Anthem Blue Cross D-SNP and Coordination Plus Plan Fact Sheet

Who are Dual Eligible beneficiaries?

- Beneficiaries who meet eligibility requirements for both Medicare and Medi-Cal and are enrolled in both programs
- Medicare beneficiaries who may require more services, including social services
- People who are older than 65 and younger than 65 who qualify based on a disability
- Due to eligibility for Medi-Cal tend to have lower income and report lower health status than other Medicare beneficiaries

What is a Dual-Eligible Special Needs Plan (D-SNP)?

- D-SNPs are plans designed specifically to meet the needs of beneficiaries who are eligible for both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medi-Cal)
- Product is similar to Medicare Fee For Service (80 percent plan pay and 20 percent member or Medi-Cal pay. (Anthem offers only HMO-based D-SNP products)
- D-SNPs also have requirements above and beyond the regulations for standard Medicare Advantage plans
  - Eligibility must be verified for the plan initially and then monthly thereafter
  - Model of Care – used to assess member needs and coordinate care, including working with an Interdisciplinary Care Team that coordinates delivery of services and benefits to members
  - Health Risk Assessment needs to be performed on enrollment and annually thereafter
- Anthem D-SNPs offer supplemental benefits that complement Medicare or Medi-Cal benefits, such as dental, vision, and hearing exams or allowances

What is a Coordination Plus Plan?

- HMO that is similar to Medicare Fee For Service (80 percent plan pay and 20 percent member or Medi-Cal) pay
  - Providers cannot bill members that 20 percent if they have Medi-Cal. This is considered balance billing. Providers cannot bill D-SNP members for services not reimbursed by Medi-Cal or Anthem’s D-SNP plan, nor can providers
balance bill for the difference between what has been paid and the billed charges. See Helpful Reminders at the end of this document.

- Anthem D-SNPs offer supplemental benefits that complement Medicare or Medi-Cal benefits, such as dental, vision, and hearing exams or allowances.

- Enrollment is open to ANYONE who qualifies for Medicare and lives in the service area.

- The Coordination Plus plan is an HMO plan with a Part D premium.
  - However, to pay $0 premium and $0 co-pays for medical services, enrollees must have Medi-Cal and Part D Extra Help (also referred to as Low Income Subsidy) that covers those costs on their behalf.

- If members lose Medi-Cal eligibility or if the state does not cover their costs, the member will be responsible for cost share amounts.

- Although all CMS-mandated materials and letters, such as the Evidence of Coverage and Outbound Enrollment and Verification (OEV) letters, will reflect the CMS filed amount of 20 percent member copay, Coordination Plus plan members may have $0 copays for premiums and medical services.

**Helpful reminders:**

- To help ensure accurate billing, members should show BOTH (Plan ID and Medi-Cal) cards to providers when receiving services.
  - The Coordination Plus plans are not D-SNP plans and, therefore, will not indicate dual eligibility; so it is critical that members in these plans present both cards to the provider.

- Medicare providers are prohibited from balance billing those the state and the Centers for Medicare & Medi-Cal Services hold harmless for Medicare cost-sharing.
  - Medicare recognizes the following dual eligible categories as cost-share protected:
    - **Qualified Medicare Beneficiary without other Medi-Cal**—QMB Only
    - **Qualified Medicare Beneficiary with Medi-Cal** (QMB Plus or QMB+)
    - **Specified Low-Income Medicare Beneficiary with Medi-Cal** (SLMB Plus or SLMB+)
    - **Other full benefit dual eligible** (FBDE)
      - Providers cannot balance bill Dual Eligibles who are held harmless.
      - Anthem’s contracts with the state determines these categories for our plans.

- Most states require a provider to have a Medi-Cal ID number to receive payment from the state.

- Federal and state regulations dictate that Medi-Cal is the payer of last resort meaning:
  - For a service covered under both Medicare and Medi-Cal, Medicare must pay first. Medi-Cal would then process any amount owed up to the Medi-Cal allowable limit. If Medicare paid more than Medi-Cal allowable, the provider would receive no additional money (they should accept Medicare payment as payment in full). This also called lesser of logic.
If the Medicare benefit is exhausted or not a covered benefit, then Medi-Cal would pay -- if it is a Medi-Cal covered service.

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