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6.1 Blue Shield Medicare Advantage Plan Program Overview

Introduction

Sections 1 through 5 of this provider manual contain information that may be applicable to Blue Shield Commercial Plans, Blue Shield Medicare Advantage plans (Individual and Group product)[1], and Blue Shield Medicare prescription drug plans (PDP Individual and Group product). In those instances where information or a process is different for Blue Shield Medicare Advantage plan members and Blue Shield Medicare prescription drug plan (PDP) members, you are referred to this section for more details.

This section contains information applicable only to Blue Shield IPA/medical groups that are contracted to provide benefits for Blue Shield Medicare Advantage plan members. It includes a general overview of the plan and administrative activities unique to delivering care to these Medicare Advantage members.

Blue Shield Medicare Advantage Plan Program Overview

The Medicare Prescription Drug Improvement and Modernization Act (MMA) introduced the Medicare Advantage Program and the Prescription Drug Benefit. The prescription drug benefit, as well as an employer subsidy for qualified retiree health plans, is referred to as Medicare Part D. Coverage for the drug benefit is being provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage plans that offer both prescription drug and health care coverage (known as Medicare Advantage - Prescriptions Drug (MA-PD) plans.

Blue Shield Medicare Advantage plans that are open to all Medicare beneficiaries, including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefits, who meet all of the applicable eligibility requirements for membership, have voluntarily elected to enroll in a Blue Shield Medicare Advantage plan, have paid any premiums required for initial enrollment to be valid, and whose enrollment in a Blue Shield Medicare Advantage plan has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare Advantage plan is offered to individual Medicare beneficiaries and to group Medicare beneficiaries retired from employer groups/unions who have selected the product as an option. Blue Shield also offers a Dual Eligible Special Needs Plan (D-SNP) for those members who are fully eligible for both Medicare and Medi-Cal.

The Blue Shield Medicare Advantage plan provides comprehensive coordinated medical services to members through an established provider network. Similar to the commercial HMO product, Blue Shield Medicare Advantage plan members must choose a primary care physician (PCP) and have all care coordinated through this physician. The Blue Shield Medicare Advantage plan is regulated by CMS, the same federal agency that administers Medicare.

[1] When the manual references Blue Shield Medicare Advantage plan, it refers to Blue Shield's Medicare Advantage-Prescription Drug plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Inspire (HMO) and Blue Shield Vital (HMO).

6.1 Blue Shield Medicare Advantage Plan Program Overview

Blue Shield Medicare Advantage Plan Service Areas

The definition of a service area, as described in the Blue Shield Medicare Advantage plan *Evidence of Coverage* (EOC), is the geographic area approved by the CMS in which a person must permanently reside to be able to become or remain a member of a Blue Shield Medicare Advantage plan. The Blue Shield Medicare Advantage plan has multiple service areas within the state. The specific service area in which the member permanently resides determines the Blue Shield Medicare Advantage plan(s) in which the member may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area. Members who temporarily move outside of the service area (as defined by CMS as six months or less) are eligible to receive emergency care and urgently needed services outside the service area. There are different service areas for Individual Blue Shield Medicare Advantage plan and Group Blue Shield Medicare Advantage plan, as follows:

Individual Blue Shield Medicare Advantage Plan Service Areas

Alameda County	San Diego County
Kern County	San Luis Obispo County
Los Angeles County	San Joaquin County
Merced County	San Mateo County
Orange County	Santa Barbara County
Riverside County	Santa Clara County
San Bernardino County	Stanislaus County

Group Blue Shield Medicare Advantage Plan Service Areas

Alameda County	San Diego County
Contra Costa County (partial county coverage)	San Francisco County
Kern County	San Joaquin County
Los Angeles County	San Luis Obispo County
Merced County	San Mateo County
Nevada County (partial county coverage)	Santa Barbara County (partial county coverage)
Orange County	Santa Clara County
Riverside County	Santa Cruz County
San Bernardino County	Stanislaus County

Blue Shield Medicare Advantage Plan Service Areas *(cont'd.)*

Dual Eligible Special Needs Plan (D-SNP) Service Areas

Los Angeles County	San Diego County
Merced County	San Joaquin County
Orange County	Stanislaus County
San Bernardino County	

Blue Shield Medicare Advantage Plan Provider Network

Most Blue Shield Medicare Advantage plan IPA/medical groups participate in the Blue Shield commercial HMO provider network. However, some contracted IPA/medical groups are strictly Blue Shield Medicare Advantage plan providers. The Blue Shield Medicare Advantage plan group plan offers more service area coverage than the Blue Shield Medicare Advantage plan individual plan; therefore, providers in some areas are only providing coverage to group members at this time.

The requirements for provider participation in the Blue Shield Medicare Advantage plan network are generally the same as those for the commercial HMO provider network. All First-Tier, Downstream, and Related Entities (FDRs) contracts must contain all CMS-required contract provisions.

Medicare Part D Prescriber Preclusion List

The Centers for Medicare & Medicaid Services (CMS) compiles a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program; or (c) Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.

CMS makes the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement began on January 1, 2019.

Medicare Part D Prescriber Preclusion List *(cont'd.)*

Additionally, the added provisions require organizations offering Part D to cover a three-month provisional supply of the drug and provide beneficiaries with individualized written notice before denying a Part D claim or beneficiary request for reimbursement on the basis of a prescriber's being neither enrolled in an approved status nor validly opted out. The three-month provisional supply is intended to give the prescriber time to enroll in Medicare or opt-out and ensure beneficiary access to prescribed medication.

Blue Shield Medicare Advantage Plan Compliance Program

The Medicare Modernization Act (MMA) established the Medicare Advantage (MA) Program, building on the prior compliance requirements for health plans contracted under the Medicare program. The MMA added Medicare Part D and new coverage for prescription drugs and continued to build on the program integrity provisions in the Balanced Budget Act of 1997. Medicare Advantage Organizations and Part D Sponsors are required by CMS to possess a compliance program through which the organization establishes and maintains compliance with all federal and state standards. Moreover, provisions in the Affordable Care Act (ACA) require that the compliance program be "effective" in preventing and correcting non-compliance with Medicare Program requirements and fraud, waste, and abuse.

The compliance program must include:

- Written policies, procedures, and standards of conduct
- Compliance Officer, Compliance Committee, and high-level oversight
- Effective training and education
- Effective lines of communication
- Well publicized disciplinary actions
- Effective system for routine monitoring, auditing, and identification of compliance risks
- Procedures and system for prompt response to compliance issues

Blue Shield has a Corporate Compliance Program in place that includes four primary components:

- Model policies for employee, officer, and director conduct
- Code of business conduct
- Toll-free hotline for reporting actual or suspected violations
- Special investigations team for fraud and abuse reviews

Blue Shield Medicare Advantage Plan Compliance Program *(cont'd.)*

All the components in our Corporate Compliance Program are supported by our company values. Blue Shield's values include doing the right thing, placing customers at the center of what we do, keeping promises, being creative and taking risks, creating an environment that promotes personal, professional, and team fulfillment, and being responsible for maintaining Blue Shield's heritage. Leadership principles reinforce our organizational commitment to our company values.

While the existing Corporate Compliance Program remains the foundation for our organizational compliance, a separate compliance structure was established for the Medicare Advantage Program and the Medicare Part D Programs. Medicare Compliance is supported by a dedicated team. Under the oversight of Blue Shield's Vice President, Chief Compliance & Ethics Officer, the Medicare Compliance Department manages communication with CMS and the Blue Shield operating departments regarding the Medicare plans. A dedicated team headed by the Medicare Compliance Officer advises about CMS requirements and monitors compliance within the organization and in relation to Blue Shield's representatives in the community. The Medicare Compliance Officer leads the day-to-day operations of the Medicare Compliance function and reports directly to the VP, Chief Compliance & Ethics Officer, who provides direct and periodic reports to Blue Shield's Board of Directors (Audit Committee), the company's Chief Executive Officer (CEO) and senior management on relevant Medicare Compliance and other Corporate Compliance issues, as appropriate. The Medicare Compliance Department builds on components of our Corporate Compliance Program and Code of Conduct, and the work of the Privacy Office, which is responsible for the oversight of Blue Shield's compliance with state and federal privacy laws, including the privacy components of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

The Medicare Compliance Officer chairs the Plan's Medicare Compliance Committee, which has representation from all areas of the company that touch the Medicare programs. The Committee serves as the forum for program direction and oversight relative to operating requirements, performance measures and the definition and implementation of effective corrective actions, when indicated.

Blue Shield Medicare Advantage Plan Compliance Program *(cont'd.)*

The Medicare Compliance Committee, and Medicare Compliance Department staff, as well as the Blue Shield team of internal auditors, validates the continuing compliant operations of functional areas within the company and the compliant performance of contractors and agents through:

- Monitoring, auditing performance, and regulatory compliance.
- Auditing of delegated and downstream providers' compliant execution responsibilities.
- Monitoring of corrective actions imposed by internal and external entities.
- Training and education of employees, temporary employees, and contracted providers and agents in Medicare program requirements and Blue Shield policies on privacy, compliance, fraud, waste, and abuse detection and reporting.
- Tracking of changes in CMS requirements and educating operating units, accordingly.
- Verifying current written policies and procedures.
- Tracking and submission of required certifications and reporting to CMS.

The Medicare Compliance Program sets the framework for our oversight vision and processes and lays out monitoring programs and activities relative to our overall compliance with CMS regulatory requirements. It is our expectation that the Medicare Compliance Program will not only enable Blue Shield to meet increasing CMS requirements, but also to improve the quality of care and service provided to our Medicare Advantage and Medicare Part D members. The overall compliance structure incorporates the Code of Conduct and the Compliance Program to promote ethical behavior, equal opportunity, and anonymity in reporting of any improprieties within the Medicare product or elsewhere within the organization.

Blue Shield has and enforces a strict non-retaliation policy for reporting actual or suspected legal, policy or Code violations, or any other misconduct, in good faith. Key compliance indicators or benchmarks, as well as concerns raised through internal and external monitoring activities, are reviewed by the Medicare Compliance Committee to help proactively identify potential issues and facilitate internal corrective actions or policy changes, as indicated. These elements of the Blue Shield Medicare Compliance Program provide examples of policies and programs that providers might wish to establish within their own organizations.

Blue Shield Medicare Advantage Plan Compliance Program *(cont'd.)*

Auditing and Monitoring

Blue Shield has various departments, e.g., Provider Claims Compliance and Delegation Oversight, that audit first-tier entities for compliance with CMS Program requirements. However, IPAs and medical groups are tasked with the oversight and audit of the entities with which they contract to ensure compliance with Medicare Program requirements. Upon request, IPAs and medical groups must provide the results of the monitoring and auditing of their downstream entities.

Confirmation of Eligibility of Participation in the Medicare Program

The Office of the Inspector General (OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, 1156, and 1892. The OIG and the General Services Administration (GSA) maintain sanction lists that identifies those individuals and entities found guilty of fraudulent billing, misrepresentation of credentials, etc. Delegated entities managing Medicare members are responsible for checking the sanction lists at minimum on a monthly basis to ensure their Board of Directors, owners or employees are not on the list. The delegated entity, its MSO, or any sub-delegates are prohibited from hiring, continuing to employ, or contracting with individuals named on the OIG List of Excluded Individuals and Entities (LEIE) and the GSA Excluded Parties Lists System (EPLS).

See the links below for the LEIE and EPLS:

- https://oig.hhs.gov/exclusions/index.asp
- https://www.sam.gov/portal/SAM

Upon audit, IPAs and medical groups must provide evidence that they are checking their employees, temporary workers, and Board of Directors against the excluded provider databases upon hire, contracting, or election to the Board, and monthly thereafter.

Fraud, Waste, and Abuse

The Medicare Prescription Drug benefit was implemented by CMS to allow all Medicare beneficiaries access to prescription drug coverage. In its effort to combat fraud in the Medicare prescription drug program, CMS has added several Medicare Drug Integrity Contractors (MEDICs). In California, the MEDIC is Qlarant Integrity Solutions, LLC. Qlarant Integrity Solutions, LLC is responsible for monitoring fraud, waste, or abuse in the Medicare Part C and Part D programs on a national level.

Qlarant Integrity Solutions, LLC has been authorized by CMS to monitor Medicare fraud, waste, and abuse and to investigate any beneficiary complaints related to Medicare Part C and Part D benefits.

Blue Shield Medicare Advantage Plan Compliance Program *(cont'd.)*

Fraud, Waste, and Abuse *(cont'd.)*

Qlarant Integrity Solutions, LLC is interested in receiving reports of potential fraud, waste, or abuse from Medicare beneficiaries. Examples of these types of complaints may include:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks the beneficiary for their Medicare or Social Security number, bank account number, credit card number, money, etc.
    - Someone asks the beneficiary to sell their Medicare prescription ID card.
    - Someone asks the beneficiary to get drugs or medical services for them using their Medicare ID card.
- The beneficiary feels a Medicare Advantage or standalone Part D plan has discriminated against them, including not letting them sign up for a specific plan because of their age, health, race, religion, or income.
    - The beneficiary was encouraged to disenroll from their current health plan.
    - The beneficiary was offered cash to sign up for a Medicare Advantage or standalone Part D plan.
    - The beneficiary was offered a gift worth more than $15 to sign up for a Medicare Advantage or Part D plan.
    - The beneficiary's pharmacy did not give them all of their drugs.
    - The beneficiary was billed for drugs or medical services that he/she did not receive.
    - The beneficiary believes that he/she has been charged more than once for their premium costs.
    - The beneficiary's Medicare Advantage or standalone Part D plan did not pay for covered drugs or services.
    - The beneficiary received a different Part D drug than their doctor ordered.

Medicare beneficiaries should contact Qlarant Integrity Solutions, LLC at (877) 772-3379 to report complaints about any of these types of fraud, waste, and abuse issues or a related complaint. Qlarant Integrity Solutions, LLC may also be contacted by fax at (410) 819-8698 or on their website at qlarant.com Reports may also be submitted anonymously directly to Blue Shield's Special Investigations Unit at (855) 296-9092 or the Medicare Compliance Department at (855) 296-9084. For information on Fraud Prevention, Special Investigations, and Provider Reporting, please refer to Section 1.1 of this manual.

Blue Shield Medicare Advantage Plan Compliance Program *(cont'd.)*

Medicare Compliance and Fraud, Waste, and Abuse Training Requirements

Blue Shield has a comprehensive program in place to detect, prevent and control Medicare Fraud, Waste, and Abuse (FWA) as part of the General Compliance Plan Requirements (42 C.F.R. § 423.504(b)(4)(vi)(H)) and 42 C.F.R. § 422.503(b)(4)(vi).

Blue Shield requires all FDRs, including but not limited to IPAs, medical groups, providers, independent sales agents, third party marketing organizations (TMOs), and contracted pharmacies who work works with the Medicare Program that they successfully complete a fraud waste and abuse (FWA) training. This training should focus on how to detect, correct, and prevent non-compliance and fraud, waste, and abuse surrounding Medicare programs.

All FDRs must ensure that all personnel, Board members, employees and contracted staff involved in the administration or delivery of Medicare benefits complete an FWA training, alternative equivalent training through another Medicare Plan Sponsor, the CMS web-based Compliance and FWA training, or deemed through enrollment into the Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier.

This requirement applies to all personnel, employees, and contracted staff. Evidence of training must be maintained for a minimum of ten (10) years and produced upon request for audit purposes. Training must be completed within 90 days of hire or election to the Board and annually thereafter.

A statement of attestation is required annually by all IPAs, medical groups, and network pharmacies contracted with Blue Shield for the Medicare programs. The compliance statement of attestation indicates that the IPA, medical group or pharmacy staff and downstream providers have completed the Medicare Compliance and Fraud, Waste, and Abuse training, equivalent training from another Plan Sponsor, or the CMS web-based compliance and FWA training accessed at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

Blue Shield Medicare Advantage Plan Compliance Program *(cont'd.)*

Model of Care

In compliance with CMS requirements, Blue Shield has developed a specific model of care (MOC) to help address the complex health care needs of members enrolled in the dual eligible special needs plan (D-SNP). Blue Shield's MOC is a written document that describes Blue Shield's responsibilities, the IPA/medical group's responsibilities, and reporting requirements.

The program also includes training for Blue Shield's employees, Blue Shield's provider network, the IPA/medical group employees, and downstream providers. The training can be face-to-face; interactive (e.g., web-based, audio/video conference), or self-study (e.g., printed materials, electronic media). A statement of attestation is required annually by all IPAs/medical groups contracted with Blue Shield for the D-SNP. The compliance statement of attestation indicates that the IPA/medical group, staff, and downstream providers have completed the D-SNP training. To access the MOC training and complete your annual attestation, please go to blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/snp-model-of-care.

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

Blue Shield Medicare Advantage Plan Benefits

Blue Shield Medicare Advantage individual and group plans provide all the inpatient and outpatient care covered by Medicare Parts A and B services, Medicare Part D prescription drug coverage, plus additional benefits not covered by Medicare, such as routine vision care. Blue Shield has submitted a formulary to the Centers for Medicare & Medicaid Services (CMS) for the Part D benefit.

Like other Blue Shield HMO plans, the Blue Shield Medicare Advantage individual and group plans emphasize health promotion and offer a health improvement program for Blue Shield Medicare Advantage plan members that includes health risk assessment, information and assistance services, health education, and a variety of wellness resources. Blue Shield Medicare Advantage plan individual and group members also have direct access to certain preventive services, including annual mammograms and influenza vaccinations.

Blue Shield Medicare Advantage plan benefits vary by service area. Blue Shield Medicare Advantage group plans include base level plans and benefits filed with CMS and include copay and co-insurance ranges, buy-ups/optional benefits, and services which allow for a wide range of flexibility to closely match an employer group/union's current active or other Medicare Advantage-Prescription Drug plan offering.

Blue Shield provides each IPA/medical group with a copy of the Summary of Benefits for Blue Shield Medicare Advantage plan individual members. Providers also may contact Blue Shield Medicare Advantage Customer Care Services to confirm eligibility and benefits at (877) 654-6500 (for Providers), (800) 776-4466 (for Members) [TTY 711].

Blue Shield files benefits with CMS on an annual basis. The benefits for contract year 2024 are effective January 1, 2024 through December 31, 2024 for individual Blue Shield MA-PD and PDP plans only. A base level benefit plan is filed with CMS for group Blue Shield MA-PD and PDP plans. Custom benefit plans are then developed and built off the "base" plan filed with CMS. These custom benefit plans are effective for the entire group contract year which can run on a calendar basis (January 1, 2024 through December 31, 2024) or on an off-calendar basis (for example, July 1, 2023 through June 30, 2024).

Medicare Part D Covered Drug

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k) (2) (A) (ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k) (6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act.

Blue Shield Medicare Advantage Plan Benefits *(cont'd)*

Medicare Part D Covered Drug *(cont'd.)*

The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In essence, if the drug is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. CMS' understanding that the practice of "brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members.

The following drug categories are covered by Medicare Part B and therefore excluded from Part D:

1. Any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., injectable chemotherapy); or
2. Any injectable or infusible drug that there exists a safety concern such that it would go against accepted medical practice for a particular injectable or infusible to be dispensed directly to a patient based on medical literature.

In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D establishes that the administration fee of a Medicare Part D vaccine is to be considered part of the Part D vaccine cost.

Medication Therapy Management Program

As part of the Medicare Part D coverage, Blue Shield provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The Blue Shield MTMP is for members meeting all of the following criteria:

- Have two of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
  - Chronic Obstructive Pulmonary Disease (COPD)
- Receive seven or more different covered Part D maintenance medications monthly.
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions.

Blue Shield Medicare Advantage Plan Benefits *(cont'd)*

Medication Therapy Management Program *(cont'd.)*

Members meeting these criteria will be automatically enrolled in the MTMP at no additional cost relating to the program and they may opt out if they desire.

MTMP members will have the option to speak with a designated pharmacist to discuss their medication therapy issues. The pharmacist consultations are designed to improve member health while controlling out-of-pocket costs and may include topics such as:

- Drug adverse reactions
- Drug side-effects
- Drug-drug interactions
- Drug-disease interactions
- Medication non-compliance and non-adherence
- Duplicate therapy
- Dosing that can be consolidated
- Non-prescription drug use

A written summary of the consultation, with relevant assessments and recommendations, will be provided to the member. The member's prescribing physician or primary care physician may be contacted by the pharmacist to coordinate care or recommend therapy changes when necessary.

Premiums and Copayments or Coinsurance

Medicare Premiums

All Blue Shield Medicare Advantage plan members (individual and group) must continue paying their Medicare Part B premium. The Medicare Part B premium is either deducted from their monthly Social Security or Railroad Retirement Board annuity check or is paid directly to Medicare by the member or someone on his/her behalf (i.e., the Medi-Cal program).

The Affordable Care Act requires Part D enrollees with higher income levels to pay a monthly adjustment amount, the Part D Income Related Monthly Adjustment Amount (IRMAA). This IRMAA applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. Part D IRMAA is paid directly to the government and, like the Part B premium, may be deducted from the monthly Social Security or Railroad Retirement Board annuity check or paid directly to Medicare by the member or someone on his/her behalf.

Failure to pay either the Medicare Part B premium or Part D IRMAA will result in the member being involuntarily disenrolled from Blue Shield's Medicare Advantage plan, both individual and group.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Premiums and Copayments or Coinsurance *(cont'd.)*

Plan Premiums

For the 2024 contract year, some of the Blue Shield Medicare Advantage individual plans have a monthly plan premium. Please refer to the *Blue Shield Medicare Advantage Plan Individual Summary of Benefits* for additional plan premium information.

For the 2024 contract year, the monthly plan premium for Blue Shield Medicare Advantage group plans are determined through an actuarial-based pricing process and model which Underwriting uses to develop the rates. Plan premiums vary by employer group.

Copayments or Coinsurance

Blue Shield Medicare Advantage plan members must pay a copayment or coinsurance for certain services. Please refer to the *Blue Shield Medicare Advantage Plan Individual or Group Summary of Benefits* for additional copayment or coinsurance information.

Pharmacy Copayments or Coinsurance

Copayment or coinsurance amounts vary by the Blue Shield Medicare Advantage individual or group plan, as well as by the tier placement of the covered medication and whether the member obtains the medications from a network pharmacy with preferred cost-sharing, an out-of-network pharmacy, a network pharmacy with standard cost-sharing, or the mail service pharmacy.

Inpatient Benefits

Blue Shield Medicare Advantage individual and group plans provide benefits for treatment in hospitals and skilled nursing facilities (SNFs) and extend the basic benefits provided by Medicare. Blue Shield Medicare Advantage individual and group plans provide coverage according to Medicare guidelines, if the member's Blue Shield Medicare Advantage plan primary care physician (PCP) authorizes care at a Blue Shield Medicare Advantage plan hospital.

In addition to hospital care, Blue Shield Medicare Advantage plan individual and group members who meet Medicare guidelines for skilled nursing facility care have coverage for SNF benefits. Please refer to the *Blue Shield Medicare Advantage Plan Summary of Benefits* for the number of days covered for care provided by a skilled nursing facility.

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Outpatient Benefits

Blue Shield Medicare Advantage individual and group plans cover all outpatient medical services according to Medicare guidelines. Outpatient medical services are provided and paid for the diagnosis or treatment of illness and injury when they are considered to be reasonable and medically necessary. Please refer to the *Blue Shield Medicare Advantage Plan Summary of Benefits* (sent separately to IPA/medical groups) for a list of covered outpatient services.

For Medicare Medi-Cal Dual Eligible Special Needs Plans (D-SNP) Participants, please refer to Blue Shield's Medicare Prior Authorization List located on Provider Connection at blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization list* for Blue Shield, for services that require prior authorization under Medicare. View the Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal Prior Authorization List at blueshieldca.com/en/bsp/providers under *Clinical policies, procedures and guidelines,* then *View prior authorization list* for services that require prior authorization under Medi-Cal. The lists are updated monthly.

Outpatient Prescription Drugs

Blue Shield Medicare Advantage individual and group plans provide coverage for plan-approved generic and brand name prescription medications included in the Blue Shield Medicare Advantage Plan Drug Formulary. The formulary may vary by plan, by plan service area, or by employer group. The formulary for group plan members includes some drugs that are "excluded" drugs per CMS. The employer groups may choose to cover some of these excluded drugs as part of their additional supplemental coverage. The Blue Shield Medicare Advantage plan benefit for Outpatient Prescription Drug coverage can be found on Provider Connection at blueshieldca.com/provider under *Authorizations, Clinical policies and guidelines*, and then *Drug formularies & policies*. Some formulary medications may require prior authorization. Prescriptions from non-plan providers are covered only if issued in conjunction with covered emergency services and filled through a network pharmacy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which are subject to a rigorous clinical review by clinical pharmacists and physicians to evaluate comparative safety, comparative efficacy, likelihood of clinical impact, cost-effectiveness when safety and efficacy are similar. The Pharmacy & Therapeutics (P&T) Committee makes formulary decisions and medication coverage policies consistent with the currently accepted medical evidence and standards. The Blue Shield P&T Committee has oversight responsibility for pharmaceutical/utilization management programs, drug utilization review programs, and other drug-related matters impacting patient care. The voting members of the P&T Committee include practicing network physicians and clinical pharmacists who are not employees of Blue Shield.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Outpatient Prescription Drugs *(cont'd.)*

The P&T Committee approves formulary status and medication coverage policies for drugs covered in the prescription benefit on at least a quarterly basis.

In general, outpatient prescription drugs are covered under Blue Shield Medicare Advantage plan when they are:

- Included in the Blue Shield Medicare Advantage Plan Drug Formulary. (Blue Shield may periodically add, remove and/or make changes to coverage limitations on certain drugs, or alter the member price of a drug. If Blue Shield implements a formulary change that limits member ability to fill a prescription, Blue Shield will notify affected enrollees in advance of the change.)
- Prescribed by a provider (a doctor, dentist, or other prescriber) who either accepts Medicare or has filed documentation with CMS showing that he or she is qualified to write prescriptions.
- Filled at a Blue Shield Medicare Advantage plan network pharmacy.
- Used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information*; the *DRUGDEX Information System*; and for cancer the *National Comprehensive Cancer Network, Clinical Pharmacology*, *Lexi-Drugs,* or their successors.

Network Retail Pharmacy – A pharmacy where members can get their prescription drug benefits. They are termed "network pharmacies" because they contract with our plan. In most cases, member prescriptions are covered only if they are filled at one of our network pharmacies.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs that members get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs

If a drug is not listed in the Blue Shield Medicare Advantage plan individual or group drug formulary, the prescriber or member may contact Blue Shield Medicare Advantage Member Services to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Medicare Advantage plan individual or group drug formulary and not covered, the member has two options:

- The member can ask the prescriber to prescribe a different drug, one that is part of the Blue Shield Medicare Advantage plan individual or group drug formulary.
- The prescriber on behalf of the member can request that Blue Shield make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

If a member recently joined Blue Shield and is taking a drug not listed in the Blue Shield Medicare Advantage Plan Drug Formulary at the time he/she joined, the member may be eligible to obtain a temporary supply. For more information, please refer to the next section, which reviews the rules that govern dispensing temporary supplies of a non-formulary drug.

Transition Policy

New Blue Shield members may be taking drugs not listed in the Blue Shield Medicare Advantage plan individual or group drug formulary, or the drug(s) may be subject to certain restrictions, such as prior authorization or step therapy. Members are encouraged to talk to their doctors to decide if they should switch to an appropriate drug in the plan formulary or request a Formulary Exception (a type of Coverage Determination) in order to obtain coverage for the drug. While these new members may discuss the appropriate course of action with their doctors, Blue Shield may also cover the non-formulary drug or drug with a coverage restriction in certain cases during the first 90 days of new membership.

For each of the drugs not listed in the formulary or that have coverage restrictions or limits, Blue Shield will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a Network Pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, Blue Shield will not pay for these drugs, even if the new member has been enrolled for less than 90 days.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Transition Policy *(cont'd.)*

If a member is a resident of a long-term-care facility (LTC) such as a nursing home, Blue Shield will cover supplies of Part D drugs for one month (unless the prescription is written for fewer days) during the first 90 days a new member is enrolled in our Plan beginning on the member's effective date of coverage. A transition supply notice will be sent to the member within 3 business days of the first incremental transition fill. If the LTC resident has been enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions, such as step therapy or dosage limits, Blue Shield will cover a temporary one-month emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

To request a Formulary Exception (a type of Coverage Determination), Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above via a prior authorization request.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours for an expedited review and 72 hours for standard requests.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Vision Services

Blue Shield Medicare Advantage individual and group plans cover vision services that meet Medicare guidelines.

In addition to Medicare-covered services, all Blue Shield Medicare Advantage individual and some group plans cover routine (non-Medicare covered) eye examinations/screenings and provide an allowance toward the coverage eyewear. For individual and group plans, services are provided through VSP. Refer to the *Blue Shield Medicare Advantage Plan Summary of Benefits* for benefit guidelines.

Note: The IPA/medical group has no financial responsibility for these services.

Hearing Services

Blue Shield Medicare Advantage individual and group plans cover hearing exams in accordance with Medicare guidelines. Members should get a referral from their PCP to go to a Blue Shield Medicare Advantage plan provider. Please refer to the member's *Blue Shield Medicare Advantage Plan Summary of Benefits* for additional information. For select plans, hearing aid examinations and fittings are covered. Depending on the plan, the member may have the choice to go to a provider of their choosing or must go to a network provider with EPIC Hearing Healthcare.

Optional Buy-Up Services (Group Members Only)

Blue Shield Medicare Advantage plan also offers optional buy-up benefits for hearing, vision, podiatry, chiropractic, and acupuncture that offer routine coverage beyond what is covered by Medicare. In addition, Silver Sneakers Fitness is available. These benefits are not part of the standard plan offering and may be available at an additional cost when selected by the employer group/union. If purchased, they must be made available to all Blue Shield Medicare Advantage plan GMAPD members within that employer group/union. (There are also optional buy-up dental plans being offered to Blue Shield Medicare Advantage individual plan members.)

Note: The IPA/medical group has no financial responsibility for these services.

National Medicare Coverage Determinations

For Blue Shield Medicare HMO and PPO Members, Blue Shield follows Medicare national and local coverage determination. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. A NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.

National Medicare Coverage Determinations that arise between contract years allow Medicare Advantage Organizations and contracted providers to bill Medicare on a fee-for-service basis for newly covered items that exceed the significant cost criterion.

When the significant cost criterion is not met:

- The MAO is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date of the NCD or as of the date specified in the legislation/regulation.

When the significant cost criterion is met:

- The MAO is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. However, a plan must pay for the following:
    - Diagnostic services related to the NCD item, service, or legislative change in benefits and most follow-up services related to the NCD item, service, or legislative change (42 CFR § 422.109(c)(2)(i), (ii));
    - NCD items, services, or legislative change in benefits that are already included in the plan's benefit package either as Original Medicare benefits or supplemental benefits.

Billing to Medicare must include a notice that the item being billed involves a new coverage issue and that the person or organization submitting the bill is requesting fee-for-service reimbursement.

For more information on NCDs, go to the Medicare Coverage Database on the CMS.gov website at www.cms.gov/medicare-coverage-database/search.aspx.

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

Exclusions to Blue Shield Medicare Advantage Plan Benefits

General Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. Coverage for the following benefits, services, and conditions are **excluded** from coverage under the Blue Shield Medicare Advantage plan, effective January 1, 2024:

- Services considered not reasonable and necessary according to the standards of Original Medicare unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.

  Note: This determination is to be based on current National (NCD) or Local Coverage Determinations (LCD). National guidelines from a recognized specialty society or governmental body or health plan policy can be applied if the member's individual circumstances are supported by literature referenced in the guidelines or policy. National guidelines from a recognized specialty society or governmental body or health plan policy are appropriately used to support a medically appropriate decision if the member's individual circumstances are consistent with the literature cited in the guidelines or policy.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in a member's hospital room or a skilled nursing facility room, such as a telephone or a television.

Exclusions to Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

General Benefit Exclusions *(cont'd.)*

- Full-time nursing care in the member's home.
- Custodial care unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps members with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by the member's immediate relatives or members of their household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, unless specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled.
- Unless the member has enrolled in the optional supplemental dental HMO or PPO benefit, routine dental care, such as cleanings, fillings, or dentures, unless specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled. Non-routine dental care received at a hospital may be covered.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines or as specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled.
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids, unless specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and low vision aids unless specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled.

Exclusions to Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

General Benefit Exclusions *(cont'd.)*

- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Routine acupuncture, except for chronic low back pain, unless specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, Blue Shield will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Immunizations for foreign travel purposes.

The plan will not cover the excluded services listed above. Even if members receive the services at an emergency facility, the excluded services are still not covered.

For D-SNP members, for services that require a prior authorization, new CMS, DHCS and DMHC guidelines will require shared and full-risk IPAs to ensure their internal processes support the new regulation. This means that some IPAs will need to work with Blue Shield and Blue Shield Promise somewhat differently. Blue Shield of California and their delegates will consider both Medicare and Medi-Cal coverage criteria as an integrated organization determination. Please see Prior Authorization Lists below.

Please refer to Blue Shield's Medicare Prior Authorization List located on Provider Connection at blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization list* for Blue Shield, for services that require prior authorization under Medicare. View the Blue Shield Promise Medi-Cal Prior Authorization List at blueshieldca.com/en/bsp/providers under *Clinical policies, procedures and guidelines,* then *View prior authorization list* for services that require prior authorization under Medi-Cal. The lists are updated monthly.

Exclusions to Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Prescription Drug Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. The following exclusions apply to the Blue Shield Medicare Advantage plan prescription drug benefits:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. This includes any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., chemotherapy and supportive/adjunctive injectable drugs), any drug that is administered to the member or dispensed within the four walls of a provider's office or facility, or any drug Blue Shield has determined, based on medical literature, there exist safety concerns such that it would go against accepted medical practice for a particular injectable or infusible drug to be dispensed directly to a patient.
- Drugs purchased outside the United States and its territories are not covered.
- Off-label use of prescription drugs is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information,* the *DRUGDEX Information System*, and for cancer the *National Comprehensive Cancer Network and Clinical Pharmacology,* and *Lexi-Drugs* or their successors. If the use is not supported by one of these reference sources, then our plan cannot cover its "off-label use."
- By law, the following categories of drugs are not covered by Medicare drug plans:
    - Non-prescription drugs (also called over-the-counter drugs)
    - Drugs related to assisted reproductive technology (ART)
    - Drugs when used for the relief of cough or cold symptoms
    - Drugs when used for cosmetic purposes or to promote hair growth
    - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
    - Drugs when used for the treatment of sexual or erectile dysfunction (ED) unless offered as supplemental coverage as specified by your plan

Exclusions to Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Prescription Drug Benefit Exclusions *(cont'd.)*

- Drugs that are prescribed for medically accepted indications approved by the FDA other than sexual or erectile dysfunction (such as pulmonary hypertension) are eligible for Part D coverage. However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off-label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information and DRUGDEX® Information System
- Drugs when used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

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6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Blue Shield Medicare Advantage Plan Eligibility Criteria

To be eligible for participation in the Blue Shield Medicare Advantage plan Individual or Group program, a person must have Medicare Part A and Part B, and permanently live within the Blue Shield Medicare Advantage plan service area (either Individual or Group). Patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, or who have ongoing dialysis, are not eligible to join Blue Shield Medicare Advantage plan unless they are already a Blue Shield commercial plan member and are in their 30-month coordination period or were previously enrolled with another Medicare Advantage HMO that has subsequently withdrawn from the county. Once a kidney transplant has occurred and the individual no longer needs dialysis, he or she is eligible to enroll in Blue Shield Medicare Advantage plan. All pre-existing conditions, except ESRD, are covered without a waiting period.

In general, an individual is eligible to elect a Medicare Advantage Prescription Drug (MA-PD) plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he or she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan.
2. The individual has not been medically determined to have ESRD prior to completing the enrollment request.
3. The individual or his or her legal representative complete an enrollment request form and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS.
4. The individual is fully informed of and agrees to abide by the rules of the MA-PD organization that were provided during the enrollment request.
5. The individual makes a valid enrollment request that is received by the plan during an election period.
6. The individual permanently resides in the service area of the MA-PD plan (Individual or Group).
7. An individual who is living abroad or is incarcerated is not eligible for Part D as he or she cannot meet the requirement of permanently residing in the service area of a Part D plan.
8. The individual cannot be concurrently enrolled in Blue Shield Medicare Advantage plan and a PDP plan at the same time, nor can the individual be enrolled in Blue Shield Medicare Advantage plan and another MA plan at the same time.

6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Blue Shield Medicare Advantage Plan Eligibility Criteria *(cont'd.)*

In addition to the above, the following applies to Group retirees:

9. The individual is a retiree from an employer group/union and meets the group's definition of an "eligible" retiree.
10. The individual must not be actively working.

All Blue Shield Medicare Advantage plan individual or group plan changes (except primary care physician (PCP) change requests) affecting the enrollment of members must be submitted by the member to Blue Shield and approved by the Centers for Medicare & Medicaid Services (CMS) before Blue Shield will process the change. Blue Shield follows Medicare guidelines and adjusts Blue Shield Medicare Advantage plan individual and group member eligibility consistent with CMS reporting.

Member eligibility may be verified using many different resources. Blue Shield Medicare Advantage plan encourages providers to use the steps detailed in this section to expedite this process.

Lock-In Election Rules

The rules for when and how often Medicare Advantage (MA) members can switch Medicare health plans were changed by Congress in an effort to help MA Plans manage health care costs and payments and plan for the members' care. The Centers for Medicare & Medicaid Services (CMS) refers to these rules as "Lock-in."

A Medicare beneficiary may make one change during the Annual Election Period (AEP), which is October 15 through December 7 of every year. In addition, during the Medicare Advantage Open Enrollment Period (MA OEP), MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP. For Group Medicare members, Blue Shield advises them to first follow their former employer group/union's open enrollment period for making any enrollment changes. With a few exceptions, a Medicare beneficiary cannot enroll in or disenroll from an MA plan, or return to Original Medicare, at any other time of the year. Refer to Chapter 2-Medicare Advantage Enrollment & Disenrollment of the *CMS Medicare Managed Care Manual* (Pub. 100-16), located at cms.hhs.gov/manuals.

In order for a Medicare Advantage organization to accept an election, the individual must make the enrollment request during an election period. An enrollment period is the time during which an eligible individual may elect an MA plan or Original Medicare. The type of enrollment period determines the effective date of MA coverage. Following are the types of election periods during which individuals may make enrollments. Group plan members must follow the open enrollment dates established by their former employer group/union, unless they are aging-in to Medicare or otherwise fall under a Special Election Period (SEP).

Lock-In Election Rules *(cont'd.)*

- The Annual Election Period (AEP);
- The Initial Coverage Election Period (ICEP);
- The Initial Enrollment Period for Part D (IEP for Part D);
- The Open Enrollment Period for Institutionalized Individuals (OEPI);
- All Special Election Periods (SEP); and
- The Medicare Advantage Open Enrollment Period (MA OEP).

Unless a CMS-approved capacity limit applies, all MA organizations must accept requests to enroll in their MA plans (with the exception of Medicare MSA plans) during the AEP, an ICEP, an IEP for Part D (MA-PD plans only), and any SEP that allows enrollment into the specific plan. When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until the limit is lifted.

Enrollment Periods

Annual Election Period (AEP)

During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. The last enrollment request made, determined by the application date, will be the enrollment request that takes effect.

The AEP is referred to as the "Fall Open Enrollment" season and the "Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage" in Medicare beneficiary publications and other tools and runs October 15 through December 7 of every year.

An employer group/union sponsored Medicare Advantage (MA) plan may have an "open enrollment" as determined by the employer group/union. This may or may not correspond with the MA annual election period. Therefore, organizations are not required to accept enrollment requests into employer group/union plans during the AEP (unless the AEP and open season occur simultaneously); however, organizations must accept valid requests for disenrollment.

Enrollment Periods *(cont'd.)*

Initial Coverage Election Period (ICEP)

The ICEP refers to the period beginning three months immediately before an individual's first entitlement to both Medicare Parts A and B and ends on the later of:

- The last day of the month preceding entitlement to both Part A and Part B; or
- The last day of the individual's Part B initial enrollment period. The initial enrollment period for Part B is the 7-month period that begins 3 months before the month an individual meets the Part B eligibility requirements and ends 3 months after the month of eligibility.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP enrollment has been used.

Initial Enrollment Period for Part D (IEP for Part D)

The IEP for Part D is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when he/she is entitled to Part A OR enrolled in Part B, AND permanently resides in the service area of a Part D plan.

Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B, which is the 7-month period that begins three months before the month an individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.

Individuals not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B have an IEP for Part D that is three months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for Part D.

Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP for Part D based upon attaining age 65.

Enrollment Periods *(cont'd.)*

Open Enrollment Period for Institutionalized Individuals (OEPI)

The OEPI is continuous for eligible individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of a:

- Skilled nursing facility (SNF) as defined in §1819 of the Act (Medicare);
- Nursing facility (NF) as defined in §1919 of the Act (Medicaid);
- Intermediate care facility for the mentally retarded (ICF/MR) as defined in §1905(d) of the Act;
- Psychiatric hospital or unit as defined in §1861(f) of the Act;
- Rehabilitation hospital or unit as defined in §1886(d)(1)(B) of the Act;
- Long-term care hospital as defined in §1886(d)(1)(B) of the Act; or
- Hospital which has an agreement under §1883 of the Act (a swing-bed hospital).

The OEPI ends two months after the month the individual moves out of the institution.

Special Election Periods (SEP)

Special election periods (SEPs) constitute periods outside of the usual IEP, AEP or MADP when an individual may elect a plan or change his or her current election. There are various types of SEPs, including SEPs for dual eligibles and for individuals whose current plan terminates, who change residence, and who meet "exceptional conditions" as CMS may provide. Depending on the nature of the particular SEP, an individual may:

- Discontinue an enrollment in an MA plan and enroll in Original Medicare
- Switch from Original Medicare to an MA plan
- Switch from one MA plan to another MA plan

It is generally the responsibility of Blue Shield to determine whether an individual is eligible for an SEP. The exception to this requirement would be enrollment and disenrollment requests completed or approved by CMS staff. To make this determination, the organization may need to contact the individual directly.

For specific details on each type of SEP, refer to Chapter 2 - Medicare Advantage Enrollment and Disenrollment of the *CMS Medicare Managed Care Manual*.

Enrollment Periods *(cont'd.)*

Medicare Advantage Open Enrollment Period (MA OEP)

During the MA OEP, MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP.

This chart outlines who can use the MA OEP and when:

Who can use the MA OEP:	MA OEP occurs:
Individuals enrolled in MA plans as of January 1	January 1 – March 31
New Medicare beneficiaries who are enrolled in an MA plan during their ICEP	The month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement

Individuals may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to:

- MA-PD
- MA-only
- Original Medicare (with or without a stand-alone Part D plan)

The effective date for an MA OEP election is the first of the month following receipt of the enrollment request.

The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan. It also does not allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. The MA OEP is not available for those enrolled in Medicare Savings Accounts or other Medicare health plan types (such as cost plans or PACE).

Effective Date of Coverage

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their enrollment effective date. The effective date is generally not prior to the receipt of a complete enrollment request by Blue Shield. Enrollment cannot be effective prior to the date the beneficiary, or their legal representative signed the enrollment form or completed the enrollment request. To determine the proper effective date for individual members, Blue Shield must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the completed enrollment request is received by the MA organization. Once the election period is identified by Blue Shield, Blue Shield must determine the effective date.

The effective date of group MA-PD plan coverage (coverage for Medicare-eligible group retirees) is based on the specific plan contract renewal date of the employer group/union. For example, most groups renew their plan contract for an effective date of January 1; however other groups may renew their plan contracts at other times during the year. For each employer group/union, the plan contract date will be different. As such, group members must follow the open enrollment period established by their former employer group/union when making plan changes unless they are aging-in to Medicare or, for another reason, fall under the exception of special circumstance. In these instances, the effective date of coverage would be based on the special circumstance and would be the first of the month following the completed enrollment request. Effective dates are as follows:

Election Period	Effective Date of Coverage	Are MA organizations obligated to accept enrollment elections in this election period?
Annual Election Period (AEP)	January 1 of the following year.	Yes, unless capacity limit applies.
Initial Coverage Election Period (ICEP) and Initial Enrollment Period (IEP) for Part D	First day of the month of entitlement to Medicare Part A and Part B. – or – The first of the month following the month the enrollment request was made if after entitlement has occurred.	Yes, unless capacity limit applies. IEP for Part D is applicable only to MA-PD enrollment requests.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request.	No. The MA organization can choose to be "open" or "closed" to accept enrollments during this period.
Special Election	Varies (refer to Chapter 2 - Medicare	Yes, unless capacity limit applies.

6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Election Period	Effective Date of Coverage	Are MA organizations obligated to accept enrollment elections in this election period?
Periods (SEP)	Advantage Enrollment & Disenrollment of the Medicare Managed Care Manual (Pub. 100-16), as outlined in §30.4).	
Medicare Advantage Open Period (MA OEP)	Individuals enrolled in MA plans as of January 1 (MA OEP January 1 – March 31)	Yes, unless capacity limit applies.
Employer Group/Union Open Enrollment Period	Based on the employer group/union contract renewal.	Yes.

Monthly Eligibility Reports

As a cost-effective measure, Blue Shield provides the combined Eligibility/Capitation and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables IPA/medical groups to use and sort the information in many ways to meet their specific reporting needs.

Blue Shield sends these eligibility reports via Blue Shield secure email or SFTP to all IPA/medical groups no later than the 10th calendar day of each month. For details on the file formats, refer to Appendix 3 in the back of this manual. The *Blue Shield Medicare Advantage Plan Product ID and Physician Office Copayment Guide* is also forwarded to IPA/medical groups each month.

Both electronic files include the member's name and ID, the member's PCP's name and ID, as well as the transaction code for all member status changes. The files also include the member's group number and Product ID, which identifies member's standard office visit copayments.

Blue Shield Medicare Advantage Coordination of Benefits (COB)

When an individual enrolls with Blue Shield Medicare Advantage Individual or Group Plan, Blue Shield will ask the member whether he or she has healthcare insurance other than Blue Shield Medicare Advantage plan. If so, this information will appear on the IPA/medical group eligibility list. IPA/medical groups should always inquire whether a member has other health insurance coverage. For those members who are over 65 years of age and retired, Blue Shield Medicare Advantage plan will generally be the primary payor.

When the Blue Shield Medicare Advantage plan is the primary payor, the IPA/medical group may bill the secondary carrier for usual and customary fees and receive compensation in addition to that received from Blue Shield Medicare Advantage plan.

Note: Under no circumstances may a member be billed for any balance due.

The Blue Shield Medicare Advantage plan will be the secondary payor in the following situations:

1. The member is age 65 or older and has coverage under an employer group health plan through an employer with 20 or more employees, either through the member's own employment or the enrollee's spouse's employment.
2. The member is under age 65 and is entitled to Medicare due to disability other than ESRD, and the member has coverage under a large employer (100 or more employees) group health plan, either through the enrollee's own employment or the enrollee's spouse's employment.
3. The member is being treated for an accident or illness that is work-related or otherwise covered under Workers' Compensation.
4. The member has ESRD and an employer group health plan. Blue Shield Medicare Advantage plan will be secondary for up to 30 months; Medicare will be the primary payor after 30 months.
5. The member is being treated for an injury, ailment, or disease caused by a third party and automobile or other liability insurance is available.

Questions regarding the Blue Shield Medicare Advantage plan COB can be directed to the Blue Shield Medicare Advantage Member Services Department at (800) 776-4466 (for Members) or (800) 541-6652 (for Providers) [TTY 711].

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6.4 Blue Shield Medicare Advantage Plan Network Administration

IPA/Medical Group Responsibilities

Access to Medical Services

Centers for Medicare & Medicaid Services (CMS) regulations require that Blue Shield Medicare Advantage plan members be able to obtain the following services without getting prior approval from their primary care physician (PCP) or IPA/medical group:

- Routine women's health care, which includes breast exams, screening mammograms, Pap tests, and pelvic exams (as long as members get them from a network provider)
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations (as long as members get them from a network provider)
- Emergency services from network providers or from out-of-network providers
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (i.e., when the member is temporarily outside of the plan's service area)
- Kidney dialysis services at a Medicare-certified dialysis facility when the member is temporarily outside the plan's service area

The IPA/medical group must at all times furnish current names, addresses, and telephone numbers of specialists, clinics, or centers that provide services referenced above to facilitate an accurate Blue Shield listing of such providers in the provider directory and on Blue Shield's website at https://www.blueshieldca.com/fap/app/find-a-doctor.html thereby enabling access for members.

> *Note:* The IPA/medical group is required to comply with any regulatory updates pertaining to access to care and services. For example, if direct access requirements change, the IPA/medical group must provide such required direct access.

IPA/Medical Group Responsibilities *(cont'd.)*

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members

Blue Shield has established procedures, based on CMS requirements, for when network providers want to end their relationship with a Blue Shield Medicare Advantage plan member for cause, such as disruptive behavior or legal action by the member against the provider. This section defines acceptable reasons and procedures for processing provider requests to transfer Blue Shield Medicare Advantage plan members involuntarily while continuing to provide appropriate treatment with an existing healthcare provider.

Providers **may not** end a relationship with a member because of the member's medical condition or the cost and type of care that is required for treatment, or for the member's failure to follow treatment recommendations.

Blue Shield Medicare Advantage plan members **may not** be involuntarily transferred without the Blue Shield Medicare Advantage plan's approval. An involuntary transfer request would be considered only for the following situations:

- The member is disruptive, abusive, unruly, or uncooperative to the extent that the provider's ability to provide services is seriously impaired.

  In this case, the Blue Shield Medicare Advantage plan must review any request for an involuntary transfer request. The Blue Shield review, for most situations, looks for evidence that the individual continued to behave inappropriately after being counseled/warned about his or her behavior and that an opportunity was given to correct the behavior. The provider must have made several attempts to provide counseling to the member. A minimum of three (3) documented written warnings must be provided for consideration of an involuntary transfer request. Counseling done by plan providers is considered informal counseling and an initial warning letter related to the member's behavior must also be sent by Blue Shield. Blue Shield requires documentation/medical records from the physician group prior to sending the member an official warning letter from the plan. If the inappropriate behavior was due to a medical condition (such as any mental health issue or a physical disability), the provider must demonstrate that the underlying medical condition was controlled and was not the cause of the inappropriate behavior.

IPA/Medical Group Responsibilities *(cont'd.)*

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members *(cont'd.)*

- Legal action by a member against a physician or physician group can create a problematic situation in balancing the state and federal 30-day notice provisions related to involuntary disenrollment, along with the physician concerns about continuing to treat an individual who has filed a suit against a physician or physician group. Blue Shield Medicare Advantage plan Member Services staff can assist by contacting the member in such a circumstance. Since such litigation demonstrates a breakdown in the patient/physician relationship, Member Services can verify if the member wishes to voluntarily transfer to a new PCP or physician group. While the circumstances will vary and may require individual review, in general, if a member does not wish to voluntarily transfer, Blue Shield would be required to provide the member with the requisite 30-day notice in order to comply with current legal requirements. In such circumstances, if the physician is not willing to see the patient during the 30-day transition period, the physician must make arrangements for the member to be seen by an alternate physician and notify Blue Shield and the member of the alternate arrangements in writing.

Procedure

Before requesting to involuntarily transfer a member for cause, the PCP must counsel the member verbally and in writing about the problem. Provider warning letters to the member must be sent by the provider via certified mail or courier service to track that the warning letter was received (a copy of the letter must also be sent to Blue Shield Medicare Advantage Member Services Department). If the behavior or problem continues, the provider may request Blue Shield to take steps to counsel the member and initiate the protocols required for the plan to involuntarily transfer the member to another provider or physician group.

Providers are required to submit all documentation related to disruptive members to Blue Shield for review. This documentation includes:

- Documentation of the disruptive behavior, including a thorough explanation of the individual's behavior and how it has impacted the providers ability to arrange for or provide services to the individual or other members;
- Written warning letters or counseling letters from the provider and/or the physician group showing serious efforts have been made to resolve the problem with the individual;

IPA/Medical Group Responsibilities *(cont'd.)*

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members *(cont'd.)*

Procedure *(cont'd.)*

- Relevant police reports or documentation of intervention by the Police Department (if applicable);
- Documentation establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Proof that the member was provided with appropriate written notice of the consequences of continued disruptive behavior;
- Member information, including diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information; and
- Proof of effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act.

The physician's or physician group's request for involuntary transfer or disruptive behavior must be complete. All documentation should be submitted to Blue Shield Medicare Advantage Member Services.

Upon receipt of the transfer request and all required documentation, Blue Shield reviews the case and may:

- Decide the evidence is not sufficient to involuntarily transfer the member. The provider or physician group (where applicable) will be notified of the plan's determination.
- Send additional counseling letters to the member (CMS requires the plan to send an official warning letter for Blue Shield Medicare Advantage plan members) describing the behavior that has been identified as disruptive and how it has impacted the plan's ability to manage the individual's care. *(Note: If the disruptive behavior ceases after the member receives notice and then later resumes, the involuntary disenrollment process must begin again.)*
- Request Medical Care Solutions intervention to assist the member in managing their healthcare.
- Transfer the member to another network provider (where the member has been provided appropriate (30-day) written notice and there has been an irreconcilable breakdown in the patient /physician relationship).

IPA/Medical Group Responsibilities *(cont'd.)*

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members *(cont'd.)*

Procedure *(cont'd.)*

> *Note:* If the transfer request is received verbally by Blue Shield from a PCP, the call is transferred to the appropriate Member Services Team Leader who will request the written documentation and forward any pertinent information to Provider Relations and Medicare Compliance, as necessary. A verbal request will still require that the provider send Blue Shield all written documentation related to the member's behavior.

Blue Shield sends the provider a written notice of its decision. Please note that CMS considers counseling done by the PCP or physician group for Blue Shield Medicare Advantage plan members as informal notice and only recognizes counseling letters sent from the health plan as formal notification to the member.

> *Note:* Providers must work with Blue Shield to provide sufficient documentation so that Blue Shield Medicare Advantage plan can send a formal warning notice to members.

- If the provider does not provide adequate documentation to substantiate an involuntary transfer request, Member Services and/or Provider Relations contacts the provider and advises them that they must provide additional written documentation of the issues or events that led to the transfer request.
- If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Member Services department. The transfer notification letter informs the member of the request made by the PCP and that the member can select another PCP in the same IPA/medical group or (if warranted) in another IPA/medical group. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new PCP within 30 days of the date the letter was mailed, a new PCP will be selected for them.

The member will be transferred once written notice is given and is effective the first of the following month. If applicable, the letter informs the member that Blue Shield may pursue involuntary disenrollment through CMS if the events leading to the transfer reoccur. An explanation of the member's rights to a hearing under the Blue Shield Medicare Advantage plan grievance procedure is also included in the letter.

IPA/Medical Group Responsibilities *(cont'd.)*

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members *(cont'd.)*

Procedure *(cont'd.)*

- When a member transfers to a new IPA/medical group, the previous provider must supply patient records, reports, and other documentation at no charge to Blue Shield, the new IPA/medical group, provider, or member.
- The existing PCP must continue to coordinate care through the date of transfer.

Blue Shield follows regulatory guidelines and retains sole and final authority to review and act upon the requests from providers to transfer a member. Members are not transferred against their will until Blue Shield carefully reviews the matter, determines that transfer is appropriate, and confirms that Blue Shield's internal procedures have been followed. All transfer requests are carefully reviewed, and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

Exclusion of Providers from the Network

CMS prohibits any employee, provider, contractor, or subcontractor from performing any activity related to Medicare Part D or other federal programs if they are listed in the General Services Administration (GSA) database of excluded individuals/entities or the Office of Inspector General's (OIG) database of excluded individuals or entities. These sanction lists identify those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. The Medicare Advantage (MA) organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. Below are links to the List of Excluded Individuals and Entities (LEIE), which can also be downloaded, and the Excluded Parties List System (EPLS). Simply enter the name of an individual or entity and determine whether they are currently excluded.

- https://www.oig.hhs.gov/exclusions/exclusions_list.asp
- https://sam.gov/content/home

CMS requires that all entities review the list for all employees and at least once a year thereafter to ensure that its employees, board members, officers, and first tier entities, downstream entities, or related entities that assist in the administration or delivery or Part D benefits are not included on such lists. If the Sponsor's employees, board members, officers, managers or first tier entities, downstream entities, or related entities are on such lists, the Sponsor's policies shall require the immediate removal of such employees, board members, or first tier entities, downstream entities, or related entities from any work related directly or indirectly on all federal health care programs and take appropriate corrective actions.

IPA/Medical Group Responsibilities *(cont'd.)*

Exclusion of Providers from the Network *(cont'd.)*

Federal regulations prohibit Blue Shield Medicare Advantage plan from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a member for the provision of covered services. The exclusion of such a provider is to be for a period of two years, beginning at the time that any direct contracts between the provider and member were entered into. Because such providers must be excluded from the network, Blue Shield will reduce the IPA/medical group's capitation fees by the amount of any reimbursement that was paid either directly or indirectly to such providers.

If, according to CMS, a provider is excluded from participating in Medicare, then the IPA/medical group is prohibited from employing or contracting with that provider for the provision of healthcare services, utilization review services, medical social work services and administrative services for Blue Shield Medicare Advantage plan and its members. In the event the IPA/medical group fails to comply with this prohibition, Blue Shield reserves the right to impose upon the IPA/medical group any sanctions that CMS may impose upon Blue Shield for violation of this prohibition.

(Reference: Code of Federal Regulations, 42 CFR 422.220 and 42 CFR 422.752)

Exclusions from Medicare and Limitations on Medicare Payment

According to the Code of Federal Regulations, 42 CFR 411.12, charges imposed by an immediate relative or member of the beneficiary's household are excluded from coverage. The regulations are outlined below:

(a) Basic rule. Medicare does not pay for services usually covered under Medicare if the charges for those services are imposed by:
  (1) An immediate relative of the beneficiary; or
  (2) A member of the beneficiary's household

(b) Definitions. As used in this section "Immediate relative" means any of the following:
  (1) Husband or wife
  (2) Natural or adoptive parent, child, or sibling
  (3) Stepparent, stepchild, stepbrother, or stepsister
  (4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
  (5) Grandparent or grandchild
  (6) Spouse of grandparent or grandchild

IPA/Medical Group Responsibilities *(cont'd.)*

Exclusions from Medicare and Limitations on Medicare Payment *(cont'd.)*

Member of the household means any person sharing a common abode as part of a single-family unit, including domestic employees and others who live together as part of a family unit, but not including a mere roomer or boarder.

Professional corporation means a corporation that is completely owned by one or more physicians and is operated for the purpose of conducting the practice of medicine, osteopathy dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by state law.

(c) Applicability of the exclusion. The exclusion applies to the following charges in the specified circumstances:

(1) Physicians' services.

(i) Charges for physicians' services furnished by an immediate relative of the beneficiary or member of the beneficiary's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation.

(ii) Charges for services furnished incident to a physician's professional services (for example by the physician's nurse or technician), only if the physician who ordered or supervised the services has an excluded relationship to the beneficiary.

(2) Services other than physicians' services.

(i) Charges imposed by an individually owned provider or supplier if the owner has an excluded relationship to the beneficiary; and

(ii) Charges imposed by a partnership if any of the partners has an excluded relationship to the beneficiary.

(d) Exception to the exclusion. The exclusion does not apply to charges imposed by a corporation other than a professional corporation.

IPA/Medical Group Responsibilities *(cont'd.)*

Continuation of Benefits

Per CMS regulations, for continuity of care purposes and for a limited amount of time (as determined on a case-by-case basis), the IPA/medical group and its physician members must continue to provide benefits to members in the event Blue Shield becomes insolvent or terminates the contract. Benefits must continue through the period for which capitation has been paid or until the discharge from an inpatient facility, whichever time is longer.

In the unlikely event that one of the following extreme conditions arises, Blue Shield Medicare Advantage plan may have to discontinue benefits:

- Epidemic, riot, war, or major disaster.
- Complete or partial destruction of facilities.
- Loss or disability of a large number of our providers.

Under these extreme conditions, Blue Shield Medicare Advantage plan contracted hospitals and contracted providers will continue to make their best efforts to provide services. The member may go to the nearest medical facility for medically necessary services and will be reimbursed by Blue Shield for those charges.

Transition of Care/Financial Responsibility Upon Enrollment/Disenrollment

1. **Prospective Payment System (PPS) Participating Hospitals**
   a. Members hospitalized prior to their effective date with Blue Shield Medicare Advantage plan
      - If a member is an inpatient in a PPS participating facility on his or her effective date of enrollment in Blue Shield Medicare Advantage plan, Blue Shield is not required to provide nor assume responsibility to pay for any inpatient services covered under Medicare Part A during the inpatient stay. Part B or physician services become an IPA/primary care physician responsibility as of the member's effective date with Blue Shield Medicare Advantage plan.
      - Under the above circumstances Blue Shield Medicare Advantage plan network providers will assume responsibility for inpatient hospital services under Part A on the day after the date of discharge from the inpatient stay. Discharge to a skilled nursing facility is considered as an inpatient hospital discharge.

        Caution: Under the above rules, CMS has viewed a "transfer to an in-plan hospital" as a discharge in the past. This makes the Health Plan liable for the admission from the date of the transfer and Medicare pays the "transfer payment" to the facility to which the member was an inpatient at the time of admission.

IPA/Medical Group Responsibilities *(cont'd.)*

Transition of Care / Financial Responsibility Upon Enrollment / Disenrollment *(cont'd.)*

b. Coverage Terminates While Blue Shield Medicare Advantage plan Member is Hospitalized

- If Blue Shield Medicare Advantage plan coverage terminates while the member is hospitalized, regardless of the reason for the termination, and the admission was authorized by the member's IPA/PCP, Blue Shield's liability for inpatient hospital services will continue until the member is discharged. Blue Shield's responsibility for coverage or payment of Part B/physician services ends as of the member's effective date of disenrollment.

  (Reference: Code of Federal Regulations, 42 CFR 422.318)

2. Non-Prospective Payment System (PPS) Hospitals

In cases where the member is in a non-PPS hospital or unit, Skilled Nursing Facility (SNF), Home Health Agency (HHA), etc., Blue Shield is responsible for payment of services on and after the day of enrollment up through the day disenrollment is effective.

To determine if a facility is subject to or excluded from the prospective payment system, refer to the Code of Federal Regulations §412 Subpart B – Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs.

(References: Code of Federal Regulations §422.268 Source of payment and effect of election of the MA plan election on payment; §422.318 Special rules for coverage that begins or ends during an inpatient hospital stay; Code of Federal Regulations Part 412—Prospective Payment Systems for Inpatient Hospital Services; and Medicare Intermediary Manual, Section 3654.2 Patient is a Member of HMO for Only Part of Billing Period).

Refer to Section 4.1 Network Administration – Provider Status Changes for more information.

IPA/Medical Group Responsibilities *(cont'd.)*

Member Billing

At no time may a provider bill a Blue Shield Medicare Advantage plan member in connection with covered services, except for plan cost-sharing amounts. Such billing is in violation of CMS federal regulations. Should a member be billed for covered services that are the responsibility of the IPA/medical group, Blue Shield will notify the IPA/medical group.

If a Blue Shield Medicare Advantage plan member contacts Member Services about a bill received, Blue Shield will instruct the member to mail the claim directly to us. Blue Shield Medicare Advantage plan will review the claims and fax the claims to the IPA/medical group, with instructions to respond to Blue Shield within 2 weeks. If the IPA/medical group does not respond within that time period, or if the response is invalid, an appropriate payment will be made by Blue Shield to the provider of the services and that amount may be deducted from the IPA/medical group's capitation. Any overpayment created as a result of the IPA/medical group's subsequent payment to the provider will be the IPA/medical group's responsibility to collect. It is not necessary that the claim be paid by the IPA/medical group within the 2-week period described above, unless the member's account has been sent to collections; but the response indicating the date that the claim will be paid or written-off must be returned to Blue Shield within that time.

Once notified by Blue Shield that the assigned member is being billed for a service that is the IPA/medical group's financial responsibility, the IPA/medical groups must take whatever steps are necessary to prevent the member from receiving further bills for a covered service. If the provider billing the member is capitated by the IPA/medical group for the services being billed, the IPA/medical group must contact that provider and ensure that the account balance is fully written-off and that the member is not billed again. If the member receives a second bill from a provider that the IPA/medical group has told Blue Shield is capitated, Blue Shield will pay the claim and that amount thus paid may be deducted from the IPA/medical group's capitation.

Hospice Billing

CMS issued Program Memorandum Intermediaries/Carriers – AB-02-015 (2/7/02) CMS Pub.60AB *Clarification of Payment Responsibilities of Fee-for-Service Contractors as it Relates to Hospice Members Enrolled in Managed Care Organizations (MCOs) and Claims Processing Instructions for Processing Rejected Claims* to clarify regulations regarding payment responsibility for hospice patients enrolled in managed care plans, as well as provide specific claims processing requirements to ensure payment for such claims. The information below is reprinted from that program memorandum:

IPA/Medical Group Responsibilities *(cont'd.)*

Hospice Billing *(cont'd.)*

Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an MCO to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

Billing of Covered Services

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bills 81x and 82x. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of Occurrence Code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment are not disrupted. The HMO may directly bill for attending physician services, as listed above, to Medicare carriers in keeping with existing processes.

Medicare physicians may also bill such service directly to carriers as long as all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were set forth in Transmittal 1728, Change Request 1910 of the Medicare Carriers Manual (MCM), Part 3, effective January 2002, and specifies use of Modifiers GW and GV. When these modifiers are used, carriers are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File (CWF) in Medicare claims processing systems.

For medical services for a condition not related to the terminal condition for which the beneficiary elected hospice, a claim must be submitted to the intermediary using the Condition Code 07. If physician services are billed to carriers, the instructions in Transmittal 1728, Change Request 1910 of the MCM should be followed and should specify the use of Modifier GW.

IPA/Medical Group Responsibilities *(cont'd.)*

Hospice Billing *(cont'd.)*

Billing of Covered Services *(cont'd.)*

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Timely Filing

These instructions apply to all contractors for claims filed in the timely filing period for managed care enrollees who have elected hospice. The timely filing period extends from the date of service to the end of the calendar year after the year service was rendered. However, if a service was provided in the fourth quarter of a calendar year, the claim will be timely to the end of the second year after the year in which the service was rendered. Since there have been allegations of lack of compliance with the regulatory requirements for Medicare fee-for-service contractors to process hospice claims for managed care beneficiaries, exceptions to timely filing will be considered on a case-by-case basis. Exceptions to the timely filing requirements will be determined by Medicare contractors on a case-by-case basis in accordance with applicable CMS guidelines.

Physician Billing Instructions For Non-Hospice Services

CMS has specific coverage rules that apply when an individual is covered under a Medicare hospice program. Treatment for the specific hospice related condition is covered under the scope of the hospice benefit. Treatment for non-hospice-related services must be specifically billed to denote the following:

1. Services are not related to the specific terminal illness covered through hospice. For example, the hospice related illness is congestive heart failure.
2. A separate medical condition not related to treatment for hospice is eligible for payment under Medicare Part B, provided the billing is done properly with the specific codes designated by Medicare (i.e., GW modifiers) and are utilized when billing. A separate medical condition not related to treatment for congestive heart failure is eligible for payment under Medicare Part B, provided that the medical documentation regarding the separate medical condition is included.

IPA/Medical Group Responsibilities *(cont'd.)*

Physician Billing Instructions For Non-Hospice Services *(cont'd.)*

3. Separate, non-hospice related treatment for things such as renal failure or related red blood cell production issues that meet Medicare criteria for Procrit injections would be distinct from the CHF condition being treated under the Hospice program. As such they are eligible for coverage under Medicare Part B.
4. The billing should be done with a GW modifier and should denote that the treatment is not for the CHF condition, which is coded as covered under hospice.

Resources: *Medicare Hospice Manual*; discussion with the Hospice staff confirming that the Renal Failure and Red Blood cell production issues are not part of the scope of the hospice treatment for CHF; Frank Abrahamian at US Government Services; and conversations with CMS staff and NHIC staff; DHHS Program Memorandum.

Subcontracting Requirements

Providers that subcontract with IPA/medical groups for the treatment of Blue Shield Medicare Advantage plan members are subject to additional requirements, as outlined in the Medicare Advantage (MA) Provider Contracting Guidelines found in Appendix 6 of this manual.

Division of Financial Responsibility

Depending on Blue Shield Medicare Advantage plan contract, the IPA/medical group will be financially responsible for certain medical/pharmacy services. The Division of Financial Responsibility (DOFR) in the Blue Shield contract outlines who is financially responsible for specific services.

> *Note:* It is not possible to list all medical/pharmacy services that may be provided to members. Financial responsibility for medical/pharmacy services not listed in the DOFR found in the Blue Shield contract shall follow Medicare guidelines for all product lines. Accordingly, medical/pharmacy services covered under Medicare Part A are the Capitated Hospital or Shared Savings financial responsibility and medical/pharmacy services covered under Medicare Part B are the group's financial responsibility. This includes drugs that administered to the member or dispensed within the four walls of a provider's office or facility.
>
> Once a member formally elects Hospice status through CMS, financial responsibility for Hospice services will revert to CMS.

IPA/Medical Group Reimbursement

CMS pays managed care organizations based upon a risk-adjustment methodology. Risk adjustments are member-specific and are based upon diagnosis data submitted to CMS by Blue Shield Medicare Advantage plan for dates of services occurring in the prior period. CMS adjusts this date range in an attempt to reflect the most accurate measurement of the members' current health status. Inpatient hospital, physician, and outpatient encounter data is utilized to determine the risk adjustment calculation.

Because IPA/medical group capitation payments are based on a percentage of CMS revenue, Blue Shield passes a portion of the CMS revenue on to the IPA/medical group, in accordance with the terms and conditions of their contract, to pay for services designated as the IPA/medical group responsibility.

> *Note:* It is imperative that IPA/medical groups send Blue Shield all encounter data for capitated Blue Shield Medicare Advantage plan members. If Blue Shield is unable to forward to CMS a comprehensive reporting of the utilization, it is very likely that the CMS reimbursement will be significantly reduced, resulting in reduced capitation payment.

Blue Shield Medicare Advantage Plan Claims Administration

Refer to Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring in this manual for information and requirements regarding the IPA/medical group's responsibility in claims payment. It describes Blue Shield's auditing and monitoring role and outlines the IPA/medical group's performance for complying with CMS requirements, including timeliness and best practices.

Medicare Regulations and Payment to Non-Contracted Providers

Any provider who is not contracted with Blue Shield and approved or certified to participate in the Medicare program must accept as payment in full the Medicare fee schedule rate if they agree to see a Blue Shield Member. They are further obligated to see patients in the case of a medical emergency.

Providers who have been sanctioned by Medicare or who have opted out of the Medicare program are not eligible to see Blue Shield members. (Again, an exception would be if they are an emergency room physician on staff and emergency stabilization care is needed).

Blue Shield or delegated providers would be able to access the Medicare fee schedules if a specialty referral or some other situation occurs with a non-contracted provider according to the regulations.

Federal regulations address the amount which MAO's must pay a non-contracting supplier of services. Section 4001 of the BBA added Social Security Act Section 1852k (42 USC § 1395w-22(k)), which states:

Blue Shield Medicare Advantage Plan Claims Administration *(cont'd.)*

Medicare Regulations and Payment to Non-Contracted Providers *(cont'd.)*

> A physician or other entity …that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare Advantage organization…shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled…

This provision was implemented by Federal Regulation 42 CFR § 422.214 *Special Rules for Services Furnished by Non-Contract Providers*.

The preamble to the regulatory provision states, in relevant part, as follows:

> Special Rules for Services Provided by Non-Contract Providers
>
> Consistent with Section 1852(k) and Section 4002(e), the regulations in § 422.214 require any healthcare provider that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan to accept as payment in full, the amounts that could have been collected if the beneficiary were enrolled in original Medicare. An MA organization (other than an MA MSA plan) satisfies its liability for Medicare covered services if the provider receives the total amount that would have been received if the beneficiary were enrolled in original Medicare. This amount equals the total of Medicare's payment (including any applicable deductible and coinsurance amounts) and any balance billing amount that would have been allowed by original Medicare. In the case of a participating physician or supplier, this amount would equal the Medicare fee schedule amount for the service…Of these amounts, the provider could collect from the MA plan enrollee the cost sharing amount required under the MA plan, approved by MCFA…and the remainder from the MA organization. (63 FR 34968-01, 35002; June 26, 1998) (emphasis added.)

In addition, SSA Section 1852(a)(2)(A) (42 USC § 1395w-22(a)(2) states that a MA Plan satisfies its obligations with respect to services beneficiaries obtain from non-contracting suppliers:

> If the plan provides payment in an amount so that – (i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least (ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B of [Medicare] including any balance permitted under such parts.

Blue Shield Medicare Advantage Plan Claims Administration *(cont'd.)*

Medicare Regulations and Payment to Non-Contracted Providers *(cont'd.)*

CMS supports this position of payment of non-contracted physicians, hospitals, and other providers according to the Medicare fee schedule and prohibit a non-contracted Medicare provider from balance billing a member for services in excess of the Medicare allowable amount, except for the applicable copayment, coinsurance, or if the service is considered to be a non-covered item. In the case of a contracted provider, the contract terms that are in place with the provider would prevail and they would be obligated to accept the contract terms, except for the applicable copayment, coinsurance, or if the service is non-covered.

Blue Shield notifies all non-contracted Medicare providers that they have been paid at the Medicare allowable charges, and if that provider continues to balance bill the member, Blue Shield will take the following steps:

- Notify the member that the claim has been paid in full according to Medicare allowable charges and that no payment is due from the member.
- Similarly advise the provider.
- Advise the member and provider that if there is additional balance billing or attempts to collect the funds, the case will be forwarded to CMS for action against the provider.

Professional Stop-Loss Requirements for Blue Shield Medicare Advantage Plan Members

For Blue Shield Medicare Advantage plan members, CMS Physician Incentive Plan requirements mandate specific stop-loss coverage requirements for providers who are placed at substantial financial risk. The definition of substantial financial risk includes but is not limited to the passing of risk through capitation payments. Annual reporting and compliance with CMS regulations is required. Non-reporting may result in Blue Shield procuring stop-loss coverage on your behalf to comply with federal law and deducting the cost of the stop-loss coverage from capitation.

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6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

Blue Shield Medicare Advantage Plan Medical Care Solutions Program

Refer to Section 2.8 for a list of all Medical Care Solutions benefit programs.

Health Risk Assessment

A Health Risk Assessment Survey is mailed to all new Blue Medicare Advantage plan members. This survey is designed to identify members who may be among the frail elderly, who require reminders for preventive health services, who may require assistance with activities of daily living, and those with certain chronic diseases. Those whose results show five or more identified risks are forwarded to IPA/medical group Medical Directors on a quarterly basis for dissemination to these members' primary care physicians and/or IPA/medical groups' case management programs. For Dual Special Needs Plan members, the Health Risk Assessment results are sent to the IPA/medical group and primary care providers with each completed Health Risk Assessment.

Individualized Care Plan for Dual Eligible Special Needs Plan (D-SNP Members)

Based on member-specific responses to the Health Risk Assessment, Blue Shield creates an Individualized Care Plan (ICP), which is stratified, that includes an itemized list of identified problems, interventions, and goals. The ICP is shared with the member or member's caregiver, the member's PCP, and the medical group. At least annually, and sooner if a member's health status changes, Blue Shield will review and revise, as applicable, the ICP.

The medical group must utilize the ICP to manage the member's care in coordination with pertinent providers and the interdisciplinary care team to provide coordinated care and services proportionate to the member's needs and stratification level, which include care coordination, basic case management, and collaboration with Blue Shield. Care records must be maintained and coordinated among the providers to ensure access in accordance with HIPAA and professional standards.

The member and/or member's caregiver should be involved, whenever feasible, through various ways of communication.

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

Medical Care Solutions Guidelines

Emergency Services

The Centers for Medicare & Medicaid Services (CMS) Region IX office has approved an emergency services automatic payment diagnosis list for Blue Shield Medicare Advantage plan members. This list is available by contacting the Blue Shield Medicare Advantage Provider Customer Service Department at (800) 541-6652.

Skilled Nursing Facility (SNF) Admissions/Transfers

Blue Shield Medicare Advantage plan members may be admitted or transferred to a Medicare-certified SNF from any environment. The SNF benefit is limited to 100 days per benefit period.

A benefit period begins on the first day of a covered inpatient SNF stay and ends when the member has been out of the SNF or rehabilitation hospital for 60 consecutive days, including the day of discharge. A benefit period is a way of measuring the use of services under Medicare Part A. A SNF benefit period begins on the first day of a Medicare-covered skilled nursing facility stay. The benefit period ends when a member has been out of the SNF for 60 consecutive days, including the day of discharge. There is no limit to the number of benefit periods per benefit year. A member may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 days have **not** elapsed between discharge and readmission. The stay does not have to be for related physical or mental conditions.

If a member is discharged from a SNF after receiving post-hospital SNF care, the member is not covered for an additional SNF admission or SNF services in the same benefit period, unless the member is hospitalized again, or their condition deteriorates and meets Medicare coverage guidelines for readmission. Re-admissions within the same benefit period continue to accrue toward the 100-day limit.

When a network provider coordinates the member's admission, Blue Shield Medicare Advantage plan waives the 3-day hospital stay required by Medicare to qualify for coverage. If the admission to an out-of-area SNF is not authorized or approved by the member's network provider, the Medicare required 3-day hospital stay applies.

Medical Care Solutions Guidelines *(cont'd.)*

Second Opinions

In keeping with current legislation, second opinion consultations must be provided when requested by a Blue Shield Medicare Advantage plan member or the participating healthcare provider who is treating the member.

According to Blue Shield Medicare Advantage plan policy, a second opinion for surgery or major procedures (see below) requested by a member is to be provided by an appropriately qualified healthcare professional from within the member's assigned IPA/medical group. Second opinions are only for recommendations about the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy). Payment for the second opinion consultation is drawn from the capitation amount paid to the IPA/medical group for that member. If the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered.

IPA/Medical Group Responsibilities

IPA/medical groups that are fully delegated for Blue Shield Medicare Advantage plan utilization management activities must perform the following functions:

- Authorize referrals in accordance with CMS regulatory requirements.
- Issue a timely notice to the member containing CMS-required appeal rights in accordance with CMS regulatory requirements.
- Authorize inpatient admissions and outpatient procedures in accordance with Medicare coverage guidelines.
- Perform authorization, prospective, concurrent, and retrospective review of services.
- Provide retrospective review of emergency room visits and emergency admissions not reviewed concurrently using the prudent layperson criteria.
- Provide out-of-plan concurrent review via telephone and arrange transfer of medically stable patients to in-network facility when appropriate.
- Use CMS' national or local coverage determinations guidelines, or in the absence of such guidelines, Blue Shield's Medical Policies or Medication Policies when applicable for referrals/hospital authorizations. When such guidelines/policies are not applicable, use nationally recognized evidence- based UM criteria approved for use by the IPA/medical group's UM Committee.

IPA/Medical Group Responsibilities *(cont'd.)*

- Submit members' grievances (in writing) or requests for appeal or direct verbal complaints to the Blue Shield Medicare Advantage Provider Customer Service Department at (800) 541-6652 or Member Customer Services at (800) 776-4466.
- IPAs that are delegated for UM are responsible to authorize/provide only those benefits covered by Medicare and Blue Shield Medicare Advantage plan. If non-covered benefits are authorized or non-covered services are provided on referral from a delegated plan provider, the IPA assumes financial responsibility for those services as a capitated medical expense.
- Notify Blue Shield Medicare Advantage Plan Medical Care Solutions at (800) 786-7474, or fax to (916) 350-8928 **of** the following:
    - Hospitalizations, within one working day of the admission for urgent /emergent admits and five business days prior to a scheduled or elective admission.
    - Services provided more than 30 miles from the member's primary hospital or more than 30 miles out-of-area.
    - Ambulatory surgeries.
    - Invasive procedures requiring the use of a facility other than a physician's office.
    - Out-of-area admissions (as appropriate, the IPA/medical group should facilitate and coordinate an enrollee's transfer to a participating primary hospital).
    - All admissions/transfers to Skilled Nursing Facility/Transitional Care Unit (SNF/TCUs) within 24 hours or one business day of admission or transfer.
- Notify Blue Shield Medicare Advantage Plan Medical Care Solutions of the denial of any requested service or treatment for Blue Shield Medicare Advantage plan members by submitting:
    - A copy of the shared risk authorization log on a weekly basis directly to the MCS department email address at IPAauths@blueshieldca.com
- As part of the annual Delegation Oversight audit, submission of the denial letter and authorization request will be required. This information may also be requested for third party audits or appeal reviews and will need to be submitted to Blue Shield within the timeframe required to meet regulatory or expedited appeal timeframes.

IPA/Medical Group Responsibilities *(cont'd.)*

- All denial letters must be CMS-approved. Blue Shield Medicare Advantage plan has developed CMS-approved letters and tools that may be used as templates. Blue Shield also accepts Industry Collaborative Effort (ICE) approved letters, unless otherwise indicated. For electronic or hard copies of these letter templates, contact the Blue Shield Utilization Management Delegation Oversight Nurse Auditor. ICE-approved letters may be found on the ICE website at iceforhealth.com.

  The following service denial letter templates are available:

  - Home health care discontinuation.
  - SNF continued stay (Acknowledgement of Receipt of Notice must be signed and attached for all facility denials).
  - SNF benefits exhausted.
  - Hospital pre-admission/admission denial.
  - Initial organization determination pre-service denial.
- Coordinate Expedited Initial Determinations (EID)
  - Any Blue Shield Medicare Advantage plan member has the right to ask that a request for services be processed as an expedited initial determination (EID). An EID is defined as an expedited (no longer than 72 hours) decision on a request for service. A member, or a physician acting on a member's behalf, may make a request to expedite a determination if he/she feels that a delay in obtaining the service would cause further harm or injury, or is life-threatening. An EID is distinct from an appeal where an initial determination to deny a service has already been rendered. EIDs are not delegated to the IPA/medical group.
  - Request that an initial review be expedited by one of the following entities:
    - All Blue Shield Medicare Advantage plan members have the right to request an expedited initial determination.
    - A member's representative may request an expedited initial determination.
    - Any physician, contracted or not contracted, may request an expedited initial determination on behalf of the member.

IPA/Medical Group Responsibilities *(cont'd.)*

- Follow the guidelines below to process a request for an expedited initial determination:
  - Immediately notify the Blue Shield Medicare Advantage Member Services Department when the IPA/medical group receives a request for an expedited initial determination. The tracking of these requests is not a delegated function.
  - Blue Shield Medicare Advantage plan members are instructed to contact Member Services to request an EID. Should a member request an EID from the IPA/medical group, the group should instruct the member to contact Member Services.
  - Blue Shield's Medicare Appeals and Grievances Department will contact the IPA/medical group to facilitate the IPA/medical group's decision making upon receipt of the request from the group and Appeals and Grievances will ensure that the request is processed within the required timeframe. As required by regulations, the health plan is responsible for the tracking of these requests.
  - All requests for EIDs are expedited in the interest of member satisfaction. Blue Shield will keep the IPA/medical group informed of the deadline for making the decision.
  - If the IPA/medical group does not reach a decision within the required timeframe, a Blue Shield medical director will make the decision to approve or deny the request based on available information. Blue Shield's Medicare Appeals and Grievances Department is also responsible for notifying the member of the determinations on behalf of the IPA/medical group. The IPA/medical group is responsible for issuing any necessary denial notices in the event that the IPA/medical group denies the requested service.
  - Blue Shield's Medicare Member Services notifies all members who request an EID of the initial determination via telephone and provides assistance with filing appeals, as necessary.

IPA/Medical Group Responsibilities *(cont'd.)*

- Adhere to reporting requirement timeframes as outlined below:

Medicare Advantage Plan Reporting Requirements

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
UM Program Description and selected supporting Policies and Procedures as necessary to meet federal, state, NCQA, and plan requirements.	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse

UM Work Plan to include:
Medicare Reporting on:
• Acute, SNF & BH
  • Bed Days/1000
  • Admits/1000
  • Average LOS
  • Readmits/1000
• Total number of processed Referrals
• Total number of Denials
• Denial Rate
• ER visit & Denial rate
• Special Needs Plan metrics
• Turn Around Time (TAT)
  • Total # of decisions compliant with TAT & % compliant (UM, BH, Pharmacy)
  • Total # of notifications compliant with TAT & % compliant (UM, BH, Pharmacy)
• % of Referrals that exceed TAT
• Member and Provider Satisfaction Results
• IRR results
• Updates to UM Program
	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.
	
	Maintain documentation of analysis and actions taken. Reports submitted must be Blue Shield specific.
		Semi-Annually	Delegation Oversight Nurse

UM Annual Evaluation	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse
UM Criteria and Guidelines	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.	**Annually** (can be reviewed at time of annual delegation audit)	Delegation Oversight Nurse
Behavioral Health Reporting • Assessment of under-and over-utilization of UM data related to behavioral health	Maintain documentation of analysis and actions taken.	**Semi-Annually**	Delegation Oversight Nurse

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
Medicare Shared Risk Authorizations (for groups with shared risk contracts ONLY)	Includes all services that delegated entities approve and deny that are paid out of shared risk pool. These include: Acute and skilled admits: med/surg/ rehab/mental health /detox /DME/Home Health. Check your individual group shared risk matrix for additional details.	**Concurrently**	Call or email Blue Shield Medicare Advantage Plan Medical Care Solutions: Phone (800) 786-7474 IPAauths@blueshieldca.com
All acute inpatient admissions		**Within 24 hours** to for urgent/emergent admits or five (5) business days prior to a scheduled/ elective admission.	Call or fax Blue Shield Medicare Advantage Plan Medical Care Solutions: Phone: (800) 786-7474 IPAauths@blueshieldca.com
All catastrophic cases		**Concurrently**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
All Skilled Nursing Facility (SNF) admissions		**Within 24 hours**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Prior Authorizations and Denials	Required to use Plan denial letter templates for Medicare denials	**Weekly** submission of auth & denial logs showing 100% of all denials	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Information on any denial or authorization which has been made. Including but not limited to the regulatory or appeals process.	Make available to Blue Shield all information requested on the denial.	**As needed**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Medicare Member Expedited Initial Determinations (EIDs)	**NOT DELEGATED** for tracking or determination of EID status	Forward to Plan **Immediately** for determination of whether or not the case meets EID criteria	Phone (800) 786-7474 Fax (844)696-0975
Requests for Investigational/Experimental Services	**DELEGATED** See Section 6.2 General Benefit Exclusions	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
Request for Cancer Clinical Trials- Commercial HMO only; Medicare Clinical Trials are handled by the Intermediary and not Blue Shield. (For Commercial HMO, upon enrollment or renewal of member's group or IFP coverage after 1/1/02)	**NOT DELEGATED**	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975
Medicare Clinical Trials Routine costs are paid for by regular Medicare. The medical group is responsible for the difference between original Medicare cost-sharing and the member's cost sharing under their MAPD plan. The group also covers any preparticipation evaluations per the DOFR.	**DELEGATED**	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975
Investigation Device Exemption (IDE)	**DELEGATED**	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975
Encounter data		**Monthly**	Email Medicare Revenue Improvement & Recovery Team at MRIRIT@blueshieldca.com
Patients with ESRD		**Monthly**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Patients who remain institutionalized in SNF		Preferred **concurrently**, at minimum **weekly**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Patients who are receiving hospice benefits		**Monthly**	Email Medicare Claims Team at ClaimsAnalystMedAdv@blueshieldca.com
Change in key IPA/medical group management and/or professional staff		**Monthly**	Blue Shield Provider Relations

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

Medicare Dual Eligible Special Needs Plan (D-SNP) Reporting Requirements

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
Evidence of IPA/Medical Group annual training for SNP Model of Care (MOC): • Training materials • Dates of training • IPA/Medical Group attestation of participation • Internal staff training	Use Blue Shield's training materials to educate employees and downstream providers initially and annually	**Annually – 1st quarter**	Email proof of completion to providerexperience@blueshieldca.com *or* Complete the training module via the Learning Management System located on the provider portal and no additional submission is required
Ambulatory/basic case management logs: • Member's Name and ID number • Date of Birth • Referral Source • Reason for Referral to CM • Case Status • Case Open Date • Diagnosis (ICD – 10/Description) • Problems/Issues Identified • Goals Identified • Interventions Documented • Care Plan sent to PCP (notification) • Communications with Member Documented • Case Closure Date • Reason for Closure/Case Outcome		**Quarterly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com
Interdisciplinary Care Team (ICT) Meetings: • Membership of the ICT • Evidence of member/caregiver participation or refusal to participate		**Quarterly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com
Evidence of Medical Group/IPA Care and Service Coordination as Delineated in Health Plan Complex Case Management Care Plan Interventions • Record of authorization • Verification of date service(s) provided • Coordination/exchange of medical information with the plan		**Monthly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com
Member data for performance and health outcomes measurement		**Quarterly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com

IPA/Medical Group Responsibilities *(cont'd.)*

Reporting End Stage Renal Disease (ESRD) Members

As a reminder, in order to be eligible for participation in the Blue Shield Medicare Advantage plan program, a person must be entitled to Medicare Part A and enrolled in Medicare Part B and live within the Blue Shield Medicare Advantage plan service area. Beginning January 1, 2021, patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, or who have ongoing dialysis, are eligible to join the Blue Shield Medicare Advantage plan.

The IPA/medical group should verify that the Dialysis facility that they have authorized or referred their members to files the CMS form (2728-U3) "ESRD Medical Evidence Report" with the local Social Security Office to register a Member as an ESRD Member. A copy of the form (CMS 2728-U3) should also be sent to the ESRD Network Organization. (Refer to the CMS website at cms.hhs.gov/center/esrd.asp for a copy of the ESRD Medical Evidence Report form.)

The following is a general description of Medicare eligibility when ESRD is involved:

ESRD coverage begins:

- When a person with ESRD has a transplant or is on maintenance dialysis, they become entitled to Medicare benefits. Eligibility typically begins on the first day of the fourth month of maintenance dialysis, however, if the person has a transplant or is on self-dialysis at home, coverage begins the first month.
- If the individual is employed or a dependent of an employed person, Medicare would be secondary to the Employer Group Health Plan (EGHP) during the first 30 months after becoming eligible. After the initial 30 month "coordination period," Medicare automatically becomes primary and the EGHP becomes the secondary payor.

ESRD coverage ends:

- Medicare ESRD coverage ends 12 months after maintenance dialysis ends or 36 months after a kidney transplant. At that time, the member would revert to standard Medicare coverage or to the Employer Group Health Plan. If, at any time, maintenance dialysis must be resumed or another transplant becomes necessary, Medicare coverage will be continued or reinstated without any waiting period.

  Note: If this were to occur, the Dialysis Facility will need to submit a new CMS form (2728-U3), ESRD "Medical Evidence Report" with the new information.

The monthly Eligibility/Capitation report will indicate the member's status, if they are classified with CMS as ESRD. If the report does not show the correct status, the IPA/medical group should contact the Dialysis Facility to verify they have correctly completed and submitted the CMS form (2728-U3) "ESRD Medical Evidence Report" with the local Social Security Office.

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

Blue Shield Medicare Advantage Plan Responsibilities

Blue Shield is responsible for:

- Establishing a formal mechanism to consult with the physician regarding the Blue Shield Medicare Advantage Plan Medical Care Solutions procedures.
- Providing technical assistance to facilitate IPA/medical group UM activities.
- Providing supplementary UM/oversight responsibilities for members of delegated IPA/medical groups. Daily selection of inpatient acute cases meeting identified criteria will be reviewed by Medical Care Solutions UM. The Utilization Care Manager will provide coordination and collaboration with the IPA/medical group case management staff for discharge planning and/or transitions to lower levels of care as needed. Cases that appear to lack medical necessity or indicate possible quality of care issues will be escalated to the Blue Shield Medical Director for clinical review, peer to peer communication, or communication with the IPA/Medical Group Medical Director as indicated. This activity will ensure that the delegated medical groups and IPAs are providing quality and appropriate care for Blue Shield MAPD members.
- Providing concurrent and/or retrospective review for out-of-area emergent care.
- Coordinating communication between the primary care physician (PCP) and the treating physician if Blue Shield Medicare Advantage plan learns of an out-of-area admission before the IPA/medical group.
- Contacting the PCP to:
    - Clarify medication orders on the patient's behalf.
    - Coordinate care and expedited initial determination requests.
    - Obtain medical records when appropriate.
    - Respond to customer service issues.
    - Facilitate discharge planning.

6.6 Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

Member Rights and Responsibilities

All Blue Shield Medicare 65 Plus plan members receive in their *Evidence of Coverage (EOC)* a Statement of Member Rights and Responsibilities. The information below is taken from the Blue Shield 65 Plus (HMO) plan EOC.

We must provide information in a way that works for you (in languages other than English, in large print, in braille or other alternate formats, etc.).

To get information from us in a way that works for you, please call Customer Care at (800) 776-4466 [TTY 711] 8 a.m. to 8 p.m. seven days a week, year-round.

Our plan has people and free language interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with:

Blue Shield of California Civil Rights Coordinator

P.O. Box 629007 El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711) Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Care.

We must ensure that you get timely access to your covered services and drugs.

As a member of our plan, you have the right to choose a primary care physician (PCP) in the plan's network to provide and arrange for your covered services. Call Customer Care to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

Member Rights and Responsibilities *(cont'd.)*

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, please refer to Chapter 9, Section 10 of the EOC for details on what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

We must protect your privacy.

Federal and state laws protect the privacy of your medical records and protected health information. We protect your protected health information as required by these laws.

Your "protected health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These following exceptions are allowed or required by law:
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others.

Member Rights and Responsibilities *(cont'd.)*

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your protected health information, please call Customer Care.

We are always committed to protecting the privacy of your personal and health information. Our Notice of Privacy Practices describes both your privacy rights as a member and how we protect your personal and health information. To obtain a copy of our privacy notice, you can:

1. Go to blueshieldca.com and click the *Privacy* link at the bottom of the homepage and print a copy.
2. Call the Customer Care phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield of California Privacy Office toll-free at (888) 266-8080 (TTY 711), 8 a.m. to 3 p.m., Monday through Friday.
4. Email us at privacy@blueshieldca.com

We must give you information about the plan, its network of providers, and your covered services.

As a member of Blue Shield 65 Plus, you have the right to get information from us in a way that works for you, including getting the information in languages other than English, in large print, or other alternate formats, such as:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Provider Directory.

Member Rights and Responsibilities *(cont'd.)*

  - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Customer Care or visit our website at blueshieldca.com/find-a-doctor.

- Information about your coverage and the rules you must follow when using your coverage.
  - In Chapters 3 and 4 of the EOC we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of the EOC plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Care.
- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of the EOC. It gives you the details how to make an appeal if you want us to change our decision. (Chapter 9 in the EOC also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the EOC.

We must support your right to make decisions about your care.

Member Rights and Responsibilities *(cont'd.)*

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choice**s. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of the EOC explains how to ask the plan for a coverage decision.

Member Rights and Responsibilities *(cont'd.)*

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Care to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Member Rights and Responsibilities *(cont'd.)*

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with Livanta. See Chapter 2, Section 4 of the EOC for contact information.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of the EOC tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Care.

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at (800) 368-1019, TTY (800) 537-7697, or call your local Office for Civil Rights.

Member Rights and Responsibilities *(cont'd.)*

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Care.**
- You can call the **State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights.

There are several places where you can get more information about your rights:

- You can **call Customer Care**.
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare.**
  - Visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

    or
  - Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the plan.

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care. We are here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the EOC to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

Member Rights and Responsibilities *(cont'd.)*

- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Care to let us know.
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.

Member Rights and Responsibilities *(cont'd.)*

        - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Care.
    - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Care for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
    - Phone numbers and calling hours for Customer are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

Member Grievance Procedures

Blue Shield investigates Blue Shield Medicare Advantage plan member complaints, grievances, and appeals and follows a standard set of procedures for their resolution. All grievances and appeals are handled by Blue Shield. If the member asks the IPA/medical group about filing a complaint, the member should be referred to Blue Shield Medicare Advantage Plan Member Services. If the IPA/medical group receives a written complaint from a member, the complaint should be immediately forwarded to:

Blue Shield Medicare Advantage Plan Appeals & Grievances
P.O. Box 927
Woodland Hills, CA 91365-9856
Fax: (916) 350-6510

Blue Shield Medicare Advantage plan encourages questions and suggestions regarding any and all aspects of Blue Shield Medicare Advantage plan and the care received by its members. Comments are utilized to help improve the service provided. The Blue Shield Medicare Advantage Plan Member Services Department may be contacted with any problems or questions including those concerning coverage, procedures, physicians, hospitals, medical care, or reimbursement. If the problem or complaint cannot be resolved informally to the member's satisfaction, a member may file a grievance with Blue Shield Medicare Advantage plan. The grievance should include information about the complaint, specific facts relating to the complaint, and the reasons for lack of satisfaction.

Once the member files a grievance:

- Blue Shield Medicare Advantage plan must acknowledge receipt of the complaint within five calendar days and provide the name of the person who is working on the grievance; and
- Blue Shield Medicare Advantage plan will resolve the grievance within 30 calendar days of receipt.

If the member is not satisfied with the resolution of the complaint, the member may file a written request for a grievance hearing. The grievance hearing will be scheduled within 31 days of receipt of request and will be held at the Blue Shield Woodland Hills office location. The panel will include a Blue Shield Medicare Advantage plan Medical Director and a representative from the Blue Shield Medicare Advantage Plan Appeals and Grievances Department.

The member will be invited to attend, and representatives of the involved parties will have the opportunity to present their position. Following the hearing, all parties will receive a proposed resolution from the panel.

Member Grievance Procedures *(cont'd.)*

To resolve member issues more expeditiously, the Blue Shield Medicare Advantage Plan Appeals and Grievance Resolution Department has implemented the following process to research and respond to member grievances.

The following summarizes the Blue Shield Medicare Advantage plan grievance categories:

1. Complaints (grievances which do not involve quality-of-care issues) such as:
    - Wait time in medical office
    - Telephone access
    - No return telephone call
    - Misplaced medical records
    - Access to providers (scheduling difficulties)

All complaints are tracked and trended for future quality assurance purposes. The IPA/medical group will receive a Provider Notification Memorandum that may require a response within five business days or is informational only. The member receives a written response from Blue Shield Medicare Advantage plan concerning such issues.

2. Grievances (include but are not limited to):
    - Inappropriate behavior of provider personnel
    - Delay in referral
    - Referral denials resulting in care being adversely affected (also could be considered an appeal)
    - Quality of care issues
    - Miscommunication between member and provider regarding care/benefits

Grievances are member complaints that require research and response to the member. Grievances involving care issues require medical records. The IPA/medical group will be sent a Provider Notification Memorandum that requests medical records and a written response within five working days. Upon receipt of this information, a Blue Shield Medicare Advantage plan Medical Director will review it.

All Requests for Assistance (RFA) received from the Department of Managed Health Care (DMHC) on behalf of the member must be filed as a grievance, if not already done so, on behalf of the member and must have a written letter of response to the member. A personalized written response from Blue Shield Medicare Advantage plan will be sent to the member within 30 days from the date the RFA notification was received by the health plan.

Member Grievance Procedures *(cont'd.)*

The purpose of the letter to the member is to explain how his/her grievance was resolved and to educate the member as to how he or she may prevent similar incidents from occurring in the future.

IPA/medical groups must comply with the DMHC and Medicare Advantage requirements by responding to all requests for information to be used for grievance resolution as outlined on the previous page. In accordance with the detailed Provider Notification Memorandum request, the IPA/medical group needs to respond to each request within five working days from the date the Provider Notification Memorandum is sent.

All information provided by the IPA/medical group, as part of a response to a grievance, is considered confidential and is protected under peer review confidentiality provisions, according to state regulations.

Blue Shield Medicare Advantage plan retains the responsibility for resolving its members' grievances and does not delegate that responsibility to the IPAs/medical groups. The IPAs/medical groups agree to cooperate with Blue Shield Medicare Advantage plan in resolving member grievances related to the IPA/medical group or IPA/medical group physicians.

Blue Shield Medicare Advantage plan will bring to the IPA/medical group's attention all member complaints involving IPA/medical group physicians. The IPA/medical group will, in accordance with its procedures, investigate such complaints and use its best efforts to resolve them in a fair and equitable manner. Any action taken or proposed action by the IPA/medical group, with respect to the resolution of such complaints and the avoidance of similar complaints in the future, should be reported promptly to Blue Shield Medicare Advantage plan.

6.6 Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

Member Complaint and Appeals Resolution

A Blue Shield Medicare Advantage plan member may appeal any denials, termination, reduction of services, or payment for services. This includes denial of services or denial of payment after service has been rendered. An appeal may also be requested for services rendered for non-plan providers or suppliers that the member believes should have been provided, arranged for, or reimbursed by Blue Shield Medicare Advantage plan. An appeal may also include any adverse initial determination for treatment or services the member believes he/she is entitled to receive, which includes any delays in providing, arranging, or approving health services. Following the submission of a member appeal, Blue Shield Medicare Advantage plan will request that the IPA/medical group provide the necessary medical records and a copy of the initial determination mailed to the member within five business days to thoroughly evaluate the member appeal. In instances where the member has sought or obtained services from a non-contracted provider, Blue Shield Medicare Advantage plan will obtain the medical records directly from the provider.

Should a member not agree with an initial determination (denial of service or denial of claim), the member may request an appeal. The member must file the appeal in writing to Blue Shield Medicare Advantage plan.

> *Note:* All Medicare appeals must be processed by Blue Shield Medicare Advantage plan. Medicare appeals are not delegated to IPA/medical groups.

IPA/Medical Group Responsibility

When the initial determination is made by the IPA/medical group or hospital, the IPA/medical group or hospital will be responsible for sending the member an Initial Determination Letter containing the appropriate CMS-approved appeals language and denial reason.

Member Complaint and Appeals Resolution *(cont'd.)*

Blue Shield Medicare Advantage Plan Responsibility

Blue Shield is responsible for:

1. Acknowledging receipt of filed appeals within five calendar days.
2. Ensuring that a proper Initial Determination Letter was sent to the member by the appropriate party. If not, Blue Shield Medicare Advantage plan will request that the appropriate letter be issued by the responsible party. Through the delegation oversight process, a corrective action plan may be requested, if there is a failure to comply with this request.
3. Requesting a response from the IPA/medical group or hospital within nine (9) calendar days from the receipt of an appeal for all medical information used in making the determination. If additional medical records, in conjunction with the clinical information used in making the determination, are required for Blue Shield Medicare Advantage plan to properly evaluate the member appeal, Blue Shield will request that the IPA/medical group provide this additional information.
4. Either making a determination that is in the member's favor and informing the member, IPA/medical group, or hospital of the fully favorable determination within 30 calendar days from the receipt of an appeal for a pre-service denial or 60 calendar days for a claims denial; or, if the request is denied or partially denied, submitting the appeal request to Maximus Federal Services (Maximus) for external review. Maximus is an independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

   Maximus will either uphold or overturn the Initial Determination. If Maximus chooses to uphold the denial, Maximus will inform Blue Shield and the member. If Maximus overturns the Initial Determination, it will inform the member and copy Blue Shield Medicare Advantage plan, which will inform the IPA/medical group or hospital of the overturn.

   If the decision is favorable to the member, for standard service denials, Blue Shield Medicare Advantage plan will authorize within 72 hours of Maximus' decision or provide the service in question as quickly as the member's health requires, but no later than 14 days following the receipt of Maximus' decision. For expedited service denials, Blue Shield Medicare Advantage plan will authorize or provide the service in question as quickly as the members health requires but no later than 72 hours following the receipt of Maximus' decision.

   In instances where Maximus overturns a claim denial, Blue Shield Medicare Advantage plan will process the claim(s) either at contracted rates or Medicare allowable charges, whichever is applicable. The IPA/medical group or hospital is

Member Complaint and Appeals Resolution *(cont'd.)*

Blue Shield Medicare Advantage Plan Responsibility *(cont'd.)*

given the opportunity to respond within 10 days whether or not the claim(s) should be processed at a fee schedule different than the Medicare allowable rate.

Maximus decisions are final and binding on all parties. If a member is unsatisfied with the Maximus' resolution, he/she may request a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration if the amount in question is $100 or more. Maximus will be responsible for arranging the ALJ hearing and will notify Blue Shield Medicare Advantage plan.

Expedited Appeals

The Center for Medicare & Medicaid Services (CMS) requires an Expedited Appeal process be made available to all members. Expedited appeals apply to denied services/referrals or discontinuation of service or referral. When a member believes that his/her health or ability to function could be seriously harmed by waiting the 30 days for a standard appeal, he/she may request an Expedited Appeal. Medicare regulations require expedited requests be processed within 72 hours (including weekends). The expedited request may be filed by the member, a member representative, or by a physician on behalf of the member, and must be filed within 60 days of the denial of or discontinuation of the services.

A Blue Shield Medicare Advantage plan Medical Director will determine within 72 hours if the request meets criteria for an Expedited Appeal. Those requests which do not meet the criteria will be automatically transferred to the standard 30-day appeal process. Expedited Appeals may be requested by contacting the Blue Shield Medicare Advantage Plan Member Service Department at (800) 541-6652 (for providers), (800) 776-4466 (for members) [TTY 711]. A request may be faxed to (800) 303-5828 during business hours, 8 a.m. to 5 p.m., Monday through Friday.

Expedited Initial Request for Services

Section 422.562(a) of the Balanced Budget Act of 1997 requires that providers adhere to Medicare's procedures for expedited requests for treatment and expedited appeals for all MA Organization (MAO) enrollees, including gathering/forwarding information on appeals to MAO.

CMS has established that beneficiaries in MAOs (like Blue Shield Medicare Advantage plan) are entitled to the review of any request for a service or treatment within specific timeframes. CMS further requires MAOs to ensure that any delegated functions meet federal guidelines.

Expedited Appeals *(cont'd.)*

Expedited Initial Request for Services *(cont'd.)*

Regulations require that MAOs (and contracted delegated provider organizations) process standard requests to approve a service or referral within 14 calendar days. If a member (or physician) believes that a member has a condition that is "time sensitive" and requires urgent attention, an "expedited or 72-hour" review may be requested. Any service or referral that a member feels requires medical treatment that cannot wait for the standard 14-day timeframe may be requested to be handled as "urgent, speedy, or expedited." If a service request is requested to be expedited, that request must be reviewed as soon as medically indicated, but no longer than 72 hours from the time of the request.

CMS Definitions related to Expedited Initial Requests

Time Sensitive - Situations where the time frame of the regular decision-making process could seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum functioning.

> *Note:* If any physician requests a review to be expedited, that review must be expedited on behalf of the member.

Expedited Handling - As soon as medically appropriate, not to exceed 72 hours (including weekends and holidays). The 72 hours is measured from the time the request is received until notification (telephonic notice) to the member of a decision on the request. Should an expedited request be denied, a written notice must be mailed within three calendar days of the telephonic notification. Section 422.572(e)(2) further indicates written approval must follow for full or partial approvals within three calendar days of the oral approval of any expedited appeal. If medical information or medical records from outside the health plan are necessary in order to determine whether a request should be expedited, then the 72 hours begins when those records are received.

An extension of up to 14 calendar days is allowed if requested by the member or if the plan finds that it is in the member's best interest to have additional information, consultation or testing done. Extensions are not allowable for gathering information that should already be available from plan providers.

Expedited Appeals *(cont'd.)*

Expedited Initial Request for Services *(cont'd.)*

Blue Shield's Role in Handling Expedited Initial Requests

Should a Blue Shield Medicare Advantage plan member feel that his or her health could be jeopardized if an expedited decision is not made, the member is requested to contact Blue Shield Medicare Advantage Plan Member Services Department to request an expedited initial determination. Blue Shield will document the member's request and immediately forward the request to the contact person in the Medicare Appeals and Grievance Department for processing. All requests for expedited initial determination will be processed according to the CMS guidelines, within 72 hours. Blue Shield will monitor that expedited requests are completed according to the mandatory timeframes and will notify the members of any adverse initial decisions. If a group is unable to meet the mandatory timeframes and does not make a timely initial determination on an expedited request, a Blue Shield medical director will make the decision whether to approve or deny the request. Blue Shield will advise the member of his or her right to appeal.

Blue Shield will advise the member of the IPA/medical group of their decision and send the approval letter or denial notice to the members within three calendar days of the decision. All expedited initial requests will be logged and tracked by Blue Shield. If an MAO denies a request for an expedited initial determination, in addition to notifying the member within three calendar days, the MAO must inform the member of the right to submit a request for an expedited reconsideration with any physicians' support.

> *Note:* The above process may be extended up to 14 calendar days if it is in the member's interest.

IPA/Medical Group Role in Handling Expedited Initial Requests

Members are requested to make all expedited initial requests through Blue Shield. However, if the IPA/medical group receives a request for an "urgent, expedited or 72-hour" review that has not already been forwarded to the IPA/medical group by Blue Shield, the IPA/medical group should contact Blue Shield Medicare Advantage Plan Appeals and Grievance Department directly at (800) 894-5487.

> *Note:* Immediately notify Blue Shield Medicare Advantage plan Member Services of any request for an expedited initial determination. Do not delay review of an expedited initial request. Blue Shield will log the request as received as of the date the expedited request is made, as this is in the member's best interest, should an urgent medical issue need to be resolved.

Blue Shield will assist IPA/medical groups by monitoring that all expedited requests are closed according to federal guidelines. This process also allows Blue Shield to provide CMS with documentation to demonstrate oversight and compliance with the federal requirements.