of a claim for a Medicare or Medicaid covered service, you have the right to file an appeal with Humana.

An appeal is a dispute of a claim determination that you receive from Humana in which the enrollee is not at financial risk. Appeals filed by enrollees and/or their authorized representatives (including providers on behalf of a enrollee) regarding adverse benefit determinations or non-coverage decisions made by Humana are handled through the Enrollee grievances, appeals and state fair hearings process found in **Chapter 14** of this manual. Humana ensures that no punitive or retaliatory action is taken against a provider who files an appeal or a provider who supports an enrollee's grievance or appeal.

To request an appeal, you must have submitted a claim for the service and/or supplies in question and received a denial or reduction in payment from Humana. You must submit a written request explaining the basis for the appeal to Humana that includes the following:

- Enrollee name
- Enrollee identification number
- Remittance notification showing the denial or reduction in payment
- Supporting documentation that should be considered with the appeal, such as proof of timely filing, medical records, reason for not obtaining authorization, or other information that supports the appeal or is pertinent to the appeal
- The name, address, and telephone number of the person responsible for filing the appeal

Process and timelines

All appeals should be directed to Humana's Provider Disputes Team. You will have 60 calendar days from receiving the claim determination to file an appeal. Based on the type of issue, your appeal will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

Your appeal may be filed in writing.

Written appeal	You can submit written appeals to: Humana Attn: Provider Appeals P.O. Box 14163 Lexington, KY 40512-4163 Upon receipt of an appeal, the provider disputes team will thoroughly investigate each appeal using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. The provider appeal resolution team will research and resolve the issue within 30 calendar days of receipt. A written notice of resolution will be sent to you once the review is completed.

Provider appeal Q&A

Please note that the time frames for filing a claims appeal or complaint are listed in the table below.

Question	Answer
How do I submit an appeal?	A written appeal can be submitted via mail to: Humana Attn: Provider Appeals P.O. Box 14163 Lexington, KY 40512-4163
What is the time frame for appeal submission?	Claims-related appeals must be submitted within 60 calendar days of the date of the final determination of the primary payer.
What communication can be expected?	Written appeal: • Resolution letter, within 30 calendar days of receipt of appeal.
What is the resolution time frame?	Claims-related appeal: • Within 30 calendar days after receipt of the appeal. • Claims under active review by a mediator, arbitrator or third-party dispute entity are not eligible for a provider appeal.

Medicaid covered services

If a non-contracted hospital disagrees with Humana's appeal decision, they may submit a request to MDHHS for Rapid Dispute Resolution (RDR). Humana must comply with the Hospital Access Agreement for any non-contracted hospital providers. This applies solely to disputes with non-contracted hospital providers that have signed the Hospital Access Agreement. Non-contracted hospital providers that have not signed the Hospital Access Agreement do not have access to the RDR process. When Humana is notified by MDHHS of a request for RDR, the request will be sent to the Humana General Counsel who will coordinate a meeting with the Humana Accounts Receivable Reconciliation Group

(ARRG), which consists of the Humana Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Financial Officer (CFO), Director of Population Health, and Director of Claims, to review the case a second time to determine if payment should be made or if the RDR process should continue. The Clinical Services Manager will attend the meeting to explain the case and determination made by the appeal reviewer. Once a determination has been made by the ARRG regarding if payment should be made, the Humana General Counsel will communicate with MDHHS regarding the RDR request, will be responsible for providing necessary documentation, will be present during the RDR hearing and will communicate the RDR outcome to the ARRG.

Binding arbitration

If you are a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement, have completed the provider appeal process and remain dissatisfied with Humana's determination, you have the option to request binding arbitration. MDHHS will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. Both parties agree to assume the burden of cost for presentation of their positions before the mediator.

Chapter 14: Enrollee grievances, appeals and state fair hearings

Process and timelines

Filing a grievance or appeal

This section outlines the enrollee's appeal rights and the grievance process. This information is supplied so you may assist Humana enrollees in this process, should they request it. You may assist enrollees in filing a grievance or appeal when the enrollee provides written consent. Please contact your Provider Relations representative with questions you have about this process. Providers and subcontractors must agree to be fully compliant with all federal and State laws, regulations, and policies governing the grievance and appeal system.

A grievance refers to any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of Humana's or a provider's operations, activities, or behavior, regardless of whether remedial action is requested. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes, without limitation, an enrollee's right to dispute an extension of time proposed by HIDE-SNP to make an authorization decision.

An appeal refers to a request for review by Humana of an adverse benefit determination (ABD) and any of the procedures that deal with the review of ABDs on the health care services the enrollee believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts enrollee must pay for a service.

Enrollees can call Member Customer Service at **855-281-6070 (TTY: 711),** Available 7 days a week, Oct 1st to March 31st and Monday to Friday, April 1st to September 30th, 8 a.m.-8 p.m., Eastern time to file a grievance or appeal. To file a grievance or appeal in writing, the enrollee may send a letter to Humana Grievance and Appeals, P.O. Box 14163, Lexington, KY **40512-4163**. Grievances and appeals can also be filed online at **Grievance and appeals forms.**

The grievance or appeal should include the following information:

- Enrollee's name, address, telephone number and Humana ID number
- Facts and details regarding the issue and the requested outcome
- The enrollee's signature and date

Enrollees can request assistance from Member Customer Service, ombudsmen and independent advocacy services when filing grievances and appeals. A provider or other authorized person can also help the enrollee during the grievance or appeal process, with the enrollee's written consent.

All grievances and appeals will be considered. The enrollee can have someone act on their behalf during the process, whether it is a provider or someone else. A provider or authorized representative acting on behalf of the enrollee must obtain the enrollee's written consent using an Appointment of Representative (AOR) Form.

Requesting a grievance

The enrollee or the enrollee's authorized representative may file a grievance at any time when they are dissatisfied with Humana or a provider. The enrollee has the right to file a verbal or written grievance. The grievance process may take up to 30 calendar days; however, Humana resolves an enrollee's grievance as quickly as the enrollee's health condition requires. An expedited grievance option is available if the complaint involves Humana's decision to extend the timeframe for an organization determination or appeal, or if the complaint involves Humana's refusal to grant an enrollee's request for an expedited organization determination or an expedited appeal. Expedited grievances will be resolved within 24 hours of receipt. Humana will send the enrollee or authorized representative a letter explaining the outcome of the grievance.

Requesting an appeal

The enrollee or the enrollee's authorized representative may file an appeal within 60 calendar days from the date on the ABD notice. The date of receipt of the ABD is presumed to be 5 calendar days after the date of the ABD notice, unless there is evidence to the contrary. For purposes of meeting the 60-calendar day filing deadline, the request is considered as filed on the date it is received by Humana Dual Integrated. Instructions for filing an appeal, along with the mailing address and fax number, are included in the notice.

If an enrollee, an authorized representative, or a physician acting on behalf of a enrollee shows good cause, Humana Dual Integrated may extend the time frame for filing a request for an integrated reconsideration. If the 60-day period in which to file a request for an appeal has expired, an enrollee, authorized representative, or a physician acting on behalf of an enrollee may file a request for an appeal with Humana Dual Integrated. The request for an appeal to extend the time frame must be in writing and state why the request for the appeal was not filed on time.

The appeal is resolved as quickly as the enrollee's health condition requires, but no later than 30 calendar days from the date of Humana's receipt of the request. Humana then mails a letter to the enrollee and their authorized representative advising the outcome of the appeal.

Humana may extend this time frame by up to 14 calendar days if the enrollee requests an extension or if more information is needed to make a decision and extending the time frame is beneficial to the enrollee (e.g., receiving the additional information would likely result in approval of the appeal). Humana will attempt to provide verbal notice of the need for an extension and we will send written notice within 2 calendar days of the decision to extend the time frame. If the enrollee or the enrollee's

authorized representative disagrees with the extension, they may file an expedited grievance.

Humana will make a determination on appeals for Children's Specialized Health Care Services (CSHCS) program enrollees no later than 10 calendar days after the appeal request is received.

Humana has only one level of appeal for enrollees.

Requesting an expedited appeal

The enrollee or the enrollee's authorized representative has the right to request an expedited or urgent appeal when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health or ability to attain, maintain or regain maximum function.

If Humana must receive medical information from non-contracted providers, Humana requests the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited appeal. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist Humana in meeting the required time frame. Regardless of whether Humana must request information from non-contracted providers, Humana is responsible for meeting time frame and notice requirements.

Expedited appeals are resolved as quickly as the enrollee's health condition requires, but no later than 72 hours after receipt. When making an appeal, the enrollee or the representative need to notify Humana that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling Member Customer Services at **855-281-6070, Customer Care is available seven days a week, Oct. 1 – March 31 and Monday – Friday, April 1 – Sept. 30, 8 a.m. – 8 p.m., Eastern time** If it is determined that an expedited process is not required, the appeal will go through the standard process. If a request to process an appeal as expedited is denied, we will attempt to provide verbal notice that the appeal will be processed within the standard resolution time frame and we will send written notification within 2 calendar days.

Humana may extend this time frame by up to 14 calendar days if the enrollee requests an extension or if more information is needed to make a decision and extending the time frame is beneficial to the enrollee (e.g., receiving the additional information would likely result in approval of the appeal). Humana will attempt to provide verbal notice of the need for an extension and we will send written notice within 2 calendar days of the decision to extend the time frame. If the enrollee or the enrollee's authorized representative disagrees with the extension, they may file an expedited grievance.

NOTE: Humana does not discriminate against or take punitive action against enrollees or providers that request an expedited appeal resolution or providers that support an enrollee's appeal, as required by 42 C.F.R 438.410(b).

Medicaid state fair hearing process

If an enrollee is dissatisfied with Humana's appeal decision regarding a Medicaid covered service or an overlapping service that is covered by both Medicaid and Medicare, the enrollee can ask for a state fair hearing. With the enrollee's permission and a signed consent form, providers may act on the enrollee's behalf and ask for a state fair hearing from the state.

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

Enrollees can contact the Michigan Department of Health and Human Services to request a state fair hearing at:

MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MI 48909
Fax: 517-763-0146
Phone Number: 1-800-648-3397

Continuation of benefits

Enrollees have the right to continue services during the appeal and state fair hearing process. If an enrollee wants services to continue, the following is required:

- For appeals, the enrollee must submit the request within 65 calendar days of the date on the notice of action.
- For state fair hearings, the enrollee must submit the request within 120 calendar days of the date on the notice of action.
- The enrollee must request that benefits be continued within 10 calendar days of the date on the notice of action, or by the intended effective date of the proposed adverse 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 time period covered by the original authorization must not have expired.

If the enrollee receives a continuation or reinstatement of their benefits while the appeal or state fair hearing is pending, then Humana will continue the benefits until one of the following occurs:

- The enrollee withdraws the appeal or state fair hearing request.
- A state fair hearing officer issues a decision that is adverse to the enrollee.
- The original authorization time period expires, or the authorization service limits are met.

If the state fair hearing is decided in the enrollee's favor and services are not provided to the enrollee while the state fair hearing is pending, Humana will approve the services as expeditiously as the enrollee's health condition requires, no later than 72 hours from the date we receive notice of the favorable decision.

Chapter 15: Credentialing and recredentialing

Overview

Provider credentialing is the process of reviewing the qualifications and appropriateness of a provider to join Humana's network. Humana conducts credentialing and recredentialing activities utilizing the guidelines established by the National Committee for Quality Assurance (NCQA), CMS, federal, state, and local regulatory agencies as required by the MDHHS. Humana 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 must 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 processes credentialing applications from all provider types within 60 business days of receipt of a completed credentialing application, including all necessary documentation and attachments.

Provider recruitment and nondiscriminatory credentialing policy

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

As part of this process, Humana 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 recredentialing application and/or Council for Affordable Quality Healthcare (CAQH) application or contact your provider relations representative to request updates.

Humana gathers information on the languages in which healthcare providers are fluent, particularly concerning their ability to communicate medical care effectively. This includes details about any language services offered through the practice. Additionally, Humana gathers data on race, language skills and ethnicity of providers. Providing this information is entirely voluntary.

Provider background checks

A background check may be applicable depending on provider type and service. A comprehensive background check may include prior provider verification, professional reference checks, education confirmation and verification that the provider is not on the OIG list, since providers on this list are ineligible for participation in Humana's network.

Individual provider credentialing

CAQH application for individual providers

Humana is a participating organization with **CAQH**. Please ensure Humana is able to access your credentialing application by completing the following steps:

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

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

- Practicing specialty
- NPI
- Contact name and email address used for credentialing purposes
- Current practice address, including suite number and fax number if applicable
  - Licensure information for each state in which the provider provides care, as applicable by provider type
  - Current Drug Enforcement Administration (DEA)/Controlled Substance License information for each state in which the provider provides care, as applicable by provider type
- Hospital privileges or coverage arrangements, as applicable by provider type
- Work history—at least 5 years of continuous work history experience, aps of more than 6 months must be explained
- Provider enrollment ID issued by the MDHHS

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

- Proof of current malpractice insurance with the minimum amount in accordance with state laws in which the provider provides care
- Summary of professional liability claim(s) pending or filed against you within the previous 5 years. Please include date of occurrence, summary of events, present status of the claim, and amount paid, if applicable

Failure to submit a complete application will result in a delay in completing or beginning the credentialing process.

Facility/organizational/ancillary providers

Required information for organizational provider credentialing

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

- The Organizational Provider Assessment form with an attestation signature date no more than 90 days from the signature date;
- W-9 tax form;
- Disclosure of ownership form;
- NPI;

A copy of the following supporting documentation attached to the facility enrollment application:

- The facility's license, as applicable
- Accreditation letter, as applicable
- CMS certification, as applicable
- Malpractice insurance policy face sheet showing effective and expiration dates and limits of liability within amounts at the minimum amount in accordance with state laws in which the organization provides care
- CLIA, as applicable
- Provider enrollment ID issued by the MDHHS
- National Council for Prescription Drug Programs (NCPDP) or National Association of Boards of Pharmacy (NAPB) for pharmacy providers
- Medical staff's drug control license for opioid treatment programs

Failure to submit a complete application will delay our ability to complete or begin the credentialing and contracting process.

Managed HCBS/LTSS providers

Required information for providers offering Community-Based MLTSS services

Humana is proud to collaborate with the Detroit Area Agency on Aging (DAAA) to coordinate home and community-based long-term services and supports. Providers delivering the home and community-based (HCBS) services listed below are encouraged to contact their local AAA for credentialing or recredentialing support.

This applies to Home and Community-Based Services (HCBS) providers offering services under the 1915(c) waiver and state plan personal care programs, including:

- Vehicle modifications
- Expanded community living supports

- Adult day programs
- Respite care
- Adaptive medical equipment and supplies
- Fiscal intermediary services
- Individually directed goods and services
- Assistive technology
- Chore services
- Environmental modifications
- Home-delivered meals
- Personal emergency response systems
- Preventive nursing services
- Private duty nursing
- Non-medical transportation
- State plan personal care services, including personal care supplements for enrollees in adult foster care homes or homes for the aged

For more information or to begin the credentialing process, please reach out to the Detroit Area Agency on Aging.

Credentialing/assessment and recredentialing/reassessment overview

Practitioners

Medical and behavioral health: individual providers

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

Evaluating providers included within the scope of credentialing for the Humana network includes, but is not limited to, the following:

Physical health providers:

- Physicians (M.D./D.O.)
- Oral surgeons
- Chiropractors
- Podiatrists

- Dentists
- Optometrists
- Audiologists
- Hearing instrument specialists
- Allied health providers, including:
  - Advanced practice registered nurses (APRN)
  - Clinical nurse specialists (CNS)
  - Certified nurse midwives (CNM)
  - Physician assistants (PA)
  - Therapists, including:
    - Speech and speech and language pathologists
    - Occupational
    - Physical
- Other medical practitioners who may be within the scope of credentialing and who are licensed, certified, or registered to practice independently, under supervision, or as required by State legislation, including but not limited to:
  - Registered dieticians
  - Physical and occupational therapy assistants
  - Genetic counselors
  - Doulas
  - Michigan Diabetes Prevention Program (MiDPP) lifestyle coaches
- Pharmacists who practice within a medical office setting, provide medication management, testing, or other medical services.

Behavioral health providers:

- Psychiatrists and other M.D. or D.O behavioral health providers
- Addiction medicine specialists
- Doctoral or master's level psychologists who are State certified or licensed
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or State certified or licensed
- Master's level Licensed Clinical Social Worker (LCSW)
- Master's level Licensed Professional Counselor (LPC)
- Master's level Licensed Marriage and Family Therapist (LMFT)
- Other behavioral health Providers who are licensed, certified, or registered to practice independently, under supervision, or as required by State legislation, including but not limited to:

- Limited licensed social workers
- Limited licensed professional counselors
- Limited licensed marriage and family therapists
- CTS navigators

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

Credentialing application

Signed and dated CAQH credentialing application, including supporting documents, signature not more than 90 days from the date inserted in the signature block.

Licensure

Unrestricted license issued by the appropriate licensing board for all states the provider offers services to enrollees.

DEA and a controlled substance registration

- Unrestricted DEA in the practicing state, as applicable;
- Unrestricted controlled substance license issued by the state pharmaceutical licensing agency, as applicable

If you state in writing that you do not prescribe controlled substances and that, in your professional judgment, the patients receiving your care do not require controlled substances, you are not required to have a DEA/Controlled substance license; but you must describe your process for handling instances when a patient requires a controlled substance.

Education and training

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

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

Board certification

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

Admitting privileges

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

Work history

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

Malpractice insurance

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

Malpractice history

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

NPI

- Provider must have an NPI verifiable via the National Plan and Provider Enumeration System (NPPES).

Eligible for Medicaid

Provider demonstrates current eligibility for participation in Medicaid.

- Provider must be enrolled with MDHHS.
- Must not be sanctioned, excluded, or debarred from participation in any Medicaid program.

In good standing with regulatory agencies

Providers, or agents or managing employees of providers, are in good standing with and not debarred, suspended or otherwise excluded by federal, state or local agencies including:

- Medicaid agencies, including the Medicaid Michigan sanction provider list: **List of Sanctioned Providers**
- Medicare intermediaries, including:
  - CMS Medicare preclusion list
  - CMS opt-out list
- Health and Human Services – Office of Inspector General (HHS-OIG)
- General Services Administration (GSA)
- State sanctions and restrictions on licensure

Performance indicators

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

Organizational providers

Hospital and ancillary providers

Evaluating providers included within the scope of credentialing for the Humana network includes, but is not limited to, the following:

- Clinical laboratories
- Comprehensive outpatient rehabilitation facilities (CORF)
- Diabetes prevention programs
- Dialysis centers/end-stage renal dialysis (ESRD) centers
- Federally qualified health centers (FQHC)
- Free standing ambulatory surgery centers
- Free-standing birthing centers
- Hearing centers
- Home health agencies
- Hospice providers
- Hospitals
- Independent diagnostic testing facilities
- Local health departments
- Medical equipment suppliers
- Pharmacies
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Portable X-ray suppliers
- Rural health clinics (RHC)
- Skilled nursing facilities
- Tribal health centers (THC)
- Urgent care clinics

Behavioral healthcare facilities providing mental health in an inpatient, residential/extended care facility, and ambulatory settings, including but not limited to:

- Community health centers (CMHC)
- Distinct part psychiatric units
- Federally qualified health centers (FQHC)

- Free-standing psychiatric hospitals
- Opioid treatment programs (OTP)Psychiatric Rehabilitation Treatment Facilities
- Rural health clinics (RHC)
- Substance use and alcohol abuse centers (outpatient)
- Substance use residential treatment facilities

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

Organizational enrollment form

Complete organizational assessment form.

Licensure/Business License/Permit, as applicable.

As required by state, federal, and local regulatory bodies the provider is currently licensed. Organizations requiring licensure must be in good standing with the appropriate licensing board.

Insurance coverage

Current general/comprehensive/malpractice liability insurance coverage or participation in Federal Tort Program as applicable per state requirements

NPI

Provider must have an NPI verifiable via the National Plan and Provider Enumeration System (NPPES)

Eligible for Medicaid

Provider demonstrates current eligibility for participation in Medicaid.

- Provider must be enrolled with MDHHS, including the Medicaid Michigan sanction provider list: **List of Sanctioned Providers**
- Provider must not be sanctioned, excluded, or debarred from participation in any Medicaid program

Eligible for Medicare

Provider demonstrates current eligibility for participation in Medicare, as applicable.

- Must not be sanctioned, excluded, or debarred from participation in Medicare
- Verification the Provider has not opted-out of participation with Medicare
- Verification the Provider does not appear on the CMS preclusion list

Free from sanctions, exclusion, or debarment

Verification the Provider has not been sanctioned, excluded or debarred by the OIG, the System for Award Management (SAM), or any other disciplinary action by any federal, state or local entity identified by CMS.

Clinical Laboratory Improvement Amendments

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

On-site quality assessment

Provider must supply evidence an on-site quality assessment has been conducted, as applicable.

- Accreditation body – Organizational provider must supply a copy of the accreditation report or evidence from the Accreditation Body that the Provider is accredited.
- CMS or State quality review – If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own onsite quality assessment. Humana will verify that an onsite 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 – If the CMS or state review is older than 3 years, Humana will conduct its own onsite 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 may choose not to conduct a site visit.

NOTE: The Provider Office and Facility Location Survey tool is used in cases where a site visit is required.

Disclosure of Ownership

- CMS disclosure form CMS 1513
- MDHHS provider controlling interest/ownership disclosure
- Humana's disclosure of ownership, business transactions and exclusions statement for providers

HCBS/LTSS providers

Providers offering LTSS services

Humana is proud to collaborate with the Detroit Area Agency on Aging to coordinate home and community-based (HCB) services. Providers delivering the home and community-based LTSS listed below are encouraged to contact the Detroit Area Agency on Aging for credentialing or recredentialing support.

This applies to Home and Community-Based Services (HCBS) providers offering services under the 1915(c) waiver and state plan personal care programs, including:

- Vehicle modifications
- Expanded community living supports
- Adult day programs
- Respite care
- Adaptive medical equipment and supplies

- Fiscal intermediary services
- Individually directed goods and services
- Assistive technology
- Chore services
- Environmental modifications
- Home-delivered meals
- Personal emergency response systems
- Preventive nursing services
- Private duty nursing
- Non-medical transportation
- State plan personal care services, including personal care supplements for enrollees in adult foster care homes or homes for the aged

For more information or to begin the credentialing process, please reach out to the Detroit Area Agency on Aging:

Email: **contractmgt@daaa1a.org**

Phone: **313-446-4444**

Helpful tips for providers

Practitioner credentialing		
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 • Certification	The information on CAQH must match the information you provide on your network participation request. • Log on to the **CAQH website** using your account information. – Select the Authorization tab. – Confirm Humana is listed as an authorized health plan; if not, please check the authorized box to add. • Ensure your CAQH application is up to date before requesting to join the network.

Practitioner credentialing		
Need	**Most common mistakes**	**Recommendation**
Supporting documents	The incorrect document is provided. The document is expired or will expire within the next 30 days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to receive requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

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

Recredentialing process

Network providers, including practitioners, organizational and HCBS providers, are recredentialed at least every 36 months/3 years. As part of the recredentialing process, Humana 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.

Credentials Committee

The credentialing committee is overseen by a Humana Chief Medical Officer and is responsible for making determinations for all credentialing and recredentialing decisions. The credentials committee

meets monthly and is comprised of 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.

Provider rights in the credentialing and recredentialing process

Notification of provider rights is contained within this Humana Provider Manual. You have the right to review information obtained to evaluate your credentialing application, attestation or CV and the right to correct erroneous information. Humana notifies you when credentialing information obtained from other sources varies substantially from information provided by you. You should be notified within 7 days of the discrepancy. The notification indicates which part of the application is discrepant, the format for submitting corrections and the person to whom corrections should be submitted. If the application, attestation and/or CV must be updated, only you may attest to the update, a staff member may not. You have 14 business days to respond to resolve the discrepancy. The receipt of any corrections should be documented in the credentialing file.

You have the right, upon request, to be informed of the status of your application. Humana should respond to these requests in a timely manner. Once your application for initial credentialing has been approved or denied, you should be notified within 30 days. Credentialing denials will be communicated to you by the medical/dental director in writing, will include the reason(s) for the denial and should be provided within 30 days of denial.

Humana will make available all application and verification policies and procedures upon written request from the applying healthcare professional.

Provider responsibilities in the credentialing and recredentialing process

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

Reconsideration of credentialing/recredentialing decisions

Humana's Credentials Committee must notify you of a denial based on credentialing/certification criteria. The notice must inform you of the reasons for the denial and, in the case of a denial based on credentialing/certification criteria eligible for Credentials Committee reconsideration, provide notice of such opportunity to request reconsideration of the decision in writing within 30 days of the notice

or sooner, as required by state or federal regulations. Unless otherwise noted, denials based on a failure to meet administrative criteria are final with no reconsideration rights. Where applicable, in the event such reconsideration is requested in a timely manner, the Credentials Committee may affirm, modify or reverse the initial decision. Humana notifies you in writing of the Credentials Committee's reconsideration decision within 30 days. Providers who have been denied are eligible to reapply for network participation once they meet the minimum health plan credentialing/certification criteria. To submit a reconsideration request, mail the reconsideration request, including all additional supporting documentation, to the medical director at:

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

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

After reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana notifies the applicant, in writing, of the Credentials Committee's reconsideration decision within 30 days. Reconsideration denials are final unless the decision is based on quality criteria; in those 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's minimum credentialing/certification criteria.

Ongoing provider monitoring

Humana 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 days of its release:

- Medicare and Medicaid sanctions and exclusions, available online
- List of Excluded Individuals and Entities (LEIE)/OIG
- Excluded Parties List System (EPLS)/SAM
- Sanctions or limitations on licensure
- Complaints
- Identified Adverse Events

Delegation of credentialing/recredentialing

Humana may delegate credentialing and recredentialing activities to organizations or entities that are able to demonstrate compliance with federal, state and accreditation requirements such as NCQA's. Humana retains the right to approve, suspend and terminate providers and sites where it has delegated decision-making.

When Humana elects to delegate credentialing and/or recredentialing, an approved written agreement outlining those delegated activities and any other responsibilities of the delegate should be signed before the delegate performs any delegated activities. The written agreement should be mutually agreed upon and contain the following information:

- Humana's and the delegated entity's responsibilities
- Description of the delegated activities
- Required minimum of semi-annual reporting to Humana
- Process by which Humana evaluates the delegate's performance
- Remedies, including revocation of the delegation agreement, available to Humana if the delegated entity does not fulfill its obligations
- A statement that Humana retains the right to approve, suspend and terminate providers and sites where it has delegated decision-making.

Prior to implementing delegation, the delegate's performance capacity is evaluated through the pre-delegation audit process to ensure the entity demonstrates compliance with the applicable federal, state and accreditation requirements. Once the delegation agreement is executed, the delegate's performance is evaluated on an annual basis to ensure the delegated entity remains compliant with applicable federal, state and accreditation requirements. Opportunities for improvement should be identified and followed up on at least once every 2 years.

If a delegate sub-delegates credentialing to another entity, documentation verifying that the delegate performs oversight and conducts annual audits is required, unless Humana chooses to conduct these activities itself. Complete listings of all providers credentialed and/or recredentialed are due from the delegate on a semi-annual basis and reviewed by Humana.

Chapter 16: Fraud, waste and abuse (FWA)

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

Abuse includes provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Humana 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 Humana 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, enrollees 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 or within their respective organization, which then must report it to Humana 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 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 an enrollee intentionally permitting others to use the enrollee's ID card to obtain services or supplies from the plan or any network provider
- Is suspicious that someone is using another enrollee's ID card
- Has evidence that an enrollee knowingly provided fraudulent information on the enrollee's enrollment form that materially affects the enrollee's eligibility

Information can be reported via an anonymous phone call to Humana's fraud hotline at **800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Humana 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 at **800-4Humana (448-6262).**

Reporting FWA

Key features of methods for direct reporting to Humana

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

Confidentiality: Processes are in place to maintain confidentiality of reports; allows confidential report follow-up. Humana 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** at **1-800-614-4126** Ethics Help Line **at 1-877-5-THE-KEY (1-877-584-3539)** to report fraud, waste or abuse.

Chapter 17: Pharmacy

Pharmacy Overview:

Humana HIDE-SNP enrollees have access to an integrated formulary that includes both their Medicare and Medicaid pharmacy benefits. Information on our formularies and pharmacy process can be found in the **Medicare pharmacy provider manual** on Humana's website. The manual includes information on the following:

- How to Join our Network
- Contact Information
- Eligibility verification
- Drug coverage
- Claims procedures
- Medicare claims coverage
- Long-term care
- Home infusion billing procedures
- Compound claims
- Medicaid Therapy Management program
- Pharmacy audit and compliance
- Complaint system
- Price source and maximum allowable cost information

Requesting coverage determinations

You can request coverage determinations, such as medication prior authorization, step therapy, quantity limits and formulary exceptions, by:

- Obtaining forms at **Humana.com/PA**
- Submitting requests electronically by visiting **https://www.covermymeds.health/prior-authorization-forms/humana** or **www.availity.com**
- Faxing requests to **877-486-2621**

- Calling Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN (800-555-2546)** Monday – Friday, 8 a.m. to 11 p.m., Eastern time.

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

To find out which services require authorization, please review the preauthorization and notification lists at **Humana.com/PAL**.

Pharmacy and Therapeutics Committee

Humana and other health plans in the state are required to follow the Common Core Formulary and Utilization Management. For drugs in Common Core Formulary open drug classes, Humana reviews changes through Humana's P&T Committee. Humana's P&T Committee ensures safe, appropriate and cost-effective use of pharmaceuticals for Humana enrollees. The P&T Committee serves in an evaluative, educational and advisory capacity to Humana staff and participating providers in matters including, but not limited to, pharmacy requirements and the appropriate use of medications. Humana P&T Committee meets at least quarterly and is comprised of physicians and pharmacists holding valid professional licenses. The committee includes at least 1 practitioner in each of the following specialties: pediatrics, gerontology/geriatrics and psychiatry. All individuals participating in the P&T Committee must complete a financial disclosure form annually, which is reviewable upon request.

Coverage limitations

Humana limits coverage to a standard supply of medication per prescription per enrollee in accordance with the prescriber's orders and applicable regulations. Humana generally allows processing of a 30-day supply, and in come cases up to a 100-day supply with certain exclusions. Specific day supply limits may vary. Providers should refer to the plan's formulary and applicable coverage benefits for guidance on drug supply limits and exceptions.

Prescription drug formulary

In accordance with 42 CFR § 438.10(i), Humana makes the following information available about our formulary in electronic or paper form:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

Humana formulary drug lists are available on the Humana website.

Humana allows access to all medically necessary nonformulary or nonpreferred drugs, other than those excluded from coverage.

If Humana administers a closed formulary, there is an exception process for circumstances where the formulary does not adequately accommodate enrollees clinical needs and a process for prescribing practitioners to submit information that supports exception requests.

Formulary updates

Humana may add or remove drugs from the formulary throughout the year. Humana may also change Utilization Management requirements for covered drugs.

Notification of negative changes to the formulary and Utilization Management requirements are provided to all affected participating providers and enrollees prior to the effective date of the change. Providers can view those changes and the current preferred drug list at **https://provider.humana.com/pharmacy-resources/tools/humana-drug-lists**. To view current medical and pharmacy coverage policies, please visit **Medical and Pharmacy Coverage Policies.**

Medications administered in the provider setting

Humana covers medications administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Utilization Management requirements exist for many injectables. Humana may add or remove drugs from the preauthorization list (PAL) throughout the year. Providers can view those changes and the current PAL at **Humana.com/PAL.**

Medication Therapy Management

Humana offers a Medication Therapy Management (MTM) program that helps ensure enrollees achieve the best possible outcomes from their medications. The patient-centered MTM program promotes collaboration between the pharmacist, enrollee 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 can call **Provider Services** at **855-281-6070** Monday – Friday, 8 a.m. – 8 p.m., Eastern time or Humana Clinical Programs at **833-349-4114**.

Chapter 18: Long-term services and supports

Humana and the Detroit Area Agency on Aging

Humana has entered into a relationship with the Detroit Area Agency on Aging (DAAA), which is a nonprofit organization that serves older adults, adults with disabilities, and caregivers, to provide network management services and service coordination for all HCBS waiver services and state plan personal care services as part of this program. Providers will need to contract with the DAAA to provide services to Humana enrollees that are enrolled in the program. The DAAA will be required to adhere to the contractual requirements outlined by the state. Specific information, such as requesting authorizations, claims submissions and contracting will be managed directly by the DAAA.

Overview

As a LTSS professional, you play a very important role in the delivery of healthcare services to Humana enrollees. Services are to be provided in accordance with an individualized care plan developed by Humana in consultation with the enrollee and which includes services determined through an assessment by Humana (either directly or through a subcontractor/DAAA) to be necessary to address the health and service needs of the enrollee. All LTSS services delivered to enrollees by Humana's contractors (either directly or through a subcontract) must be guided by the following service delivery principles:

- Services must be individualized as a result of a competent, comprehensive understanding of an enrollee's multiple needs.
- Services must be delivered in a timely fashion in the least restrictive, cost-effective and appropriate setting.
- LTSS must be based on an enrollee's plan of care and include goals, objectives and specific treatment strategies.
- Services must be coordinated to address comprehensive needs and provide continuity of care.
- Services must be delivered regardless of geographic location within the service area, function level, cultural heritage and degree of enrollee illness.
- The provider's administration and service delivery system must ensure enrollee participation in care planning and delivery and, as appropriate, allow for the participation of family, significant others and caregivers.

- Humana must provide interpreter services (in-person, where practical, but otherwise by telephone) for enrollees who do not speak English as a primary language. Annual agency-provided non-English versions of materials are required if the county population that speaks a particular non-English language exceeds 5%.
- Services must be delivered by qualified providers as defined by applicable contract.
- All facilities providing Enrollee Services must be accessible to persons with disabilities, be smoke free and have adequate space, supplies, adequate sanitation and fire and safety procedures, per federal, state and local laws and regulations.

Covered services

Through its contracted provider network, Humana is required to arrange for medically necessary services for each enrollee, including both community-based and skilled nursing facility services. When providing covered services to plan enrollees, you must adhere to applicable plan coverage provisions and all applicable state and federal laws. In addition to the HCBS timely access services below, Humana must ensure that 90% of enrollees have access to skilled nursing facility services within the required time and distance standards below:

	Large Metro	Metro	Micro	Rural	Counties with extreme access considerations
Time in minutes to a Skilled Nursing Facilities	20	45	80	75	95
Distance in miles to Skilled Nursing Facilities	10	30	60	60	85

For a complete list of LTSS covered services please refer to the **LTSS Covered Services** section within the Appendix of this manual.

Care coordination and service authorization

LTSS service authorizations for Home and Community-Based waiver services and state plan personal care services are created by the HCBS care coordinator employed by the DAAA.

The care coordinator completes a comprehensive assessment and works with the enrollee to identify care needs and identify resources to meet those needs. The care coordinator creates the LTSS service plan during the visit. If care needs exceed the state-provided service cost maximums, then the service authorization request is sent to the LTSS management team for further evaluation and review for medical necessity based on enrollee care needs. Service denials or reductions are issued

from the medical director. Providers can request LTSS services, but all service authorization additions or changes must go through the care coordinator and be based on enrollee assessment of needs. Providers can email Humana LTSS care coordinators at **HumLTSStransitions@Humana.com** to request LTSS services on behalf of a Humana-covered enrollee.

LTSS claims

For home and community-based waiver services and state plan personal care services, Humana contracts with the Detroit Area Agency on Aging for claims management, adjudication, and payment. Providers of these services must submit claims through the process identified by the Detroit Area Agency on Aging.

LTSS provider responsibilities

Humana uses an ICT to support coordination of care for all enrollees Our ICT approach will use our CMS approved model of care to provide ICT services.

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

We convene an ICT skilled in nursing, social work and behavioral health for enrollees In addition to the minimum ICT participants (the enrollee, the care coordinator, the service coordinator and any enrollee-selected supports, including informal caregivers), the care coordinator will elicit the feedback of the enrollee on who else the enrollee 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 enrollee's individualized needs and goals. The care coordinator may suggest adding participants to the ICT, including Humana associates, network providers, representatives from community-based organizations and other care coordinators, in reflection of the enrollee's needs. However, the enrollee has ultimate signoff on who is engaged in the ICT and reserves the right to invite others as the enrollee deems necessary.

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

Level-of-care assessment and reassessment processes

Humana contracts with the Detroit Area Agency on Aging to perform NFLOC assessments for HIDE-SNP waiver eligibility. Humana collaborates with the long-term care facilities (nursing facilities) to complete NFLOC assessments to establish enrollee's eligibility for state plan nursing facility coverage. Humana incorporates the level-of- care assessment results from the assessment into the

comprehensive health assessment tool (CHAT). If the enrollee's circumstances have substantially changed since the level-of-care assessment was completed, or if more than 3 months have elapsed between completion of the level-of-care assessment and completion of the CHAT, the enrollee's Humana care coordinator reviews the level-of-care assessment responses with the enrollee to confirm their accuracy.

The HCBS Care Coordinator employed by the Detroit Area Agency on Aging will complete annual re-assessment and interval re-assessments for changes in condition. For enrollees residing in nursing facilities, the results of the enrollee's annual level-of-care reassessment conducted by the nursing facility and/or the Humana Care Coordinator, after which the enrollee's care coordinator will conduct a visit to the enrollee to review and update the enrollee's ICP and complete any other needed reassessments. As with the initial assessment process, the care coordinator and service coordinator encourage the enrollee to invite the enrollee's caregivers, natural supports and other chosen ICT participants in the ICT process. The care coordinator and service coordinator ensure that the updated assessments and ICP are shared with ICT participants via our Clinical Documentation System or another participant-preferred method of data sharing.

Needs assessment service planning requirements

Humana performs strengths-based, LTSS-specific service planning processes for these enrollees, 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 state required assessments including the Nursing Facility Level of Care Determination, Personal Care Assessment, and InterRAI HC.

The person-centered approach encourages the enrollees completing LTSS -specific assessments to include their informal caregivers, family members and other individuals in the enrollee's circle of support in the assessment conversations.

To reduce enrollee abrasion and support a cohesive and streamlined assessment process, dual visits with both the HIDE-SNP care coordinator and the HCBS care coordinator will be offered. This ensures that both the HIDE-SNP care coordinator and HCBS care coordinator get the full picture of the enrollee's needs, preferences and goals, across all service types.

The HCBS care coordinator uses the information gathered via the LTSS assessments to develop the enrollee's service plan, working in collaboration with the enrollee and the enrollee's supports and ICT to identify those services and supports that best meet the enrollee's needs and goals, including a goal to transition to a less restrictive setting. The service coordinator will ensure that all enrollee needs are addressed with a service that fits the enrollee's preferences and desires.

HCBS

During service planning, care coordinators leverage their experience, training and expertise to evaluate individual enrollee needs and recommend appropriate services and supports. The HCBS care coordinator will issue a service authorization that meets the state-identified thresholds.

Policies related to LTSS authorization

Humana adheres to the following policies pertaining to LTSS authorization:

- LTSS authorizations are created by DAAA partners based on the results of strength-based assessments including the state-required HCBS assessment tool.
- Recommended services can be approved by the service coordinator in real time if the enrollee agrees. All enrollee requests that differ from the recommendation are sent to our UM team for review.
  - Our UM program is evidence-based and guided by a set of clinical practice guidelines adopted from clinically sound and reputable agencies.
  - 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.
  - All enrollee-initiated decisions to authorize a service authorization request for a service in an amount, duration or scope that is less than recommended are auto-approved and indicated that the enrollee declined the additional services.
  - Once the service plan is created and authorizations are approved, service authorizations are automatically delivered to you.
  - Humana aligns authorizations with the services documented and agreed upon by the enrollee/representative on the enrollee's plan of care. The authorized services will be ongoing according to the time frames specified in the agreed-upon service plan.
  - The service request/authorization sent to you 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.
  - The service plan provided to the enrollee includes a listing of the services and items that will be authorized by Humana, 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, and your name.
  - Humana typically authorizes HCBS services for a duration of 12 months which will update when the enrollee's condition changes.
  - Continuing authorization of services occurs via the process described above.
  - Humana 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 is not required to approve claims for which written authorization is not available.
- Humana 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 days of enrollment when the enrollee has already been determined to meet NFLOC and is receiving HCBS.

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

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

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

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

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

For enrollees who are determined to meet NFLOC by the state-designated entity(ies) following a referral by or on behalf of an enrollee, regardless of referral source, the service coordinator will conduct a face-to-face visit with the enrollee and complete and approve a service plan within 20 days of receiving the enrollee's NFLOC determination notification from the state-designated entity.

Providers should begin services as soon as possible upon receiving a notification from the service coordinator, and no later than the LTSS Timely Access Standards outlined in the table below.

HIDE-SNP network adequacy standards - LTSS timely access standards					
LTSS provider and service type	Length of time, measured in calendar days, from authorization to initiation of service				
	Large Metro	Metro	Micro	Rural	Counties with extreme access considerations
Adaptive/enhanced durable medical equipment and supplies	21			28	
Assistive technology devices	21			28	
Chore services	14			21	

HIDE-SNP network adequacy standards - LTSS timely access standards					
LTSS provider and service type	Length of time, measured in calendar days, from authorization to initiation of service				
	Large Metro	Metro	Micro	Rural	Counties with extreme access considerations
Expanded Community living supports	7			14	
Home delivered meals	14			21	
Personal emergency response system	30			30	
Preventive nursing services (non-agency and agency)	7			14	
Private duty nursing (non-agency and agency)	7			14	
Respite	7			14	
Respite - non-waiver (provided in the home)	7			14	
Vehicle modifications	90			120	

Timely access is measured in Calendar Days

For requests related to HCBS, once a decision to deny has been made, a notice to the enrollee will be provided within 14 days.

Our care coordinators ensure that the requisite level of support is provided for ensuring that the enrollee 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 enrollees in gaining access to LTSS services and other covered services
- Identifying, coordinating and assisting enrollees in gaining access to noncovered medical, social, housing, educational, financial and other services and supports, including services provided by other community resources
- Informing enrollees about available LTSS, required assessments, the person-centered service plan, service alternatives and service delivery options, including participant direction, risks and responsibilities
- Protecting an enrollee's health, welfare and safety, including developing an emergency plan
- Facilitating enrollee access to locating, coordinating and monitoring needed services and supports
- Collecting additional necessary information, including, at a minimum, enrollee preferences, strengths and goals

- Reassessing an enrollee's level of care annually
- Assisting in identifying and choosing willing and qualified providers
- Coordinating efforts and prompting the enrollee to complete activities necessary to maintain LTSS eligibility
- Exploring coverage of services to address enrollee-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 enrollee 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

Appendices

Phonebook

Contact	Phone	Hours	Other information
Availity Essentials	800-282-4548	8 a.m. to 8 p.m., Eastern time, Monday to Friday	This is the customer service/technical support information for enrollees' secure provider portal, Availity Essentials.
Care coordination	Phone: 877-264-2547 (TTY: 711) Fax: 844-252-1705	9 a.m. to 6 p.m. Eastern time, Monday to Friday	For enrollee care coordination referrals.
Claim and Encounter Submissions			Providers can submit claims and encounters electronically or on paper. Electronic claim submissions can be made via Availity Essentials. Humana medical claims, dental claims, and encounters can be submitted via mail. Humana medical claims | submit via mail to: Humana Claims P.O. Box 14359 Lexington, KY 40512-4359 Humana encounters | submit via mail to: Humana Encounters P.O. Box 14055 Lexington, KY 40512-4055
Clinical Intake Team	855-281-6070	6 a.m. to 7 p.m., Central time, Monday to Friday	For medical services and Humana behavioral health service prior authorization requests and notifications

Contact	Phone	Hours	Other information
Communication Assistance, Interpreters, and Alternative Formats	877-320-2233	8 a.m. to 8 p.m., Eastern time	Humana provides over-the-phone interpretation in over 150 languages at Humana touchpoints. Humana 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. Email: ADAservices@humana.com
DentaQuest In-Network Provider Services Line	844-870-3977		This is the in-network provider service line for DentaQuest.
Electronic eligibility, claim status, prior authorization			**Availity Essentials**.
Ethics Helpline	877-5-THE-KEY, 877-584-3539		This is a tool for reporting fraud, waste and abuse.
General correspondence			General correspondence for Humana can be mailed. Mail: Humana P.O. Box 14359 Lexington, KY 40512-4359
Grievances and appeals (provider)			Providers can submit written appeals to: Humana Attn: Provider Appeals P.O. Box 14163 Lexington, KY 40512-4163
Hearing: TruHearing		844-255-7144	This is the provider contact number for our hearing vendor, TruHearing.
Humana clinical pharmacy review (HCPR)	Phone: 800-555-CLIN / 800-555-2546 Fax: 877-486-2621	8 a.m. to 11 p.m., Eastern time, Monday to Friday	

Contact	Phone	Hours	Other information
Member Customer Service	855-281-6070	Available 7 days a week, Oct 1st to March 31st Monday to Friday, April 1st to September 30th, 8 a.m.-8 p.m., Eastern time	This is the customer service number for Humana Dual Integrated enrollees.
Go365 by Humana®	877-240-4588	Monday to Friday, 8 a.m. - 7 p.m., Eastern time	Enrollees can call for assistance regarding the Go365 by Humana well-being and rewards program.
Medication Intake Team	866-461-7273	8 a.m. to 11 p.m., Eastern time, Monday to Friday	The Medication Intake Team performs prior authorizations for medications administered in the provider setting and can be reached via telephone.
Population health	866-331-1577	8 a.m. to 5:30 p.m., Eastern time, Monday to Friday	Humana population health (HRSN) support is available.
Population Insights Compass			An **online FAQ document** has been compiled for providers seeking to access the population insights compass program.
Prior authorization assistance	855-281-6070	8 a.m. to 8 p.m., Eastern time, Monday to Friday	Assistance for prior authorization requests related to medical procedures and behavioral health is available via telephone.
Prior authorization search tool			**https://provider.Humana.com/coverage-claims/prior-authorizations/prior-authorizations-search-tool**
Prior authorizations for medications administered in a provider setting			Prior authorizations for medications administered in a provider setting can be submitted online or via fax. Prior authorization and notification lists are also available online. Fax: 888-447-3430

Contact	Phone	Hours	Other information
Provider Overpayments			Coordination of benefits overpayments can be sent via mail to Humana. Mail: Humana P.O. Box 931655 Atlanta, GA 31193-1655
Provider Services	855-281-6070	8 a.m. to 8 p.m., Eastern time, Monday to Friday	Provider Relations Email: **MIProviderRealations@Humana.com**
Reconsideration of Credentialing/ Recredentialing Decisions			Requests for Humana to reconsider credentialing or recredentialing decisions can be submitted via mail to our regional medical director. Mail: Humana Attn: Shoba Srikantan, M.D. 101 E. Main Street Louisville, KY 40202
Special Investigations Unit (SIU)	Direct line: 800-558-4444, ext 1500724 Hotline: 800-614-4126	Direct line: 10 a.m. to 6 p.m. 8 a.m. to 5:30 p.m., Eastern time, Monday to Friday Hotline: 24 hours a day, 7 days a week	The Special Investigations Unit serves as a reporting organization for fraud, waste and abuse. SIU support is available via telephone, mail, or online. Mail: Humana Special Investigations Unit 1100 Employers Blvd. Green Bay, WI 54344 Email: **SIUReferrals@Humana.com** Email: **ethics@Humana.com**
SSI Group (Clearinghouse)	800-820-4774		The SSI Group is one of several different clearinghouses you may consider using for electronically filing claims with Humana. Additional support is available via telephone.

Contact	Phone	Hours	Other information
Trizetto (Clearinghouse)	800-556-2231		TriZetto is one of several different clearinghouses you may consider using for electronically filing claims with Humana. Additional support is available via telephone.
Update your contact information			**Humana Provider Application**
Vision: EyeMed	888-289-0595	7:30 a.m. - 11:00 p.m., Eastern Time, Monday - Saturday and 11:00 a.m. - 8:00 p.m., Eastern Time, Sunday	This is the provider contact number for our vision vendor, EyeMed.

Definitions

Term	Definition
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Humana Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes enrollee practices that result in unnecessary cost to the Humana Program.
Action	As defined in 42 CFR §431.201, a termination, suspension of, or reduction in covered benefits or services, or a termination, suspension of, or reduction in Medicaid eligibility or an increase in Enrollee liability, including a determination that Enrollee must incur a greater amount of medical expenses in order to establish income eligibility in accordance with 42 CFR §435.121(e)(4) or §435.831 or is subject to an increase in premiums or cost-sharing charges under 42 CFR Part 447, subpart A. It also means a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State with regard to the preadmission screening and resident review requirements of section 1919(e)(7) of the Act.
Advance Directive	An individual's written directive or instruction, such as a power of attorney for health care or a living will, for the provision of that individual's health care if the individual is unable to make their health care wishes known.
Adverse benefit determination (ABD)	An ABD is: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of 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" is not an ABD. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of Humana to act within the time frames provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one HIDE-SNP, the denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. g. 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
Adverse Events	An event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient, also referred to as a Serious Reportable Event. Aligned with the Serious Reportable Event categories defined by the National Quality Forum.
Alternative Format	Provision of enrollee information in a format that takes into consideration the special needs of those who, for example, are blind or vision impaired or have limited English reading proficiency. Examples of Alternative Formats must include, but not be limited to, braille, large font, audio, video, non-English language translation, and information read aloud to the enrollee.
Appeal	As defined in 42 CFR 438.400(b), a request for review by Humana of an adverse determination, and as defined in 42 CFR §422.561, any of the procedures that deal with the review of adverse determinations on the health care services the enrollee believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts enrollee must pay for a service, as defined under 42 CFR §422.566(b). This includes reconsiderations, and if necessary, an independent review entity, hearings, ALJs, review by the Medicare Appeals Council (Council), and judicial review.
Appeal Decision Letter	As required by 42 CFR §422.633(f)(4), Humana sends written notices when denying an enrollee's plan-level integrated appeal.
Authorized representative	As defined in §42 CFR §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in the grievance or appeal. Unless otherwise stated in Subpart M of 42 CFR §422, the Representative must have all rights and responsibilities of an enrollee or party filing a grievance, and in obtaining a determination in Humana or in dealing with any of the levels of appeals process, subject to the applicable rules described in 42 CFR Part 405.
Behavioral health	A state of health that encompasses mental, emotional, cognitive, social and behavioral stability, including freedom from SUDs.
Behavioral health services	Services that assist people with needs related to a mental illness, intellectual/developmental disability, and/or SUD.
Benefit(s)	The healthcare items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules[11].

11. HealthCare.gov. (n.d.) Benefits. Glossary. **https://www.healthcare.gov/glossary/benefits/**

Term	Definition
Care coordination	A process used by a person or team to assist enrollees in accessing Medicare and Medicaid services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes.
Care coordinator	A Michigan licensed registered nurse, nurse practitioner, physician's assistant, limited licensed or fully licensed Bachelor's or Master's prepared social worker, or clinical nurse specialist employed or contracted with Humana who is accountable for providing the full range of Care Coordination services described in this contract and who is trained in person-centered planning techniques.
Care coordination	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes[12].
Case manager	Healthcare professionals who serve as patient advocates to support, guide and coordinate care for patients, families and caregivers as they navigate their health and wellness journeys[13].
Centers for Medicare & Medicaid Services (CMS)	The federal agency under Department of Health and Human Services responsible for administering the Medicare and Medicaid programs, among other programs.
Chronic disease management	An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment and patient education. It can improve the enrollees quality of life while reducing healthcare costs if the enrollee has a chronic disease by preventing or minimizing the effects of a disease[14].
Claim	An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS-1500 or UB-04, or their successor forms. LTSS providers may submit Claims via paper or electronic invoice or a cash register receipt or a service/work.
Clean claim	Claims that can be processed without obtaining additional information from the provider of the service or from a third party.

12. Case Management Society of America. (n.d.) What is a case manager? **https://cmsa.org/who-we-are/what-is-a-case-manager/**
13. Ibid.
14. HealthCare.gov. (n.d.). Chronic disease management. *Glossary.* **https://www.healthcare.gov/glossary/chronic-disease-management/**

Term	Definition
Community Mental Health Services Program (CMHSP)	A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended. CMHSPs provide publicly funded (Medicaid, Medicare, General Fund, in addition to other local fund sources) behavioral health services directly and/or through contractual arrangements. CMHSPs may also provide behavioral health services to beneficiaries residing in Medicare and/or Medicaid certified nursing facilities through the Omnibus Budget Reconciliation Act (OBRA) Pre-Admission Screening and Resident Review program requirements.
Community transition services (CTS)	CTS are HCBS for Medicaid beneficiaries who meet eligibility criteria. The benefit is administered by the MDHHS on a fee-for-service basis through transition agencies including Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations. Enrollees eligible for CTS include nursing facility and institutional residents who meet needs-based criteria and have at least 1 risk factor as described in the CTS chapter of the Michigan Medicaid Provider Manual.
Cost sharing	The share of costs covered by the insurer that the enrollee pays out of pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums[15].
Covered services	Services included in health plan and covered by Humana. This also is referred to as benefits or covered benefits.
Credentialing	Humana' determination as to the qualifications and ascribed privileges of a specific provider to render specific healthcare services.
Critical incident	Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of an enrollee, including Adverse Events and Serious Reportable Events as defined by the National Quality Forum.
Cultural competence	Understanding and being able to respond appropriately to values, beliefs, and needs that are associated with the enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care and supports and services to persons with congenital or acquired disabilities. A competency based on the premise of respect for the enrollee and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

15. HealthCare.gov. (n.d.). Cost sharing. *Glossary.* **https://www.healthcare.gov/glossary/cost-sharing/**

Term	Definition
Disenroll	Action taken by a department or its designee to remove a Medicaid managed care program enrollee from a plan following the receipt and approval of a written request for disenrollment or a determination made by the department or its designee that the enrollee is no longer eligible for Medicaid or the Medicaid managed care program.
Drug list	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits; also called a formulary[16].
Dual diagnosis (disorder)	An individual who has a diagnosed mental health problem and a problem with alcohol and/or drug use.
Dual eligible(s)	Any Medicare managed care recipient who is also eligible for Medicaid, and for whom MDHHS has at least partial responsibility for payment of Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB only, QMB Plus, SLMB only, SLMB Plus, QI, QDWI and FBDE.
Durable medical equipment (DME)	Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics[17].
Eligible(s)	A person who has been determined eligible to receive Medicaid or Medicare benefits.
Emergency medical condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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 placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
Emergency services	Inpatient and outpatient services covered under this Contract that are furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize an enrollee's Emergency Medical Condition.
Encounter	A Medicare Part C covered service or group of covered services, as defined by the MA Agreement, or a Medicaid covered service delivered by a health care service provider to a Dual Eligible Enrollee during a visit between the Dual Eligible Enrollee and health care service provider.
Enrollment	The processes by which a potential enrollee is enrolled into the HIDE-SNP .

16. HealthCare.gov. (n.d.). Drug list. *Glossary.* **https://www.healthcare.gov/glossary/drug-list/**
17. HealthCare.gov. (n.d.). Durable medical equipment (DME). *Glossary.* **https://www.healthcare.gov/glossary/durable-medical-quipment-dme/**

Term	Definition
Evidence of coverage	Services and supplies provided to enrollees, including specific information about benefits, coverage limitations and services not covered or excluded. The term "evidence of coverage" is interchangeable with the term "certificate of coverage."
Excluded services	Healthcare services not paid for or covered by the health insurer[18].
Exclusion	Items or services furnished by a specific provider who has defrauded or abused the Medicaid program. These items or services are not reimbursed under Medicaid.
Expedited appeal	The accelerated process by which Humana must respond to an Appeal by an enrollee if a denial of care decision by a Contractor may jeopardize life, health or ability to attain, maintain or regain maximum function.
Fee-for-service (FFS) Medicaid rate	A method of making payment for healthcare services based on the current Medicaid fee schedule.
Fraud	Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. Includes any act that constitutes Fraud under federal or State law.
Fraud, waste and abuse (FWA)	The collective name for the terms fraud, waste and abuse.
Federally qualified health center (FQHC)	Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. FQHCs provide primary care services on a sliding scale fee based on ability to pay[19].
Grievance	Any complaint or dispute, other than one that constitutes an Organization Determination, expressing dissatisfaction with any aspect of Humana's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested. The term Grievance(s) as used in this Contract includes Integrated Grievances.
Grievance system	The overall system that includes grievance and appeal processes and Medicaid managed care enrollee access to state fair hearings.
Health Disparities	A particular type of health difference closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).

18. HealthCare.gov. (n.d.). Excluded services. *Glossary.* **https://www.healthcare.gov/glossary/excluded-services/**
19. HealthCare.gov. (n.d.). Federally Qualified Health Center (FQHC). *Glossary.*

Term	Definition
Health Equity	The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.
Health Risk Assessment (HRA)	A comprehensive assessment of an enrollee's medical, psychosocial, cognitive, and functional status to determine their medical, behavioral health, LTSS, and social needs.
Healthcare Effectiveness Data and Information Set (HEDIS)	Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.
High-risk enrollee	High-risk enrollees do not meet low- or moderate-risk criteria.
Dual Integrated Special Needs Plan (HMO D-SNP)	An integrated care plan that combines the benefits of Medicare and Medicaid from a managed care organization into a more unified care plan including Managed LTSS. Medicaid Behavioral Health benefits are carved out to the Prepaid Inpatient Health Plans. Although less integrated than FIDE SNPs, HIDE-SNPs still incorporate both behavioral health and Managed LTSS benefits into the plan.
Home- and community-based services (HCBS)	A variety of Medicaid home and community-based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (Nursing Facility) placement.
Home health care	Healthcare services a person receives at home[20].
Hospice services	Comfort and support services provided to an individual and their family during the last stages of a terminal illness[21].
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care[22].

20. HealthCare.gov. (n.d.). Home health care. *Glossary.* **https://www.healthcare.gov/glossary/home-health-care/**
21. HealthCare.gov. (n.d.). Hospice services. *Glossary.* **https://www.healthcare.gov/glossary/hospice-services/**
22. HealthCare.gov. (n.d.). Hospitalization. *Glossary.* **https://www.healthcare.gov/glossary/hospitalization/**

Term	Definition
Individualized care plan (ICP)	The plan of care developed by an enrollee, the enrollee's care coordinator and the enrollee's ICT which incorporates the following elements: assessment results; summary of the enrollee's health; the enrollee's preferences for care, supports and services; the enrollee's prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring and Reassessment; and the due date for the intervention and Reassessment. The ICP is also referred to as person-centered plan or plan of care. The ICP will be maintained in the Electronic Health Record along with evidence of the enrollee's acceptance of the ICP including enrollee and/or provider(s) signature when appropriate per ICP guidance.
Integrated Care Team (ICT)	A team including the enrollee, enrollee's chosen allies or legal representative, PCP, care coordinator, LTSS representative(s) or PIHP representative(s) as applicable and others as needed. The ICT works with the enrollee to develop, implement, and maintain the ICP and to coordinate the delivery of services and benefits as needed for the enrollee.
Inpatient care	Healthcare received when an individual is admitted as an inpatient to a healthcare facility such as a hospital or skilled nursing facility[23].
List of excluded individuals/entities (LEIE)	A database maintained by HHS-OIG[24] that is accessible to the public and provides information about parties excluded from Medicare, Medicaid and all other federal healthcare programs. The LEIE website is available in 2 formats: • The online search engine (located at https://exclusions.oig.hhs.gov/gov) identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match by entering the Social Security number or EIN. The downloadable version of the database, located at **www.oig.hhs.gov/exclusions/exclusions_list.asp** may be compared against an existing database maintained by the provider; however, the downloadable version does not contain Social Security numbers or EINs. Instead, those identifiers may be entered in the searchable database within the HHS-OIG site, as referenced in the first bullet.

23. HealthCare.gov. (n.d.). Inpatient care. *Glossary.* **https://www.healthcare.gov/glossary/inpatient-care/**
24. U.S. HHS Office of Inspector General. (n.d.). Exclusions program. **https://www.oig.hhs.gov/exclusions/index.asp**

Term	Definition
Long-term supports and services (LTSS)	A variety of supports and services that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.
Low-risk enrollee	A enrollee who does not meet moderate- or high-risk criteria.
MDHHS	The Michigan Department of Health and Human Services was formerly 2 departments: the Michigan Department of Community Health and the Michigan Department of Human Services.
Medically necessary services	Services that must be provided in a way that provides all protections to covered individuals provided by Medicare and Michigan Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 U.S.C. 1395y. Per Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in their community.
Enrollee	A Medicaid beneficiary who is currently enrolled in the State's Medicaid managed care program, specifically a managed care organization such as Humana.
Medicaid	A federal/state program authorized under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being 400.105 of the Michigan Compiled Laws; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.

Term	Definition
Medicare	Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits
Moderate-risk enrollee	Enrollees who do not meet low- or high-risk criteria.
National Committee for Quality Assurance	A private 501(c)(3) not-for-profit organization that is dedicated to improving health care quality and that has a process for providing accreditation, certification, and recognition, e.g., health plan accreditation.
Noncovered services	Services not covered.
Nonparticipating provider physician	A physician licensed to practice who has not contract with or is not employed by Humana to provide healthcare services.
Outpatient services	Preventive, diagnostic, therapeutic, rehabilitative, surgical and mental health facility services for dental and emergency services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours.
Overpayment	The amount paid by Humana to a provider which exceeds the amount allowable for serviced furnished under 42 U.S.C. § 1902 or to which the provider is not entitled and is required to be refunded under 42 U.S.C. § 1903.
Pre-paid inpatient health plan (PIHP)	PIHPs manage the Medicaid specialty services under the Michigan 1115 Behavioral Health Demonstration, consistent with the requirements of 42 C.F.R. Part 401. This benefit plan covers mental health and substance use services for people eligible for Medicaid who have a need for behavioral health, intellectual/developmental disabilities services and supports, or substance use services.
Primary care provider (PCP)	Practitioner of primary care selected by the enrollee or assigned to the enrollee by Humana and responsible for providing and coordinating the enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. PCP may be advanced practice registered nurse, nurse practitioners, physician assistants or physicians who are board certified, or a specialist selected by an enrollee.

Term	Definition
Prior authorization (preauthorization)	A decision by a health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called a prior authorization, prior approval or precertification. The health insurer may require preauthorization for certain services before they can be rendered, except in an emergency. Approval from a health plan that may be required before a service is rendered or a prescription is filled in order for the service or prescription to be covered by the plan[25],[26].
Protected health information (PHI)	Individually identifiable health information as defined in 45 C.F.R. § 160.103
Provider	Any individual or entity furnishing Medicare-Medicaid services under a provider agreement with Humana or the Medicaid agency in accordance with 42 C.F.R. § 400.203.
Preventive services	Routine healthcare including screenings, check-ups and patient counseling to prevent illness, disease or other health problems[27].
Post-stabilization care services	Covered services related to an emergency medical condition that are provided after the enrollee's emergency medical condition has been stabilized to maintain the stabilized condition and/or under the circumstances described in 42 C.F.R. § 438.114(e) to improve or resolve the enrollee's condition.
Quality assessment and performance improvement (QAPI)	Activities aimed at improving the quality of care provided to enrollees through established quality management and performance improvement processes.
Recoupment	The recovery by, or on behalf of, either the State agency or Humana of any outstanding Medicaid debt.
Referral	A written order from a primary care physician for an enrollee to see a specialist or receive certain medical services.
Service area	A geographic area where a health insurance plan accepts enrollees if it limits membership based on where those individuals live. For plans that limit which doctors and hospitals may be used by the enrollee, it is also generally the area where the enrollee may receive routine (non-emergency) services. The plan may end the enrollee's coverage if they move out of the plan's service area[28].

25. HealthCare.gov. (n.d.). Prior authorization. *Glossary.* **https://www.healthcare.gov/glossary/prior-authorization/**
26. HealthCare.gov. (n.d.). Preauthorization. *Glossary.* **https://www.healthcare.gov/glossary/preauthorization/**
27. HealthCare.gov. (n.d.). Preventive services. *Glossary.* **https://www.healthcare.gov/glossary/pre https://www.cms.gov/files/document/rhcfactsheetpdfventive-services/**

Term	Definition
Social determinants of health (SDOH)	The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. SDOH are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.
State Fair Hearing	An impartial review of a decision made by the MDHHS or one of its contract agencies which is conducted by a Michigan Office of Administrative Hearings and Rules (MOAHR) Administrative Law Judge under the oversight, supervision, and authority of MDHHS, so as to provide due process rights required by applicable law and consistent with 42 C.F.R. §431 subpart E.
Treating Provider	Someone who provides or has provided clinical treatment or evaluation to the enrollee and who has, or has had, an ongoing treatment relationship with the enrollee within the past (twelve) 12 months. Generally, an ongoing treatment relationship is considered to be when the clinical evidence establishes that the enrollee sees, or has seen, the provider with a frequency consistent with accepted clinical practice for the type of treatment, evaluation and/or service required for clinical need(s). Treating Providers include PCP, specialists, physician assistants, advanced practice registered nurse, psychiatrists, counselors, and therapists. Treating Providers are not those who provide services that are non-clinical in nature like chore services or provide only routine preventative care like preventive dental.
Utilization management (UM)	The process of evaluating the necessity, appropriateness, and efficiency of health care services against established guidelines and criteria.
Waste	The unintentional misuse of funds through inadvertent error that most frequently occurs as incorrect coding and billing.

Acronyms

Acronym	Definition
ABD	Adverse benefit determination
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act
ADT	Admits, discharges and transfers
ALD	Assistive Listening Device
AOR	Appointment of representation
ARNP	Advanced registered nurse practitioners
BA	Behavior analysis
BAHD	Bone Anchored Hearing Device
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAQH	Council for Affordable Quality Healthcare
CDC	Centers for Disease Control and Prevention
CE	Continuing education
CHW	Community Health Worker
CMHSP	Community Mental Health Services Program
CLIA	Clinical Laboratory Improvement Amendment
CMME	Commercial and Medicare Enrollee Equivalent
CNM	Certified nurse-midwife
CMO	Chief medical officer
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CSS	Customer service specialist
CTS	Community transition services
CVO	Credentialing verification organization
DAAA	Detroit Area Agency on Aging
DEA	Drug Enforcement Administration
DME	Durable medical equipment
DSNP	Dual Eligible Special Needs Plan
EDI	Electronic data interchange
EFT	Electronic funds transfer
EHR	Electronic health record
EOB	Explanation of benefits
EPLS	Excluded parties list system
ER	Emergency room
ERA	Electronic remittance advice
ESRD	End Stage Renal Disease

Acronym	Definition
FFS	Fee-for-service
FQHC	Federally qualified health clinic
GSA	General Services Administration
HCB	Home- and community-based
HCBS	Home- and community-based services
HCPCS	Healthcare Common Procedure Coding System
HCPR	Humana Clinical Pharmacy Review
HIDE-SNP	Highly Integrated Dual Eligible Special Needs Plan
HIV	Human Immunodeficiency Virus
EHR	Electronic health record
HCBS	Home- and community-based services
HEDIS	Healthcare Effectiveness Data and Information Set
HHC	Home healthcare
HHS	Health and Human Services
HIE	Health information exchange
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HRA	Health risk assessment
HRSN	Health-related social needs
HSW	Habilitation Supports Waiver
IADL	Instrumental Activity of Daily Living
ICP	Individualized care plan
ICT	Integrated care team
ID	Identification
I/DD	Intellectual and/or Developmental Disabilities
IV	Intravenous
LDCT	Low Dose Computed Tomography
LEIE	List of Excluded Individuals and Entities
LTACH	Long-Term Acute Care Hospital
LTC	Long-term care
LTSS	Long-term service and supports
MCE	Managed entity
MCO	Managed care organization
MDHHS	The Michigan Department of Health and Human Services
MiDPP	Michigan Diabetes Prevention Program
MIHP	Maternal and Infant Health Program
MIT	Medication intake team
MM	Medical management
MMA	Managed medical assistance

Acronym	Definition
MRDR	Medical record documentation review
NCQA	National Committee for Quality Assurance
NEMT	Non-emergency medical transportation
NFLOC	Nursing Facility Level of Care
NICU	Neonatal Intensive Care Unit
NPI	National Provider Identifier
OB-GYN	Obstetrician gynecologist
OIG	Office of Inspector General
PAD	Peripheral Artery Disease
PAL	Prior authorization list
PCMH	Patient centered medical home
PCP	Primary care provider
PDL	Preferred drug list
PERS	Personal emergency response system
PHI	Protected health information
PIHP	Pre-paid inpatient health plan
PIP	Physician Incentive Program
PML	Provider Master List
PMP	Primary medical provider
PSA	Prostate Specific Antigen
QAPI	Quality Assessment and Performance Improvement
QI	Quality improvement
QIC	Quality improvement committee
RHC	Rural health clinic
SAM	System for Award Management
SBIRT	(Training for) Screening, Brief Intervention, and Referral to Treatment
SDOH	Social determinants of health
SET	Supervised exercise therapy
SIU	Special Investigations Unit
SMI	Serious mental illness
SNF	Skilled nursing facility
STI	Sexually Transmitted Infection
SUD	Substance use disorder
UM	Utilization management
U.S.	United States
USPSTF	United States Preventive Services Task Force
URL	Uniform resource locator

Benefit grids

Please see the **Covered services** section of this manual for a summary list of the benefits and services covered by Humana's HIDE-SNP in Michigan for our HIDE-SNP enrollees. For a comprehensive list of all services covered, providers can check benefits at **Availity Essentials** or call Humana Provider Services at **855-281-6070**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

LTSS covered services

Covered service	Limitations, exceptions and additional benefit information
Adaptive medical equipment and supplies	Humana covers devices, controls, or appliances that enable enrollees to increase their ability to perform ADL's or to perceive, control, or communicate with the environment in which they live. Prior authorization and/or referral may be required. Waiver may be required.
Adult day programs	Humana covers structured day activities at a program of direct care and supervision if an enrollee meets eligibility requirements. This service supports social, physical, and emotional well-being. Prior authorization and/or referral may be required. Waiver may be required.
Assistive technology	Humana covers technology items used to increase, maintain or improve functioning and independence. Prior authorization and/or referral may be required. Waiver may be required. Some examples of services include: • Assistive dialing device • Communication boards • Computerized voice system • Hand controls • Power door mechanisms • Specialized alarm or intercom • Van lifts • Voice activated door locks
Chore services	Humana covers services needed to maintain enrollees home in a clean, sanitary and safe environment if they meet eligibility requirements. Prior authorization and/or referral may be required. Waiver may be required.

Covered service	Limitations, exceptions and additional benefit information
Environmental modifications	Humana covers modifications to an enrollees home to ensure enrollees health, safety and welfare or make them more independent in the home. Prior authorization and/or referral may be required. Waiver may be required. Modifications may include: • Installing ramps and grab bars • Modifying bathroom facilities • Widening of doorways
Expanded community living supports	For enrollees to be eligible for this service, they must have a need for assistance with completing ADL's like eating, bathing and/or dressing, etc. Prior authorization and/or referral may be required. Waiver may be required.
Fiscal intermediary services	Humana will cover a fiscal intermediary to assist with enrollees to live independently in the community and help manage and distribute funds contained in an enrollee's individual budget. Prior authorization and/or referral may be required. Waiver may be required.
Home delivered meals	This plan covers up to two prepared meals per day brought to an enrollees home if they meet certain qualifications. Prior authorization and/or referral may be required. Waiver may be required.
Individual goods and services	This benefit provides coverage for items or services that are not typically included under standard benefits, when such goods or services directly address an enrollees needs and support their health, safety, or independence. Examples may include: • Specialized assistive devices • Adaptive equipment • Specific services that enable enrollees to achieve established goals in their care plan. Prior authorization and/or referral may be required. Waiver may be required.
Non-medical transportation	Humana covers transportation services to enable enrollees to access waiver and other community services, activities and resources. Prior authorization and/or referral may be required. Waiver may be required.
Preventive nursing services	Humana covers nursing services provided by a RN or LPN. Enrollees must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. These services are not provided on a continuous basis. Prior authorization and/or referral may be required. Waiver may be required.
Private duty nursing	Humana covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day to meet health needs. The enrollee must meet certain medical criteria to qualify for this service. Prior authorization and/or referral may be required. Waiver may be required.

Covered service	Limitations, exceptions and additional benefit information
Personal emergency response system	$0 copayment for a personal help button. Enrollees must be at a high risk for falls. Enrollees must reside in a home and/or community-based setting and Humana care coordinator approval required.
Respite care services (in home and out of home)	Humana enrollee's may get respite care services on a short-term, intermittent basis to relieve their family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Prior authorization and/or referral may be required. Waiver may be required.
Vehicle modifications	Humana covers necessary changes to a vehicle to accommodate a qualifying disability or medical condition for eligible enrollees. Approved modifications may include the installation of adaptive equipment, such as hand controls or wheelchair lifts, ensuring safe and accessible transportation. Prior authorization and/or referral may be required. Waiver may be required.

