2017 Special Needs Plans (SNP) Training for Physicians and Clinicians

Humana Gold Plus® SNP – Dual eligible (HMO)
Humana Gold Plus® SNP – Chronic condition (HMO)

2017

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Agenda

Section 1

1. Notable changes for 2017
2. SNP overview
3. Humana SNPs
4. Dual-eligible SNPs
5. Chronic-condition SNPs
6. The physician's role

Section 2

1. Physician involvement
2. Model of care

Notable changes for 2017

- Two new dual-SNP state contracts
  - Nebraska
  - Pennsylvania
- State dual-SNP contract changes – added cost-share protected categories
  - Maine
  - South Carolina
  - Virginia
- Five dual-SNPs terminated and/or consolidated
  - See slide 29 for a list of all D-SNPs offered by Humana

Notable changes for 2017 (cont.)

- Two chronic-condition SNPs added
  - Greenville
  - Cincinnati-Columbus
- 19 chronic-condition SNPs terminated and/or consolidated
  - Arizona no longer has any SNPs
- New slides 20-23 contain important Medicaid information:
  - Medicaid coverage for dual eligibles
  - Full dual eligibles vs. partial dual eligibles (Medicare Savings Program)
  - Medicaid waivers

SNP overview

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Special Needs Plans (SNP)

- A type of Medicare Advantage (MA) plan
- Created by the Medicare Modernization Act of 2003

Requirements

- Mandated by the Medicare Improvements for Patients and Providers Act (MIPPA):
  - Initial and annual health risk assessments
  - Case management and individualized care plans
  - Dedicated interdisciplinary care team
  - Process for reporting health outcomes and quality
- Many requirements depend on the primary care physician's active involvement.

Enhanced features

SNPs must go above and beyond regular MA plans

- Additional or enhanced benefits such as:
  - Vision, dental, hearing, routine transportation (varies by plan)
  - Over-the-counter drugs
- Lower cost shares
  - $0 cost share for most benefits on the dual-eligible SNP
- Enhanced care coordination
- Assistance to help patients understand benefits provided through Medicare Advantage and Medicaid

CMS guidance for SNPs

- Medicare Managed Care Manual
  - Chapter 5: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf
  - Chapter 16b: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

Humana's SNPs

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Two types of SNP

Humana offers two types of SNPs:

- **Dual-eligible** – Covers individuals eligible for both Medicaid and Medicare
- **Chronic condition** – Covers one or more of these condition categories:
  - Diabetes mellitus
  - Chronic lung disorders
    - Asthma, chronic bronchitis, emphysema, pulmonary fibrosis, pulmonary hypertension
  - Cardiovascular disorders
    - Cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder
  - Chronic heart failure
  - End-stage renal disease (ESRD) requiring dialysis

Humana SNP availability for 2017

	Dual SNP	Chronic SNP
Alabama*	✓	
California	✓	
Colorado		✓
Florida*	✓	✓
Georgia	✓	
Illinois		✓
Indiana	✓	✓
Kentucky	✓	✓
Louisiana	✓	✓
Maine	✓	
Missouri	✓	
Mississippi	✓	
Montana	✓	
North Carolina	✓	
Nebraska	✓	
Nevada		✓
New York	✓	
Ohio	✓	✓
Pennsylvania	✓	
South Carolina	✓	✓
Tennessee	✓	
Texas*	✓	✓
Virginia	✓	✓
Washington	✓	
Puerto Rico	✓	

* Indicates state where Humana coordinates reimbursement with the state's Medicaid authority.

General SNP enrollment process

- Completed by licensed, trained sales agents using CMS-compliant materials and processes
- Supplies applicants with comprehensive plan information

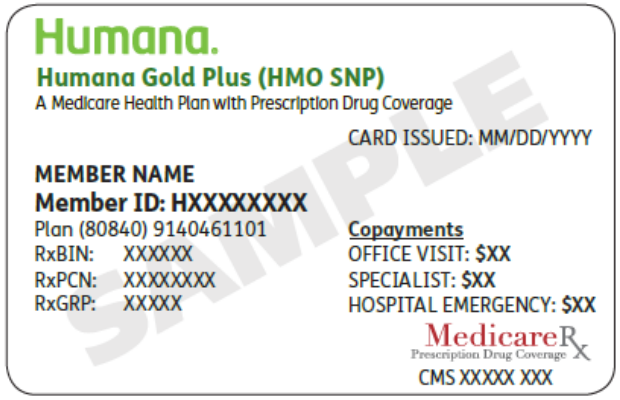
General SNP enrollment process (cont.)

- SNP agents must complete additional training on unique plan attributes.
  - CMS rules allow sales agents to ask applicants if they have one of the chronic conditions.
  - If the response is “yes” for the condition, presentation of a SNP may be appropriate.
- SNP educational materials can be placed in physician office common areas, but not where patients receive health care.

Identifying patients with SNPs

- Humana SNP patients have a unique ID card.
- Clinicians can identify the specific type of SNP by referencing the plan number in the lower right corner of the card or by contacting customer service.
- Dual-eligible SNP patients should present both their Humana ID card and their Medicaid card.

Sample Humana ID Card



Dual-eligible SNPs

(D-SNPs)

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Medicaid eligibility levels for D-SNPs

- Qualified Medicare Beneficiary without other Medicaid (QMB only)*
- Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits (QMB+)*
- Specified Low-income Medicare Beneficiary without other Medicaid (SLMB)
- Specified Low-income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+)**
- Qualifying Individual (QI)
- Qualified and Disabled Working Individual (QDWI)
- Other Full Benefit Dual Eligible (FBDE)**

*Indicates patients who are always cost-share-protected
**Indicates patients who may be cost-share-protected – varies by state contract

Medicaid benefits by eligibility category

Dual-eligible category	Full Medicaid	Medicaid coverage of Medicare premiums and cost sharing				Medicaid coverage of Medicare Part C premiums and cost sharing		
		Part A premium	Part B premium	Part D premium	Out-of-pocket cost sharing	Premium		Out-of-pocket cost sharing
						Part A, Part B and mandatory supplemental	Optional supplemental	Required
QMB	No	Yes	Yes	No	Yes	Optional	Not permitted	Required
QMB+	Yes	Yes	Yes	No	Yes	Optional	Optional	Required
SLMB	No	No	Yes	No	No	Not permitted	Not permitted	Not permitted
SLMB+	Yes	No	Yes	No	No	Not permitted	Optional	Conditional
QI	No	No	Yes	No	No	Not permitted	Not permitted	Not permitted
QDWI	No	Yes	No	No	No	Not permitted	Not permitted	Not permitted
FBDE	Yes	No	No	No	No	Not permitted	Optional	Conditional

Medicaid coverage for D-SNPs

- Dual-eligible plan patients qualify for both Medicare and Medicaid coverage.
  - Medicare covers most acute care services.
  - Medicaid covers Medicare premiums and cost sharing, based on the patient's level of eligibility as determined by Medicaid.
  - Medicaid may also cover some wrap benefits and some long-term care services for qualified patients.
- Eligibility and benefits vary greatly by state.

Full dual-eligible vs. partial dual-eligible (Medicare Savings Program)

Full Dual-eligible		
QMB+	Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits	• Receive full Medicaid benefits not covered by Medicare: - Nursing home/other institutional care - Waiver services - Wrap benefits • Dentures, eyeglasses, hearing aids, transportation and prescription drugs not covered under Part D
SLMB+	Specified Low-income Medicare Beneficiary with Comprehensive Medicaid Benefits	
FBDE	Full Benefit Dual Eligible	

Partial Dual-eligible		
QMB	Qualified Medicare Beneficiary without other Medicaid	• Somewhat higher income and asset levels - Not eligible for full Medicaid • Limited Medicaid coverage • Qualified for assistance with Medicare premiums and (for QMB) cost sharing.
SLMB	Specified Low-income Beneficiary without other Medicaid	
QI	Qualifying Individual	
QDWI	Qualified and Disabled Working Individual	

Medicaid waivers

- D-SNP patients may also receive long-term care services from Medicaid, including nursing facility and waivers.
- Home and community-based waivers allow states to treat certain Medicaid populations in home or other community-based settings, rather than in institutional or long-term care facilities such as hospitals or nursing homes.
- To receive home and community-based services, patients must meet certain eligibility criteria, including income and resource limits, medical criteria and institutional level-of-care criteria.
- Waivers are specific to each state, and eligibility varies state to state.

Medicaid waivers (cont.)

- Waiver programs can provide a combination of standard medical services and nonmedical services.
- Standard services include but are not limited to:
  - Case management (i.e. supports and service coordination)
  - Homemaker
  - Home health aide
  - Personal care
  - Adult day health services
  - Habilitation (both day and residential)
  - Respite care
- States can also propose other services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and communities.

D-SNPs and cost shares

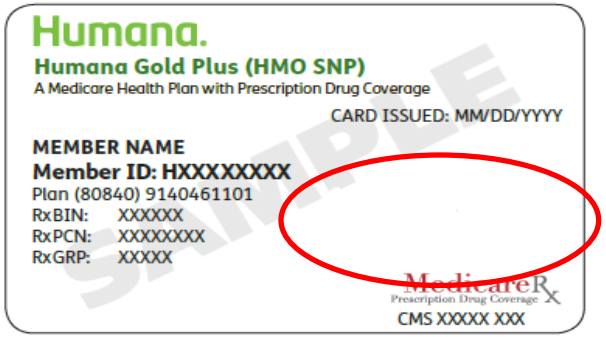
Humana-covered patients will receive cost-share protection in the following circumstances:

- Medicaid has enrolled the patient in a cost-share-protected eligibility category, for example:
  - Qualified Medicare Beneficiary without other Medicaid
  - Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits
  - Specified Low-income Medicare Beneficiary without other Medicaid
  - Full Benefit Dual Eligible
- The patient is enrolled in a general Medicare Advantage prescription drug plan or a D-SNP.
- The patient sees a participating clinician.

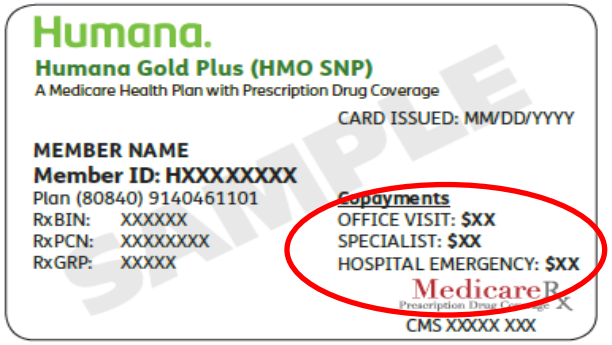
D-SNPs and cost-shares (cont.)

- Patients who are cost-share protected do not have cost shares listed on their Humana ID card.
- Patients who are **not** cost-share protected have cost-shares listed on their Humana ID card.

Sample ID card – Member with cost-share protection



Sample ID card – Member without cost-share protection



D-SNPs and cost shares (cont.)

- All claims should be submitted to Humana first for payment for Medicare-covered services. Bill any remaining cost to Medicaid for secondary payment. If a patient has lost Medicaid eligibility, Humana will reimburse.
- D-SNP patients with cost-share protection are **not** responsible for copayments, coinsurance or any other form of payment to practitioners for medical services (including Part B drugs).

D-SNPs and cost shares (cont.)

- All D-SNPs provide an additional six months of coverage to members who lose plan eligibility.
- If Medicaid denies payment due to lack of eligibility within this six-month grace period, clinicians **should not bill or balance bill** the patient. Cost-sharing for patients who are not eligible for Medicaid cost-share will be paid by Humana.
- When a patient is cost-share protected, the patient should show both a Humana ID card and a Medicaid ID card at the time of service.

Humana Gold Plus SNP – Dual-eligible (HMO) enrollment process

- Applicants who are Medicaid eligible can join a Humana Gold Plus SNP dual-eligible HMO plan in states where Humana has a contract with the state.
- Certain levels of Medicaid may be required to enroll in the plan.
- Applicants have a continuous special election period that begins when their plan becomes effective and continues as long as they remain eligible for Medicaid.

Humana Gold Plus D-SNP – benefit summary

- Physicians help patients understand and access Medicaid benefits through referrals and by coordinating with Medicaid, as appropriate.
- Comparison of benefits available to the patient through Medicaid and/or Humana can be found in the patient's summary of benefits, which also provides state Medicaid contact information if referral to or coordination of those benefits is indicated.
- To access the summary, a physician can:
  - Log into the secure provider website at **Humana.com/providers** using your user ID and password
  - Choose "Eligibility and Benefits"
  - Select "Provider Group"
  - Enter the patient's ID to search for his/her benefits
  - Click "Certificate, Summary Plan Document or Policy"

State Medicaid contacts for D-SNPs

State	Level of Coverage	Contact Info	State Medicaid Website
Alabama	All Duals	1-800-362-1504	http://www.medicaid.alabama.gov/CONTENT/9.0_Recipients/
California	QMB+, SLMB+, FBDE	1-800-541-5555	http://www.medi-cal.ca.gov/
Florida	All Duals	1-888-419-3456	http://ahca.myflorida.com/
Georgia	QMB, QMB+, SLMB+	1-866-211-0950	http://dch.georgia.gov/medicaid
Indiana	QMB, QMB+	1-800-457-4584	http://www.indianamedicaid.com/
Kentucky	QMB, QMB+	1-800-635-2570	http://chfs.ky.gov/dms/
Louisiana	QMB, QMB+, SLMB+	1-888-342-6207	http://new.dhh.louisiana.gov/index.cfm/subhome/1
Maine	QMB, QMB+, FBDE	1-800-977-6740	http://www.maine.gov/dhhs/oms/member/member_index.html
Mississippi	QMB, QMB+, FBDE, SLMB+	1-800-421-2408	http://www.medicaid.ms.gov/
Missouri	QMB, QMB+	1-800-392-2161	http://www.dss.mo.gov/mhd/
Montana	QMB, QMB+	1-800-362-8312	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/montana.html
Nebraska	QMB, QMB+, SLMB, FBDE	1-855-632-7633	http://dhhs.ne.gov/medicaid/Pages/med_medindex.aspx
New York	QMB, QMB+, FBDE	1-800-541-2831	http://www.health.ny.gov/health_care/medicaid/
North Carolina	QMB, QMB+, FBDE, SLMB+	1-800-662-7030	http://www.ncdhhs.gov/dma/medicaid/medicare.htm
Ohio	QMB, QMB+, FBDE	1-800-324-8680	http://jfs.ohio.gov/ohp/
Pennsylvania	QMB, QMB+, SLMB, FBDE	1-866-550-4355	https://www.healthinsurance.org/pennsylvania-medicaid/
Puerto Rico	All Duals	1-877-772-7701	https://www.medicaid.pr.gov/
South Carolina	QMB, QMB+, FBDE	1-888-549-0820	http://www.scdhhs.gov/
Tennessee	QMB, QMB+, FBDE, SLMB+	1-866-311-4287	http://www.state.tn.us/tenncare/
Texas	QMB, QMB+, SLMB+	1-877-541-7905	http://www.hhsc.state.tx.us/
Virginia	QMB, QMB+, SLMB+, FBDE	1-804-786-6145	http://www.dmas.virginia.gov/
Washington	QMB, QMB+, SLMB+	1-800-562-3022	http://hrsa.dshs.wa.gov/

Chronic-condition SNPs

C-SNPs

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Humana Gold Plus C-SNP (HMO) enrollment process

- Applicants can enroll year-round if diagnosed with one of the approved chronic conditions (see slide 11).
- Applicant must be diagnosed with the condition by a physician and complete two forms:
  - **Prequalification form**
    - Completed at time of sale
    - Includes disease-specific questions
    - Must be received with the application to process enrollment
  - **Verification of Chronic Condition (VCC) form**
    - Completed after enrollment
    - Must be signed by patient's physician
    - Must be received within first month of coverage

SNPs, Part 2

Humana SNP Model of Care (MOC) and Physician involvement

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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

SNP MOC goals

MOC goals are:

- To improve patient access to:
  - Medical, mental-health and social services
  - Affordable care
  - Preventive health services
- To improve coordination of care through an identified point of contact (e.g., Humana At Home)
- To improve transition of care across health care settings and practitioners
- To ensure appropriate utilization of services
- To ensure cost-effective service delivery
- To improve beneficiary outcomes

SNP MOC elements 1-2

1. Description of the SNP population
   - Sub-population: Most vulnerable Medicare beneficiaries

2. Care coordination
   - SNP staff structure
   - Health risk assessment tool (HRAT)
   - Individualized care plan (ICP)
   - Interdisciplinary care team (ICT)
   - Care transition protocols

SNP MOC elements 3-4

3. SNP provider network
   - Specialized expertise
   - Use of clinical practice guidelines and care transition protocols
   - MOC training

4. MOC quality measurement and performance improvement
   - MOC quality performance improvement plan
   - Measureable goals and health outcomes
   - Measuring patient experience of care (SNP patient satisfaction)
   - Ongoing performance improvement evaluation
   - Dissemination of SNP quality performance

SNP MOC elements – Health risk assessment (HRA)

- Applicants are evaluated within 90 days of enrollment.
  - CMS-approved HRA tool is used.
- Patients are stratified into levels of intervention (LOIs). LOIs can vary by MOC implementer:
  - Low
  - Medium
  - High
- LOI reassessment is required within 365 days of the previous assessment.

Note: Each LOI defines a minimum level of proactive contact with the patient. The actual level of contact is patient-specific and is based on clinical assessment and identified needs.

SNP MOC elements – Care plans

- Care plans based on:
  - HRA results
  - Claims history
- Plans developed for each patient by the ICT:
  - Include short- and long-term goals, objectives and interventions
  - Address specific services and benefits
  - Provide measurable outcomes

Note: When a patient cannot be reached or declines participation in care management, a basic care plan is developed in collaboration with the patient's PCP.

SNP MOC elements – individualized care plan (ICP)

- Plans are communicated to patients, caregivers and practitioners, as appropriate.
- Care plan records are maintained for access by all stakeholders.
- Confidentiality of records is maintained in accordance with HIPAA and state requirements.
- Plans are reviewed and revised annually or when health status changes.

SNP MOC elements – interdisciplinary care team (ICT)

- ICT – A team of individuals from different professional disciplines who work together to deliver care services. These services are focused on care planning to optimize quality of life and support the individual and/or family.
- The ICT may include:
  - The patient's physicians and/or nurses
  - Humana's clinical-care managers and coordinators
  - Social workers and community social-service providers
  - Humana's and/or the patient's behavioral health professionals
  - Humana's community health educators and resource-directory specialists
  - The patient's caregivers

SNP MOC elements – physician participation in ICTs

The physician-inclusive ICT model supports:

- The physician's treatment and medication plans
- The physician's goals, which are managed by a team of nurses, social workers, pharmacy specialists and behavioral health specialists
- Patient education and enhancement of direct patient-to-physician communication
- Self-care management and informed health care decision-making
- Care coordination and care transitions
- Access and connections to community resources and Medicaid services
- Appropriate end-of-life planning

SNP MOC elements – physician participation ICT (cont.)

- PCPs for SNP patients identified as “clinically at risk” (scoring high in the overall health risk category) receive pertinent health-risk assessment reports for review and input.
- Under the MOC, CMS requires physicians to:
  - Participate in ICT care conferences via phone, through exchange of written communications and possibly in person
  - Participate in inbound and outbound communications to foster care coordination
  - Promote Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
  - Capture SNP-only HEDIS measures for medication reconciliation post-discharge and care for older adults

SNP MOC elements – personalized care manager

The care manager serves as the primary point of contact for SNP patients and is responsible for the implementation and oversight of all aspects of care management. The care manager also coordinates and engages ICT participants, including the physician, to participate in the patient's plan of care.

- Clinical "quarterback"
- Patient health risk assessment assistance
- Individualized care plan assistance
- Discharge planning and support
- Pharmacy coordination
- Physician services coordination
- Patient/caregiver education
- Health support and research
- Community resource connections and social service coordination
- End of life/advance directive guidance

Note: The information on this slide does not pertain to Puerto Rico.

For more information

- Visit **Humana.com/providers**.
- Call Humana provider relations at 1-800-626-2741.