

# 2024 Special Needs Plans Training for Physicians

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

Effective Jan. 1, 2024

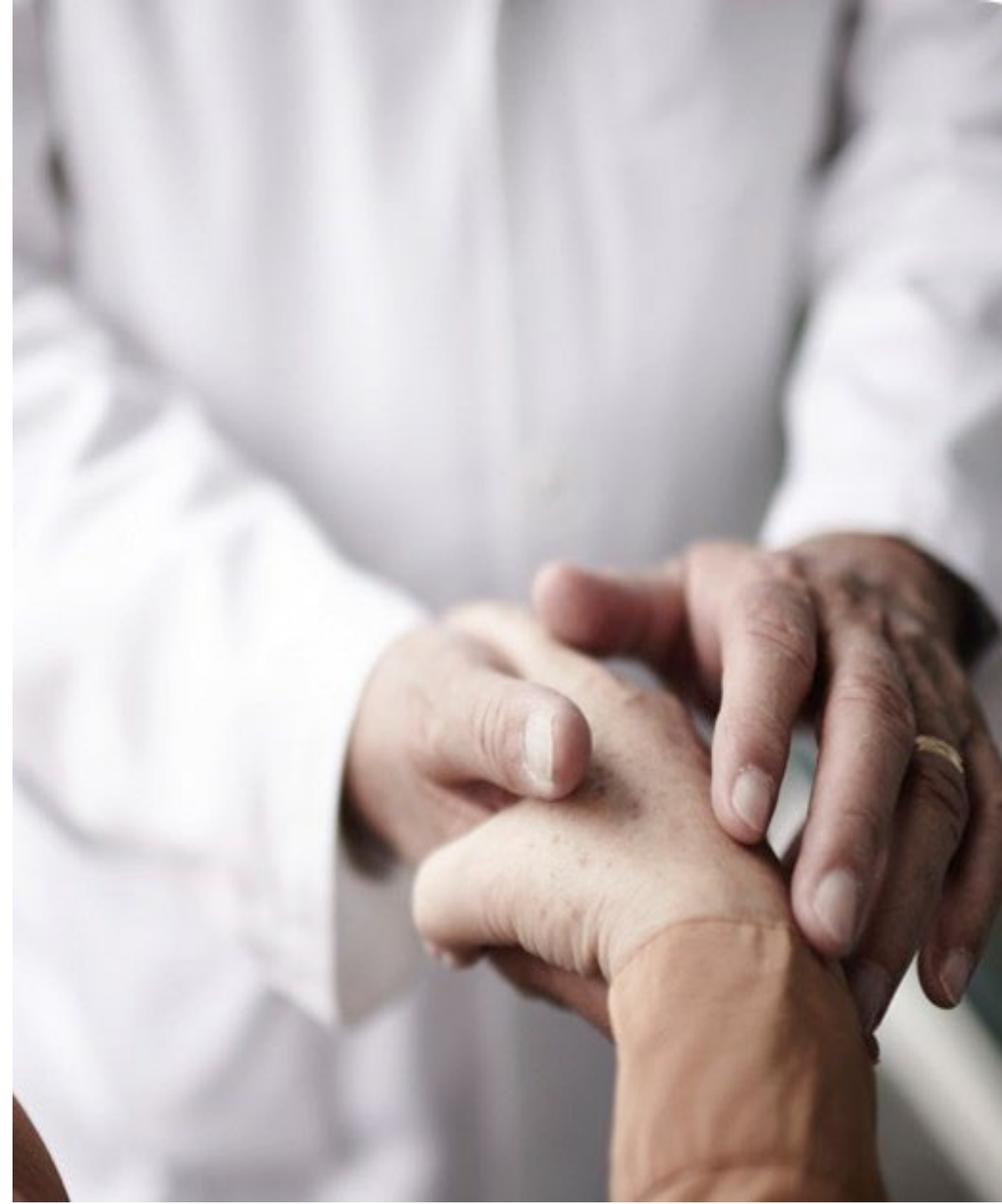
**Humana**®



# 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 3 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 Medicare who have at least one of the following conditions:
    - Diabetes mellitus, chronic lung disorders, cardiovascular disorders and 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 Medicare eligible members that also require an institutional level of care.
  - 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 the primary payer.
- Per CMS, physicians/providers may not balance-bill a Qualified Medicare Beneficiary (QMB), 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 found 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.
- CMS may impose sanctions on physicians/healthcare providers who balance bill a cost-share protected member.
- Enhanced benefits such as vision, dental, hearing, routine transportation and over-the-counter drugs may be provided.

# Dual-eligible members and cost-share protection (CSP)

## Practices may NOT bill patients who have cost-share protection

- Federal law prohibits balance-billing of cost share-protected members.
- 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 member.

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

- CSP is a category of dual eligibility that defines the type of Medicare benefits a member receives.
- Members with CSP status have the member portion of their Part A and B deductibles, copays and coinsurances **reduced to \$0**.
- A member's CSP status can be found at [Availity.com](https://www.availability.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."*

Find more information about balance-billing and dual-eligible beneficiaries [here](#):

# Humana SNP availability for 2024

State	Dual SNP	Chronic SNP	I-SNP
Puerto Rico*	✓		

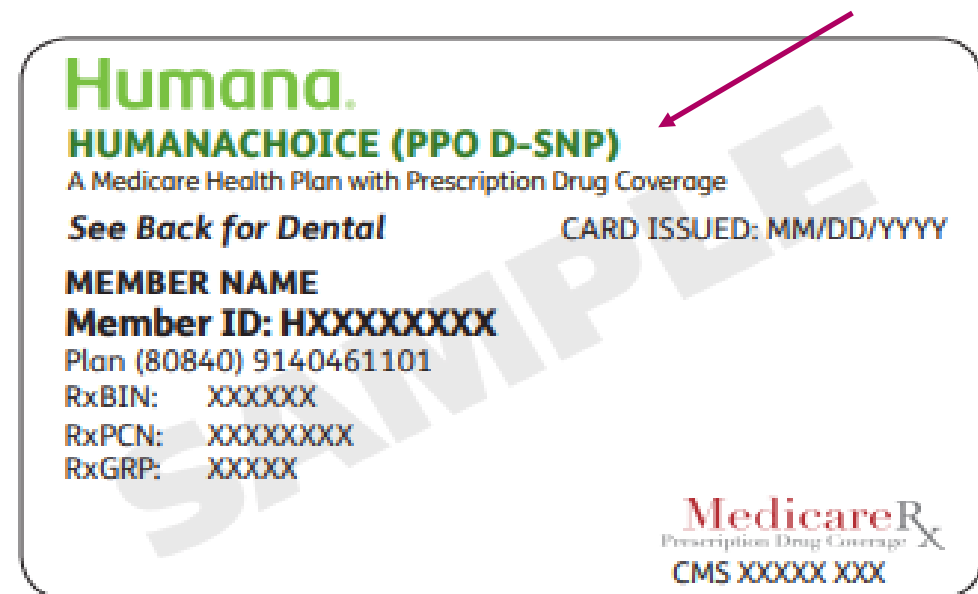
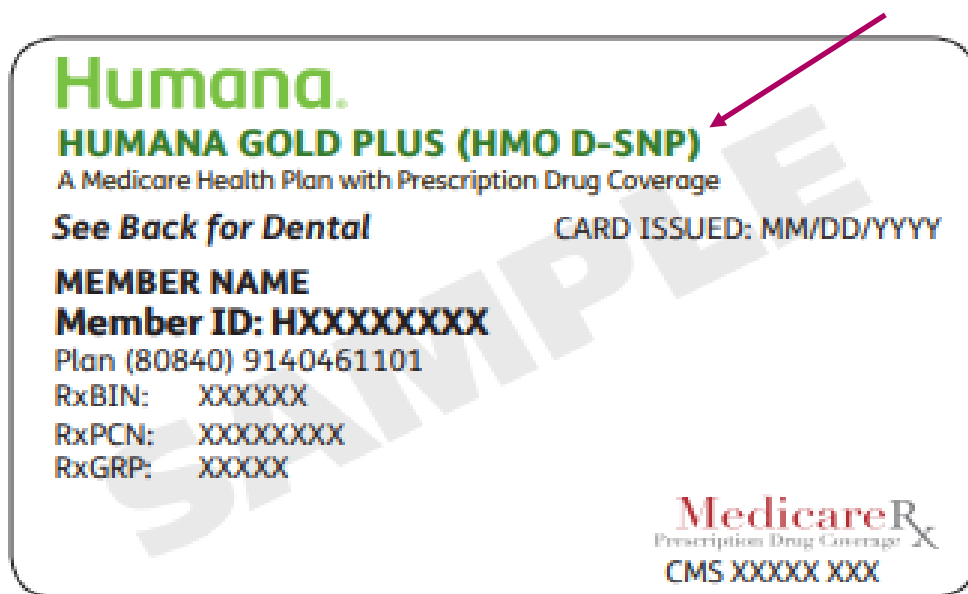
\*Indicates states where Humana coordinates cost-share reimbursement with the state's Medicaid authority.

† Indicates where an IE-SNP is available.

# Identifying members with SNPs

- Humana SNP members have a unique ID card.
- The front of the card, just under the Humana logo, indicates the type of SNP a member has. Healthcare providers can contact Humana customer service or visit [Availity.com](http://Availity.com) to obtain this information.
- Dual-eligible SNP members should present both their Humana ID and their Medicaid cards.

## Sample HMO SNP and PPO SNP Humana ID Cards



# D-SNP claims submission

- **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.



# Eligibility requirements

State	Plan Type & Contract-PBP	Legal Entity	Subtype	Covered Eligibility Categories
<p><b>Puerto Rico</b></p>	<p>HMO - HIDE (AIP)</p> <p>H4007-016, 018, 019, 026, 027, <b>030</b></p>	<p>Humana Health Plans of Puerto Rico, Inc.</p>	<p>Non-\$0 Cost Share</p>	<p>Enrolls all dual eligibles - As a territory does not have "traditional" Medicaid eligibility categories/Does not have Cost-Share protection/Does not have LIS "Extra Help"</p>

\*Indicates Cost-Share protected categories for that state.

Red font indicates changes for 2024.

# Benefit summary

- Healthcare providers can help members understand their benefits by accessing their summary of benefits.
- The summary contains a comparison of benefits available to the member through Medicaid and/or Humana. It offers state Medicaid contact information if referral or coordination of benefits is indicated.
- To access the member'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 member's benefits.
  - Review the “Plan Maximums and Deductibles” section to determine if a member is cost-share protected. CSP means the member cannot be balance-billed.
  - Select the “Medicare Certificate of Coverage” link.
  - 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 member's plan by ZIP code.
  - Be sure to review the “Plan Maximums and Deductibles” section to determine if a patient is cost share protected (CSP).
    - \*CSP means the patient cannot be balance billed.

# 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 member outcomes by coordinating care and ensuring care transitions
- To improve member access to and utilization of services and benefits
- To increase members' 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 measurable 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

## To access the patient's HRA and ICP:

- Log in to [www.availity.com](http://www.availity.com)
- Select "Patient Registration" at the top left of the page
- Select "Eligibility and Benefits Inquiry" to look up the patient's eligibility and benefits information
- On the results page, select the "Assessment & Care Plan" and "Member Summary"

# 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 member and optimize his/her quality of life.
- An ICT typically includes:
  - The member and/or member's caregivers
  - The member's provider
  - Humana's clinical-care manager and coordinators
  - Social workers and community social-service providers
  - Humana's and/or the member's behavioral-health professional
- Starting CY2024, 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 (PCP) meets the CMS requirement, preventive 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
- Complete Verification of Chronic Condition (VCC) form for C-SNP members
- 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 members and is responsible for implementing and overseeing all aspects of care management. The care manager's duties include:

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

# Resources

## Medicare Managed Care Manual

- [Chapter 5](#)
- [Chapter 16-B](#)

MLN Matters article about balance-billing can be found [here](#):

## SNP MOC — CMS guidance

- [Chapter 5 — Quality Assessment of the Medicare Managed Care Manual](#)