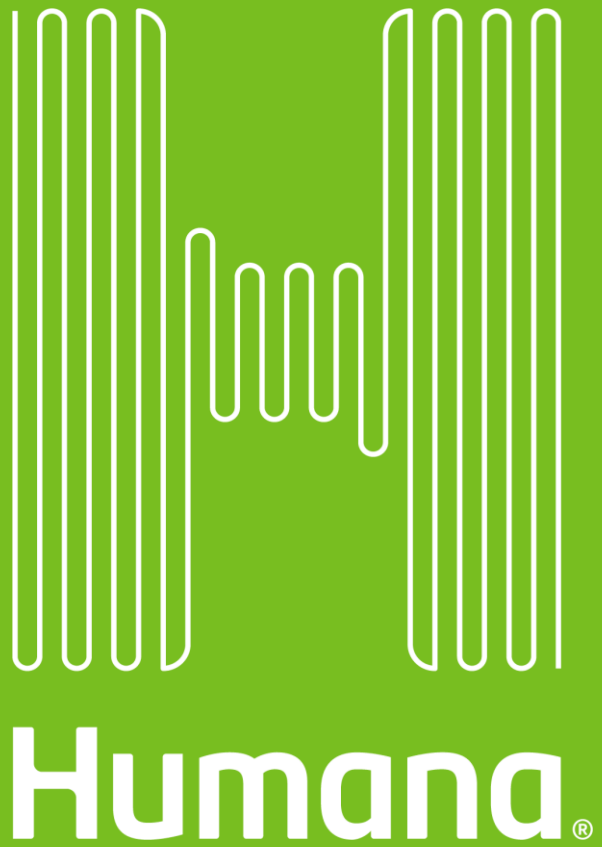

Medicaid Provider Training

Information for dual Medicare-Medicaid Plan (MMP) healthcare providers and administrators

Illinois
January 2024

335001IL1023-B (ILHM64BEN)

Training topics

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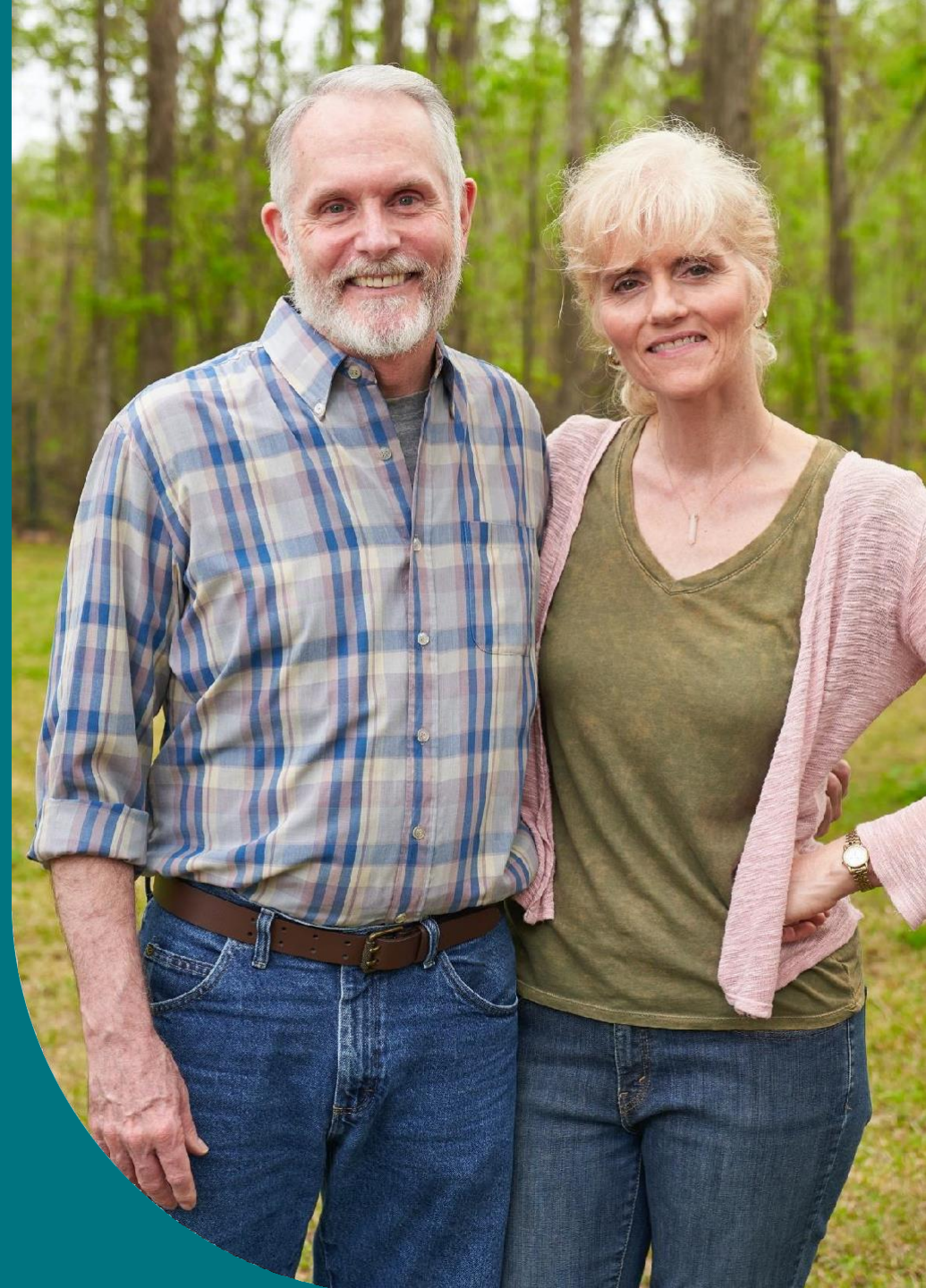
Centers for Medicare & Medicaid Services (CMS)-approved model of care



CMS-approved model of care

- Humana's model of care is designed to help improve access to affordable and preventive medical, mental health and social services.

- The model promotes:
  - Focused coordination of care through an identified point of contact.
  - Seamless transition of each member's care between healthcare settings and healthcare providers. The model allows providers to focus on health outcomes and member satisfaction with health status and services.

- Humana's model of care provides appropriate service utilization and facilitation of cost-effective health services delivery.

CMS-approved model of care (cont'd)

- Key provider participation includes the following activities:
  - Care conferences (via phone, written or in-person communication) for interdisciplinary care team (ICT) members
  - Inbound and outbound communications that foster care coordination
  - Promotion of Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
  - Support to fulfill Humana's state and federal regulatory and accreditation obligations (e.g., HEDIS, NCQA) via forwarding all requested medical record documentation and information

Provider role and responsibilities

Provider role and responsibilities

- Ensure members are informed of healthcare needs requiring specific follow-up and receive self-care training that includes discussion of medication adherence and other ways to manage their health.
- Ensure members receive necessary, appropriate specialty, ancillary, emergency and hospital care.
- Provide necessary referrals, information and communications to specialists, hospitalists, skilled nursing facilities (SNF) and other providers that assists through consultation.
- Recommend member treatments, equipment and/or services.

Provider role and responsibilities (cont'd)

- Work with Humana case management entities (CME) to ensure access to care (through home visits by nurse practitioners or physicians and/or home-and community-based services) for members who are homebound or have significant functional mobility limitations.
- Track and document member appointments, clinical findings and treatment plans from referred specialists, other healthcare providers or agencies to ensure continuity of care.
- Obtain authorizations and notify Humana for any out-of-network services when a network specialist is unavailable in the geographical area.

Provider role and responsibilities (cont'd)

- Work with Humana's care coordination team to arrange a member-requested second opinion appointment, either with a qualified network provider or a qualified out-of-network provider, if a qualified in-network provider is unavailable.
- Initiate or assist member discharges or transfers from inpatient facilities to the member's permanent home or the most medically appropriate, level-of-care facility.
- Consider the availability of in-network facilities and obtain appropriate authorizations for out-of-network facilities.

Provider role and responsibilities (cont'd)

- Help develop and implement an individualized plan of care with ICT support and communication that facilitates effective care coordination.
- Provide timely access to medical records or information for quality management and other purposes, including audits, complaint reviews or appeals, HEDIS and other studies.
- Respond to improvement recommendations for development and enactment of a corrective/improvement plan promptly and appropriately.
- Follow preventive care guidelines set by the U.S. Preventive Services Task Force and provide and document NCQA-required preventive care services for HEDIS.

Creation of individual care plans (ICPs)

Developing an ICP

Each Humana member is assigned a care coordinator who works closely with the member's primary care provider (PCP) to develop and lead an ICT. The ICP ensures the member receives necessary medical, behavioral health and long-term care services.

The ICP is based on:

- Initial and ongoing health risk assessment and comprehensive assessment results
- Claims history

ICT-developed member plans:

- Include member-driven short- and long-term goals, objectives and interventions
- Address specific services and benefits
- Provide measurable outcomes

Provider participation in interdisciplinary care teams (ICTs)

Provider ICT participation

Humana offers healthcare management services to Medicare-Medicaid Alignment Initiative (MMAI) members for effective coordination between providers and services across the full range of medical and social supports.

MMAI members are assigned a care coordinator to review their medical, behavioral health, social and long-term service, and support needs. The coordinator then conducts a health screening assessment within 30 days after enrollment to determine the member's risk level—low, moderate or high. The care coordinator then develops an ICP based on the member's risk level.

In addition to developing a plan for care, the care coordinator is responsible for leading an ICT, which may include, but is not limited to, the following:

- Providers (PCPs and specialists)
- Behavioral health providers
- Social workers
- Counselors/clinicians experienced in advance directives, care preferences and palliative care
- Community health workers
- Community based support and beneficiary advocacy groups
- Family members
- Caregivers
- Pharmacists

Provider ICT participation (cont'd)

The provider-inclusive ICT model supports:

- Treatment and medication plans
- Provider goals via the Humana care management team of nurses, social workers, pharmacy specialists and behavioral-health specialists
- Member education and enhancement of direct patient-provider communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources and Medicaid services, including long-term services and supports (LTSS), if member is eligible
- Appropriate end-of-life planning

Provider ICT participation (cont'd)

Provider communication and reporting expectations include:

- Maintaining phone or in-person ICT communication that includes the care coordinator, other providers of care and services, hospitals and/or ancillary providers to ensure effective continuity of care and care coordination.
- Reporting actual or suspected child or elder abuse, domestic violence or exploitation to local law enforcement immediately via phone and submitting a follow-up written report to appropriate law enforcement agencies within the required timeframe. (See Health, Safety and Welfare Education Training for specific reporting information.)
- Providing all requested medical record documentation and information to support Humana's fulfillment of state and federal regulatory and accreditation obligations (e.g., HEDIS, NCQA).

Coordination of Medicare and Medicaid benefits

Coordination of Medicare-Medicaid benefits
(including long-term services and supports)

- Member-centered, coordinated care is provided by a knowledgeable team that provides an array of medical, nonmedical, behavioral services and other benefits to meet a member's needs and are critical to achieving optimum wellness. The care also focuses on helping the member live at home for as long as appropriately possible.
- Some state-assessed members require a broad range of LTSS and community support to meet their functional needs. Effective LTSS benefits administration and easy access to these services help ensure a member's needs are adequately met and reduce reliance on less-appropriate, more-costly emergency hospital-based or nursing facility care.

Coordination of Medicare-Medicaid benefits
including long-term services and supports (cont'd)

Members face a variety of daily life challenges. Humana aims to eliminate the challenge and frustration of navigating a complex healthcare system through integration of member and provider administrative processes.

Humana coordinates Medicaid-Medicare to ensure the appropriate services are provided at the right time in the right place. For example, both Medicare and Medicaid cover certain durable medical equipment items but have different requirements and limitations. Humana works with providers to ensure the correct benefit is accessed for the member.

Barriers to member care

Identifying barriers to care

- Programs with diverse coverage and payment structures often deliver ineffective member care due to poor benefit and service coordination.
- A shortage of health professionals in rural areas and inner cities can make it difficult for MMP members to access quality, cost-effective preventive services and care.
- Organizational barriers, including lack of interpreter services, inadequate wheelchair accessibility and long appointment wait times increase member frustration and potential refusal to seek and participate in his/her own care.

Identifying barriers to care (cont'd)

- Often, a lack of coordination between behavioral health and other medical and nonmedical services results in poor health outcomes.
- Cultural and religious beliefs impact member health beliefs and behaviors, including provider relationships and compliance with recommended treatments.
- Socioeconomic status may present issues related to poor education, lack of knowledge regarding available health options, support, healthy behaviors and inability to pay out-of-pocket.
- Member homelessness impacts the ability of healthcare providers to engage and provide member education and support.

Treating members with mental health and substance use diagnoses

Working with members with mental health diagnoses

- Facilitate member referral to specialists, specialty care, behavioral healthcare, health education classes and community resource agencies, when appropriate.
- Integrate behavioral health screening into basic primary care services; provide screening and evaluation procedures for detection, referral and treatment for known or suspected behavioral health problems.
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty providers.
- Coordinate care and information sharing between primary care and behavioral health providers after obtaining required member consent.
- Ensure confidentiality of members' medical and behavioral health and personal information as required by state and federal laws.

Chronic and complex conditions

Types of chronic conditions prevalent in target population

Multiple chronic conditions increase the risk for poor outcomes, such as mortality or functional limitations. High-cost services, such as hospitalizations, emergency room visits and nursing facility care, also can affect member health. Frequent and consistent preventive care of chronic conditions can delay the onset of major conditions and decrease emergency room visits and readmissions.

Types of chronic conditions prevalent in target population (cont'd)

Humana's clinical practice guidelines* incorporate relevant, evidence-based medical and behavioral health recommendations (includes preventive care and management of certain nonpreventive acute and chronic conditions) from recognized sources, such as professional medical associations, voluntary health organizations and National Institutes of Health (NIH) centers.

Humana provides chronic disease management services and support to promote self-management for individuals with chronic conditions.

* Guideline specifics available to both affiliated and nonaffiliated providers on Humana's website: www.humana.com/manage-your-health/health-condition-management

Comprehensive diabetes care

Comprehensive diabetes care includes the following:

- **Diabetic retinal examinations**—Humana is committed to early intervention and continuous monitoring of diabetic eye disease to reduce diabetes-induced blindness in members.
- **Fundoscopic exams**—Based on guidelines proposed by the American College of Physicians, the American Diabetic Association and the American Academy of Ophthalmology, Humana PCPs will provide or manage services for recipients with a history of diabetes should perform at least one fundoscopic exam every 12 months

Comprehensive diabetes care (cont'd)

Attention to glycohemoglobin levels—Humana acknowledges that responsible control of blood glucose levels can delay the onset of many diabetic side effects. Glycohemoglobin is a laboratory indicator of how well a member's blood sugar is controlled. Consistent with American Diabetic Association recommendations, Humana primary care providers will provide or manage services that allow members with a history of diabetes to receive glycohemoglobin screenings at least twice yearly.

Comprehensive diabetes care (cont'd)

Monitoring lipid levels—Humana recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinemias and diabetes mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, Humana network PCPs will provide or manage services for members with a history of diabetes, including annual lipid and lipoprotein determination. If any anomaly is found in the annual baseline, additional studies should be conducted as medically necessary.

Nephropathy

Humana network PCPs are encouraged to screen for nephropathy to delay or prevent loss of renal function through early detection and initiation of effective therapies and to manage complications in those identified with a renal disease. PCPs will manage the care by identifying evidence of a positive test for protein in the urine (microalbuminuria testing). The member will be monitored for several disorders, including end-stage renal disease, chronic renal failure, renal insufficiency or acute renal failure, and referred to a nephrologist when appropriate.

Congestive heart failure

There are effective options for treating congestive heart failure (CHF) and its symptoms. Humana recognizes early detection can reduce disease symptoms, and many heart failure patients can resume normal active lives. To further these goals, Humana PCPs are encouraged to provide or manage care of the CHF member by prescribing and monitoring use of an angiotensin-converting-enzyme (ACE) inhibitor, diuretic and angiotensin II receptor blockers (ARB) and by reviewing the contraindications of prescribed medications.

An echocardiogram should be performed annually, and the member should be instructed on nutrition, while education should continue throughout his or her disease.

Asthma

Humana PCPs are expected to measure member lung function, assess disease severity and monitor the course of therapy that:

- Introduces comprehensive pharmacologic therapy for long-term management that reverses and prevents airway inflammation characteristic of asthma, as well as pharmacologic therapy to manage asthma exacerbations.
- Includes instructing the member about the need to avoid or eliminate contributing environmental factors that precipitate asthma symptoms or exacerbations.
- Facilitates education that fosters a partnership among the member, his or her family, and clinicians.

Hypertension

Humana believes PCPs can assist members by checking blood pressure at every opportunity and counseling members and their families about ways to prevent hypertension. Members benefit from general advice on healthy lifestyle habits, in particular healthy body weight, moderate alcohol consumption and regular exercise. The Humana PCP should document in each member's medical record the confirmation of hypertension and identify a member's hypertension risk.

HIV/AIDS

Humana requires PCPs to assist members in obtaining necessary care in coordination with Humana Health Services staff. Providers should call Medicare/Medicaid case management at 800-322-2758 or contact their provider contract representative for more details.

Patient-centered medical home

What is a patient-centered medical home?

A **patient-centered medical home** is a model of care that strengthens the provider-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.

Through the model, a PCP-led medical team takes responsibility for patient care, meeting member healthcare needs and arranging for appropriate care with other qualified clinicians. The goal of the medical home is to provide personalized, coordinated, effective and efficient care.

Source: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

What is a patient-centered medical home? (cont'd)

Implementation of the medical home model of care involves:

- Achieving high-level accessibility
- Providing excellent communication between members, providers and staff
- Taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance

Source: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

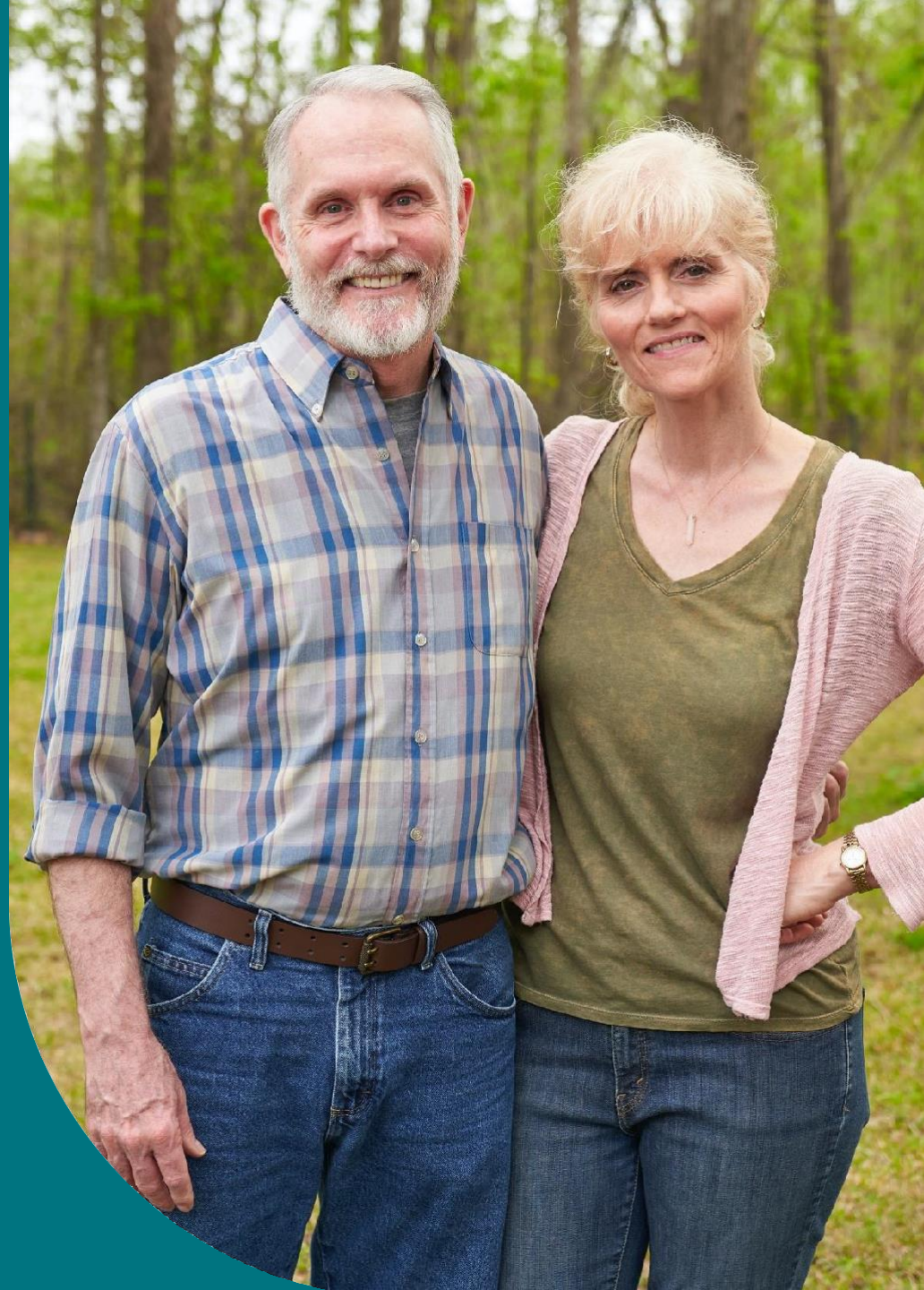
What is a patient-centered medical home? (cont'd)

- Participating patient-centered medical homes are required to manage and provide evidence-based member services to integrate care with specialty and sub-specialty practices. The medical home is required to adhere to the following:
  - **Access enhancement and continuity**—Accommodate member needs with access and advice during and after hours, give members and their families information about their medical home and provide patients with team-based care.
  - **Member population identification and management**—Collect and use data for population management.

What is a patient-centered medical home? (cont'd)

- **Care planning and management**—Use evidence-based guidelines for preventive, acute and chronic care medicine and mental health management.
- **Provisioning of self-care support and community resources**—Supply the information, tools and resources members and their families need to manage member self-care.
- **Care tracking and coordination**—Follow and analyze trends in tests and referrals and coordinate transitions of care.
- **Performance measurement and improvement**—Use performance and patient experience data for continuous quality improvement.

Person-centered planning and self-determination



Member special needs consideration

Providers must make efforts to understand special member needs. The member may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease, isolation, depression and polypharmacy are some of the challenges facing these members each day.

Recognizing these significant member needs, Humana incorporates all of the principles of multidisciplinary integration, as well as person-centered care planning, coordination and treatment in our care coordination program.

Member special needs consideration (cont'd)

- Care management is delivered within an ICT structure and holistically addresses the needs of each member.
- To ensure the existence of person-centered and supported self-care, the member or authorized caregiver comprises the model of care core.
- Each Humana MMAI member is assigned a care coordinator who leads the member's ICT and works closely with the member's PCP to ensure necessary member care across the full spectrum of medical, behavioral health and long-term care services.

Member special needs consideration (cont'd)

- Humana's predictive model is based on claims history and analytics, which are used to determine the risk and intervention levels necessary to channel the member to the appropriate level of coordination.
- The mDAT, a scored and weighted assessment tool, produces a clinically sound snapshot of the member's health status. The mDAT provides an overall risk score, which when combined with the predictive model score, is used to direct interventions.

Member participation

Members are encouraged to participate in all aspects of care management and coordination, including ICP development. The care coordinator and ICT ensure all necessary member assistance and accommodation (including those mandated by the ADA) to fully participate in the care planning and management process. The team also provides the member clear information about:

- His or her health conditions and functional limitations
- How the member can include family and social supports in the care planning process
- Self-directed care options and available self-manage care assistance
- Educational and vocational opportunities
- Available treatment options, supports and/or alternative courses of care

Ombudsman program

What is the Ombudsman program?

The Ombudsman program is a long-term-care advocate effort for members in nursing homes, care homes and assisted-supportive living facilities. The program also serves member friends and families, as well as the long-term care facility staff and administration.

- The program:
  - Provides information about the rights of members and their families
  - Provides information about residents' needs to appropriate parties
  - Addresses complaints
  - Advocates for individualized care improvements in the long-term-care system

NOTE: Ombudsman program contacts are located in the appendix.

Quality enhancements (QE)

Quality enhancements

QE are defined as health-related, community-based member services to which Humana and its contracted providers (affiliated and subcontractors) must offer access. Costs of these programs will not be reimbursed. In addition to the covered services specified in this section, Humana and its contracted providers should offer QE in member-accessible community settings.

The provider shall include documentation of community program referrals and follow-up to ensure receipt of services in the member's medical record.

QE (cont'd)

QE programs include, but are not limited to:

- **Domestic violence screening**—Providers must screen members for signs of domestic violence and offer referral to appropriate community prevention agencies and services.
- **Pregnancy prevention**—Humana and its contracted providers are required to regularly conduct pregnancy prevention programs or make good faith efforts to involve members in existing community prevention programs, such as an abstinence education program. Member programs are open to everyone, regardless of age, gender, pregnancy status or parental consent.
- **Prenatal/postpartum pregnancy programs**—Humana provides noncompliant pregnant and postpartum members with educational materials, counseling and regular home visits from home health nurses or aides.

QE (cont'd)

- **Smoking cessation**—Humana and its contracted providers are required to regularly conduct smoking cessation programs for all members or make good-faith efforts to involve members in existing community cessation programs. Counseling must be available to all members. Providers should consult the Department of Health and Human Services, Agency for Health Care Research & Quality (AHRQ) website for reference material regarding identifying tobacco users and supporting and delivering effective cessation interventions.
- **Substance use disorder**—Humana offers substance use disorder screening training to providers. Humana and Humana-contracted providers are required to offer targeted members either community- or plan-sponsored substance use disorder programs.

Americans with Disabilities Act (ADA) requirements

Americans with Disabilities Act requirements

Providers are required to comply with all Americans with Disabilities Act (ADA) requirements, including:

- Waiting room and exam room furniture that meets the needs of all members, including those with physical and nonphysical disabilities
- Interpretation services for members with limited English proficiency and auxiliary aids for hearing and visually impaired members
- Clear signage throughout provider offices
- Adequate provider office parking and access for members

Affordable Care Act (ACA): Non-discrimination requirements

Section 1557 requirements

Providers that operate a health program or activity and receive federal financial assistance from the Department of Health and Human Services (HHS) for any part of that program or activity are required to comply with Section 1557 of the Affordable Care Act (ACA). Requirements include:

- Posting of a nondiscrimination statement in provider offices
- Posting of a notice about nondiscrimination and accessibility requirements

Helpful links:

- Model Notice of Nondiscrimination in English and Translated Versions
- Training Materials for Section 1557

Olmstead ruling and independent living

Olmstead v. L.C.

On June 22, 1999, the U.S. Supreme Court held in Olmstead v. L.C. that "unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity."

Source: www.ada.gov/olmstead/olmstead_about.htm

Olmstead v. L.C. (cont'd)

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment."

Source: www.ada.gov/olmstead/olmstead_about.htm

Access to recovery

Access to recovery

- Recovery access provides clients with options for clinical treatment and support services that reinforce their efforts to live drug- and alcohol-free or recover from mental illness.
- Services typically are performed in face-to-face individual or group settings.
- Some services require reimbursement and others are free of charge.
- Access to these recovery services can be obtained from community-based, faith-based and secular organizations or from facilities licensed by the state Division of Alcoholism and Substance Abuse.

NOTE: If interested in becoming a program provider, please see consult the appendix for state-specific information.

Access to recovery (cont'd)

Available services include:

- **Continuing care services**—Post-discharge services provided by inpatient treatment programs and performed by experienced counselors who assist members in meeting goals of continued care plan.
- **Employment coaching**—Skills-based member training related to employment that may include resume writing, mock interviewing and job search coaching.
- **Pastoral counseling**—Services that provide supportive witness to members during times of transition, emotional stress and life changes.
- **Peer and recovery coaching**—Services that include topics such as relapse prevention, coping skills, anger management, domestic violence, decision-making, lifestyle choices, pursuing interests and participating in drug-free recreation.

Other coaching opportunities may be available.

Community outreach provider compliance

Requirements

Providers must comply with the following requirements:

- Healthcare providers **may** display health-plan-specific materials in their own offices.
- Healthcare providers **cannot** orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network.
- Healthcare providers **may** announce a new affiliation with a health plan and give patients a list of health plans with which they contract.
- Healthcare providers **may** cosponsor events such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisements.

Requirements (cont'd)

- Healthcare providers **shall not** furnish patient lists to the health plan with which they contract, or to any other entity; nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment.
- Providers **may** distribute health plan information about non-health plan-specific healthcare services and the provision of health, welfare and social services by the state or local communities, if inquiries from prospective members are referred to the member services section of the health plan or the agency's choice counselor/enrollment broker.

Fraud, waste and abuse

Fraud, waste and abuse in Medicaid

- Both the federal government and individual states establish and monitor Medicaid requirements designed to reduce fraud, waste and abuse (FWA) in the Medicaid program.
- Healthcare FWA can involve providers, pharmacists, members and medical equipment companies. Success in combating healthcare FWA is measured not only by convictions, but also by effective deterrent efforts.

Additional information about FWA is available in a CMS-published training document, *Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training*. Its concepts also apply to Medicaid. Access directions are located at Humana.com/fraud.

Reporting FWA concerns

Anyone who suspects or detects an FWA violation is required to report it either to Humana or within his/her respective organization, which will then forward the information to Humana.

Telephone contacts

SIU direct line: 800-558-4444

Monday through Friday: 9 a.m. to 5 p.m., Central time

SIU hotline: 800-614-4126 (24/7 access)

Ethics Help Line: 877-5-THE-KEY (877-584-3539)

- **Email**: siureferrals@humana.com or ethics@humana.com
- **Web**: www.ethicshelpline.com
- **Fax**: 920-339-3613

Key features of reporting directly to Humana

- **Anonymity**: If the person making the report chooses to remain anonymous, he/she is encouraged to provide enough information about the suspected violation (i.e., 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; Humana 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.

Any entity supporting Humana that offers a reporting option to its employees and downstream entities must provide 24/7 access and the same key features outlined here.

Appendix

Illinois state-specific information

- For more information on how your practice can become a patient-centered medical home, call Humana Medicare-Medicaid Dual Provider Call Center at 800-787-3311.
- Contacts for the Illinois Ombudsman Program are listed at: www2.illinois.gov/aging/programs/LTCOmbudsman/Pages/default.aspx
- For more information on how to become a provider for Illinois Access to Recovery (ATR) II program, call the Illinois Department of Alcoholism and Substance Use Disorders at 800-843-6154 to request an application.

Illinois-specific references

- Illinois Department on Aging
- Illinois Department of Human Services
- Illinois DHS Division of Rehabilitation Services