Fact sheet: 2024 Medicare Advantage California EAP DSNP changes

California | Medicare Advantage

September 2023

Overview

California Advancing and Innovating Medi-Cal (CalAIM), is a multi-year initiative to transform and strengthen Medi-Cal Managed Care (Medi-Cal) for Californians. The aim is to improve care coordination and person-centered care for beneficiaries that are eligible for both Medi-Cal and Medicare.

A key component was to transition Full Dual Eligible beneficiaries into Exclusively Aligned Enrolled Dual Eligible Special Needs Plan (EAE D-SNP) that started in plan year 2023 and continues into 2024. To continue with the state's plans for full dual beneficiaries, EAE D- SNP is expanding into additional counties for 2024.

On January 1, 2024, full dual eligible beneficiaries in Fresno, Kings, Madera, Sacramento, and Tulare will automatically transition into EAE D-SNPs available through Anthem Blue Cross (Anthem), in addition to existing plans in Los Angeles and Santa Clara counties. Detailed grids below.

Anthem's planned transitions comply with these new guidelines, which are aimed at improving care integration and person- centered care for the highest-need enrollees.

To comply with these CalAIM and CMS required changes, Anthem will help members transition to new or similar plans, based on the beneficiary's needs, eligibility, and available plans we offer, for Plan Year 2024, beginning January 1, 2024.

Members impacted

The transitions outlined in the overview impact current members in the following plans. No action is required from members. For D-SNP member transitions see additional eligibility and county nuances in the respective sections below as well as details on plan changes.

County	2023 Contract-PBP	2023 Plan Name
Santa Clara, Los Angeles, Fresno, Kings, Madera, Tulare, Sacramento	H4161-001-000	Anthem MediBlue Full Dual Advantage (HMO D-SNP)
Santa Clara	H0544-003-000	Anthem MediBlue Connect (HMO D-SNP)
Los Angeles	H0544-003-000	Anthem MediBlue Connect (HMO D-SNP)

CABC-CR-048988-24-SRS48928 January 2024

Santa Clara	H0544-129-000	Anthem MediBlue Dual Advantage (HMO D-SNP)
Los Angeles	H0544-129-000	Anthem MediBlue Dual Advantage (HMO D-SNP)
Fresno, Kings, Madera, Tulare	H0544-052-000	Anthem MediBlue Dual Advantage (HMO D-SNP)
Fresno, Kings, Madera, Tulare	H0544-087-000	Anthem MediBlue Dual Plus (HMO D-SNP)
Sacramento	H0544-054-000	Anthem MediBlue Dual Advantage (HMO D-SNP)
San Francisco	H0544-054-000	Anthem MediBlue Dual Advantage (HMO D-SNP)
Sacramento	H0544-089-000	Anthem MediBlue Dual Plus (HMO D-SNP)
San Francisco	H0544-089-000	Anthem MediBlue Dual Plus (HMO D-SNP)

Member communications and service

ANOC kits: mailed to all members by late September announcing changes to plan, premium, service area, and benefits covered for the next plan year. ANOCs must be in home by September 30, 2023. ANOCs will also be available in the Member Portal. Members should carefully read their ANOC letter to learn about all plan and benefit changes.

Retention letter: mailed to all members in October highlighting key plan features and benefits for the coming plan year.

Welcome Kits and new Member ID cards: mailed to all members changing plans and new members beginning October 15. Materials in the new member Welcome Kit include:

- Plan Guide (which includes language as to how members can access Handbook, Formulary and Provider/Pharmacy directory online)
- Welcome message on inside front cover of Plan Guide
- Member ID card

Exclusively Aligned Enrollment (EAE) D-SNP product FAQs

What is the advantage of an Exclusively Aligned Enrollment Dual-eligible Special Needs Plan (EAE D-SNP)?

- EAE D-SNPs offer an integrated approach to care and care coordination. The aligned Medicare and Medi-Cal plans will work together to deliver care to their members.
- And as all members in the plan are also enrolled in the aligned Medi- Cal Managed Care Plan (MCP), they can receive integrated member materials, such as one integrated member ID card.

What Is Exclusively Aligned Enrollment (EAE)?
Under exclusively alignment enrollment, members enroll in a dual eligible special needs plan (D-SNP) for Medicare benefits and in a Medi-Cal managed care plan for Medi-Cal benefits, which are both operated by the same parent organization for better care coordination and integration.

Enrollment into the exclusively aligned enrollment D-SNP will result in the member's Medi-Cal plan changing to the same parent organization's Medi-Cal plan.

For Anthem plans in California, the EAE D-SNP will be Anthem Blue Cross California

Partnership Plan D-SNP (Anthem Full Dual Advantage Aligned (HMO D-SNP)) with a Blue Cross of California Partnership Plan Medi-Cal plan (Medi-Cal) in: Fresno, Kings, Los Angeles, Madera, Sacramento, Santa Clara, and Tulare. counties.

What is the name of the EAE D-SNP for Anthem?
Anthem Full Dual Advantage Aligned (HMO D-SNP) H4471-001-000

How are D-SNP members in CCI counties being transitioned, do members need to do anything?
No action is required from current D-SNP members. Full dual eligible beneficiaries will transition into the new EAE D-SNP, while partial dual eligible beneficiaries will remain in a data coordination DSNP. There will be no lapse in coverage. Beginning 01/01/2024, impacted D-SNP members will be automatically transitioned into an Exclusively Aligned Enrolled Dual Eligible Special Needs Plan (EAE D-SNP) as outlined in the table below.

County	2023 Contract-PBP	2023 Plan Name	Risk	2024 Contract-PBP	2024 Plan Name
SantaClara, Los Angeles, Fresno, Kings, Madera, Tulare, Sacramento	H4161-001-000	Anthem MediBlue Full Dual Advantage (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Santa Clara	H0544-003-000	Anthem MediBlue Connect (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Los Angeles	H0544-003-000	Anthem MediBlue Connect (HMO D-SNP)	Partial	H4471-009-000	Anthem Dual Advantage (HMO D-SNP)
Santa Clara	H0544-129-000	Anthem MediBlue Dual Advantage (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Los Angeles	H0544-129-000	Anthem MediBlue Dual Advantage (HMO D-SNP)	Partial	H4471-009-000	Anthem Dual Advantage (HMO D-SNP)
Fresno, Kings, Madera, Tulare	H0544-052-000	Anthem MediBlue Dual Advantage (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Fresno, Kings, Madera, Tulare	H0544-052-000	Anthem MediBlue Dual Advantage (HMO D-SNP)	Partial	H4471-002-000	Anthem Dual Advantage (HMO D-SNP)
Fresno, Kings, Madera, Tulare	H0544-087-000	Anthem MediBlue Dual Plus (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Fresno, Kings, Madera, Tulare	H0544-087-000	Anthem MediBlue Dual Plus (HMO D-SNP)	Partial	H4471-002-000	Anthem Dual Advantage (HMO D-SNP)
Sacramento	H0544-054-000	Anthem MediBlue Dual Advantage (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Sacramento	H0544-054-000	Anthem MediBlue Dual Advantage (HMO D-SNP)	Partial	H4471-004-000	Anthem Dual Advantage (HMO D-SNP)
San Francisco	H0544-054-	Anthem MediBlue Dual Advantage (HMO D-	All	H4471-004-	Anthem Dual Advantage (HMO D-SNP)

	000	SNP)		000	
Sacramento	H0544-089-000	Anthem MediBlue Dual Plus (HMO D-SNP)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Sacramento	H0544-089-000	Anthem MediBlue Dual Plus (HMO D-SNP)	Partial	H4471-004-000	Anthem Dual Advantage (HMO D-SNP)
San Francisco	H0544-089-000	Anthem MediBlue Dual Plus (HMO D-SNP)	All	H4471-004-000	Anthem Dual Advantage (HMO D-SNP)

With DSNP Look-a-Like plans going away in 2024, how will members be transitioned to a DSNP plan?
Beneficiaries have two options: an EAE DSNP for full dual eligibles or a Data Coordination DSNP for partial dual eligibles.

County	2023 Contract-PBP	2023 Plan Name	Risk	2024 Contract-PBP	2024 Plan Name
Los Angeles	H0544-081-000	Anthem MediBlue Extra (HMO)	Full	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)
Los Angels, Orange	H0544-081-000	Anthem MediBlue Extra (HMO)	Full	H4161-009-000	Anthem Prime (HMO)

Which categories of dual eligible beneficiaries can enroll in a EAE D-SNP?
Beneficiary enrollment in a D-SNP or other Medicare Advantage plan is voluntary. Each D-SNP may have different requirements.

EAE D-SNP for Anthem for full dual beneficiaries are: Qualified Medicare Beneficiaries Plus (QMB+), Specified Low-Income Medicare Beneficiaries Plus (SLMB+), and other full dual eligible beneficiaries who reside in the following counties: Fresno, Kings, Los Angeles, Madera, Sacramento, Santa Clara and Tulare.

Definitions of all types of Qualified Medicare Beneficiary programs are available on the Centers for Medicare and Medicaid Services (CMS) Medicare- Medicaid Coordination Office website.

For non-EAE D-SNP, what categories of dual eligible beneficiaries can enroll?
Beneficiary enrollment in a D-SNP or other Medicare Advantage plan is voluntary. Each D-SNP may have different requirements.

For Anthem non-EAE D-SNP, all dual eligible beneficiaries who were already enrolled in the D-SNP in CY 2023 can remain in CY 2024, inclusive of currently enrolled partial dual eligible beneficiaries. Newly enrolled members to the health plan in CY 2024 are limited to full dual categories, and enrollees can only be full dual eligible beneficiaries, such as Qualified Medicare Beneficiaries Plus (QMB+), Specified Low-Income Medicare Beneficiaries Plus (SLMB+), and Other Full-benefit Dual-Eligible Beneficiaries.

Definitions of all types of Qualified Medicare Beneficiary programs are available on the Centers for Medicare and Medicaid Services (CMS) Medicare- Medicaid Coordination Office website.

What is the process for duals that lose "full dual" eligibility and becomes a "partial dual" eligible?
Members will be put into the 90-day deeming period. During that time, if they meet the requirement for the Partial Plans, they must complete an application and submit for enrollment in one of those PBPs. If Enrollment does not receive that new application, the member will be disenrolled at the end of the 90-day deeming period.

What happens when a beneficiary applies for enrollment into an exclusively aligned enrollment (EAE) D-SNP, effective January 1, 2024, or after?
Enrollment in the exclusively aligned enrollment D-SNP will trigger the Department of Health Care Services to reassign the member's Medi-Cal plan to the same parent organization. No action is needed by the beneficiary.

Will partial dual eligible beneficiaries be able to enroll in an Exclusively Aligned Enrollment (EAE) D-SNP?
No, only full benefit dual eligible beneficiaries will be able to enroll into an exclusively aligned enrollment D-SNP.

What is the benefit of the new EAE D-SNP for members?
The EAE D-SNP allows us to provide more coordinated care between Medicaid and Medicare. This means members only need to contact one source for their health plan needs.

Provider network

What is the effective date of these EAE D-SNP transitions and expansions?
January 1, 2024.

Will the provider networks be the same for the members transitioning to new plans?
While there may be some differences, for the most part provider networks will be substantially similar.

Will there be a new EAE D-SNP provider directory?
Yes, a new provider directory will be available for the EAE D-SNP and accessible either online or by calling customer service for members to order.

Will members who transition into the EAE D-SNP change PCPs?
Anthem has pursued best efforts to keep all members with their current PCP. Anthem anticipates the providers networks will be the same, or better, in the new EAE D-SNP for beneficiaries. We strive to offer members a full comprehensive network to meet all of their healthcare needs.

Will prior authorizations be required for admissions and/or certain services?
Yes, prior authorization is required for all non-emergency admissions and certain other services.

What services require prior authorizations?
Independent Practice Association (IPA) participating providers will follow the current prior-authorization list used by Anthem, which can be located on Anthem's website: **anthem.com/ca/provider/prior-authorization/.**

What should a member do if care is needed from a specialist?
Members' primary care physician will coordinate any specialty care ensuring a high quality, positive experience.

Will members receive a new ID card?
Yes, members should receive a new ID card and would present that when services are rendered.

How should claims or encounters be billed for the EAE D-SNP?
Claims should be submitted through Availity using the Payor ID on the back of the member's card. See Section, "Encounter Submissions Using an 837 – How to Report Prior Payment Information," below for details.

Will my reimbursement rates change with the new EAE D-SNP?
PMGs should refer to their provider contract for specific reimbursement information related to EAE D-SNP.

For hospitals and ancillary providers, there is no change in reimbursement.

Will supplemental benefits for routine hearing, dental and vision on the EAE D-SNP be handled through a vendor?
Yes, supplemental services for routine hearing, dental and vision will continue through vendors identified by the health plan.

Will Anthem provide Model of Care training for the new EAE D-SNP?
As required by CMS for all Special Needs Plans, Anthem will provide annual Model of Care training for the EAE D-SNP. Participating providers will be notified when the training is available in Availity.

If I take Model of Care training for another payor for their EAE D-SNP, do I still have to take training for Anthem?
Yes, each model of care training is specific to that payor.

Are doula services covered under EAE D-SNP?
Yes, doula services will be covered under EAE D-SNP. See the Doula fact sheet here:
Doula Services (doula) (anthem.com)

What is the provider's role in palliative care for EAE D-SNP members?
As a participating provider in EAE D-SNP, you are required to assist members in accessing their palliative care benefits when the criteria are met (see **Palliative Care** section below). Collaborating with Anthem, providers should do the following:

- Coordinate inpatient and outpatient/community-based palliative care referrals for EAE D-SNP members
- Assistance in identifying eligible members and assessing for medical necessity when delegated for utilization management
- Contracted PMGs/IPAs should contract with palliative care providers within their network to ensure adequate coverage for EAE D-SNP members
- Coordinate the palliative care services

What is needed to support Population Health Management (PHM) and related initiatives?

California Department of Health Care Services (DHCS) is transforming Medi-Cal to get Californians the care they need to live healthier lives (**https://dhcs.ca.gov/CalAIM/Pages/CalAIM.aspx**). Population Health Management intends Admission, Discharge and Transfer (ADT) notification feeds to be used for timely provider notification that helps identify and address member needs at time of hospital discharge: **Discharges Against Medical Advice Flyer FINAL.pdf**

Additional information can be found here: **2023 DHCS PHM Strategy Deliverable Template Due October 31, 2023 (Published August 2023) (ca.gov)**

What is expected as a provider when it comes to member's receiving behavioral health treatment?

EAE D-SNP members have mental health benefits above the normal Medicare covered benefits. Once a member exhausts their Medicare covered benefits, members would use their Medi-Cal covered benefits through the county behavioral health plan (MHP). PCPs are expected to help members coordinate these benefits between the Medicare covered and the additional Medi-Cal benefits to receive the optimal experience.

What resources are available to providers to help support delivery of culturally and linguistically appropriate services?

Our Cultural Diversity and Linguistic Services Toolkit called Caring for Diverse Populations was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients. The toolkit can be downloaded by selecting the link below: **CA_CAID_CaringforDiversePopulationToolkit.pdf (anthem.com)**.

This toolkit gives you the information you'll need to continue building trust. It will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to your office staff so that all aspects of an office visit can go smoothly. In addition to the caring for diverse populations toolkit, Anthem offers additional resources to support provision of culturally and linguistically appropriate services, including My Diverse Patients and a Cultural Competency Training, which can be accessed at: **Provider Training Academy | California Provider - Anthem Blue Cross .**

The My Diverse Patients website offers resources, information, and techniques to help provide the individualized care every patient deserves regardless of their diverse backgrounds.

Integrated UM review

Integrated UM is a key component of CalAIM. UM reviews apply to organizational determinations for pre- and post- service authorizations and continued or extended services. Integrated UM reviews shall take into account the full scope of coverage under CA EAE DSNP for the service(s) requested, including the Medicare, Supplemental, and Medicaid components of coverage under the plan, and the full extent of the Medicare Improvements for Patients and Providers Act (MIPPA) wrap benefit. . As a participating PMG in the EAE D-

SNP, you are responsible for authorizations and coordination of the member's DSNP benefits and Medicaid only benefits.

Per CMS regulation (**cms.gov/files/document/dsnpartscdgrievancesdeterminationsappealsguidanceaddendum.pdf**), if the applicable integrated plan expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the integrated organization determination must be reviewed by a physician or other appropriate healthcare professional with sufficient medical and other expertise, including knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated organization determination.

Per CMS regulation (**cms.gov/files/document/dsnpartscdgrievancesdeterminationsappealsguidanceaddendum.pdf**), for integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the *Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716)*, also known as the *Coverage Decision Letter*.

As you review the requests and reach the final determination, please ensure to consider all benefits, Medicare, Supplemental, and Medicaid, using the following sequence of evaluation:

Step	If...	Then....	Member communication
1	Covered by Medicare or Supplemental, and meets medical necessity	Approve	• Approval letter • Multi-Language Insert (MLI), which includes the non-discrimination language * Copy of approval letter to provider
2	Not covered by Medicare or Supplemental, and/or medical necessity is not met	Review with Medicaid	N/A
3	Covered by Medicaid and meets medical necessity	Approve	• Approval letter • Multi-Language Insert (MLI), which includes the non-discrimination language * Copy of approval letter to provider
4	Not covered by both Medicare or Supplemental, and Medicaid, and medical necessity is not met for both Medicare and Medicaid	Deny	• CDL • Multi-Language Insert (MLI), which includes the non-discrimination language • NOA Your Rights • *Independent Medical Review Form (IMR)* • Envelope addressed to DMHC to enclose *IMR* * Copy of CDL to provider
5	Organization determination is split decision (partial approval, partial denial)	Approve and deny	• CDL • Multi-Language Insert (MLI), which includes the non-discrimination language • NOA Your Rights

			• *Independent Medical Review Form (IMR)* • Envelope addressed to DMHC to enclose IMR * Copy of CDL to provider

For convenience, the English and translated versions of the documents referenced are available in the Health Industry Collaboration Effort's (HICE) Health Plan Specific Letter Template library in the folder for Anthem at the following link: **iceforhealth.org/library.asp?sf=&scid=5272#scid5272.**

The CA EAE- DSNP specific *Your Rights notice* will also be available in the library as soon as it is ready for external distribution. Your organization will be notified as soon as it is posted.

Important:

- Standard organizational determinations (also referred to as utilization management [UM] decisions) are to be made within five business days from the plan's receipt of information reasonably necessary to make the determination and no later than 14 calendar days from when it receives the request (*DHCS Policy Guide*: **dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs- Plans-(D-SNP)-Contract-and-Program-Guide.aspx** > D-SNP Policy Guide (2023)).
- In the case of expedited integrated organizational determinations, CA EAE DSNPs must provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours from when it receives the request.
- CA EAE DSNPs may not extend the deadlines for integrated organization determinations.

Members often request authorizations for incontinence supplies. It is important to note the incontinence supplies are covered under the CA EAE DSNP member's benefits through their Medicaid benefits. The member should not be using over the counter (OTC) benefits or paying out of pocket.

Notes:

- CA EAE DSNPs must provide information about the integrated grievance and integrated appeal system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on integrated grievance, integrated reconsideration, and State fair hearing procedures and timeframes, as applicable. For additional information, please contact your Provider Relationship Account Manager.
- Prior to terminating, suspending, or reducing a previously approved item or service, CA EAE DSNPs must provide enrollees with an integrated coverage determination at least 10 calendar days in advance of the effective date of the adverse organizational determination. In the event of the adverse organizational determination, the enrollee must request continuation of benefits for the previously approved Medicare and/or Medicaid benefit(s) that the plan is terminating, suspending, or reducing within 10

calendar days of the notice's postmark date or by the intended effective date of the action, whichever is later.

- Health plan social services staff serving as liaisons for the long-term supports and services (LTSS) provider community should be engaged in the Interdisciplinary Care Team (ICT) as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. The contact for Anthem is Mina Farag, Mina.Farag@anthem.com.
- Requests can also be emailed to DualReferrals@anthem.com.
- Plans are encouraged to reference and direct providers to the Dementia Care Aware website and associated resources, available here: **dementiacareaware.org/**
- DHCS D-SNP reference information: **dhcs.ca.gov/services/Pages/Integrated-Care-for-Dual- Eligible-Beneficiaries.aspx**
- View the 2024 member benefits for Anthem on our provider website at: **anthem.com/ca/medicareprovider.**

Encounter submisions using an 837 — How to report prior payment information

General information:

- Refer to the TR3 for usage guidelines for any highlighted 837 loop, segment, or data element.
- The below example is from an 837p, similar loops, segments and data elements apply to 837I. **Values in yellow indicate key loops, segments or data elements and have specific usage instructions identified below.**
- These segments may not reflect all segments your transaction needs for your specific billing scenario.
- Use the loops identified in 2320 and below to report your prior payments as well as any other payer payments. Below is an example of an 837p.

HEADER
ST*837*XXXXXX*005010X222A1~
BHT*0019*00*XXXXXX*20210802*1047*RP~ **Identify an Encounter claim using BHT06 value = RP (Reportable)**

NM1*41*2*SUBMITTER NAME*****46*XXXXXX ~
PER*IC*SUPPORT*TE*3609757000~
NM1*40*2*AVAILITY*****46*123456789~
HL*1**20*1~
PRV*BI*PXC*332B00000X~
NM1*85*2*BILLING PROVIDER*****XX*0000000000~
N3*ADDR LN1~
N4*CITY*ST*100009999~
REF*EI*123456789~
PER*IC*CONTACT*TE*9999999999~
NM1*87*2~
N3*ADDR LN1~

N4*CITY*ST*100009999~
HL*2*1*22*0~

LOOP ID – 2000B — SUBSCRIBER HIERARCHICAL LEVEL
SBR*S*18*GROUP******CI~
NM1*IL*1*SUB LAST*SUB FIRST****MI*MEMBER ID~
N3*ADDR LN1~
N4*CITY*ST*100009999~
DMG*D8*DOB*GENDER CODE~

LOOP ID – 2010BB — PAYER NAME
NM1*PR*2*ANTHEM INC.*****PI*WGEVLM~ **Use the Destination payer ID as instructed by your Anthem Blue Cross contact.**

CLM*XXXXXX*{TOTAL CHARGES}***12:B:1*Y*A*Y*I*P~
REF*D9*XXXXXXXXXX~
HI*ABK:XXXXX~

(continued)
LOOP ID – 2320 - OTHER SUBSCRIBER INFORMATION - Use the Coordination of Benefits Loop to send your prior payment details. Include ONE 2320 Loop for EACH PRIOR PAYMENT/PAYER. Report claim level reductions using this Loop. Refer to the example below and the TR3 for usage requirements.

If providing information on a **prior Medicare payment only:**
SBR*P*18**{DELEGATE NAME}*****{MA or MB**}~ Provide the Delegate Name in SBR04. Use the Claim Filing Indicator Code SBR09 appropriate to the Line of Business associated with prior adjudication. MA = Institutional Medicare MB = Professional Medicare**

AMT*D*{claim level payment amount}~ **Include Claim Level Prior Payment Amount**
OI***Y***I~

If providing information on a **prior Medicaid payment only:**
SBR*P*18**{DELEGATE NAME}*****MC~ **Provide the Delegate Name in SBR04.**
MC = Medicaid

AMT*D*{claim level payment amount}~ **Include Claim Level Prior Payment Amount**
OI***Y***I~

If providing information on prior payments **for a member with dual coverage** include a Medicare primary loop and a Medicaid secondary loop:

First Loop 2320
SBR*P*18**{DELEGATE NAME}*****{MA or MB}~
AMT*D*{claim level payment amount}~
OI***Y***I~
Loop 2330A (see usage instructions below)
Loop 2330B (see usage instructions below)

Second Loop 2320
SBR*S*18**{DELEGATE NAME}*****MC~
AMT*D*{claim level payment amount}~
OI***Y***I~
Loop 2330A (see usage instructions below)
Loop 2330B (see usage instructions below)

LOOP ID – 2330A - OTHER SUBSCRIBER NAME
NM1*IL*1*SUB LAST*SUB FIRST****MI*MEMBER ID~
N3*ADDR LN1~
N4*CITY*ST*100009999~

LOOP ID – 2330B Other Payer Name NM1– It is IMPERATIVE that one of the NM109 values indicated below is used when reporting prior payments. DO NOT SEND OTHER VALUES UNLESS INSTRUCTED.

If reporting a prior Medicare payment use: NM1*PR*2*{DELEGATE OR PAYER NAME}*****PI*MEDICARE~
If reporting a prior Medicaid payment use: NM1*PR*2*{DELEGATE OR PAYER NAME}*****PI*MEDICAID~

If providing information on prior payments **for a member with dual coverage** your 837 should contain a 2330B loop for each coverage.

(continued)
LOOP ID – 2330B Other Payer Secondary Identifier REF
REF*2U*{DELEGATE TIN}~

LOOP ID - 2400 SERVICE LINE NUMBER - **Dollar amounts including any reported reductions must balance.**
LX*1~
SV1*HC:A6252:A1*136.12*UN*15***1~
DTP*472*D8*20210126~
REF*6R*XXXXXXX-1~
HCP*10*56.85~ **HCP - LINE PRICING/REPRICING INFORMATION, can be used to provide line level rate details for the service.**

LOOP ID - 2430 LINE ADJUDICATION INFORMATION - **Use to provide line specific prior payment processing details, for example, reductions, prior payments. Refer to TR3 for usage requirements.**

SVD*MEDICARE*0*HC:A6252:A1**15~ **Use the SVD segment to report prior payments at the line. Populate SVD01 with value used in 2330B NM109 (MEDICAID, MEDICARE)**

CAS*PI*226*136.12~← **use line level CAS segments to report line reductions. Refer to TR3 for usage requirements. In this example, the Claim Adjustment Reason Code or CARC is used to provide additional details. PI = Payor Initiated Reduction, 226 = Information requested from the Billing/Rendering provider was not provided or not provided timely or was incomplete/insufficient.**

DTP*573*D8*20210401~
LX*2~
SV1*HC:A6446:A1*67.5*UN*60***1~
DTP*472*D8*20210126~

REF*6R* XXXXXXX-2~
HCP*10*27.6~
SVD*MEDICARE*0*HC:A6446:A1**60~
CAS*PI*226*67.5~
DTP*573*D8*20210401~
LX*3~
SV1*HC:A6454:A1*163.12*UN*75***1~
DTP*472*D8*20210126~
REF*6R* XXXXXXX-3~
HCP*10*68.25~
SVD*MEDICARE*0*HC:A6454:A1**75~
CAS*PI*226*163.12~
DTP*573*D8*20210401~
LX*4~
SV1*HC:A6196:A1*307.12*UN*15***1~
DTP*472*D8*20210126~
REF*6R* XXXXXXX-4~
HCP*10*128.55~
SVD*MEDICARE*0*HC:A6196:A1**15~
CAS*PI*226*307.12~
DTP*573*D8*20210401~

Palliative care

What is palliative care?

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not the prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

Is palliative care covered under the EAE D-SNP?

Yes, effective January 1, 2024, EAE D-SNP will cover palliative care services for dual eligible members.

General criteria:

- The member is likely to, or has started to, use the hospital or emergency department (ED) as a means to manage their advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
- The member has an advanced illness, with appropriate documentation of continued decline in health status and is not eligible for or declines hospice enrollment.

- The member's death within a year would not be unexpected based on clinical status.
- The member has either received appropriate member-desired medical therapy or is an individual for whom member-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
- The member and, if applicable, the family/member's designated support person agrees to:
    - Attempt, as medically/clinically appropriate, in-home, residential- based, or outpatient disease management/palliative care instead of first going to the ED; and
    - Participate in Advance Care Planning discussions.

Disease-specific criteria:
A member must also meet the general and disease-specific criteria of one of the four conditions below:

1. Advanced Cancer
2. Congestive Heart Failure (CHF)
3. Chronic Obstructive Pulmonary Disease (COPD)
4. Liver Disease

Refer to the *2024 CalAIM D-SNP Policy Guide* for more information regarding the disease specific criteria for palliative care eligibility.

What services are covered under palliative care for EAE D-SNP members?
At a minimum, palliative care includes the following seven services if medically necessary and reasonable for the member:

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Plan of Care
- Palliative Care Team
- Care Coordination
- Pain and Symptom Management
- Mental Health and Medical Social Services

Members and providers can contact Anthem for specific benefit questions and guidance on palliative care resources.

Pharmacy

What is the pharmacy billing information for Part D drugs?

EAE DSNP members will receive a new Member ID card, which will have a new Member number and a new Rx Group number. Using the new member ID number, the pharmacy will process 2023 Part D claims to:
BIN: 020115 PCN: IS
Rx Group: WM2A

What do EAE D-SNP members need to bring to the pharmacy?
At the pharmacy, members that are enrolled on the EAE D-SNP should give the pharmacist their Member ID card and the Medi-Cal plan ID card issued by the state.

What if the member does not have their member ID card with them at the pharmacy?
Pharmacies can look up the BIN, PCN, Rx Group, and Member ID by submitting an E-1 transaction to Relay Health.

An E1 transaction is a Medicare Eligibility Verification transaction intended to provide the status of a beneficiary's Medicare health plan covering the individual, along with details regarding primary and supplemental coverage if applicable.

The transaction is comprised of a request and a response. The pharmacy submits a request transaction that contains beneficiary demographic information, (see bulleted list below), that is sent in the E1 Request to the Transaction Facilitator. In the request the pharmacy submits the following beneficiary demographic information:

- Cardholder ID*
- Full Last Name
- Full First Name (optional)
- First Initial of First Name
- Date of Birth
- ZIP/Postal Code

If a Part D beneficiary match is found in the CMS Eligibility Database, the beneficiary's Part D plan information is returned along with any other health insurance coverage in the response to the pharmacy.

* Note: Valid Cardholder ID values for an E-1 Transaction include

- Medicare Beneficiary Identifier (MBI)
- Nine-digit Social Security Number (SSN)
- Last four digits of the Social Security Number (SSN) — match probability increases with submission of a full ID number

When should a pharmacy submit an E-1 transaction?
There are number of situations when a pharmacy may need to submit an E1:

1. A prescription is called into a pharmacy, the pharmacy has not filled a prescription for the patient before, and the patient would qualify for Medicare.

2. The pharmacy has filled prescriptions for the patient before and they have been covered by a commercial plan or by Medicare Part A, B, or D. However, those claims are not rejecting for the member as "not covered." If the patient is eligible for Medicare, the pharmacy should submit an E1 to see if there is other coverage.

3. The pharmacy is told by a patient that has Medicare Part D that they have other coverage, but the patient does not have the coverage information. By submitting an E1, if the other coverage is on file with CMS, the E1 will return the 4Rx (BIN, PCN, Group ID, Cardholder ID), for the other health insurance so that the pharmacy can submit a Coordination of Benefits (COB) supplemental claim.

4. If the patient comes to pick up a prescription and cannot provide evidence of Medicare enrollment, the pharmacy can submit an E1 to get plan information and other health insurance coverage.

Does the pharmacy need to use the member's Original Medicare Fee For Service (red, white and blue) card to process Part B prescriptions like Diabetic Supplies, Continuous Glucose Monitors, or Part B drugs such as immunosuppressants or nebulizing solutions?
No. Part B benefits are included in the EAE D-SNP.

How does the pharmacy process Part B prescriptions like Diabetic Supplies, Continuous Glucose Monitors, or Part B drugs such as immunosuppressants or nebulizing solutions?
EAE D-SNP members will receive a new Member ID card with a new Member number and a new Rx Group number. Using the Member ID number, the pharmacy will process 2023 Part B claims to:
BIN: 020115 PCN: IS
Rx Group: WM2A

Are there formulary changes for DSNP members who changed to the EAE D-SNP?
Yes. EAE DSNP members enrolled in the EAE D-SNP for 2024 will have a 5-tier formulary. Covered Part D drugs live on each of the five tiers (Preferred Generic, Generic, Preferred Brand, Non-Preferred Drug, and Specialty). Some drugs may be subject to utilization management edits such as Prior Authorization, Step Therapy, or Quantity Limits.

What are the Part B cost share changes for the EAE D-SNP?
There is a change in process for Part B cost shares. EAE DSNP members who enroll in the EAE D-SNP for 2024 will need to bring their Medi-Cal card issued by the state to the pharmacy.

The pharmacy will process Part B drugs to the EAE D-SNP for primary coverage. The pharmacy must then submit any Part B deductibles or cost shares to the Medi-Cal

plan ID card for secondary coverage. Members in the EAE D-SNP may not be balance billed Part B deductibles or cost shares.

Are there Part D copay changes for members enrolled on the EAE D-SNP?
Members will see no changes or a reduction in copays on the EAE D-SNP. The EAE D-SNP is participating the Value Based Insurance Design (VBID) model. Members enrolled in this plan are eligible for Extra Help and will have a $0 copay for covered Part D drugs for the benefit year. $0 also applies to Part D non-formulary drugs that transition or that are approved for coverage through an exception request.

Are non-Medicare drugs like Over the Counter (OTC) or Part D excluded drugs like vitamins, minerals, cough and cold, etc. covered on the EAE D-SNP?
EAE D-SNP members will need to bring their Medi-Cal card issued by the state to the pharmacy. The pharmacy will submit non-Part D and OTC drugs to the Medi-Cal plan.

Will members enrolled in the EAE D-SNP be eligible for transition fill (TF?)
Yes. For 2024 all members that are enrolled in the new EAE D-SNP will be eligible for TF.

How will TF work?
TF provided as defined by CMS Chapter 6 for: 1. new enrollees into prescription drug plans following the annual coordinated election period; 2. newly eligible Medicare beneficiaries from other coverage; 3. enrollees who switch from one plan to another after the start of the contract year; 4. current enrollees affected by negative formulary changes across contract years; and 5. enrollees residing in LTC facilities.

Part D drugs that are eligible for transition will process and pay upon initial submission and messages in the claim will indicate when claims have paid under transition fill (TF) rules. Pharmacies do not need to resubmit a TF Prior Authorization code for TF-eligible claims to adjudicate upon initial submission.

Part D drugs that transition eligible are typically 1. non-formulary or 2. have an edit, such as prior authorization, step therapy, or quantity limit.

How long will members be in transition?
Members will be in transition for the first 90 days following their enrollment effective date with the plan. During this time, members have access to up to a cumulative 30-day transition supply per transition eligible drug. For members in Long Term Care (LTC), they have access to up to a cumulative 34-day transition supply per transition eligible drug.

Are all drugs eligible for transition?
No. We apply edits for certain drugs during the transition period to prevent coverage of non-Part D drugs (for example, excluded drugs such as a drug that may be used for sexual dysfunction, or formulary drugs being dispensed for an indication that is not medically accepted, certain B vs. D drugs).

Part B drugs and non-Medicare drugs (OTC & Part D exclusions like vitamins, minerals,

erectile dysfunction drugs, cough and cold meds) are not eligible for transition.

Will members be notified if their drug transitions?
Yes. When a drug transitions for a member we send a letter to the member and the prescriber to notify them of the transition fill, why the transition occurred, and what the next steps for the prescriber and member are. Part D TF letters are mailed per CMS guidelines within 3 business days of the claim adjudication (excluding weekends and holidays).

Are Diabetic Supplies still covered?
Yes. EAE DSNP members that transition to the EAE D-SNP will have coverage of diabetic supplies and continuous glucose monitors (CGM). Refer to Chapter 4 of the Explanation of Coverage for details.

Sales and broker (for use during AEP)

Why is Anthem making changes to California's dual-eligible beneficiaries plans?
These changes are not specific to Anthem.

- The EAE D-SNP changes are required by CalAIM for all carriers.
- The change for non-EAE D-SNP limiting enrollment of new partial dual eligible members is required by DHCS for all carriers.
- The planned transitions for Anthem comply with these new guidelines, which are aimed at improving care integration and person-centered care for the highest-need enrollees.

When will members find out about these changes?

Impacted members will initially receive this information in the Annual Notice of Change (ANOC) kit, no later than September 30, 2023. ANOCs will also be available in the Member Portal. Members should carefully read their ANOC letter to learn about all plan and benefit changes.

- Welcome Kits and new Member ID cards will be mailed to all members changing plans beginning October 15. Materials in the new member Welcome Kit include:
- Plan Guide (which includes language as to how members can access Handbook, Formulary and Provider/Pharmacy directory online)
- Welcome message on inside front cover of Plan Guide
- Member ID card

Why should members stay in the new EAE D-SNP with Anthem?

When evaluating health insurance options, it's a good idea to look at several factors. We advise prospects and members to consider the company's experience, the services it provides and the benefit plans and value-added options it offers.

The member's current health plan, Anthem, will provide Medicare benefits through the aligned enrollment Anthem MediBlue Full Dual Advantage (HMO D-SNP) plan and work with its matching Medi-Cal plan to coordinate the member's Medi-Cal benefits. These plans work together to offer a network of providers and pharmacies that will provide Medicare and Medi-Cal services and Medicare Part D prescription drugs in one place.
Together these plans are called a Medicare-Medi-Cal Plan.

- Members will continue getting care as they do today from their current health plan and there will be no gap in coverage.
- Members will have a single health plan to help with all of their health care needs and will continue to coordinate benefits and care. This includes medical and home and community-based services. It also includes medical supplies and medications.
- The plan will include the doctor's members use now or help to find a new doctor with more options to choose from.
- Members will not pay a plan premium or deductible when they receive services from a provider in the health plan's provider network.
- Members will receive integrated member materials, such as one integrated Member ID Card, Annual Notice of Change (ANOC), List of Covered Drugs (LOCD), Provider & Pharmacy Directory (PPD) and Member Handbook.

Will full dual D-SNP members transition automatically, or will sales/brokers have to enroll in a new plan?
All members will be automatically transitioned to their new plan. There is no action that sales/brokers need to take.

What should members do if they have questions or want to change their plan?
Members can call Customer Service at the number on their member ID card for questions. During AEP Members who have questions can work with their agent to review all plan options.

Key terms/acronyms

SNP: Dual Special Needs Plans are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi- Cal and offer care coordination and wrap-around services. All D-SNPs have a contract with Medicare and the state Medicaid program.

EAE D-SNP: Exclusively Aligned Enrollment Dual Eligible Special Needs Plans. They offer an integrated approach to care and care coordination that is similar to Cal MediConnect. The aligned Medicare and Medi-Cal plans will work together to deliver care to their members.

Non-EAE D-SNP: How the CA DHCS refers to all Dual Eligible Special Needs Plans in the state of California that are not EAE D-SNPs.

DHCS: Department of Health Care Services

Dually eligible: Dually eligible individuals are enrolled in both Medicare and Medicaid/Medi-Cal.

Full Duals: Beneficiaries that qualify for full state Medicaid/Medi-Cal benefits as well as Medicare.

Partial Duals: Beneficiaries that qualify for a Medicare Savings Program (MSP), which are programs managed by Medicaid in each state. MSP covers certain Medicare costs, but beneficiaries do not receive full Medicaid benefits. Beneficiaries may qualify for D-SNP but will have some out-of-pockets costs. There are four eligibility categories for Partial Duals.

Medicare Medi-Cal Plans (MMPs or Medi-Medi plans): The California-specific program name for EAE D-SNPs is Medicare Medi-Cal Plans (MMPs or Medi-Medi plans). The goal of this branded program name is to describe the type of plan and differentiate EAE D-SNPs from Medi-Cal plans, regular Medicare Advantage plans, unaligned D-SNPs, or PACE products. DHCS will also use this name for Health Care Options (HCO) and on the DHCS website. While not required, DHCS recommends EAE D-SNPs leverage the naming convention.

Resources:
CalAIM D-SNP Policy Guide (2024)
CA DMHC Contract and Program Guide
D-SNP-Palliative-Care-Fact-Sheet
DHCS SB 1004 Medi-Cal Palliative Care November 2017