2023 Special Needs Plans Training for Physicians

Humana Gold Plus® SNP – Dual-eligible (HMO)
Humana Gold Plus® SNP – Chronic condition (HMO)
HumanaChoice SNP – Dual-eligible (PPO)
Humana Together in Health – I-SNP (HMO/PPO)
Humana Senior Living– IE –SNP (HMO)

Effective Jan. 1, 2023

Humana®

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A quick word about the guestbook

- If you are viewing this presentation through our online BrainShark SNP training located at Humana.com/ProviderCompliance, please be sure to enter all requested information in the guestbook that appears when you open the presentation. That information will enable Humana to give you credit for the training and will ensure you receive a certificate of completion after you view the presentation.

- If you have more than 4 Tax Identification Numbers (TINs) to attest for, please email a roster of all your TINs, including provider name, address, original date and organization name you used to complete the training to: NNO_ProviderCompliance@Humana.com.

What is a Special Needs Plan?

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan specifically created to focus on the needs of some of your most vulnerable patients.

In collaboration with you, we can work to create a care plan designed specifically for each SNP member.

Humana offers three types of SNPs

- Dual-eligible SNP
  - Identified on a Humana member's ID card as a D-SNP
  - Covers members eligible for both Medicare and Medicaid

- Chronic SNP (C-SNP)
  - Identified on a Humana member's ID card as a C-SNP
  - Covers members eligible for both Medicare and Medicaid who have one of the following conditions:
    - Diabetes mellitus – chronic lung disorders – cardiovascular disorders – chronic heart failure

- Institutional or institutional-equivalent SNP (I-SNP/IE-SNP)
  - Identified on a Humana member's ID card as an I-SNP – (this applies to IE SNPs, too)
  - Covers members eligible for both Medicare and Medicaid
  - Eligibility is based on:
    - Confirmation of a minimum 90-day stay in a facility contracted with Humana to offer I-SNP, or
    - A CMS-approved needs assessment confirming the patient's condition will likely require a 90-day stay
  - Patients living in Illinois or Wisconsin who require an institutional level of care may be eligible for an IE-SNP.

General SNP information

- MA is always primary.
- Physicians/providers may not balance-bill a QMB/Qualified Medicare Beneficiary, also referred to as a cost-share-protected member.
  - Please refer to your Remittance Advice Remark Codes (RARC) located on your Electronic Remittance Advice (ERA) and your EX codes located on your paper Traditional Explanation of Remittance (TEOR) to help you identify members who are not to be balanced billed.
- Physicians/providers may not refuse service to a member based on secondary payer status.
- Enhanced benefits, such as vision, dental, hearing, routine transportation and over-the-counter drugs, may be provided.

Dual-eligible patients and cost-share protection (CSP)

Practices may NOT bill patients who have cost-share protection

- Federal law prohibits balance-billing of cost share-protected patients.
- Providers must accept payment from Humana or Medicaid as payment in full **even if** they choose not to bill Medicaid.
- Any remaining balance must be written off by the provider; it may not be balance-billed to the patient.

What is a cost-share-protected (CSP) patient?

- CSP is a category of dual eligibility that defines the type of Medicare benefits a patient receives.
- Patients with CSP status have the patient portion of their Part A and B deductibles, copays and coinsurances **reduced to $0**.
- A patient's CSP status can be found at Availity.com or verified by calling Humana Customer Service at **800-626-2741**.

What does the contract with Humana say?

Humana's MA provisions attachment *(r)* states that "*Physician agrees not to collect or attempt to collect copayments, coinsurance, deductibles or other cost-share amounts from any Humana Medicare Advantage Member who has been designated as a Qualified Medicare Beneficiary ("QMB") by CMS.*"

For more information about balance-billing and dual-eligible beneficiaries, visit:
CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244469.html.

Humana SNP availability for 2023

State	Dual SNP	Chronic SNP	I-SNP
Alabama*	✓		
Arkansas	✓	✓	
California	✓		
Colorado	✓		
Connecticut	✓		
Delaware	✓		
Florida*	✓	✓	
Georgia	✓	✓	✓
Illinois			✓
Indiana	✓	✓	
Iowa	✓	✓	
Kansas		✓	
Kentucky	✓	✓	
Louisiana	✓		
Maine	✓		
Michigan	✓		
Mississippi	✓	✓	
Missouri	✓	✓	
Montana	✓		

State	Dual SNP	Chronic SNP	I-SNP
Nebraska	✓		
Nevada	✓	✓	
New York	✓		
North Carolina	✓		
Ohio	✓	✓	
Oklahoma	✓	✓	
Oregon		✓	
Pennsylvania	✓		
South Carolina	✓	✓	✓
South Dakota	✓		
Tennessee	✓		
Texas*	✓		
Utah	✓		
Virginia		✓	
Washington	✓		
West Virginia	✓		
Wisconsin†			✓
Wyoming	✓		
Puerto Rico*	✓		

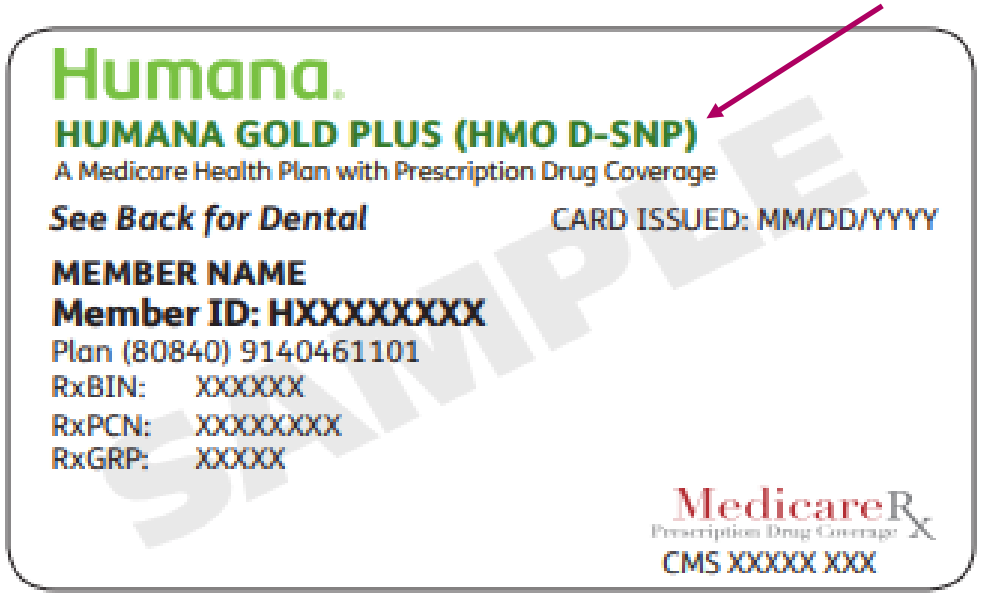
*Indicates states where Humana coordinates cost-share reimbursement with the state's Medicaid authority.

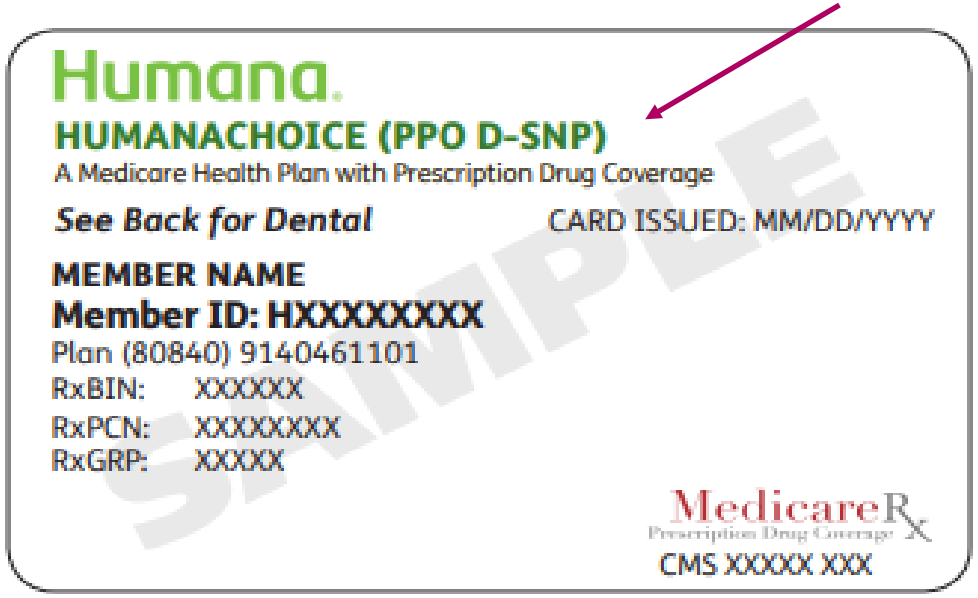
† Indicates where an IE-SNP is available.

Identifying patients with SNPs

- Humana SNP patients have a unique ID card.
- The front of the card, just under the Humana logo, indicates the type of SNP a patient has. Healthcare providers also can contact Humana customer service or visit Availity.com to obtain this information.
- Dual-eligible SNP patients should present both their Humana ID card and their Medicaid card.

Sample HMO SNP and PPO SNP Humana ID Cards





D-SNP claims submission by state

- **Alabama, Florida, Texas and Puerto Rico** — Humana receives a per-member per-month (PMPM) payment that covers the cost-sharing portion Medicaid would cover for all cost-share-protected categories.
    - Medicare and Medicaid portions are paid at the same time.

- **Tennessee –** After claim adjudication, Humana passes Tennessee D-SNP claims directly to Tennessee Medicaid. Providers do not bill Tennessee Medicaid for consideration of secondary payment.

- **All other states** — The healthcare provider bills Humana, then bills Medicaid for secondary payment.

Benefit summary

- Healthcare providers can help patients understand their benefits by accessing their summary of benefits.
- The summary contains a comparison of benefits available to the patient through Medicaid and/or Humana. It offers state Medicaid contact information if referral or coordination of benefits is indicated.
- To access the patient's plan summary:
  - Log in to Availity.com.
  - Select "Patient Registration" at the top left of the page.
  - Choose "Eligibility and Benefits Inquiry."
  - Complete the "New Request" form to search for the patient's benefits.
  - Review the "Coverage and Benefits" tab to determine if a patient is cost-share protected. CSP means the patient cannot be balance-billed.
  - Select the "Medicare Certificate of Coverage" button.
  - Accept the disclaimer that states you are leaving the Availity site. Humana's website will open at a page where you can search for the patient's plan by ZIP code.

Humana's SNP model of care

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a model of care (MOC) approved by the National Committee for Quality Assurance (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 4 goals:

- To improve patient outcomes by coordinating care and ensuring care transitions
- To improve patient access to and utilization of services and benefits
- To increase patients' satisfaction with their healthcare experience and health status
- To ensure cost-effective service delivery

Humana achieves these goals by:

- Conducting Health Risk Assessments (HRAs) to identify risk needs
- Developing a plan of care to address identified needs

HRAs and ICPs

Health Risk Assessments (HRAs)

- Administered within 90 days of enrollment and within 365 days of a previous assessment
- Produce a current health status profile and overall risk score
- Enable patient stratification into levels of intervention (LOI) to determine the minimum level of proactive outreach

Individualized Care Plan (ICP)

- Developed by the care manager with input from the patient and healthcare provider
- Based on HRA results and LOI
- Includes goals, objectives, interventions and measureable outcomes
- Addresses specific services and benefits available
- Reviewed and updated by the care manager during the annual reassessment process, upon significant change in patient's health status, upon patient's request or when deemed necessary by the care manager
- Replaced with a basic care plan when the patient cannot be reached or declines to participate

The interdisciplinary care team (ICT)

- Humana assembles a team of providers from different professional disciplines who work together to deliver care.
- Services focus on care planning to support the patient and optimize his/her quality of life.
- An ICT typically includes:
  - The patient and/or patient's caregivers
  - The patient's provider
  - Humana's clinical-care manager and coordinators
  - Social workers and community social-service providers
  - Humana's and/or the patient's behavioral-health professional
- Starting CY2023, all SNP members are encouraged to complete an annual face-to-face encounter with a member of the ICT
  - Examples of qualifying types: The Annual Wellness Visit completed by the primary care provider meets the CMS requirement, preventative care, treatment and management of health conditions, care management activities, and behavioral health
  - Face-to-face encounter must be completed either in-person or through a visual, real-time, interactive telehealth encounter

The healthcare provider's role

- Receive and review health risk assessments, as appropriate
- Collaborate with the care manager to develop and modify the care plan
- Participate in care conferences via phone, through exchange of written communications and possibly in person to foster care coordination
- Promote Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures. Capture these SNP-only HEDIS measures:
  - Medication reconciliation post-discharge
  - Care for older adults

SNP MOC elements — the personalized care manager

The care manager serves as the primary point of contact for SNP patients and is responsible for implementing and overseeing all aspects of care management. The care manager's duties include:

- Acting as clinical quarterback, engaging patient and ICT participants
- Coordinating ICT care – physicians, pharmacy, etc.
- Administering Health Risk Assessments
- Assisting with ICP
- Planning for and supporting discharges
- Educating patient and his/her caregivers
- Offering patient health support and research
- Connecting patient to community resources and social services
- Providing end-of-life/advance-directive guidance

Resources

Medicare Managed Care Manual

- Chapter 5: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf
- Chapter 16-B: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

MLN Matters article about balance-billing: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

SNP MOC — CMS guidance

- Chapter 5 — Quality Assessment of the Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

For more information

- Visit Humana.com/Provider
- Call Humana Provider Relations at 800-626-2741
- Email NNO_ProviderCompliance@Humana.com

Do you have any additional TINS you are attesting for?

Provide additional TINS, NPIs or addresses for which you are attesting.

Thank you

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