GOVERNMENT PROGRAMS COMPLIANCE OFFICER NEWSLETTER

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HEALTH CARE SERVICE CORPORATION

Message from Kim Green
HCSC Government Programs Compliance Officer

Welcome to the fourth quarter newsletter!

Over the past year, you probably have been hearing a lot about how HCSC has been expanding its presence in the government market place. In this edition, we are going to examine what that means especially as it relates to Medicare and Medicaid products. We are going to illustrate the government product landscape for 2014 and the various products that will be offered. A glossary defining the various Medicare and Medicaid products is also included.

I hope that you find this information helpful. If you would like additional information about Medicare and Medicaid, please refer to www.cms.gov, www.medicare.gov or www.medicaid.gov.

As always, please remember that you are required to report any suspicious behavior or potential wrongdoing related to any government contract. All calls to our hotline can be made anonymously and without fear of intimidation or retaliation.

Our Medicare and Fraud hotline numbers and email address are also included in this newsletter so that you may contact us should you have any questions or concerns. I would also like to encourage you to visit our website and submit any general questions or news items that you would like to hear about in future newsletters. Our website is www.hisccompliance.com and our email address is HISCCOMPLIANCE@BCBSIL.COM.

As 2013 comes to a close, I want to wish you and your family a Happy Holiday Season and all the best in the New Year!

Kim Green

HCSC Government Programs Compliance Officer

In this issue

Medicare Compliance Issues?

Contact HCSC Medicare Hotline 1.877.211.2290

Your 24/7 resource for questions about Medicare Part D or MAPD

2014 Products by State

Medicare Products*	HCSC States				
	IL	TX	OK	NM	MT
Blue Cross Medicare Advantage Basic (HMO)	x		x	x	
Blue Cross Medicare Advantage Value (HMO)				x	
Blue Cross Medicare Advantage Basic Plus (POS)	x				
Blue Cross Medicare Advantage Premier (HMO)				x	
Blue Cross Medicare Advantage Premier Plus (HMO-POS)	x		x	x	
Blue Cross Medicare Advantage Choice (PPO)			x	x	
Blue Cross Medicare Advantage Choice Plus (PPO)		x			x
Blue Cross Medicare Advantage Choice Premier (PPO)		x			x
Blue Cross Medicare Advantage Dual Care (HMO DSNP)				x	
Blue Cross Medicare Rx Basic (PDP)	x	x	x	x	x
Blue Cross Medicare Rx Value (PDP)	x	x	x	x	
Blue Cross Medicare Rx Plus (PDP)	x	x	x	x	x

Medicaid Products*	HCSC States				
	IL	TX	OK	NM	MT
Centennial Care				x	
Texas Star & CHIP		x			
Medicare-Medicaid Alignment Initiative (MMAI)	x				
Integrated Care Program (ICP)	x				
Long Term Services & Supports (LTSS)	x				

*Information current as of 12/2013

Glossary

Medicare: Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Original Medicare (Part A and Part B): Original Medicare is fee-for-service coverage under which the government pays health care providers directly for member's Part A and/or Part B benefits.

Medicare Part A (Hospital Insurance): Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance): Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Health Plan: A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Part C (Medicare Advantage (MA) Plan): A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If the person is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. Medicare Advantage Plans may offer extra coverage like vision, hearing, dental, and/or health and wellness programs. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans (MAPD).

Medicare Part D (Medicare Prescription Drug Coverage): An optional prescription drug benefit available to all people with Medicare for an additional charge. These plans (sometimes called "PDPs") adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. Medicare Part D is offered by insurance companies and other private companies approved by Medicare.

Medicare Advantage Prescription Drug (MAPD) Plan: A Medicare Advantage Plan (Part C) that offers Medicare prescription drug coverage (Part D), Part A, and Part B benefits in one plan.

Medicare Preferred Provider Organization (PPO) Plan: A type of Medicare Advantage Plan (Part C) in which the member pays less if the member use doctors, hospitals, and other health care providers that belong to the plan's network. The member can use doctors, hospitals, and providers outside of the network for an additional cost***.***

Medicare Health Maintenance Organization (HMO) Plan: A type of Medicare Advantage Plan (Part C) in which the member can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Most HMOs also require the member to obtain a referral from the member's primary care physician***.***

Medicare Health Maintenance Organization with a point-of-service option (HMO-POS): A type of Medicare Advantage Plan (Part C) that provides a more flexible network by allowing members to use out-of-network healthcare without referral for certain situations or treatments. The member will pay additional fees for these services and the plan may limit use.

Medicare Special Needs Plan (SNP): A special type of Medicare Advantage Plan (Part C) that provides all Medicare Part A and Part B health care and services to people who can benefit the most from things like special care for chronic illnesses, care management of multiple diseases, and focused care management. These plans may limit membership to people:

- in certain institutions (like a nursing home),
- eligible for both Medicare and Medicaid, or with certain chronic or disabling conditions.

Medicare Dual Eligible Special Needs Plan (DSNP): Dual eligible special needs plans enroll beneficiaries who are entitled to both Medicare and Medicaid. DSNP offer the members the opportunity for enhanced benefits by combining those available through Medicare and Medicaid.

Medicaid: A joint federal and state program that helps with medical costs for some people with limited income and resources.

Medicaid Health Plan: A plan offered by a private company that is similar to HMO plans where the company agrees to provide most Medicaid benefits to people in exchange for a monthly payment from the state.

Medicare Medicaid Alignment Initiative (MMAI): CMS (Federal Government) & HFS (Illinois Government) administer MMAI. Medicare and Medicaid benefits are administered jointly so that dual eligible members can experience health coverage as an single integrated program. MMAI establishes a single point of accountability for the delivery and coordination of primary, acute, behavioral health and long term care services and supports (LTSS).

Eligibility requirements:

- Age 21 and older at the time of enrollment; Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits; and enrolled in the Medicaid Aid to the Aged, Blind, and Disabled (AABD) category of assistance.
- Individuals including those with End Stage Renal Disease (ESRD).
- Individuals in LTSS waiver programs for the elderly, persons with disabilities, HIV/AIDS, brain injury and supportive living are also eligible.

Long Terms Services & Supports (LTSS)/ Waiver Programs**:** The Medicaid statute also authorizes a number of "waiver" programs through which states can get approval from the Centers for Medicare and Medicaid Services (CMS) to waive certain requirements when providing certain services or serving certain populations.

- There are two main waiver programs states can use to provide community-based long-term services and supports: Home and Community-Based Services (HCBS) waivers and demonstration waivers. LTSS services provided through these waivers are subject to the particular rules associated with each program, and any general Medicaid Act requirements that haven't been explicitly waived by CMS.

- LTSS services are services that help older adults and people with disabilities manage chronic conditions, as well as accomplish everyday tasks such as bathing, getting dressed, fixing meals, or managing a home. LTSS services include residential care in facilities like nursing homes. But they also include home and community-based service options (HCBS) such as home health care, personal care assistance, adult day care and homemaker services that help meet peoples' needs without institutional placement.

Integrated Care Program (ICP)

The Integrated Care Program is a program for older adults and adults with disabilities who are eligible for Medicaid but not eligible for Medicare. The Integrated Care Program brings together local primary care providers (PCPs), specialists, hospitals, nursing homes and other providers to organize care around a patient's needs. The program's intent is to keep enrollees healthy through coordinated medical care and as a result prevent unnecessary healthcare costs.

Integrated Care Program members have:

- Choices of doctors, specialists and hospitals;
- Better coordination of care, as members work with a team of providers to give them the best possible healthcare;
- Control of managing their healthcare needs, and;
- Additional programs and services to help them live a more independent and healthy life.

Eligibility requirements:

- Age 19 and older.
- Non-Medicare eligible older adults and adults with disabilities receiving Medicaid including Long Terms Support & services (LTSS)/ waiver programs.

Visit our website:

www.hisccompliance.com

Fraud Hotline: Available 24/7

Report fraud issues anonymously

1-800-543-0867 – for Members

1-877-272-9741 – for Producers, Vendors & Providers

1-877-211-2290 – for Employees

If you have any news or questions that you would like included in the newsletter, please send an email to:

HISCCOMPLIANCE @ BCBSIL.COM