Healthy Blue + Medicare™ (HMO-POS D-SNP)

2025
Special Needs Plan (SNPs) and Model of Care (MOC) Training Overview and Provider Attestation

CONFIDENTIAL & PROPRIETARY

Medicare Advantage (MA) and Special Needs Plans (SNP)

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In 2003, Congress passed the *Medicare Modernization Act*(*MMA*), which enabled insurance companies to create, market and sell Special Needs Plans (SNPs).

- SNPs are different from most types of MA plans in that they focus on members who have special needs and could benefit from enhanced coordination of care, as described in our Model of Care (MOC).
- As provided under section 1859(f)(7) of the *Social Security Act*, every SNP must have a MOC approved by NCQA and CMS.
- CMS requires all contracted providers and our staff to receive training about the SNP plans.
- Our SNP program is designed to optimize the health and well-being of our aging, vulnerable and chronically ill members.

Types of SNPs

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There are 3 types of SNPs:

- **I-SNPs (Institutionalized beneficiaries)** - Individuals who live in an institution (i.e. nursing home) or require nursing care at home for more than 90 days

- **C-SNPs-** Individuals with server or disabling chronic conditions as specified by CMS. I.e. cardiovascular disease, congenital heart failure, diabetes mellitus

- **D-SNPs (Dual eligible)** - Individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility

  DSNP is the Blue Cross NC Offering

Characteristics and Requirements of Dual-Eligible Members

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- Dual eligible beneficiaries qualify for both Medicaid and Medicare
- A Medicare Advantage plan, dual-eligible special needs plan (D-SNP), is designed to target the specific needs of this population
- Members must maintain eligibility requirements for both Medicare and Medicaid, be enrolled in both programs
- Individuals who are dually eligible may change their coverage during the year
- Duals may be *full benefit duals* or *partial benefit duals*: Characteristics and requirements of dual-eligible members
- Full duals are eligible for Medicaid benefits
- Partial duals are only eligible for premium and for some levels, assistance with Medicare cost share
- States set asset levels to determine full benefit status

Dual Eligible Members

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- Dual Eligible Members (Duals) are low-income individuals who are entitled to benefits from both the Federal Medicare and state-run Medicaid programs.
- Duals represent more than nineteen (19) million elderly and disabled Americans.
- Duals are adults 65 and over and younger individuals with disabilities, all with low income and assets.

Dual Eligible Members have unique characteristics:

- Lower Income / Lower Health Status
- Multiple Chronic Conditions
- Difficulty with daily activities (Dementia, Physical & Developmental Disabilities)
- Twice as likely to have cognitive or mental impairment*
- 13X more likely to live in a long-term care facility*

Source: American Action Forum, http://www.americanactionforum.org/weekly-checkup/dual-eligibles/)

Coordination of Care for Dual-Eligible Members

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- When dual-eligible members need care or access to benefits, it is everyone's responsibility to help and coordinate that care
- The following will assist in coordinating care, and in the management of billing and service issues:
  - Dual-eligible members (unless a FIDE plan) should show both the plan ID and Medicaid card to all providers
  - Check Medicaid coverage prior to billing
    - In some dual types, CMS prohibits balance billing
- Know what services are covered under both plans
- Access tools and information on the provider website including:
  - Benefit information
  - Results of HRA and the member's care plan
  - Transition information
  - Medications

Most Vulnerable Dual Eligible Enrollees

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Our Dual Eligible plan is designed to cover care for the most complex and chronically ill, or the most vulnerable. All enrollees are considered at a higher risk when they qualify for a DSNP; however, within our population we customize the level of intensive management for those most vulnerable. The most vulnerable enrollees (MVEs) are defined as those enrollees that are:

- Have 6 or more chronic complex conditions
- Have a risk stratification level that falls in Group 3-4 with chronic and disabling conditions
- Identified as frail, disabled, socially challenged and/or with end-of-life needs

Most Vulnerable Enrollee's Conditions

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Enrollees considered most vulnerable have multiple chronic conditions, high medical costs, more frequent admissions and/or readmissions, frequent visits to the ER and/or have the conditions determined in this population makes them most vulnerable for adverse events. Some of the most frequent conditions our enrollees experience include but not limited to:

- Aids/HIV
- Cancer
- Cardiovascular
- Central Nervous System
- Diabetes
- Frailty
- Gastrointestinal
- Hematologic
- Psychiatric
- Pulmonary
- Renal
- Skeletal
- Skin
- Substance Abuse

These may be targeted conditions; however, comorbidities are the greatest factor and are displayed to provide a comprehensive evaluation of the enrollee.

Most Vulnerable Enrollee - Provider Engagement

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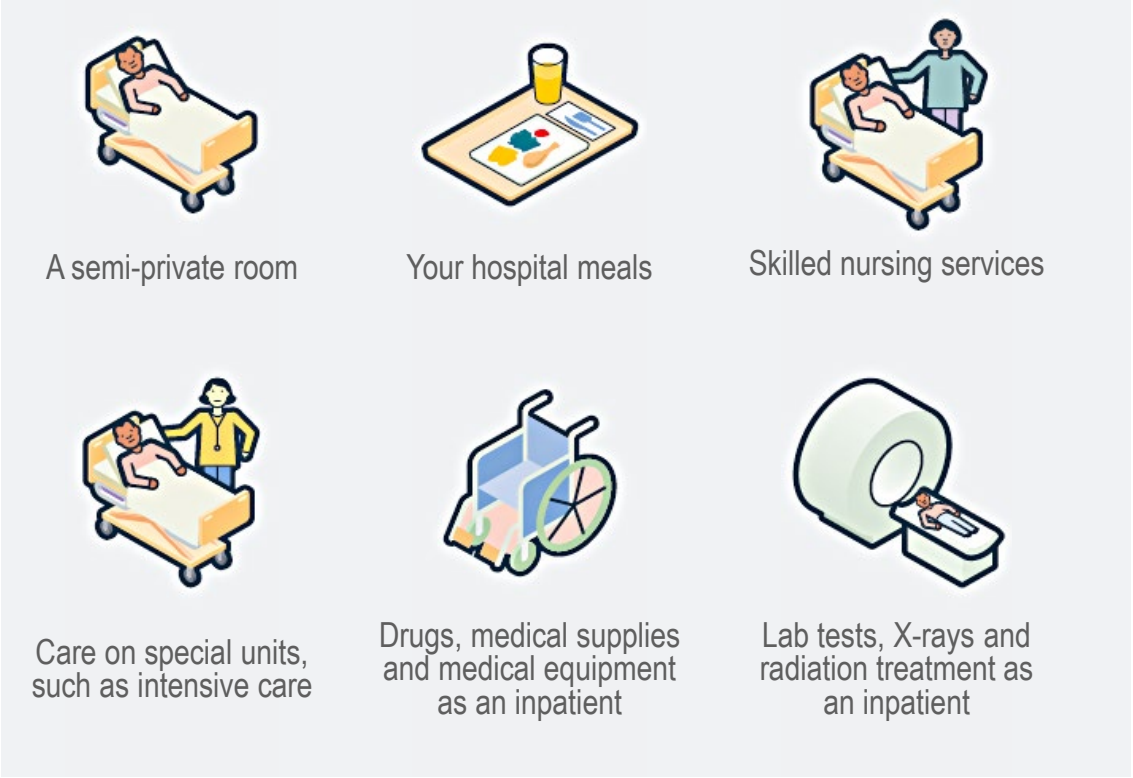
- The care manager is responsible for coordinating the identification, implementation and management of needed services, benefits, and healthcare needs for the DSNP enrollees in accordance with enrollee/caregiver preferences.
- The identified DSNP most vulnerable enrollees require focused care coordination and care management and a high level of engagement from the care team .
- Care managers work closely with the enrollee's primary provider and other participants of the enrollee's identified Interdisciplinary Care Team (ICT), including those delegates responsible for Utilization Management, Concurrent Review and Inpatient teams, Behavioral Health, and Enrollee services for coordination of benefits.

HOW IS COVERAGE COORDINATED?

How does Dual Eligibility Coordinate Coverage?

Medicare = Primary

+ Hospital
+ Skilled Nursing / Hospice
+ Physician
+ Home Health
+ Durable Medical Equipment



HOW IS COVERAGE COORDINATED?

How does Dual Eligibility Coordinate Coverage?

<u>Medicaid = Secondary</u>

+ Transportation
+ Dental, Vision, Drugs
+ Long Term Care
+ Personal Care Services
+ Durable Medical Equipment

Note: Most Medicaid covered services are determined by the state – variances will occur.

What is included in an MOC?

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Population Description

Care Coordination

Provider Network

Quality Measurement and Performance Improvement

Program Components

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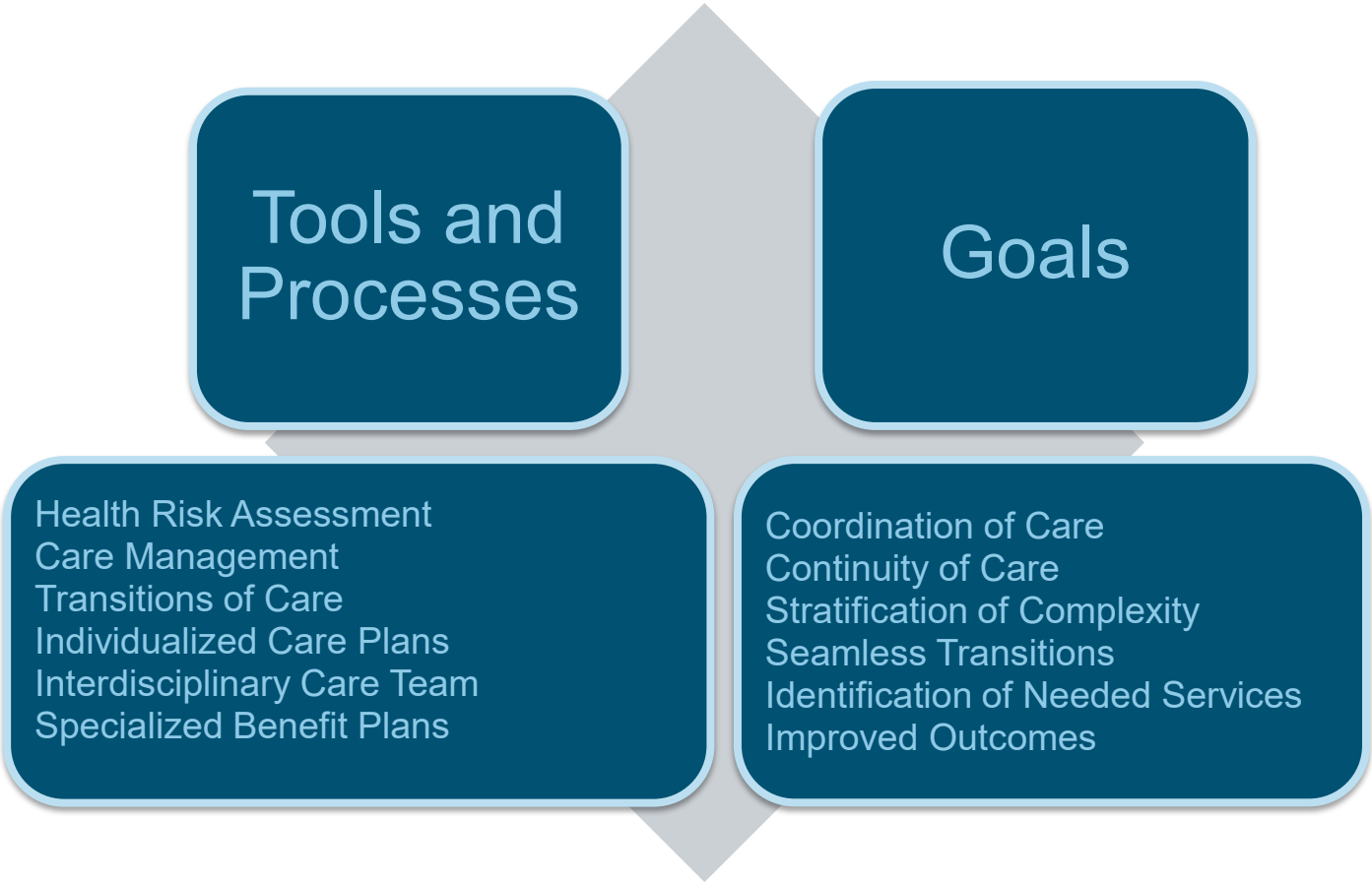
- Program Components



Health Risk Assessment (HRA)

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- Are completed within 90 days of enrollment and repeated within 365 days
- Require multiple and ongoing attempts to contact the member including by phone, mail, through provider outreach, in person or electronically
- Assesses physical, behavioral, cognitive, psychosocial and functional areas
- Used to help create the member's individualized care plan (ICP)
- Are an important part of care coordination
- Help identify members with most urgent needs
- Contain member self-reported information
- Results are available to providers and members on the secure portal. Results may lead to referrals for other programs. Additional assessments may be completed based on a significant change in condition, disease specific needs, or enrollment in other programs.

Individualized Care Plan (ICP)

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- Working with the member and the Interdisciplinary Care Team (ICT), the case manager helps develop the ICP for each member
- The ICP has member-specific goals and interventions, addressing issues identified during the HRA process and other team interactions
- Our team may contact your office for updated contact information for those members we are unable to reach or to coordinate care needs of your patient
- Providers have access to the HRA results and the ICP through the secure provider portal
- The ICP includes member preferences and personal goals as applicable
- The ICP is updated as the member's needs change
- Providers can access your member's ICP on the secure provider website

Interdisciplinary Care Team (ICT)

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- Each member is managed by an ICT
- The ICT coordinates care with the member, the member's PCP and other participants of the member's ICT
- ICT members are responsible for reviewing care plans, collaborating with multiple providers, coordinating with other carriers (Medicaid) or community resources, and providing recommendations for management
- Providers may be asked to participate in initial care planning and ongoing ICP management
- The structure and frequency of the ICT is based on the member's preference, identified needs and complexity
- The PCP or attending provider (if plan does not require a PCP selection) is a key member of the ICT responsible for coordinating care and managing transitions
  - Other provider responsibilities include: communicating treatment options, advocating, informing and educating members, performing assessments, diagnosing/treating, and accessing information on the portal

ICT (Continued)

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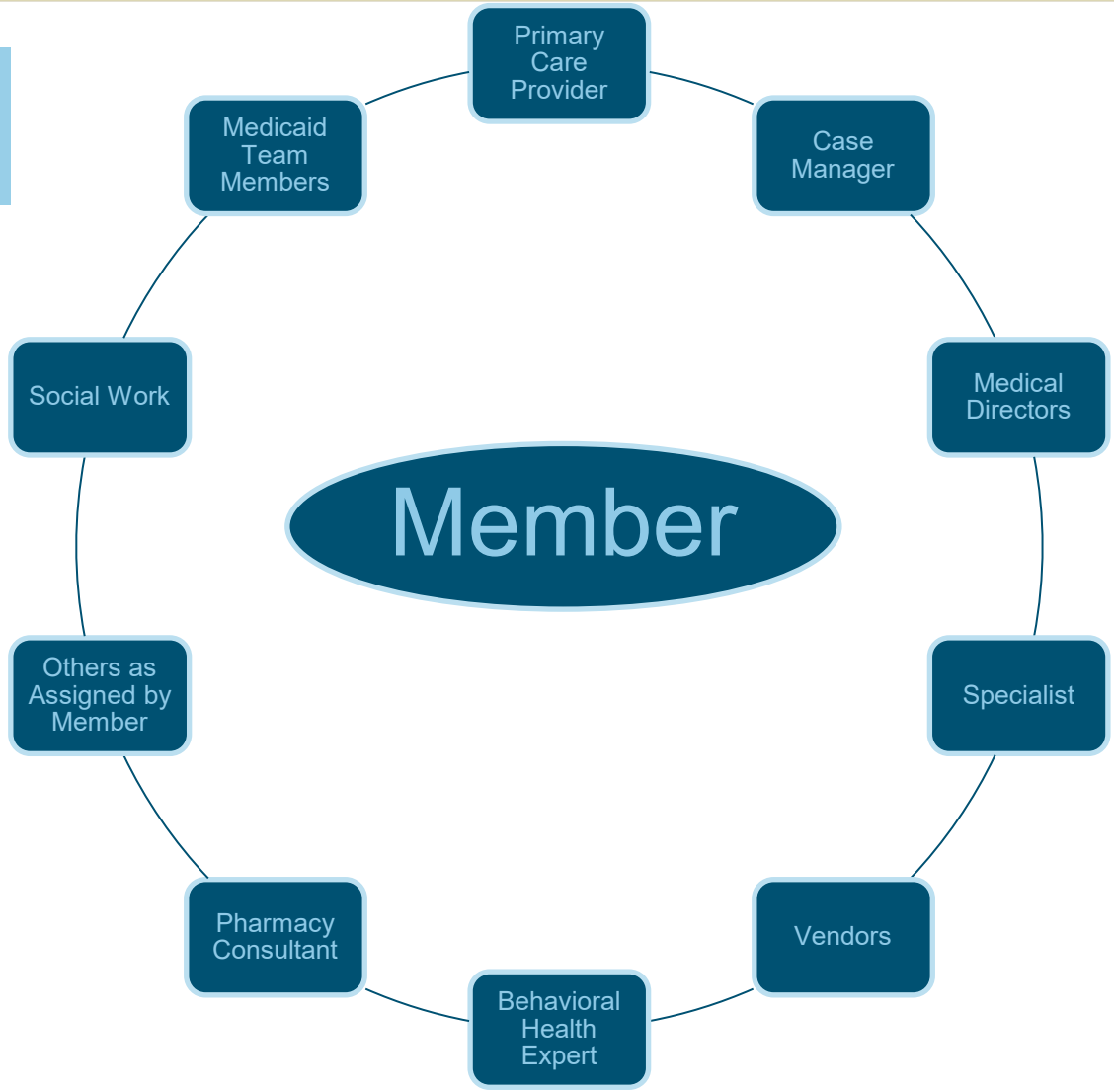
PCP is the Gatekeeper



Communication and Care Transitions

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- We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members and our care team.
  - You may reach your members' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card.
  - Valuable information on member utilization, transitions and care management is available on the secure provider website.
- SNP members typically have many providers and may transition into and out of health care institutions. Providers are key to successful coordination of care during transitions.
  - Contact us if you would like our team to assist in coordinating care for your patient.
  - Our care team may be contacting you and your patient at times of transitions to ensure needs are met, services are coordinated, prescriptions are filled and medications are taken correctly.
  - Members may also contact customer service for assistance.

Performance and Quality Outcomes

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- Performance, quality and health outcome measurements are collected, analyzed and reported to evaluate the effectiveness of the MOC. These measurements are used by our Quality Management Program and include 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) - multi-purpose member survey used to compute physician and mental component scores to measure the health status
  - CMS Part C Reporting Elements including benefit utilization, adverse events, organizational determinations and procedure frequency
  - Medication therapy measurement measures
  - Clinical and administrative/service quality projects

Program Evaluation and Process Improvements

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- Measurable goals must be in place to evaluate the performance of SNP plans in the following areas:
  - Improve access and affordability of health care needs
  - Improve coordination of care and delivery of services
  - Improve transitions of care across health care settings
  - Ensure appropriate use of services for preventive health & chronic conditions
- Below are some areas we monitor to improve the care our members receive:
  - Adequacy of our network
  - Our rates of completion of the HRA, developing member care plans and completing an ICT review
  - Rates on certain preventive care services and chronic condition management
  - Frequency of follow-up care post discharge
  - Visits to the PCP
  - Utilization rates of ER and inpatient admissions
  - A program evaluation occurs annually and results communicated

How our D-SNP is Structured

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- For QMBs and those with full Medicaid benefits, any Medicare cost sharing applied to a claim is covered under the member's Medicaid coverage, which may be:
  - The plan under an agreement with the state
  - Another Medicaid managed care organization
  - Fee-for-service Medicaid
- For all other Medicaid eligibility categories applicable to the DSNP, any Medicare cost sharing applied to a claim can be billed to the member after claim is filed with Medicaid
- Verify cost share or benefit copay
- Most plans do not have out-of-network benefits unless it is urgent/emergent or out-of-area renal dialysis. PPO D-SNP plans may allow access to some out-of-network providers
- Please call the plan if you need to refer outside of the plan network or refer to the plan details for limitations if the plan is a PPO plan.

What is Healthy Blue + Medicare?

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- A $[0] Medicare Advantage (Part C) plan for people eligible for both Medicare and Medicaid.
- Works alongside your Medicaid benefits to give you additional coverage when needed.

Healthy Blue + Medicare

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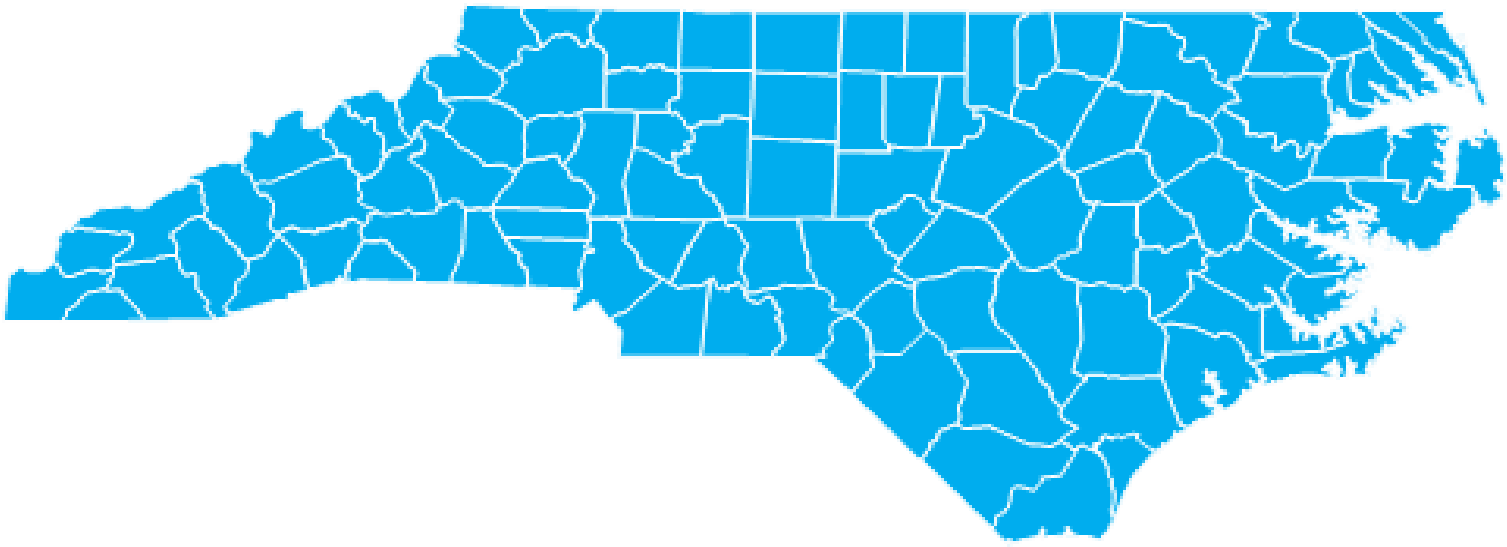
- Healthy Blue + Medicare is available in all 100 North Carolina counties to those that are eligible.



Who's Eligible?

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To be eligible for Healthy Blue + Medicare you must:

- Be enrolled in the North Carolina Medicaid program
- Be enrolled in Medicare Parts A and B
- Permanently reside in the service area where the plan is available
- Be a U.S. citizen or lawfully present in the U.S.

Qualifying North Carolina Medicaid statuses:
Full Benefit Dual Eligibles (FBDE), Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary with full Medicaid (QMB+), Specified Low-Income Medicare Beneficiary with full Medicaid (SLMB+). For more information, see the Healthy Blue + Medicare enrollment kit.

Healthy Blue + Medicare 2025 Product Overview

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Plan Benefits		Healthy Blue + Medicare (HMO-POS D-SNP) – H9147-001
Premium		$0
Annual maximum out-of-pocket		$9,350
Physician	Primary care provider	$0 copay
	Specialist:	$0 copay
Hospital*	Days 1-90:	$0 copay
Outpatient surgery	Outpatient hospital:	$0 copay
	Ambulatory surgical center:	$0 copay
Skilling nursing facility**	Days 1-100	$0 copay

Unless otherwise noted, there are in-network benefits.

*Our plan covers 60 "lifetime reserve days." These are extra days that we cover.
If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

**Our plan covers up to 100 days in a Skilled Nursing Facility.

Healthy Blue + Medicare 2025 Product Overview

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Healthy Blue + Medicare 2025 Product Overview

BlueCross BlueShield of North Carolina
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Plan Benefits		Healthy Blue + Medicare (HMO-POS D-SNP) – H9147-001
Diagnostic services/labs/imaging*		$0 copay
Ground and air ambulance*		$0 copay
Emergency room		$0 copay
Urgent care		$0 copay
Vision care	Routine eye exam:	$0 copay, 1 per year
	Eyewear allowance:	$400 per year

Additional Plan Benefits	Healthy Blue + Medicare (HMO-POS D-SNP) – H9147-001
Fitness	$112/month to spend on gym memberships, classes and select equipment, no rollover
Hearing aids ($3,000 maximum plan benefit per year)	$0 copay
Dental allowance (preventive and comprehensive): Unlimited plan benefit combined OON on covered dental services	$0 copay
Meals (post-discharge)	Two per day for 14 days
OTC/healthy food and produce/home safety devices allowance*	$259 per month

Unless otherwise noted, there are in-network benefits.

*May require prior authorization.

*You may qualify for Special Supplementary Benefits for the Chronically Ill (SSBCI) if you are at high risk for hospitalization or adverse health outcomes and require intensive care coordination to manage chronic conditions such as cardiovascular disorders, cancer, stroke, diabetes or chronic lung disorders. Eligibility must be established before the benefit is provided and cannot be guaranteed based solely on your condition. For a full list of covered chronic conditions or to learn more about eligibility requirements, please contact your plan.

Healthy Blue + Medicare (HMO-POS D-SNP)

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Prescription Benefits		Healthy Blue + Medicare (HMO-POS D-SNP) – H9147-001
Rx deductible		$0*
Rx deductible applies to		No deductible
Rx – 30-day supply	Tier 1: Preferred generic	$0
	Tier 2: Generic	$0
	Tier 3: Preferred brand	$0-$12.15 copay
	Tier 4: Non-preferred drug	$0-$12.15 copay
	Tier 5: Specialty**	$0-$12.15 copay
	Tier 6: Select care	$0

Unless otherwise noted, these are in-network benefits.

*Without "Extra Help," there is a $590 deductible applied to Tiers 3, 4 & 5.

**Tier 5 drugs limited to 30 day supply.

Healthy Blue + Medicare ID Card

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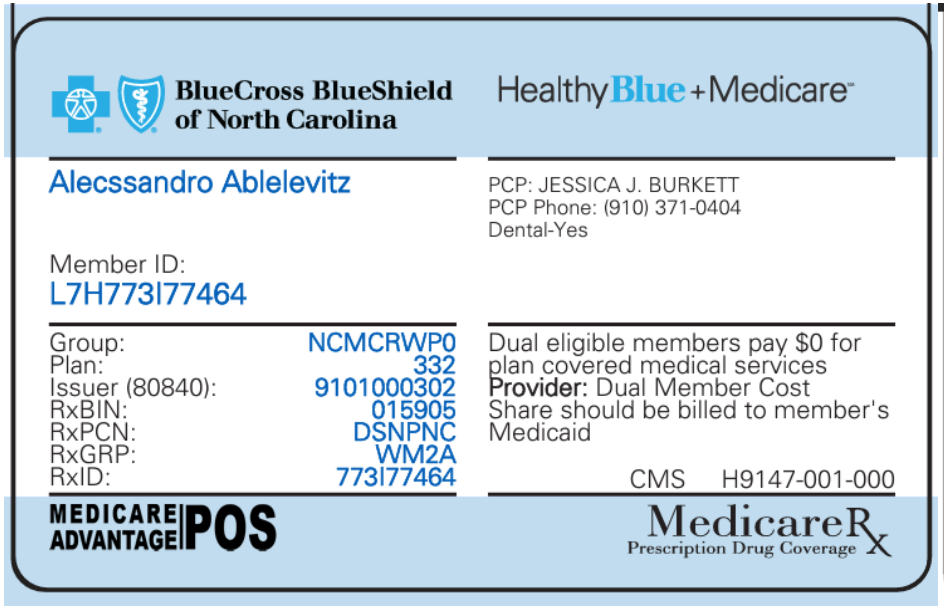

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HealthyBlue+Medicare

Alecssandro Ablelevitz

Member ID:
L7H773I77464

Group:	NCMCRWP0
Plan:	332
Issuer (80840):	9101000302
RxBIN:	015905
RxPCN:	DSNPNC
RxGRP:	WM2A
RxID:	773I77464

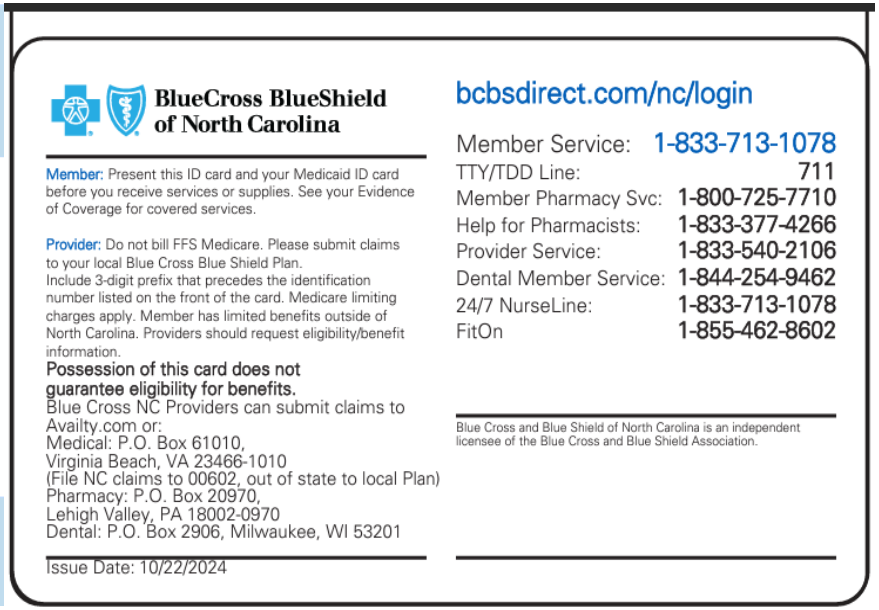
PCP: JESSICA J. BURKETT
PCP Phone: (910) 371-0404
Dental-Yes

Dual eligible members pay $0 for plan covered medical services
Provider: Dual Member Cost Share should be billed to member's Medicaid

CMS H9147-001-000

MEDICARE ADVANTAGE POS

MedicareRx
Prescription Drug Coverage



BlueCross BlueShield of North Carolina

bcbsdirect.com/nc/login

Member Service: 1-833-713-1078
TTY/TDD Line: 711
Member Pharmacy Svc: 1-800-725-7710
Help for Pharmacists: 1-833-377-4266
Provider Service: 1-833-540-2106
Dental Member Service: 1-844-254-9462
24/7 NurseLine: 1-833-713-1078
FitOn 1-855-462-8602

Member: Present this ID card and your Medicaid ID card before you receive services or supplies. See your Evidence of Coverage for covered services.

Provider: Do not bill FFS Medicare. Please submit claims to your local Blue Cross Blue Shield Plan.
Include 3-digit prefix that precedes the identification number listed on the front of the card. Medicare limiting charges apply. Member has limited benefits outside of North Carolina. Providers should request eligibility/benefit information.
Possession of this card does not guarantee eligibility for benefits.
Blue Cross NC Providers can submit claims to Availty.com or:
Medical: P.O. Box 61010,
Virginia Beach, VA 23466-1010
(File NC claims to 00602, out of state to local Plan)
Pharmacy: P.O. Box 20970,
Lehigh Valley, PA 18002-0970
Dental: P.O. Box 2906, Milwaukee, WI 53201

Issue Date: 10/22/2024

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D-SNP Claims Processing

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- Most D-SNP members are protected by state and federal regulations from balance billing. Providers cannot balance bill members who have Medicare cost share protection and must accept the Medicare and Medicaid (if applicable) payments as payment in full.
- Members who have Medicare cost share protection are classified as QMBs or those with full Medicaid benefits.
- Claims are processed in accordance with the benefits filed within those plans and are subject to Medicare cost sharing. Refer to your Medicare Advantage Agreement.
- Coverage of Medicare cost share depends on the services performed and Medicaid allowed amounts (lesser of Logic or COB requirements for the state may be used).
- Rules differ by state, and it is possible some providers will receive the full Medicare-allowed amount.
- Most states require a Medicaid provider ID to bill services and receive payment.
- Check the member's Medicaid coverage prior to billing.

D-SNP Claims Processing (Continued)

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- For members enrolled in both our Medicare D-SNP and Medicaid plan:
- A single claim will be processed under each plan and payment made according to payment rules governing your state's Medicaid program or our contract with the state (some exceptions apply). A separate claim must be filed to the state for any Medicaid portion of the claim.
- *Explanation of Payment* (*EOP*) will provide further guidance on next steps or pending payments.
- The member must be actively enrolled in both plans on the date of service.
- Service(s) must be covered under the respective plan.
- For non-Medicare covered services, the service must be one the plan has contracted with CMS to cover, or the state has contracted with the Medicare SNP plan to cover (for example, unlimited inpatient days).
- You must be contracted for Medicare Advantage with us as well as Medicaid (with the state) to receive payments for cost-sharing or Medicaid only services.
- Providers must ensure they obtain the enrollee's consent for both in-person and virtual face-to-face encounters.

Helpful Resources

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- Provider website – https://www.bluecrossnc.com/provider
- Provider services – 833-540-2106
- *Medicare Managed Care Manual* (Chapter 16-B: Special Needs Plans) (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf).

Provider Attestation

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- Annual provider attestation is required. Failure to complete annual MOC training can result in corrective action, which may include suspension or termination from the network.
- Please attest that you have reviewed this presentation and have an understanding of the SNP plans and MOC requirements.
- **Don’t forget your attestation below!**

Please click on the link below to electronically attest that the provider practice has reviewed the SNP and MOC presentation.

https://forms.bcbsnc.com/model-care-attestation-form/

Thank You

U43484, 9/23