2025 Medicare Advantage California EAE D-SNP Fact Sheet

California | Anthem Blue Cross | Medicare Advantage

Overview

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

Anthem will offer Full Dual Eligible beneficiaries Exclusively Aligned Enrolled Dual Eligible Special Needs Plans (EAE D-SNP) in the following counties for 2025:

County	2025 contract-PBP-segment	2025 plan name
Fresno Kings Los Angeles Madera Sacramento Santa Clara Tulare	H4471-001-000	Anthem Full Dual Advantage Aligned (HMO D-SNP)

Member communications and service

Annual Notice of Change (ANOC) kits: Mailed to **All members** yearly in September announcing changes to plan, premium, service area, and benefits covered for the next plan year. ANOCs must be in home by September of each year. 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 new members beginning October 15. Materials in the new member Welcome Kit include:

- Plan Guide (explains how members can access Handbook, Formulary and Provider/Pharmacy directory online)
- Welcome message on inside front cover of Plan Guide
- Member ID Card

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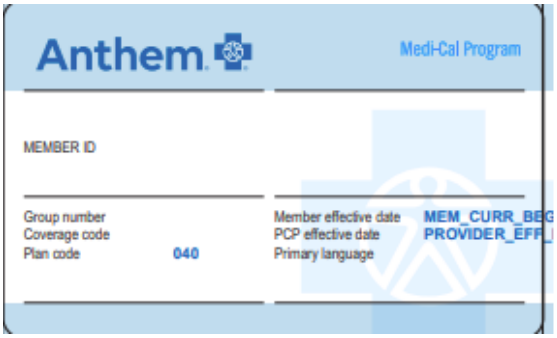

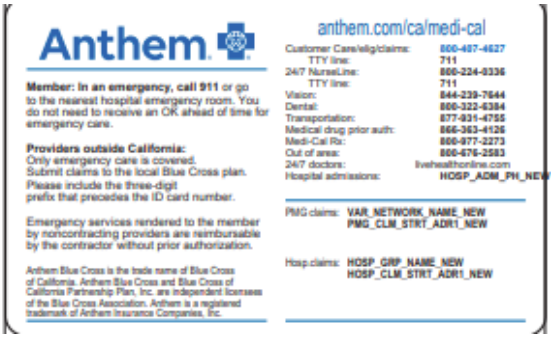

Exclusively aligned enrollment (EAE) D-SNP product FAQs

What Is exclusively aligned enrollment (EAE)?
Under exclusively aligned enrollment (EAE), members enroll in a dual eligible special needs plan (D-SNP) for Medicare benefits and in a Medicare Advantage managed care plan for Medicare Advantage benefits, which are both operated by the same health plan for better care coordination and integration.

Enrollment into the EAE D-SNP will result in the member's Medicare Advantage plan changing to the same parent organization's Medicare Advantage plan as their Medicare coverage.

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

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 Medicare Advantage plans will work together to deliver care to their members. This means members only need to contact one source for their health plan needs.
- All members in the plan are enrolled in the aligned Medicare Advantage Managed Care Plan (MCP) so they can receive integrated member materials, such as one integrated member ID card.
- Members who select an EAE D-SNP plan are eligible for additional benefits with this plan which include Long-Term Services and Supports (LTSS) services, Community Supports (CS) and (CBAS) Community Based Adult Services. For these additional LTSS, CS, and CBAS services, the provider would need to coordinate with Anthem for authorization.
- Due to the integrated nature of this plan, claims processing will be synchronized, meaning a single claim submission for Medicare and Medicaid by the rendering provider. A separate claim submission is not required for the Medicaid services.

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

	Anthem EAE D-SNP 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. Newly enrolled members to the health plan in CY 2025 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 a member who loses "full dual" eligibility and becomes a "partial dual" eligible?** Members will be put into the 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 deeming period. Members should contact customer service at the number on the back of their ID card for additional help. **What happens when a beneficiary applies for enrollment into an exclusively aligned enrollment (EAE) D-SNP?** Enrollment in the exclusively aligned enrollment D-SNP will trigger the Department of Health Care Services to reassign the member's Medicare Advantage plan to the same parent organization. No action is needed by the beneficiary. **Will partial dual eligible beneficiaries be able to enroll in an EAE D-SNP?** No, only full benefit dual eligible beneficiaries will be able to enroll in an exclusively aligned enrollment D-SNP.
Provider/network	**Where is the EAE D-SNP provider directory located?** The provider directory is available online or by calling customer service at the number on the back of the member's ID card. **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. Providers should contact Anthem for authorization of Long-term Services and Supports (LTSS), Community-Based Adult Services (CBAS), and

Community Supports (CS) services and access to supplemental benefits such as routine hearing, dental, vision, podiatry, and transportation. Groups are responsible for issuing all other authorizations for Medicare and Medicaid covered services, directing to group or Anthem contracted networks as applicable for services outlined on the DOFR. For more detail, please review the "Integrated UM review" section of this communication.

What services require prior authorizations?
For authorization of LTSS/CBAS/CS, and supplemental benefits such as routine hearing, dental, vision, and transportation, members should be directed to Anthem using their single Medicare Member ID (including alpha prefix). PMGs and IPAs are responsible for review and issuing authorizations for other Medicare and Medicaid covered services. Members should be directed to the group or Anthem contracted networks as applicable for services outlined on the DOFR. For more details, please review the "Integrated UM review" section of this communication.

Participating providers should follow the prior authorization list used by Anthem, which can be located on provider website
https://www.anthem.com/ca/provider/prior-authorization/

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

How should claims or encounters be billed for the EAE D-SNP?
Claims for Medicare or Medicaid services administered under Anthem should be submitted through Availity using the Payor ID and the single Medicare ID number including the alpha prefix. See Section, "Encounter Submissions Using an 837 – How to Report Prior Payment Information," below for details.

What are reimbursement rates for the EAE D-SNP?
PMGs should refer to their provider contract for specific reimbursement information related to CA EAE D-SNP.

For hospitals and ancillary providers, reimbursement is the same as the other Medicare Advantage networks for which they are contracted.

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

How do EAE members get access to LTSS, CS, and CBAS services?
Eligible members requiring Long Term Services and Supports (LTSS), Community Supports (CS), and Community Based Adult Services (CBAS) should be connected

to Anthem for confirmation of eligibility and health plan authorization to contracted providers. Submission of a Treatment Authorization Request (TAR) may be necessary.

Will Anthem provide Model of Care training for the 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. Model of Care training can be found in Medicare Advantage Training & Resources or we have provided the link here: Model of Care Training. Please note Model of Care training is not complete until the provider attestation is completed and submitted to our plan.

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

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

Why are Admission, Discharge and Transfer (ADT) notifications required?
Facilities are required to send Admission, Discharge and Transfer (ADT) notification to a member's Medicaid plan in order to help identify and address member needs at time of facility admission, discharge, and transfer.

What is expected of a provider when it comes to members receiving behavioral health treatment?
EAE D-SNP members have mental health benefits beyond the normal Medicare covered benefits. Once a member exhausts their Medicare covered benefits, members would use their Medicare Advantage 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 Medicare Advantage benefits with the relevant behavioral health program for their county

https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx

Fresno	800-654-3937	https://www.fresnocountyca.gov/Departments/Behavioral-Health
Kings	800-655-2553	http://www.kcbh.org/
Los Angeles	800-854-7771	https://dmh.lacounty.gov/
Madera	888-275-9779	https://www.maderacounty.com/government/behavioral-health-services
Sacramento	888-881-4881	https://dhs.saccounty.gov/BHS/Pages/BHS-Home.aspx
Santa Clara	800-704-0900	https://bhsd.santaclaracounty.gov/home
Tulare	800-320-1616	https://tchhsa.org/eng/behavioral-health/

	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. 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 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 group in the EAE D-SNP, you are responsible for authorizations and coordination of the member's DSNP benefits and Medicaid only benefits. Incontinence supplies EAE members have coverage for incontinence supplies through their Medicaid benefits. Delegated groups are responsible for authorizing these supplies. The member should not be using over the counter (OTC) benefits or paying out of pocket. Referrals should be to contracted vendors as delineated in the DOFR and billed using the member's Anthem I am running a few minutes late; my previous meeting is running over. issued EAE Medicare ID number with alpha prefix. DME Medicare and Medicaid coverage for certain items and services (such as wheelchairs, bed products, at home blood pressure monitors, orthotics/routine podiatry care) may differ. Determinations should be performed referencing both Medicare and Medicaid criteria. (https://www.dhcs.ca.gov/services/Documents/MMP-DME-Provider-Factsheet.pdf) Per CMS regulation

(https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.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 (https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.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 citing both Medicare & Medicaid criteria* • 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, partially denied)	Approve and deny	• CDL citing both applicable criteria* • 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 Anthem folder at the following link: https://www.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: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx > D-SNP Policy Guide)].
- 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.

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. **Resources:** https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf Applicable Integrated Plan Coverage Decision Letter instructions: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-10716 https://www.cms.gov/medicare-coverage-database/search.aspx DHCS Medical Provider Publications: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications DHCS Medicare Non-Covered Service CPT Codes https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/6B724B76-FE3C-4C5D-9F16-44301101CD64/medinoncpt.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO https://www.dhcs.ca.gov/services/Documents/Dental-Benefits-Provider-Fact-Sheet.pdf https://www.dhcs.ca.gov/services/Documents/MMP-DME-Provider-Factsheet.pdf
Care coordination	Member care management, as well as coordination across Medicare and Medicare Advantage benefits, is a primary function of D-SNPs. The D-SNP is responsible for coordinating with the Medicare Advantage Plan and ensuring care managers are exchanging information to update the Member's care plan and engage providers in care plan development and care team meetings. Group and physician collaboration and participation in care planning and meetings is critical. • Health plan social services staff serving as liaisons for the long-term services and supports (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. Requests can also be emailed to [DualReferrals@anthem.com]. • Providers are encouraged to reference the Dementia Care Aware website and associated resources, available here: https://www.dementiacareaware.org/ • DHCS D-SNP reference information: https://www.dhcs.ca.gov/services/Pages/Integrated-Care-for-Dual-Eligible-Beneficiaries.aspx • View Anthem's [2025] member benefits on our provider website at https://www.anthem.com/ca/medicareprovider.]

Encounter submissions 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
- Below example is from an 837p, similar loops, segments & data elements apply to 837I.
- 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.

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~
NM1*PR*2*ANTHEM*****PI*{AGEMCD, AGEMCR, WGEVLM}~ Use the payer ID as instructed by your our parent company.

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

LOOP ID – 2320 - OTHER SUBSCRIBER INFORMATION - Use the Coordination of Benefits Loop to send your prior payment details. Include a 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.

SBR*P*18**{DELEGATE NAME}*****{MA, MB, MC}~ 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 MC = Medicaid

AMT*D*0~ Include Claim Level Prior Payment Amount
OI***Y***I~

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
NM1*PR*2*{DELEGATE OR PAYER NAME}*****PI*{MEDICAID, MEDICARE}~ Use to identify the Name of the Delegated Vendor/Prior Payer. Choose the value for NM109 that corresponds to 2320 SBR09 value used above.

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, e.g. reductions, prior payments. Refer to TR3 for usage requirements.

SVD*MEDICAID*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 provide 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*MEDICAID*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*MEDICAID*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*MEDICAID*0*HC:A6196:A1**15~ CAS*PI*226*307.12~ DTP*573*D8*20210401~ SE*68*XXXXXX~
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. **What is the provider's role in palliative care for EAE D-SNP members?** As a participating provider in EAE D-SNP, you are responsible for ensuring member access to palliative care benefits when the criteria are met. Collaborating with Anthem, providers should do the following: • Ensure PMGs/IPAs have contracts with palliative care providers within their network to ensure adequate coverage for EAE D-SNP members • Identifying eligible EAE members and assess medical necessity when delegated for utilization management • Provide inpatient and outpatient/community-based palliative care referrals for EAE D-SNP members • Coordinate the palliative care services

Is palliative care covered under the EAE D-SNP?
Yes, EAE D-SNP covers palliative care services for dual eligible members. Participating provider groups should ensure their members have access to a contracted provider in their network for services.

What are the criteria for palliative care referrals for EAE D-SNP members?

General Criteria

- The member is likely to, or has started to, use the hospital or emergency department (ED) 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:
    1. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the ED; and
    2. 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 2025 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 or access more information at: D-SNP-Palliative-Care-Fact-Sheet. Additional resources: DHCS SB 1004 Medi-Cal Palliative Care November 2017
Pharmacy	**What is the pharmacy billing information for Part D drugs?** EAE DSNP members will receive a Member ID card, which will have a Member number and a Rx Group number. Using the member ID number including the alpha prefix, the pharmacy will process 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 who are enrolled on the EAE D-SNP should give the pharmacist their Medicare Member ID card and the Medicare Advantage 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 a 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 who 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 Member ID card with a member number and a Rx Group number. Using the Member ID number, the pharmacy will process Part B claims referencing the BIN, PCN, and Rx Group numbers.
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 present both their Anthem and their Medicare Advantage Medicaid card issued by the state to the pharmacy. The pharmacy will submit non-Part D and OTC drugs to the Medicare Advantage plan.

Key terms/ Acronyms

AIP: Applicable Integrated Plan

ANOC: Medicare plan “Annual Notice of Change" (ANOC). The ANOC includes any changes in coverage, costs, and more that will be effective in January.

CalAIM: California Advancing and Innovating Medicare Advantage

CBAS: Community-Based Adult Services: A Medicare Advantage program offering daytime health services to older adults and adults with disabilities, aiming to support their independence and helping to delay or prevent institutionalization.

CS: Community Supports: A menu of 14 non-clinical, optional, cost-effective services offered at the option of the Medicare Advantage that members can substitute for covered Medicare Advantage services and support members who qualify to live or stay in their homes.

CCI: The Coordinated Care Initiative (CCI) is a program that changed the way certain people in California get their health care and their long-term services and supports (LTSS). Members must reside in these counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

D-SNP: Dual Special Needs Plans are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medicare Advantage 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-Medi Connect. The aligned Medicare and Medicare Advantage 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/Medicare Advantage.

Full Duals: Beneficiaries that qualify for full state Medicaid/Medicare Advantage 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-pocket costs. There are 4 eligibility categories for Partial Duals.

LTSS: Long-Term Services and Supports: Includes services that help individuals with chronic illnesses or disabilities with daily activities. These services support

daily activities, such as bathing and eating, and can be delivered in homes, communities, or care facilities like nursing homes.

Medicare Advantage Plans (MMPs or Medi-Medi plans): The California-specific program name for EAE D-SNPs is Medicare Advantage 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 Medicare Advantage 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

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To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the left or via our online form: **http://anthem.ly/signup-abc-ca.**