Healthy Blue + Medicare
(HMO D-SNP)

Healthy Blue + Medicare℠

Healthy Blue + Medicare Dual-Eligible Special Needs Plan

Supplemental Guide

BlueCross BlueShield of North Carolina MEDICARE

Healthy Blue + Medicare Dual-Eligible Special Needs Plan Supplemental Guide

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Introduction

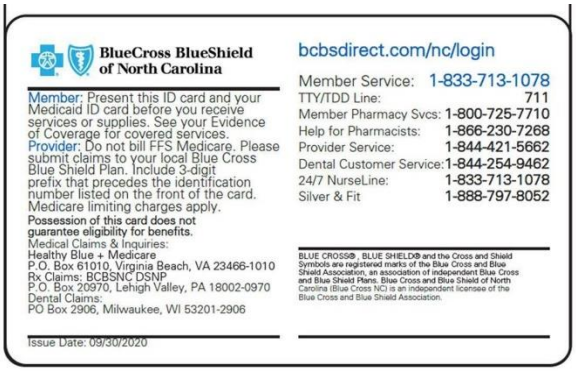
Healthy Blue + Medicare[SM] (HMO D-SNP) is offered pursuant to a contract between CMS and Blue Cross and Blue Shield of North Carolina Senior Health, a wholly-owned subsidiary of Blue Cross and Blue Shield of North Carolina (Blue Cross NC). Healthy Blue + Medicare is an included MA plan for all Blue Cross NC Medicare Provider Agreements, and its members are served by the same network that serves all other MA plans offered by Blue Cross NC. The amounts due, bundling edits, policies and procedures may differ based on the specific product as a result of different benefit designs and claims adjudication methodologies. Claims will be paid consistent with current contract provisions, and Blue Cross NC will use its best efforts to apply bundling logic that is consistent with industry AMA HCPCS (Level I and Level II) or CMS CCI standards in effect at the time of the date of service.

To view the member benefits guide for Healthy Blue + Medicare, visit **https://medicare.bluecrossnc.com/medicare**.

Contacts

Point of contacts	Telephone	Fax	Address	Hours of operation
Customer Care (Medical & Drug)	**1-833-713-1078**	**1-855-358-1226**	Healthy Blue + Medicare Customer Service P.O. Box 62947 Virginia Beach, VA 23466-2947	8 a.m. to 8 p.m. seven days per week, except Thanksgiving & Christmas
Grievances and Appeals (Medical & Drug)	**1-833-713-1078**	**1-888-458-1406**	Medicare Complaints, Appeals, Grievances 4361 Irwin Simpson Rd Mail Stop: OH0205-A537 Mason, OH 45040	8 a.m. to 8 p.m. seven days per week, except Thanksgiving & Christmas
Provider Services (Medical & Drug)	**1-844-895-8160**	**1-877-799-4129**	Healthy Blue + Medicare P.O. Box 60007 Los Angeles, CA 90060-0008	8 a.m. to 8 p.m. seven days per week, except Thanksgiving & Christmas
Case Management (Medical & Drug)	**1-866-611-4287**	**1-855-443-7821**	Healthy Blue + Medicare 3350 Peachtree Rd NE Mail Stop: GAG006-0012 Atlanta, GA 30326	8 a.m. to 5 p.m. M-F, except holidays

Sample ID card



Vision care

Providers in the Community Eye Care Blue Medicare network will be in-network for the Healthy Blue + Medicare medical vision benefits. Routine vision services are not covered through the Healthy Blue + Medicare medical vision network. All medical claims for vision care for Healthy Blue + Medicare members should be submitted to the address on the back of the member's ID card.

Please refer to the member benefits guide for routine vision care on the *More Healthy Benefits* page.

Diabetic supplies

Members requiring diabetic test strips (diabetic supplies) will only be covered through their pharmacy network. Test strips are limited to two manufacturers: Ascensia and LifeScan. These supplies will not be covered as in-network when supplied by durable medical equipment providers. This applies to our Medicare Advantage HMO and PPO benefits.

Provider training and attestation requirements

The Centers for Medicare & Medicaid Services (CMS) requires all contracted providers and staff receive basic training about the D-SNP Model of Care. This training and completion of an attestation are required for new providers and annually thereafter. Additional information regarding training will be provided at a later date.

Managed care plan enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A and B and continue paying Part B premiums.
- Live in the plan's service area.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7 each year, with a January 1 plan effective date.

Medicare Dual Eligible Special Needs Plans

Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Health Plan under Title XIX (Medicaid). D-SNPs offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-The following Medicaid eligibility categories are presently eligible for Healthy Blue + Medicare:

- Qualified Medicare Beneficiary without other Medicaid (QMB only),
- QMB+,
- Specified Low-Income Medicare Beneficiary with full Medicaid SLMB+,
- Other full benefit dual eligible (FBDE)

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

- Medicare zero-cost-sharing D-SNPs
- Medicare non-zero cost-sharing D-SNPs

Cost-sharing and billing

Cost-sharing responsibility for special needs plan members

Members that are dually eligible for Medicare and for full Medicaid coverage of their Medicare Part A and Part B premiums and other cost sharing (such as deductibles, coinsurance, and copayments) through a Medicare Savings Program, are protected from liability for payment of Medicare premiums, deductible, coinsurance and copayment amounts. Some Medicare Savings Programs cover some but not all of the premiums and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the QMB (Qualified Medicare Beneficiary) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services – even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a full eligible dual member or a QMB member are in violation of Federal law and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as ‘private pay’ in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Blue Cross NC and/or its designee processes the claim for reimbursement when there is an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Blue Cross NC and/or its designee does not have an arrangement with the state Medicaid agency.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS-5010* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of MA plan, noncontracting and Original Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare)-participating provider
The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the members' cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.
- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan allowed cost-sharing, which equals:
    - The copay amount, if the MAO uses a copay for its cost-sharing; or
    - The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in the *MA Payment Guide for Out of Network Payments*, at **https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.**

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefi*ts (SOB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting, nonparticipating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Loss of Medicaid coverage for Special Needs Plan members
Blue Cross NC D-SNP (Dual Eligible Special Needs Plan) members are dual-eligible beneficiaries with both Medicare and Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB+). Medicare members who do not receive full Medicare cost share assistance under Medicaid may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length Of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services

Model of care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified. Goals are defined in our model of care and are specific to the population. The SNP model of care is designed to improve the care of our members in all of the following areas:
    - Improving access and affordability of the healthcare needs of the population.
    - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), individualized care plan (ICP) and interdisciplinary care team (ICT).
    - Enhanced care transitions across all health care settings and providers.
    - Ensuring appropriate utilization of services for preventive health and chronic conditions.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an individualized interdisciplinary care team which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.
3. We work to complete a health risk assessment (HRA) on each member. For new members, the goal is to complete the initial HRA within 90 days of eligibility and then annually before the next anniversary of the last HRA. We perform outreach in multiple ways to attempt to reach all our members. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental topics and serves as the basis for the member's individualized care plan (ICP). Providers have access to the HRA results and the individualized care plan (ICP) through the provider portal.
4. Based on the results of the HRA, an ICP will be developed by the case manager working directly with the member and the interdisciplinary care team (ICT) to address identified needs. The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual special needs members. The member's care plan will coordinate with and support your medical plan of care
5. An ICT is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, our members and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, HRA results and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case

manager asking you to review, make comments or recommendations about the care plan or the needs that have been identified during the care planning process. You may reach your patients' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.

8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include any of the following measures:
    - HEDIS® — used to measure performance on dimensions of care and service
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
    - *Health Outcomes Survey* (*HOS*) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited to SNP members responses we use these results to assist us in the population assessment.
    - CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
    - Medication therapy measurement measures
    - Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider portal.

Annual program evaluation

We conduct an annual evaluation of the model of care to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we review our program to identify any issues. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that are not trending toward our benchmarks. We compare our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets, we are meeting or exceeding in many areas. We are also showing an upward trend when we compare our year over year results. We continue to work on ways to improve our outreach to our members and improve our completion rates for the health risk assessments, individualized care plans and interdisciplinary care teams for each of our special needs plan members. We manage use of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and post discharge management which continue to improve in most markets. Preventive care goals are established for our programs and managed as a part of HEDIS. Multiple interventions are put in place to improve the HEDIS and STAR measures.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

Care transition protocols and management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and include changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high-quality, cost-effective medical care.

Personnel responsible for coordinating care transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are protocols when managing transitions

- Participate in the interdisciplinary care team meetings.
- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member about the transition process.
- Communicate health status and plan of care to the member.
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- Provide relevant patient history to the receiving provider.
- Forward pertinent diagnostic results to treating providers.
- Communicate any test results and the treatment plan back to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments.

- Coordinate between Medicaid and Medicare benefits.
- Perform medication reconciliation.
- Arrange transportation.
- Refer the member to external or internal programs.
- Coordinate care with behavioral health services.
- Assist with arranging DME and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease-specific education and self-management techniques.
- Contact high-risk members post-discharge to reduce unnecessary readmissions.
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition.

Participating provider responsibilities in the member appeals process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an *Appointment of Representative Form* may be required. The *Appointment of Representative Form* can be found online and downloaded at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207**
- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process.

Appeal time frames

- Members or their authorized representatives have 60 days from the date of the initial adverse determination to file an appeal. The 60-day filing deadline may be extended where good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug, must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe
    - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals are resolved within 72 hours, unless it is in the member's interest to extend this time period.
    - A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
    - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
    - Part D payment appeals must be resolved within 14 days from the date the request was received.

- Part D appeals timeframes cannot be extended.

Further appeal rights

If Blue Cross NC is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Blue Cross NC will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
  - Within 24 hours of the adverse decision, if expedited.
  - Within 30 days if the appeal is related to authorization for health care that is not a Part B drug.
  - Within 7 days if the appeal is related to authorization of a Part B drug.
  - Within 60 days if the appeal involves reimbursement for care. (or 30 days for integrated DSNP plans with unified grievance and appeal procedures)
  - Part D prescription drug appeals are not forwarded to the IRO by Blue Cross NC but may be requested by the member or representative; information will be provided on this process during the Blue Cross NC Medicare member appeals process.
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Blue Cross NC continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

Member grievances

A member grievance is the type of complaint a member makes regarding any other type of problem with Blue Cross NC or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Blue Cross NC must accept grievances from members orally or in writing within 60 days of the event.* Blue Cross NC must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Blue Cross NC has 24 hours to respond. An expedited grievance can only be initiated if Blue Cross NC refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). Blue Cross NC can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

* Note: Some plans may not limit the time in which a member grievance is filed (for example, certain integrated DSNP plans and MMPs). These plans allow the member to file a grievance at any time.