2013 Virginia Medicare Advantage Update

Dear Healthcare Provider,

Two new Medicare Advantage plans, Anthem Medicare Preferred Core (PPO) will be available to beneficiaries in select Virginia counties effective January 1, 2013. You can help members manage their health care costs by being aware of these benefits. In addition, it is important to check the Medical ID card at the beginning of each calendar year as the member may have changed plans. Listed below are just a few of the benefits of this new health care option that also has optional supplemental benefits.

Each year, we renew our contract with the Centers for Medicare and Medicaid Services (CMS). CMS re-evaluates and approves the benefits we’ll offer to our Medicare Advantage members for the upcoming year.

Notable 2013 benefit highlights by plan type.

**Anthem Medicare Preferred Core (PPO) plan highlights**

- In 2013 we will be offering two new PPO plans, one plan available in the following counties: James City Co, King And Queen, Lancaster, Richmond, Roanoke, Roanoke City, Salem City, Suffolk City, Surry, Williamsburg City, and York and another plan available in Gloucester, Hampton City, and Mathews counties.
- The following counties will no longer have the Anthem Medicare Preferred Standard PPO available to them in 2013: Charles City, Chesapeake City, Chesterfield, Colonial Heights City, Dinwiddie, Goochland, Hanover, Henrico, Hopewell City, Middlesex, New Kent, Newport News City, Norfolk City, Northumberland, Petersburg City, Poquoson City, Portsmouth City, Powhatan, Prince George, Richmond City, and Virginia Beach City.
- Primary care physician (PCP) copays range from $10 to $15 and specialist copays are $35.
- Anthem Medicare Preferred Core (PPO) plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain network-level benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider. You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the “MA” in the suitcase, which indicates the member is covered under the MA PPO network sharing program. In 2013 we have added the states of New Jersey and Texas to the service area.
- $0 copay for Medicare-covered Preventive Care.

**New Medicare Advantage HMO and HMO based Special Needs Plans (SNP)**

New in 2013, Medicare beneficiaries in the City of Richmond and in parts of Henrico County and Chesterfield County will have access to four new plans that include exclusive access to the CareMore health delivery system and its neighborhood Care Centers. Care Center services support primary care providers and deliver individualized support to members through preventative medicine, disease management and health education services.
Plans include a MediBlue (HMO) plan (“Anthem MediBlue Local”) and three MediBlue (HMO-SNP) special needs plans designed to meet the needs of individuals who have diabetes (“Anthem MediBlue Diabetes”), COPD (“Anthem MediBlue COPD”) or are living in certain long-term care facilities (“Anthem MediBlue Care To You”). Featured benefits include:

- No monthly plan premium
- $0 copay for PCP visit, lab test and routine X-rays
- Generic drug copays of $0 to $5, plus generic drug coverage in the coverage gap
- Optional Supplemental dental care benefits (available for an additional fee).
- Preventative benefits and disease management programs

Providers contracted with CareMore to provide services to members in these plans will receive specific information about plans, benefits, and programs.

To learn more about the CareMore Health Delivery System, visit www.getcaremore.com or call (888) 291-1358
Select Option 3, then Option 5.

Optional Supplemental Benefits (OSB)
For 2013, many of our Medicare Advantage plans will be offering three Optional Supplemental Benefit (OSB) packages for an additional premium. These packages will allow the Medicare Advantage plan to be tailored to add additional dental, vision, chiropractic and acupuncture coverage by enrolling in an OSB package. WellPoint will offer the following Optional Supplemental Benefit (OSB) packages on select plans in which members will have up to 90 days from their plan effective date to enroll. New for 2013 will be the removal of the 10 visit limit on chiropractic and acupuncture benefits, but the yearly dollar cap for these services will still apply.

1.) Preventive Dental Package
2.) Comprehensive Dental and Vision Package
3.) Combination Package (includes dental, vision, chiropractic, and acupuncture).

Medicare Part D Prescription drug coverage

For Anthem Medicare Preferred Core (PPO) Plans:

- Initial Coverage Limit (ICL) for Medicare Part D will increase from $2,930 to $2,970.
- TROOP amount will increase from $4,700 to $4,750.

For Anthem Medicare Preferred Core (PPO) Plans:

- During the Catastrophic Coverage Phase: Members will pay 5% or $2.65 whichever is more for generic drugs, and members will pay 5% or $6.60 for brand drugs.
- Group/Union Sponsored Plans are not impacted by the changes described above for Pharmacy plans.

Help your patients get the best buy—each year—for their health care needs

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes in the upcoming year include: actual formulary change, tier name changes,
the tier that a drug may sit on, drug removals, and new Prior Authorization, Step Therapy and Quantity Limit requirements. Your patients experiencing formulary changes will likely want to discuss their options with you. They will need your help to ensure they get their needed treatments at the most affordable cost.

Encourage your patients to review the 2013 formulary information within their Annual Notice of Change (ANOC) mailing, or to view the information online when it is available, beginning October 1, 2012. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications in a lower cost-sharing tier that may meet their need.

**Balance Billing Reminder:**
The Centers for Medicare and Medicaid Services and our plan does not allow you to “balance bill” Medicare Advantage HMO and PPO members for Medicare covered services. CMS provides for an important protection for Medicare beneficiaries and our members such that, after our members have met any plan deductibles, they only have to pay the plan’s cost-sharing amount for services covered by our plan. As a Medicare provider and/or a plan provider, you are not allowed to balance bill members for an amount greater than their cost share amount. This includes situations where we pay you less than the charges you bill for a service and includes charges that are in dispute.

Here is how this protection works.

- If the member cost sharing is a copayment (a set amount of dollars, for example, $15.00), then the member pays only that amount for any services from a network provider. Copayments may be higher for services performed by an out-of-network provider.
- If the member cost sharing is a coinsurance (a percentage of the total charges), then the member never pays more than that percentage. However, the cost depends on the type of provider:
  - If the member obtains covered services from a network provider, the member pays the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
  - If the member obtained covered services from an out-of-network provider who participates with Medicare, then the member pays the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
  - If a member obtains covered services from a provider who has opted out of Medicare, then the plan will not pay for these services, and depending upon the circumstances, the member may be liable for the entire amount.

**Medicare Advantage: The Annual Wellness Visit**

**What Providers Should Know**
The Annual Wellness Visit (AWV) was a new benefit effective on all plans January 1, 2011. Beneficiaries new to Medicare will continue to be covered under the once in a lifetime “Welcome to Medicare” exam. However, now all beneficiaries are covered for the AWV every 12 months.

**What codes are billed for the AWV?**
For the first visit, providers should bill G0438 for the AWV which includes the Personalized Prevention Plan Service. Thereafter, providers should bill G0439 for the AWV and Personalized Prevention Plan Service, subsequent visit.
Routine Physical Exams and the Annual Wellness Visit
Medicare Advantage plans may offer extra supplement benefits that could include a routine physical exam. Providers should check with the plan to confirm if this is an extra benefit on the member’s plan before billing. The codes for the routine physical (under preventive services) include: CPT code range 99381 through 99397. These codes are not covered by original Medicare and may not be an extra benefit on the member’s plan.

However, all Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs.

What if additional services are provided at the same time as the AWV?
If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as appropriate.

Prior authorization updates for Medicare Advantage Plans.
A list of the 2013 prior authorization requirements will be posted in December to the Medicare Advantage Provider Portals. Please reference the document: Medicare Advantage 2013 Precertification Requirements; for the list of precertification requirements. The most current list of Precertification Requirements can be found at www.anthem.com/medicareprovider or applicable website such as www.empireblue.com/medicare.

Private Fee For Service Claims
Anthem Blue Cross Blue Shield discontinued sales of Medicare Advantage Private Fee for Service (PFFS) plans as of 12/31/11. We will continue to provide run out services for original timely claims as well as provider submitted adjustments through 12/31/12.

Please review any PFFS members’ you may have seen to determine if claims submissions or adjustment requests and submit them for payment by October 1, 2012 to ensure claims and adjustments are reviewed and processed prior to 12/31/12.

The claims submission, adjustment request, and Grievance and Appeal addresses will remain the same during this run-out period. The dedicated PFFS Provider Service will also be available for questions regarding PFFS claims processing through 12/31/12.

Please visit our website at www.anthem.com/medicareprovider for more detailed product information or contact Provider Services at the number on the back of the member’s ID card. You can find important Medicare Advantage updates in the Plan & Administrative Changes/Update section. Contact your provider representative for participation details for our contracted plans.

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