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

2026
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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Most Vulnerable Enrollees (MVE) risk levels are determined using a proprietary risk stratification method that assigns a risk level and threshold. Six categories (including medical, behavioral, financial, geographic, risky behavior and SDoH) differentiate and describe unique characteristics of each enrollee.

Enrollees are stratified by risk levels 1 through 4, with 1 being the lowest and 4 being the highest risk, most complex enrollees.

The most vulnerable enrollees (MVEs) are defined as those who stratify into risk level 4.

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	Hematologic
Cancer	Psychiatric
Cardiovascular	Pulmonary
Central Nervous System	Renal
Diabetes	Skeletal
Frailty	Skin
Gastrointestinal	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 care 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?

<u>Medicare = Primary</u>

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

A semi-private room

Your hospital meals

Skilled nursing services

Care on special units, such as intensive care

Drugs, medical supplies and medical equipment as an inpatient

Lab tests, X-rays and radiation treatment as an inpatient

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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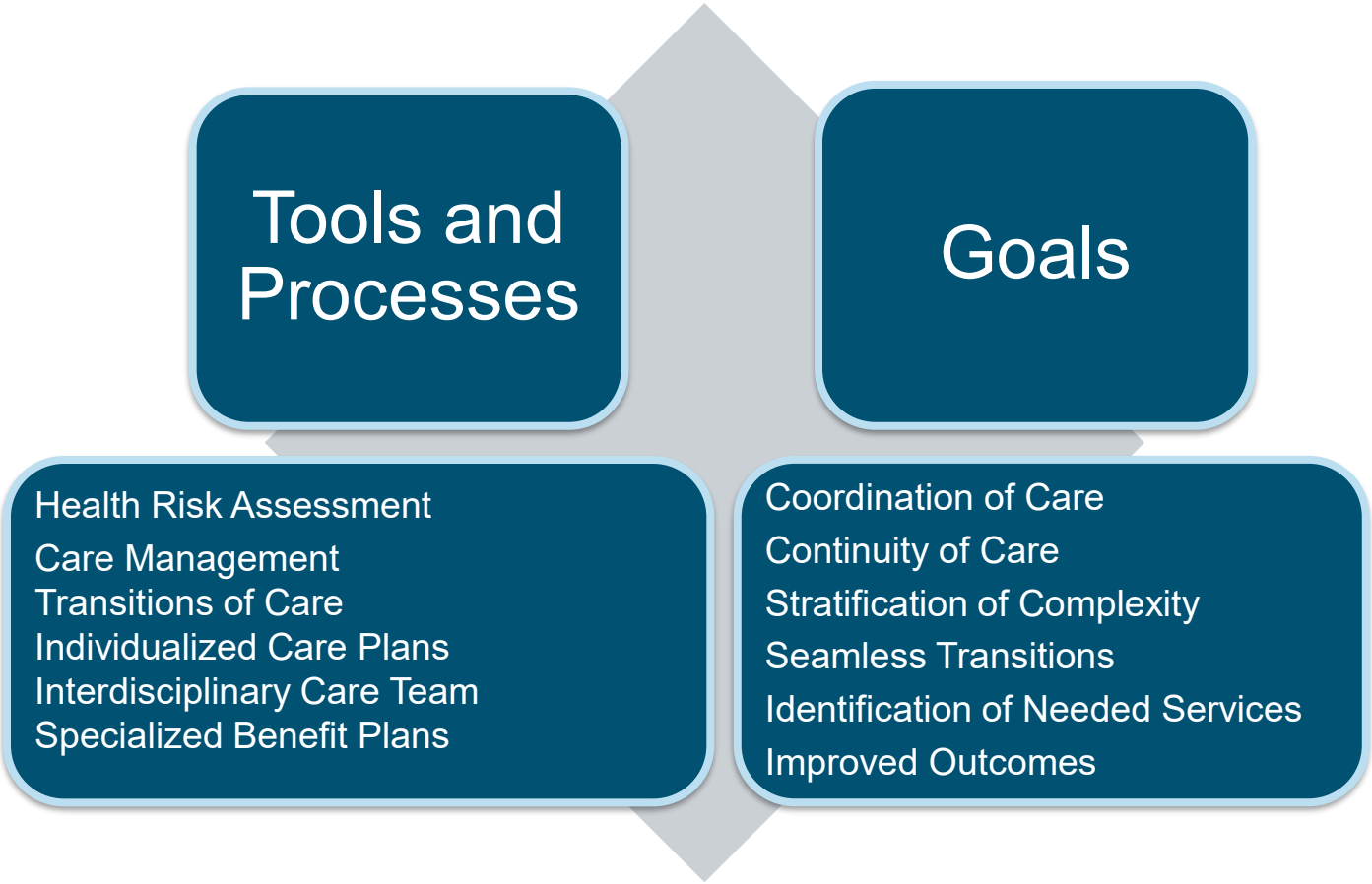
- Program Components



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 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, using available data and/or 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 ICP through the secure provider portal, if MOC training has been completed
- The ICP includes member preferences and personal goals as applicable
- The ICP is updated as the member's needs change

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 as needed
- 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

ICP and ICT (Continued)

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In accordance with regulations, Blue Cross NC Care Management staff develop and implement an individualized Care Plan (ICP) for all DSNP enrollees. Each D-SNP enrollee also has an Interdisciplinary Care Team (ICT), led by the Medicare Advantage case manager, who works together with the team to address the needs of the enrollee.

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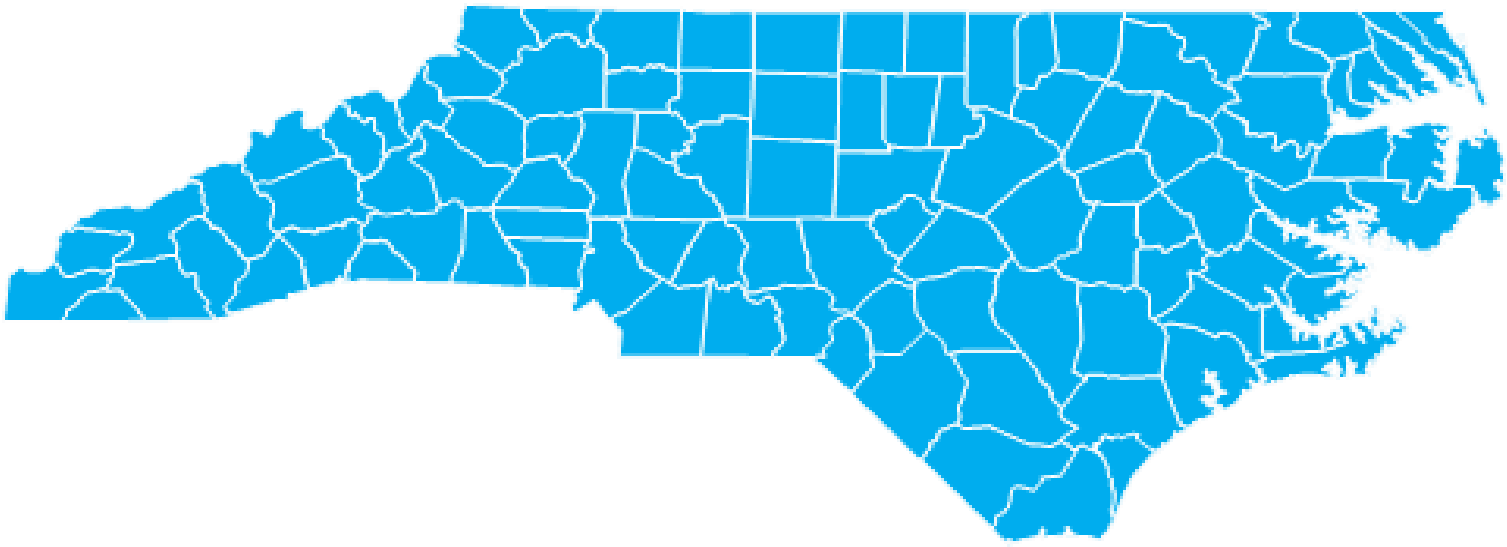
- Healthy Blue + Medicare is available in all 100 North Carolina counties to those that are eligible.



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.

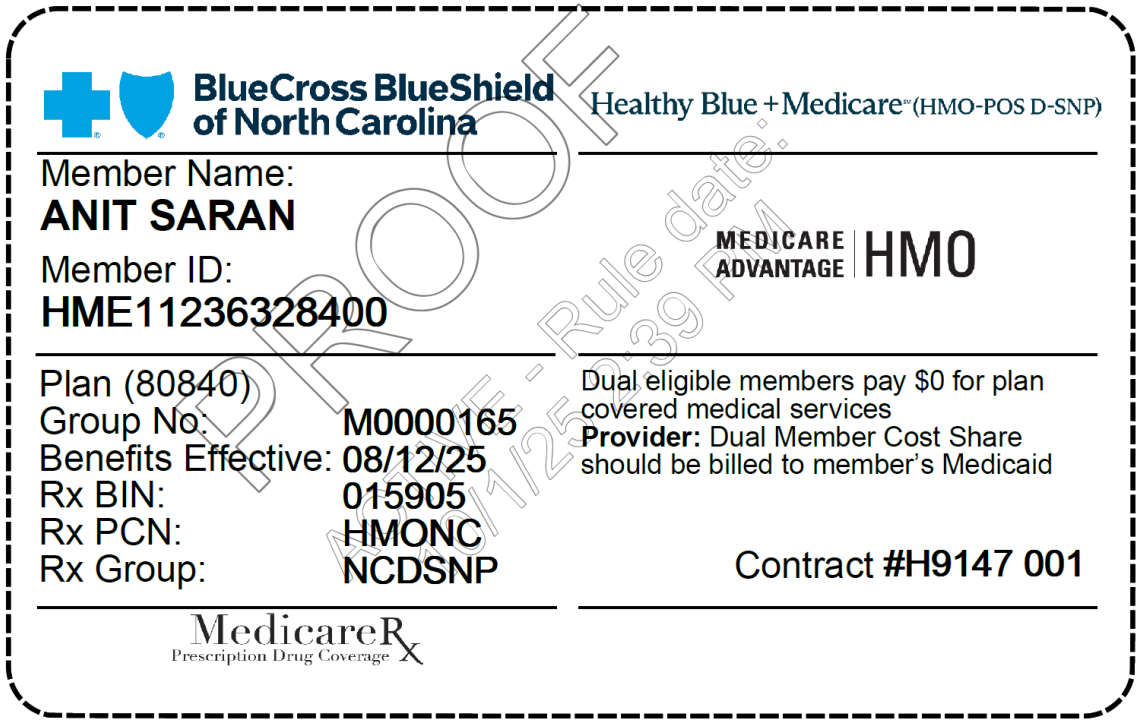
2026 Key Benefit Changes

2026 Healthy Blue + Medicare (HMO-POS D-SNP)

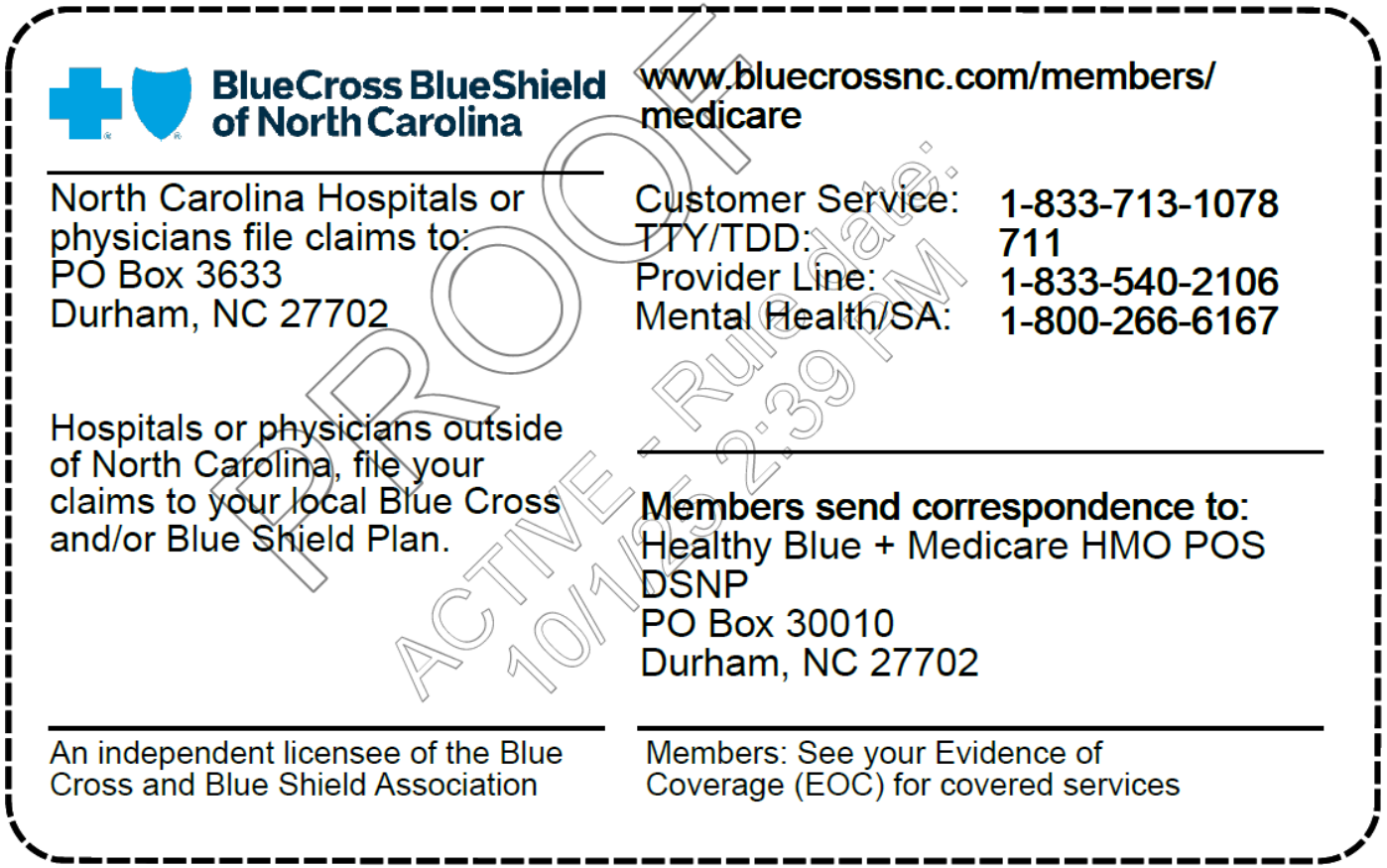
	2025	2026
Member Premium	$0	$0
Out of Pocket Maximum	$9,350	$9,250
BlueFlex Card Allowance*	OTC/Groceries/Home Safety Devices $259/mo.	OTC/Healthy Food & Produce $250/mo.
Transportation	$0, unlimited trips to health & non-health related locations	48 trips to health & non-health related locations
Part D Drugs	$0 – Tiers 1, 2, 6 LIS Copays ($0-$12.15) Tiers 3, 4, 5	$0 – Tiers 1, 2, 6 LIS Copays ($0-$12.65) Tiers 3, 4, 5

* Benefit covered through Special Supplemental Benefits for the Chronically Ill (SSBCI) Qualification

Healthy Blue + Medicare ID Card



Healthy Blue + Medicare ID Card



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) in order to receive payments for cost-sharing or Medicaid only services.
- Providers must ensure they obtain the enrollee's consent for virtual visits.

Helpful Resources

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- Provider website – https://www.bluecrossnc.com/provider-home
- 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.
- Model of Care (MOC) training must be completed for providers to participate in their members' Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT) meetings.
- Please attest that you have reviewed this presentation and understand 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://commonforms.bcbsnc.com/model-care-attestation-form

Thank You

U43484, 9/23