



What you should know when serving dual-eligible Blue Cross Complete members

A dual-eligible member is one who qualifies for both Medicare and Medicaid. Dual-eligible members are those enrolled in Original Medicare, BCN AdvantageSM HMO-POS (Basic, Elements, Classic or Prestige option), BCN AdvantageSM HMO ConnectedCare, BCN AdvantageSM HMO MyChoice Wellness or Medicare Plus Blue PPOSM as their primary plan and Blue Cross Complete as their secondary plan.

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

For dual-eligible members, the Medicare plan — 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, coinsurance 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 services rendered.

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?**

When billing for dual-eligible members (those members with either Original Medicare, BCN Advantage or Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), providers should always bill the primary plan.

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

For members' 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.

- **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 Medicare Advantage plan. In addition, 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.

- **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.

- **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 (those members with Original Medicare, BCN Advantage or Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), providers should consult the applicable Medicare Part D formulary first.

If a medication is not covered under the Medicare plan's formulary, it may be covered under the Blue Cross Complete formulary, with the exception of some medications included in the Medicaid Health Plan Carve-Out (Michigan Medicaid) list.

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.