
Definitions

QMB+ means Qualified Medicare Beneficiary whose income is no more than 80% of the Federal Poverty Level and are considered a zero cost share dual eligible member since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

QMB means Qualified Medicare Beneficiary whose income is between 80% and 100% of the Federal Poverty Level and are considered a zero cost share dual eligible member since they are not responsible for paying their Part A or Part B cost sharing. These members are not eligible to have full Medicaid benefits.

SLMB+ means Specified Low-Income Medicare Beneficiary whose income is between 100% and 120% of the Federal Poverty Level and are considered a zero cost share dual eligible member since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

SLMB means Specified Low-Income Medicare Beneficiary whose income is between 100% and 120% of the Federal Poverty Level and are considered partial dual eligible members since they are responsible for paying their Part A and Part B cost sharing. These members are not eligible to have full Medicaid benefits.

QI means Qualifying Individual whose income is between 120% and 135% of the Federal Poverty Level are considered partial dual eligible members since they are responsible for paying their Part A and Part B cost sharing. These members are not eligible to have full Medicaid benefits.

QDWI means Qualified Disabled Working Individual whose income is between 135% and 200% of the Federal Poverty Level are considered partial dual eligible members since they are responsible for paying their Part A and Part B cost sharing. These members are not eligible to have full Medicaid benefits.

FBDE means Full Benefit Dual Eligible members who are eligible to have full Medicaid benefits (SLMB+ and QMB+)

Zero Cost Share Dual Eligible Member means a Dual Eligible Member that is not responsible for paying any Part A or Part B cost sharing.

Types of Dual Eligible Members

States provide Medical Savings Programs (MSP), which provide medical cost assistance to dual eligible members, and depending on the level of Medicaid eligibility, may provide coverage of Medicare Parts A and B Member Expenses. There are multiple MSP categories and the categories are based upon the beneficiary's income and asset levels as well as "medically needy" status. Members learn of their MSP from an award letter they receive from the Social Security Administration (SSA) and possibly through notification from the State Medicaid agency. See the chart below for the different categories of Dual Eligible members. (see chart below)

Medicare Savings Program (MSP) Assistance	FFS Part A Premium Covered?	FFS Part B Premium Covered?	Part A & B Cost Sharing Covered?	Full Medicaid Benefits Provided?
Qualified Medicare Beneficiary (QMB)	YES	YES	YES	NO
QMB Plus (QMB+)	YES	YES	YES	YES
Specified Low-Income Medicare Beneficiary (SLMB)	NO	YES	NO	NO
SLMB Plus (SLMB+)	NO	YES	YES	YES
Qualifying Individual (QI)	NO	YES	NO	NO
Qualified Disabled Working Individual (QDWI)	YES	NO	NO	NO
Full Benefit Dual Eligibles	YES	YES	YES	YES

QMB, QMB+, SLMB+ and FBDE beneficiaries are considered "zero cost share" dual eligibles since they pay no Part A or Part B Member Expenses.

Payment for Dual Eligible Member Expenses

For all Zero Cost Share Dual Eligible Members (QMB, QMB+, SLMB+ and FBDE) Providers acknowledge and agree that they shall not bill these members the balance of ("balance-bill") the Medicare Part A and B Member Expenses for which the State Medicaid Plan is

responsible for – regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider’s billed charges due to limitations on additional reimbursement provided in the State Medicaid plan. Provider agrees that it will accept Health Plan’s payment as payment in full or will bill the appropriate State source. If Health Plan has assumed the State’s financial responsibility under an agreement between Health Plan and the State, Health Plan shall be considered the “appropriate State source”.

Many State Medicaid Plans calculate their liability based upon “lesser of” logic. This means that if the State’s Medicaid fee schedule is less than the amount paid by Health Plan, then their liability for the services is \$0. In these instances the Provider will not balance bill the Zero Cost Share Dual Eligible Member for the Part A and Part B Member Expenses.

Referral of Dual Eligible Members

When a Participating Provider refers a Dual Eligible Member to another provider for services, the Provider should make every attempt to refer the Dual Eligible Member to a provider who participates with both the Plan and the State Medicaid agency. Providers who participate with the State Medicaid plan can be located at the applicable State’s Medicaid website.

Dual Eligible Members Who Lose Medicaid Eligibility/Status

CMS requires Dual Special Needs Plans to provide a period of time from 30 days to 6 months (the “Deeming Period”) to allow its Dual Eligible Members who have lost Medicaid or had a change in status and opportunity to regain Medicaid eligibility or status. A change in status means a beneficiary is no longer eligible for cost sharing protection for Medicare A and B covered services from the State but retains Medicaid eligibility. During the Deeming Period, Participating Providers are prohibited from balance billing beneficiaries for Medicare Part A and B Member Expenses, and must accept Plan’s payment as payment in full.

Dual Eligible State Specific Contract Obligations

MISSOURI
Provider agrees that in order to bill MO HealthNet for its financial obligations, the Provider shall be enrolled with MO HealthNet as a Medicaid provider.

<p>NEW YORK (LIBERTY AND ADVOCATE COMPLETE PRODUCTS)</p>
<p>Provider must accept payment received from the Plan for services included in the Combined Medicare Advantage and Medicaid Advantage benefit package as payment in full for services provided to enrollees. In the event the Plan does not reimburse for a service, Provider may not seek payment from State Department of Health, Local Departments of Social Services, Enrollees or person's acting on Enrollee's behalf.</p>
<p>OHIO</p>
<p>Providers may access the Ohio Administrative code at the following website: http://emanuals.odjfs.state.oh.us/emanuals/GetDocument.do?nodeId=%23node-id(297)&docId=Document(storage%3DREPOSITORY%2CdocID%3D%23node-id(730024))&locSource=input&docLoc=%24REP_ROOT%24%23node-id(730024)&version=8.0.0 and, the Ohio Medicaid Handbook at the following website: http://emanuals.odjfs.state.oh.us/emanuals/GetTocDescendants.do?nodeId=%23node-id(629)&maxChildrenInLevel=100&version=8.0.0</p>
<p>TEXAS</p>
<p>Providers may access a list of Health Plan's benefit offerings at the following website: http://www.wellcare.com/medicare_sb/texas. Information concerning Medicaid provider participation is available on the Health Plan's website at the following address: http://www.wellcare.com/medicare_eoc/texas, and the state's website at the following address: http://www.tmhp.com/OPL/providerManager/AdvSearch.aspx.</p>
<p>LOUISIANA</p>
<p>WellCare of Louisiana, Inc. Providers may access a list of the Health Plan's benefit offerings at the following website: http://www.wellcare.com/medicare_sb/louisiana. Information concerning Medicaid provider participation is available on the Health Plan's website:</p>

http://www.wellcare.com/medicare_eoc/louisiana, and the state's website:
<http://www.lamedicaid.com/provweb1/default.htm>.

GEORGIA

WellCare of Georgia, Inc. Providers may access a list of the Health Plan's benefit offerings at the following website:

http://www.wellcare.com/medicare_sb/georgia.

Information concerning Medicaid provider participation is available on the Health Plan's website:

http://www.wellcare.com/medicare_eoc/georgia and the state's website:
http://www.georgia.gov/00/channel_title/0,2094,314467_31944147,00.html.

DSNP Case Management Program

CMS and Plan contracted for Plan to provide comprehensive, cost-effective managed care health care services to Dual Eligible Members.

Overview

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was approved by Congress and became law in July of 2008. MIPPA mandates a health risk assessment, care plan, interdisciplinary care team for members, and evaluation of care effectiveness by the health plan.

Plan's Model of Care (MOC) is tailored specifically to the Dual Eligible Members in an effort to meet the populations' social, medical, and behavioral needs in a member centric fashion.

Health Risk Assessment: Conducted by Plan

Plan's Case Management MOC begins with the Health Risk Assessment (HRA). The HRA assesses member risk in the following areas: functional, psychosocial, and medical. Once completed, the HRA is stratified and reviewed by a DSNP Registered Nurse (RN) Case Manager. The stratification of the HRA is an indicator of the needs of the member and is verified with the Comprehensive Medical Assessment. WellCare utilizes four (4) levels of stratification starting with level 1 (low risk) and going to level 4 (high risk). The RN Case Manager outreaches to the Dual Eligible Member and

begins the Case Management process.

**Comprehensive
Medical
Assessment:
Conducted by
Plan**

The RN Case Manager telephonically conducts the Comprehensive Medical Assessment with the Dual Eligible Member and/or Caregiver, if appropriate, in order to collect additional social, medical, and behavioral information to generate a robust *member centric* Individualized Care Plan. The Comprehensive Medical Assessment is based on Clinical Guidelines and allows for the plan of care to be generated utilizing these guidelines.

**Individualized
Care Plans (ICP):
Generated by Plan**

Once the RN Case Manager and the Member/Caregiver complete the comprehensive medical assessment, an ICP is generated that reflects the members' specific problems, short and long-term goals, and interventions. The RN Case Manager and the Dual Eligible Member and/or Caregiver, if appropriate, agree on the Plan of Care and set goals. The ICP generated tracks dates and goal progress. The contact times will vary depending on the stratification of the member and specific goal timeframes. The ICP is shared with all members of the Interdisciplinary Care Team (ICT) for input and updates.

**Interdisciplinary
Care Team (ICT):
Plan and
Providers**

The RN Case Manager shares the ICP with all the members of the Interdisciplinary Care Team (ICT) in an effort to inform all those involved in the member's care and ensure that all are aware of the members' goals and current health status. The RN Case Manager communicates and coordinates with the members of the ICT (PCP, Specialists, Social Worker, etc.) to assist the member in navigating the health care system, education, and advocacy. The team provides the basis for meeting the goals of the ICP.

Provider Required Participation

To meet the intent of the MIPPA legislation providers are required to participate in the model of care for all DSNP plan members. The expectations for participation are as follows:

1. Review the member care plan faxed to you by the Plan case manager.
2. Update the care plan with any required changes and return to the Plan case manager at the

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number provided.

3. Participate in ICT for all DSNP members and give feedback as appropriate. A case manager will contact you regarding the date and time of such meetings.

The RN Case Manager will communicate with the members of the ICT for any updates to the ICP and will be available to assist the Dual Eligible Member to meet the goals of the ICP.

Re-cap of the benefits of the DSNP Case Management Program:

- All Members are outreached for a Health Risk Assessment.
- Members are stratified according to the severity of their disease process, functional ability and psychosocial needs.
- Comprehensive Medical Assessment is completed by RN Case Manager and is the basis for the Individualized Care Plan.
- Individualized Care Plan generated by RN Case Manager in collaboration with the member and Care Team.
- Sharing of Individualized Care Plan with Providers for review and comments as needed.
- Continued monitoring, education, coordination of care and member advocacy by RN Case Manager.
- Providers receive Clinical Practice Guidelines based on nationally-recognized evidence-based guidelines.
- Providers receive newsletters that feature articles regarding the latest treatments for patients.