Dual Advantage
October 2020

Healthy Blue

# Louisiana 2021 Dual Advantage plan changes

## Annual benefit changes for Medicare Advantage plan members under Healthy Blue will be effective January 1, 2021.

The following is a summary of these changes. Complete details are in the member's Evidence of Coverage. Please visit **https://providers.healthybluela.com** and select **Healthy Blue Dual Advantage D-SNP**. Then, select **2020 Evidence of Coverage** under *D-SNP Benefits for Evidence of Coverage*, formularies and benefit summaries, or contact Provider Services at the number on the back of the member's ID card. Changes may include medical and Part D benefits, copays, coinsurance, deductibles, formulary coverage, pharmacy network, premiums and out-of-pocket maximums.

Some group-sponsored Medicare Advantage plan benefits vary from the Medicare Advantage plans offered to individuals. Please refer to the member's evidence of coverage or call Provider Services at the number on the member ID card for more benefit detail.

## 2021 highlights:

Not all benefits listed below are available to all Medicare Advantage members. Complete details are in the member's *Evidence of Coverage*.

### End-stage renal disease (ESRD)

Medicare beneficiaries with end-stage renal disease (ESRD) may enroll in all Medicare Advantage plans beginning January 1, 2021.

- Previously, ESRD beneficiaries could only obtain Medicare Advantage coverage under limited circumstances. With this new enrollment option, ESRD beneficiaries may select a Medicare Advantage plan during open enrollment, regardless of previous coverage.

### Acupuncture

Medicare coverage of acupuncture: Beneficiaries are covered for up to 12 visits in 90 days under the following circumstances (copays or coinsurance may apply):

- Chronic low back pain defined as:
  - Lasting 12 weeks or longer
  - Nonspecific, in that it has no identifiable systemic cause (for example, not associated with metastatic, inflammatory, infectious diseases, etc.)
  - Not associated with surgery
  - Not associated with pregnancy
- An additional eight sessions will be covered for members demonstrating improvement. No more than 20 acupuncture treatments may be administered annually.
- Treatment must be discontinued if the member does not improve or regresses.

* Tivity Health, Inc. is an independent company providing the SilverSneakers fitness program on behalf of Healthy Blue. CVS Pharmacy, Giant Eagle, Kroger, Target and Walmart are independent companies providing pharmacy services on behalf of Healthy Blue. Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

### Emergency World Wide Coverage

Emergency World Wide Coverage limit increases from $25,000 to $100,000.

## Essential Extras:

The Essential Extras package allows members to select one of the following benefits to help them achieve their health goals. These benefits may help your patients with meals, mobility and more. Prior authorization and/or recommendation from a licensed clinician may be required for some of these benefits. Members may choose one of the following benefits at enrollment or throughout the plan year. Members can request their selection through Customer Service. Because some benefits have an eligibility requirement, members are encouraged to consult their physician prior to their selection. On many plans, these benefits may be embedded as individual benefits. Please refer to the member's *Evidence of Coverage*.

### Personal home helper

This benefit provides in-home support for caregiver respite, home based chores and activities of daily living (ADL) to address needs while recovering from injury or illness. It covers up to four hours per day for 31 days or 124 hours of care in a calendar year. Prior authorization is required. Benefit levels may vary by plan.

### Transportation

Transportation to and from medical visits, SilverSneakers®* locations and pharmacy visits arecovered by this benefit. This benefit covers up to 60 one-way trips each calendar year. The service requires approval at least 48 hours in advance. Benefit levels may vary by plan.

### Assistive devices

This provides up to a $500 allowance toward the purchase of assistive or safety devices, such as toilet seats compliant with the *Americans with Disabilities Act* (*ADA*) standards, shower stools, hand-held shower heads, reaching devices, temporary wheelchair ramps and more. Benefit levels may vary by plan.

### Healthy meals

Members can receive meals to prevent, treat or avoid a health-related issue. Member must have a recent discharge and a BMI greater than 25, a BMI less than 18.5 or an HbA1C greater than 9.0. Nutritional assessment and prior authorization are required.

### Adult day center

This benefit includes one visit per week for up to eight hours. It also includes transportation to and from the adult day care location. To be eligible, the member must need help with at least two ADL, and a clinician must recommend the benefit. The member must submit a request for reimbursement for a plan-approved, licensed facility. The maximum reimbursement is $80 per day. Prior authorization is required.

### Health and fitness tracker

Members can receive a wearable health and fitness tracker to help them achieve their health goals. Members are eligible for one device every two years. This benefit also comes with access to online programs to improve their physical health and brain skills. These programs include fitness and health coaching, as well as exercises that can improve their attention, memory and navigation abilities.

### Healthy pantry

Members are eligible for monthly nutritional counseling sessions, plus monthly pantry staples (nonperishable) to help them make changes to their diet that would help a diagnosed chronic medical condition. This benefit is filed under CMS' guidelines for Special Supplemental Benefits for the Chronically Ill (SSBCI). Prior authorization is required.

**Pest control**
Based on qualifying clinical criteria, members could have their home treated every three months to control pests if an infestation is having a direct impact on a diagnosed chronic medical condition. This benefit is filed under CMS' guidelines for SSBCI. Prior authorization is required.

**Service dog support**
Members can get up to $500 per year to help pay for items used to care for their ADA service dog, like leashes or vests. This benefit is filed under CMS' guidelines for SSBCI. Prior authorization is required.

## Medicare Advantage HMO

One existing HMO will expand into the following areas in 2021:

| Expanding plans for 2021 | Counties |
|---|---|
| Healthy Blue Dual Advantage (HMO D SNP) | Allen, Avoyelles, Beauregard, Bienville, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Evangeline, Franklin, Grant, Jackson, Jefferson Davis, La Salle, Morehouse, Natchitoches, Ouachita, Plaquemines, Rapides, Red River, Richland, Sabine, St. Landry, Tensas, Union, Vermillion, Vernon, Winn |

## Formulary and pharmacy

| Formulary and pharmacy benefits for 2021 are as listed below: | |
|---|---|
| | **100-day prescription refills**<br>Members are eligible to receive up to a 100-day supply for tier six select care drugs. |

Please encourage your patients to review the 2021 formulary information within their *Annual Notice of Change* (*ANOC*) mailing, their new member kit or online. 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 needs.

Most individual MAPD plans have a pharmacy network that includes preferred and standard network retail pharmacies. **Our preferred pharmacies include CVS Pharmacy,* Giant Eagle,* Kroger,* Target,* Sam's Club* and Walmart*. Additional independent pharmacies have been added to the cost-sharing network for 2021.**

## Balance billing reminder

CMS and Healthy Blue do not allow you to balance bill most Medicare Advantage HMO, PPO, D-SNP, C-SNP or I-SNP members for Medicare-covered services. CMS provides 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. This also includes charges that are in dispute.

Members who are dually eligible may be protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. These dual eligibles include: Qualified Medicare Beneficiaries (QMB/QMB+) and other Full Benefit Dual Eligibles (FBDE) who have no Share of Cost (SOC). This protection includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in *The Balanced Budget Act of 1997*. Providers who serve dual eligible beneficiaries must accept as payment in full the amounts paid by Medicare, as well as any payment under the state Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as *private pay* in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

There are some dual-eligible Medicare Advantage members, including Specified Low-Income Medicare Beneficiary (SLMB/SLMB+), Qualified Individual (QI) and Qualified Disabled Working Individual (QDWI) Medicare Advantage members, where billing is appropriate. Providers should always validate Medicaid benefits for any additional coverage beyond Medicare to confirm the appropriateness of balance billing. Once confirmed, providers may balance bill Medicaid as a secondary payer then balance bill the member for the remaining balance. As reminder, you are not allowed to balance bill members for an amount greater than their cost share amount.

## Prior authorization for Medicare Advantage plans

Prior authorization requirements are available at **https://www.availity.com**. Contracted and noncontracted providers who are unable to access Availity* may call our Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Please check the member ID card for any identification and/or group number changes that may affect claim submissions. To view sample 2021member ID cards, go to **https://www.anthem.com/medicareprovider** and select your state. Member ID Card Samples may be viewed by selecting **Member ID Card Samples** under *Provider Guides & Forms*.

## Member enrollment receipts

The *Member Enrollment Receipt* is a document found at the end of member enrollment kits that allows the agent or broker to fill in Healthy Blue provider and agent information for the new member's reference. The receipt includes:

- Rx BIN, Rx PCN and Rx GRP numbers.
- Names, phone numbers and websites for ancillary benefit information like dental, vision and hearing.

The enrollment receipt does not contain a member ID, and we expect our plan members to continue to bring their plan ID cards to their provider visits. If a member arrives to an appointment without their plan ID card, please follow your standard procedure for validating enrollment in our plan.