Tennessee Appendix to the Humana Provider Manual for Healthcare Providers

Humana Medicare Advantage Dual-eligible Special Needs Plans

Welcome.

This is a Tennessee appendix to the Humana Provider Manual. It provides additional information for Tennessee physicians and other healthcare providers regarding members of Humana's Medicare Advantage dual-eligible special needs plans (D-SNPs). Please reference it in conjunction with the Humana Provider Manual.

The appendix discusses key points related to Humana Gold Plus SNP-DE H4461-022 (HMO SNP) policies and procedures. It explains how the plan works and what you should expect from Humana and TennCare.

Thank you for your participation with Humana, where our goal is to provide quality services to your Tennessee Medicare Advantage-covered patients. We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact your Humana network management consultant.

Sincerely,

Tracey Collake
Regional Vice President
Provider Experience
Mid-South Region

Humana®

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I. Introduction

This document is a Tennessee appendix to the Humana Provider Manual. It provides additional information for Tennessee physicians and other healthcare professionals regarding Humana's Medicare Advantage dual-eligible special needs plans (D-SNPs). Please reference it in conjunction with the Humana Provider Manual.

The Humana Gold Plus SNP-DE H4461-022 (HMO SNP) is a Medicare Advantage (MA) health maintenance organization (HMO) special needs plan (SNP) that contracts with the federal government. The D-SNP plan limits membership to people who receive assistance from the state and Medicare. Humana has entered into an agreement with TennCare to arrange and coordinate Medicaid benefits for Humana's dual-eligible enrollees.

II. Glossary of Terms

Cost-sharing obligations – Medicare deductibles, premiums, copayments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries: Qualified Medicare beneficiaries (QMB and QMB Plus), specified low-income Medicare beneficiary plus (SLMB plus), and other Medicare/Medicaid full-benefit dual-eligible enrollees (FBDE). For SLMB plus and other Medicare/Medicaid FBDE, TennCare is not required to pay Medicare coinsurance on Medicare services that are not covered by TennCare, unless the enrollee is a child younger than 21 or a Supplemental Security Income (SSI) beneficiary. No plan can impose cost-sharing obligations on its members that would be greater than those that would be imposed if he or she were not a member of the plan.

Crossover claims – Claims that are sent electronically from Humana to TennCare for the purposes of TennCare processing and paying (if applicable) as secondary payment for services rendered to Humana D-SNP members.

Dual-eligible – For purposes of the Tennessee D-SNP, a Medicare enrollee who also is eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare cost-sharing obligations under the state plan. Enrollment in the D-SNP is limited to the following categories of recipients: QMB only, QMB plus, SLMB plus and FBDE.

Full-benefit dual eligible (FBDE) – An individual who is eligible for Medicare Part A and/or Part B benefits and is eligible for TennCare benefits (services), including those who are categorically eligible and those who qualify as medically needy under the state plan.

MA agreement – The Medicare Advantage agreement between Humana and the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Part C and other health plan services to Humana's members.

National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) administrative simplification standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Qualified Medicare beneficiary (QMB) – An individual who is entitled to Medicare Part A, who has income that does not exceed 100 percent of the federal poverty level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and copayments (except for Medicare Part D). Collectively, these benefits (services) are called "QMB Medicaid Benefits [Services]." Categories of QMBs covered by this contract are as follows:

- **QMB only –** QMBs who are not otherwise eligible for full Medicaid.
- **QMB plus –** QMBs who also meet the criteria for full TennCare Medicaid coverage and are entitled to all benefits (services) under the state plan for fully eligible Medicaid recipients.
- **Specified low-income Medicare beneficiary (SLMB) plus –** An individual entitled to Medicare Part A who has income that exceeds 100 percent FPL but less than 120 percent FPL, and whose resources do not exceed twice the SSI limit, and who also meets the criteria for full TennCare Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full state Medicaid benefits.

TennCare – The medical assistance program administered by the Tennessee Department of Finance and Administration, Bureau of TennCare, pursuant to Title XIX of the Social Security Act, the Tennessee State Plan and the Section 1115 research and demonstration waiver granted to the state of Tennessee and any successor programs.

TennCare MCO – A managed care organization (MCO) under contract with the state to provide TennCare benefits.

III. Tennessee Cost-sharing Responsibility for SNP Members for Plan-covered Services

After Humana has paid its portion of the claim, TennCare may be obligated to make a secondary payment for Medicare cost sharing for beneficiaries classified as QMB, QMB plus, SLMB plus and FBDE.

Cost-sharing obligations do not include:

- Medicare Part C premiums
- Medicaid services that are covered solely by TennCare
- Any cost sharing for Part D prescription drugs

The Humana D-SNP is a dual-eligible subset – Medicare zero cost-sharing SNP. This means that members of this plan will never be responsible to pay cost sharing for covered medical services as long as they remain a member of the plan, even if they lose their cost-sharing eligibility with the state. The provider must accept whatever TennCare pays as cost sharing as payment in full and cannot bill the member. If the member loses TennCare eligibility but remains enrolled in the plan, the provider must seek any remaining cost-share payment from Humana as long as the member is enrolled in the plan. The member cannot be billed for the cost sharing for covered medical services.

IV. Claims payment process

Humana electronically submits crossover claims information to TennCare for professional and institutional claims received for Humana Dual Eligible SNP members for the state to process and pay (if applicable) the Medicaid portion of the claim.

This submission allows TennCare to process and pay cost sharing to providers electronically and no longer requires providers to bill paper claims to TennCare.

Providers continue to submit claims to Humana for payment of the Medicare portion of the claim. Humana processes the claim and electronically sends the claim and payment information to TennCare. TennCare processes the claim for the Medicaid portion of the payment and releases any applicable payment to the provider. Providers MUST be registered with TennCare with a valid Tennessee Medicaid ID to be eligible to receive payments. This process provides more timely and efficient processing and payment of claims for providers.

Providers should refer to the TennCare Bureau Medicare and Medicaid Crossover Claims directions outlined on the TennCare Bureau website at www.tn.gov/tenncare/ pro-claims.shtml for claims submission requirements.

It is important that the National Provider Identifier (NPI) and tax identification number submitted on claims match the information provided to TennCare when registration was completed. If the NPI and tax identification information submitted on a claim to Humana does not match the NPI and tax identification information provided to TennCare at the time of registration for a Medicaid provider number, the Medicaid portion of the reimbursement will be denied.

To update provider information in TennCare's system, please contact TennCare Provider Services at 1-800-852-2683 and select option 5. To update provider information in Humana's system, please call Humana Provider Relations at **1-800-626-2741,** Monday – Friday, 8 a.m. – 5 p.m., Central time.

V. Other Responsibilities

Providers in the Humana network are required to refer all full-benefit dual-eligible members to the members' TennCare managed care organization (MCO) for the provision of TennCare benefits that are not covered by the Humana Medicare D-SNP plan.

Additional information about the TennCare Managed Care Organizations and available TennCare programs can be found at:

- https://www.tn.gov/tenncare/providers.html
- https://www.tn.gov/tenncare/members-applicants.html
- https://www.tn.gov/tenncare/long-term-services-supports.html