Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

What you should know when serving dual-eligible Blues members

A dual-eligible member is one who qualifies for both Medicare and Medicaid. For dual-eligible Blues members, there are some things you'll need to know about billing, referral and clinical review processes and medications. Beginning Dec. 1, 2011, some of these individuals were enrolled in either Original Medicare, a BCN Advantage℠ product or BCBSM's Medicare Plus Blue℠ PPO as their primary plan and Blue Cross Complete of Michigan as their secondary plan.

Q&A about dual-eligible Blues members

- **QUESTION 1: Which plan is primary? Which is secondary?**

  For all dual-eligible Blues members, the Medicare plan — either Original Medicare, BCN Advantage or Medicare Plus Blue PPO — is always the primary plan. Blue Cross Complete is secondary.

- **QUESTION 2: What does the secondary plan cover?**

  As the secondary plan, Blue Cross Complete covers the copayments, coinsurances and deductible — the member's out-of-pocket expenses — that are not covered by the primary plan. In general, Blue Cross Complete pays the lesser of the member's liability under the primary plan or the amount Blue Cross Complete would have paid as the primary plan less any payments made by the Medicare primary plan. Providers must hold the member harmless for any remaining sums.

  Note: This applies to medical services. Blue Cross Complete does not pay copayments, coinsurances and deductible for Medicare-covered Part D (pharmacy) services.

- **QUESTION 3: What about billing? Which plan should we bill?**

  Always bill the primary plan — either Original Medicare, BCN Advantage or Medicare Plus Blue PPO.

- **QUESTION 4: What about billing the secondary plan when the primary plan is Original Medicare, BCN Advantage or Medicare Plus Blue PPO?**

  For members with primary coverage through Original Medicare, BCN Advantage or Medicare Plus Blue PPO, you should submit the claim to the primary plan first. Wait for the Remittance Advice, then bill Blue Cross Complete as the secondary plan. Be sure to include the Remittance Advice when billing Blue Cross Complete.

  Note: Effective Sept. 1, 2013, providers may not submit one bill to BCN Advantage and Blue Cross Complete, for members who are covered by both.

- **QUESTION 5: What if services are denied by the primary carrier or the primary carrier's benefits are exhausted?**

  If the dual-eligible member's primary carrier denies services or if the primary carrier's benefits are exhausted, Blue Cross Complete may be able to cover the services as the member's secondary carrier. That's why it's important for all providers to determine up front whether members have secondary coverage through Blue Cross Complete when their primary coverage is through Original Medicare or a Medicare Advantage plan. In addition, skilled nursing facilities and other facilities admitting a dual-eligible member should ensure prior to the admission that they are able to provide services for both Medicare and Medicaid members in case the member's Medicare days are exhausted and the member requires additional services that would need to be covered through the member's Medicaid benefits.

- **QUESTION 6: What about member cost-sharing?**

  Per federal regulations, providers who service dual-eligible members may not bill a member for cost-sharing amounts that exceed the cost-sharing amounts the member would be responsible for if he or she were not enrolled with BCN Advantage.

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Q&A about dual-eligible Blues members *(continued)*

- **QUESTION 7: What about Blue Cross Complete members who are eligible for Medicare but have not yet enrolled?**

  Eligible members should be encouraged to enroll in either Original Medicare or a Medicare Advantage product. For Blue Cross Complete members who are eligible for but not yet enrolled in either Original Medicare or a Medicare Advantage product, Blue Cross Complete may not cover the services that Medicare would normally cover or the copayments, coinsurances and deductible that would have been left for the member to pay after Medicare covered the services.

  Note: For additional information, see Section 2.6.A, Medicare Eligibility, in the Coordination of Benefits section of the Michigan Department of Community Health's *Medicaid Provider Manual*.

- **QUESTION 8: What about the member's primary care physician assignment? Won't dual-eligible members need a primary care physician when they enroll in Blue Cross Complete as their secondary plan?**

  When an individual is enrolled as a dual-eligible member, the Blue Cross Complete secondary plan selects a Blue Cross Complete-affiliated primary care physician and sends the member a notification letter. The primary care physician selected by Blue Cross Complete may or may not be the physician the member is used to seeing under the primary Medicare plan. Although Blue Cross Complete is required to identify a primary care physician for its records, dual-eligible members are not required to see the primary care physician selected. These members may continue to receive Medicare-covered services from their current physician.

- **QUESTION 9: Which plan oversees referrals and clinical reviews?**

  Follow the rules of the member's primary plan. Remember, Blue Cross Complete is always secondary and covers only the out-of-pocket expenses not covered by the member's primary plan.

- **QUESTION 10: What about medications? Which drug list (formulary) should we follow?**

  For dual-eligible members, consult the applicable Medicare Part D drug list first. If a medication is not covered under the Medicare plan's drug list, it may be covered under the Blue Cross Complete drug list, with the exception of some medications included in the *Medicaid Health Plan Carve-Out (Michigan Medicaid)* list, which can be accessed online. To access that list, go to **michigan.fhsc.com**. Under the Provider tab, click on *Drug Information*. Finally, click on **Medicaid Health Plan Carveout**. As a reminder, prescriptions for the carveout drugs are covered by the state of Michigan and must be processed through Magellan.

Background information

The Michigan Department of Community Health began moving dual-eligible enrollees to the private health plans in late 2011. The state's intention is to create one payment mechanism for these individuals and coordinate services more effectively. Members will be automatically enrolled by the state but will be able to opt out later.

The goal of this initiative is to make it easier to coordinate services for each member in line with a person-centered plan. The emphasis is on incorporating all normal Medicare and Medicaid services as well as using community and home-based service options. Particular concerns include long-term services and supports, behavioral health and developmental disability services, medical care, family caregiver involvement and increased sharing of data among providers via electronic health records.

For additional information

Additional information on this initiative is available through the **MDCH Bulletin MSA 11-37**, issued Oct. 1, 2011.