# Medicare Advantage Plans

Medicare Advantage plans are a type of Medicare health plan offered by insurance companies that contract with CMS to provide members with coverage for the same benefits available as traditional Medicare, plus additional benefits.

## Service areas

We offer the following types of Medicare Advantage plans in these service areas:

| | Regence MedAdvantage PPO | Regence Medicare Advantage HMO |
|---|---|---|
| **Regence BlueShield of Idaho** | | |
| | Ada, Boise, Bonner, Boundary, Canyon, Gem, Kootenai, Latah, Nez Perce and Owyhee counties in Idaho | Ada and Canyon counties in Idaho |
| **Regence BlueCross BlueShield of Oregon** | | |
| | Benton, Clackamas, Columbia, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties in Oregon and Clark County in Washington | Lane County |
| **Regence BlueCross BlueShield of Utah** | | |
| | Box Elder, Cache, Davis, Iron, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington and Weber counties in Utah | Not available |
| **Regence BlueShield (in select counties of Washington)** | | |
| | King, Pierce, Snohomish, Thurston and Yakima counties in Washington | Snohomish County |

In this administrative manual, “Regence” refers to the following: Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah, and Regence BlueShield (in select counties of Washington). When information does not apply to all of these plans across the four states, then this administrative manual will identify the plan(s) or state(s) to which that specific information applies.

## Additional resources

In addition to the important information, rules and guidelines in this section for you and your staff to be familiar with as a contracted Medicare Advantage provider, the following important items are available on our provider website, **regence.com**.

- **Access and availability standards** are available in the Quality Program section: Programs>Quality>Quality Program. This program requires providers to adhere to our access and availability standards and guidelines, including emergency and after-hours care.
- **Durable medical equipment (DME) guidelines** are available in the Facility Guidelines section of this manual. Providers must follow CMS guidelines when providing DME.
- The **Claims and Payment** section allows you to learn how to identify members by reviewing sample member cards.
- **General product information** is available in Products. For complete and current benefit, copay, or coinsurance information, access Availity Essentials. All copays should be collected from the member at the time of service, except for members who are eligible for both Medicare and Medicaid benefits, when the state is responsible for paying any cost sharing amount.
- Physicians, other health care professionals and facilities are responsible for obtaining pre-authorization for all services listed on the **Medicare Pre-authorization List** in the Pre-authorization section.
- **Search for network providers** using our Find a Doctor tool. Services provided by network physicians, other health care professionals and facilities are reimbursed at the in-network benefit level.
- Learn more about our **Medical Management programs** in the Programs section.
- We participate in **Medicare Advantage PPO network sharing** with other Blue Cross and/or Blue Shield Plans (Blue Plans). Learn more in our BlueCard section. Regence MedAdvantage PPO providers whose patients are Medicare Advantage PPO members from other Blue Plans will:
  - Be reimbursed using Regence MedAdvantage PPO contracted rates
  - Receive payment for in-network benefits according to the member's contract
  - Extend the same contractual access to care to these members as Regence MedAdvantage PPO members
- Review important information and requirements for **risk adjustment** in the Risk Adjustment section of this manual and the Risk Adjustment program page under Programs.
- Our **Medicare Advantage incentive programs** are designed to reward providers who ensure that identified medical care or diagnosis gaps for Medicare Advantage patients are addressed and closed prior to the end of each year and can be found in the Programs section.

## Medicare Advantage requirements

CMS has implemented a significant number of Medicare Advantage regulations and requirements for health plans that also apply to contracted networks of providers.

As a Medicare Advantage participating provider, you are required to comply with these regulations and requirements, including the laws and regulations related to the prevention of fraud, waste and abuse. To assist with this effort, we provide information about relevant Medicare rules and regulations in the *Medicare Advantage Compliance Requirements* section of the *Administrative Manual*.

The first-tier, downstream and related entities (FDR) resources page on our provider website contains additional information regarding compliance program requirements: **regence.com/provider/products/medical/medicare/fdr-resources**.

Administrative requirements

- Providers agree to furnish all encounter data necessary to characterize the context and purpose of each encounter with a Medicare Advantage member. Providers agree that all encounter data will be used by us in validating rates with CMS and that all encounter data and other information submitted to us and ultimately CMS is accurate, complete, truthful and is based on the provider's best knowledge, information and belief. Providers acknowledge that misrepresentations about the accuracy of encounter data may result in federal civil action and/or criminal prosecution.
- Providers and entities delegated by them to perform administrative services are covered entities under federal and state privacy laws. To the extent required by law, providers, Regence and our contracted business associates will keep all medical records containing patient-identifiable information confidential and will not disclose any patient-identifiable information to any third party without the prior written consent of the member.
- Providers shall ensure services rendered are documented and incorporated into the member's primary care medical record. It is important for specialty physicians and other health care professionals to advise the referring physician when follow-up care is necessary.
- At all reasonable times, providers will grant Regence, CMS, the Comptroller General of the United States, and their duly authorized representatives the right of access to its facilities and to its financial and medical records which are directly pertinent to Medicare Advantage members in order to monitor and evaluate cost, performance, compliance measures reporting, quality improvement activities, appropriateness, and timeliness of services provided.
- In the event we terminate our Medicare Advantage contract with CMS, providers agree to continue to furnish health care services to our Medicare Advantage members for:
    - The duration of the period for which premiums have been paid, and
    - If the member is hospitalized on the date of termination or in the event of insolvency, through date of discharge from the hospital.
    - In the event a Medicare Advantage provider terminates their agreement with us, providers agree to notify us in writing in advance of the termination as indicated in their provider agreement. This timeframe is required in order to allow CMS required advance notification to our affected members, including any arrangements for continuity of care.

- The payments that providers receive from us are, in whole or in part, federal funds. We comply with all laws and regulations applicable to entities receiving federal funds.
- Claims for our Medicare Advantage members must be approved or denied no later than 60 calendar days from the date of receipt or as outlined in your agreement.

Cultural competency requirements

Medicare Advantage organizations are asked to ensure that services are provided in a culturally competent manner and allow members to choose those providers who may best serve their needs. CMS policy includes people:

- With limited English proficiency or reading skills
- Of ethnic, cultural, racial or religious minorities
- With disabilities
- Who identify as lesbian, gay, bisexual or other diverse sexual orientations
- Who identify as transgender, nonbinary and other diverse gender identities
- Who were born intersex
- Who live in rural areas and other areas with high levels of deprivation
- Who are otherwise adversely affected by persistent poverty or inequality

Providers also need to comply with these requirements. You can do this by:

- Keeping the information in our provider directories up-to-date by:
  - Confirming that practice information, including cultural competencies available within your practice, are correct in our provider directory
  - Indicating non-English languages you may speak, including whether you use American Sign Language (ASL)
  - Following the steps to validate and update the information in our provider directory, available on our provider website: Contact Us>Update Your Information
- Assisting patients in your offices by:
  - Keeping your location accessible for people with physical disabilities
  - Having skilled medical interpreters to help those members who need assistance

Occasionally, CMS calls providers to review the accuracy of our data in our provider directories. During those calls they may ask if you offer “Regence,” or the formal marketing name of the plan in their system. Please keep your staff up to date on the various names the member plan could be listed under.

Member benefits and services

- Medicare Advantage PPO plans allow members to be out of the service area for up to 12 months before being disenrolled. Medicare Advantage HMO plans allow members to be out of the service area for up to six months before being disenrolled.
- Medicare requires all members of Medicare Advantage plans to complete a Health Risk Assessment within 90 days of enrollment. We will send all newly enrolled Medicare Advantage members a Health Risk Assessment. We will assist physicians with enhanced case management for their patients who have complex or serious medical conditions. Case managers will work with physicians and other health care professionals to assess health status and establish and implement a treatment plan.

- Providers may not deny, limit or apply conditions to the coverage or furnishing of covered services to members enrolled in Medicare Advantage plans on the basis of any condition related to the member's current health status.
- Providers may not impose any cost-sharing to our Medicare Advantage members for influenza or pneumococcal vaccine.
- Neither Regence, nor any provider shall make any specific payment, directly or indirectly, to another physician or physician group as an inducement to reduce or limit medically necessary services furnished to a Medicare Advantage member.
- Providers agree not to bill our members for covered services (except for deductible, copayments or coinsurance) if payment has been denied because the provider has failed to comply with the terms of the agreement between the provider and us. Providers must notify the Medicare Advantage member of their financial obligation for non-covered services.
- Providers will make individual medical records available to patients or their legally designated representative upon request.

CMS guidelines for provider activities and materials

Providers may engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options.

Providers are permitted to make available and/or distribute plan marketing materials as long as they do so for all plans with which they participate. Additionally, providers may display posters or other materials announcing their contractual relationships.

Providers cannot accept enrollment applications or offer inducements to persuade beneficiaries to join plans. Providers are advised to refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their state Medicaid Office, local Social Security Administration Office, **medicare.gov**, or 1 (800) MEDICARE as providers may not be fully aware of all Medicare plan benefits and costs.

Provider affiliation information

Providers may announce new provider network affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., publicity, radio, television).

- An announcement to patients of a new provider network affiliation which names only one plan may occur only once when such announcement is conveyed through direct mail and/or email. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include all plans with which the provider contracts.
- Affiliation banners, displays, brochures, and/or posters located on the premises must include all plans with which the provider contracts.
- Materials that indicate the provider has an affiliation with certain plans and only lists plan names and/or contact information do not require CMS approval.
- Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS.

To obtain CMS approval for materials which promote or market your network affiliation with us, please send materials to us to ensure the content is appropriate. We will review the materials, make necessary corrections, and forward them to CMS for approval. To initiate this process, contact Robyn Meirose at (503) 391-8668. Please be advised that the CMS review process may take as long as 45 days.

Comparative and descriptive plan information

Providers may distribute printed information to their patients comparing the benefits of different plans (all or a subset) with which they contract.

- Providers may not health screen when distributing information to their patients.
- Materials may not "rank order" or highlight specific plans and should include only objective information.
- Materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution.

Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party.

Providers/Provider group websites

Providers may indicate website links to plan enrollment applications and/or provide downloadable enrollment applications. The website must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

Educational events

Providers may not distribute plan marketing materials or distribute or collect plan applications at educational events.

- Educational events are intended to provide objective information about the Medicare program and/or health improvement and wellness.
- Educational events must be identified with the disclaimer, "This event is only for educational purposes and no plan specific benefits or details will be shared."

## Required notices for hospitals, skilled nursing facilities and home health agencies

Medicare requires specific forms to be issued for every discharge from a hospital or skilled nursing facility (SNF).

Medicare Outpatient Observation Notice
The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act requires all hospitals and critical access hospitals (CAHs) to provide written notification and an oral explanation to Medicare beneficiaries who are receiving observation services as outpatients for more than 24 hours.

To accommodate this requirement, CMS created the *Medicare Outpatient Observation Notice* (MOON), form *CMS-10611*. All hospitals and CAHs are required to provide this notice to Medicare beneficiaries, including Medicare Advantage members. You can find the notice and accompanying instructions at: **cms.gov/Medicare/Medicare-General-Information/BNI**.

The MOON was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.

Hospital discharge notice
The *An Important Message From Medicare About Your Rights* form, along with additional information is available at **cms.gov/Medicare/Medicare-General-Information/BNI**.

Notice of Medicare non-coverage (NOMNC)
Our network SNF, home health and hospice (applies to participating MA hospice providers in Oregon and Utah only) providers with Medicare contracts are expected to deliver the NOMNC according to CMS guidelines at least two days before the last day of covered SNF, home health or hospice services for Medicare members. The NOMNC informs our members of the date they no longer meet criteria for SNF, home health or hospice care and describes their appeal rights.

We will request the clinical documentation to support continued SNF, home health or hospice care three to five days before the current authorization period ends. Based on our review, we will notify you of our determination as follows:

- If we determine that continued SNF, home health or hospice care is appropriate, we will send notification of the new authorized dates.
- If we determine that the patient no longer meets the criteria for SNF, home health or hospice coverage, we will prepare the patient-specific NOMNC and send it to you with our determination. **It is your responsibility to deliver the NOMNC to the patient or their authorized representative at least two days prior to the last day of coverage.**

Please follow these steps to ensure that the NOMNC is delivered in compliance with the requirements:

1. The SNF. home health or hospice agency discusses discharge with the patient and family or authorized representative informing them of the last covered day of services and presents the NOMNC provided by Regence.

2. The patient or authorized representative signs page 2 of the NOMNC. If the patient is unable to sign and the SNF. home health or hospice agency is working with an authorized representative who is unable to be present that day, the SNF, home health or hospice agency may issue the NOMNC by telephone. For a telephonic notice to be valid, the documentation on the NOMNC must include all of the following:

   - The name of the staff person initiating the contact
   - The name of the representative contacted by phone
   - The date and time of the telephone contact
   - The telephone number called
   - A notation that full appeal rights were given to the representative

   The date of the telephone conversation is the date of the receipt of the notice. The facility or agency must confirm the telephone contact by sending written notice to the authorized representative on that same date.

3. Please indicate on the NOMNC that the member is a participant in the VBID Hospice Model. This will be helpful for CMS Quality Improvement Organizations (QIOs), if needed.

4. Copies of the completed NOMNC are:
   - Given to the patient or the authorized representative who signed the NOMNC
   - Placed in the patient's medical record at the SNF,home health or hospice agency
   - Faxed to Regence at 1 (855) 240-6498 as soon as possible after the form is signed

NOMNCs can be issued early to accommodate a weekend or to provide a longer transition period. After delivery of the NOMNC, the patient may choose to appeal the decision. They must contact the Quality Improvement Organizations (QIO) to request a review no later than noon on the day before services are to end. The QIO appeal decision will generally be completed within 48 hours of the patient's request. Please be prepared to provide documentation to us quickly to assist the QIO review process.

<u>Provider responsibility for failure to deliver a valid NOMNC:</u>
Medicare Advantage providers are responsible for the delivery of the NOMNC. **If a QIO or Regence determines that you did not deliver a valid NOMNC to a beneficiary or that requested records were not returned by a stated deadline, you will be financially liable for continued services until two days after the beneficiary receives valid notice, or until the effective date of the valid notice, whichever is later.** You must supply all information, including medical records, requested for the QIO Appeal to Regence.

Notification requirements for Medicare Advantage home health agencies

In accordance with Medicare guidelines, home health agencies are required to submit a notice of admission (NOA) within five calendar days from the start of care date. There is a reduction in payment amount for late NOA submission. CMS instructions to submit the NOA can be located in the MLN Matters Article, *Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions*, on the CMS website: **cms.gov/files/document/mm12256.pdf.**

Home health agencies are required to provide written notification to Medicare patients before reducing or terminating an item and/or service and when home health services are ending.

In accordance with Medicare guidelines, home health agencies are responsible for issuing the following beneficiary rights and protections notices to Medicare patients when required:

- *Home Health Change of Care Notice* (HHCCN) Form CMS-10280
- *Advance Beneficiary Notice of Noncoverage* (ABN) Form CMS-R-131
- *Notice of Medicare Non-coverage* (NOMNC) Form CMS-10123
- *Detailed Explanation of Non-coverage* (DENC) Form CMS-10124

These forms are available on the CMS website at: **cms.gov/Medicare/Medicare-General-Information/BNI**.

## Releasing a member from medical care

Participating physicians and other health care professionals may release a patient who is enrolled in a Medicare Advantage plan from their medical care when in their professional judgment, it is in the best interest of the patient to do so.

Reasons for release

The reasons a member may be released from medical care include, but are not limited, to the following:

- Missed copayments, coinsurance or deductible.
- Threat or commission of an act of physical violence directed at a provider, their office staff, or other patients on their property.
- Disruptive, unruly or abusive behavior to the point that it seriously impairs the provider's ability to furnish services either to the member or other patients.
- Fraudulent or illegal acts, including permitting the use of their member card by others, altering prescriptions, theft or other criminal acts committed on the health care professional's office premises.
- Missed appointments, two or more. (The provider should document that they have attempted to ascertain the reasons for the missed appointments and has assisted the member in receiving services.)

While we recognize that a provider may release a patient from care based on their professional judgment, we discourage releasing Medicare Advantage members solely because:

- The member has requested a hearing.
- The member has a physical or mental disability.
- There has been an adverse change in the member's health.

- The member has been diagnosed with end-stage renal disease or placed in a hospice.
- The member has exercised their option to make decisions regarding their treatment.
- The member's utilization of services (either excessive or lack of) or mental illness, unless such mental illness has a direct impact on the physician or other health care professional's ability to deliver services.

Procedures for releasing a member from medical care

In cases of threats or acts of physical violence and fraudulent or illegal acts, the provider may immediately release a member from their medical care and simultaneously give Regence verbal notice that they have done so. In follow-up, the provider must provide written documentation to Regence documenting the circumstances leading to the release upon request.

For all other circumstances, the following steps must be adhered to when releasing a member from medical care:

1. Consistent with professional and ethical standards, the provider must notify the member within a reasonable time up to 30 days in advance of the provider's intent to release the member from their care. Providers should simultaneously provide verbal notice to Regence. The written notice to the member can be either by certified mail or first-class US mail to the member's last known address (when it is the policy of the practice to confirm current addresses at each visit). The words "address services requested" must appear in the upper left corner, under the return address on the front of the envelope.
2. During the period after notification has been given and before termination becomes effective, the provider will remain responsible for providing acute, urgent or emergent medical care to the member.
3. The provider agrees to make medical records available to another provider on request from the member.
4. We can assist in locating another provider on the network who will accept the member as the provider's patient. If needed, we shall obtain a release of information in order to share the information necessary for a new provider to evaluate if they can treat the member.
5. The provider should make every effort to work with the member to resolve the presenting problem or problems. The provider must document in the medical record all efforts made to resolve the situation.

## Advance directive

The goal of the Federal Patient self-determination Act (Section 4751 of OBRA 1991) and Natural Death Act (Chapter 70.122 RCW) is to provide the member with the knowledge and tools necessary to create an advance care document if they so desire and to ensure that it becomes part of the medical record.

"In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control their health may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care". Washington State Chapter 70.122 RCW, Natural Death Act, 1966.

There are two advance directive forms:

- The "Power of Attorney for Health Care"
- The "Living Will – Directives to Physicians"

If members have signed either of these forms, copies should be included in their medical record. For all Medicare Advantage members, documentation should include discussions of a member's right to predetermine future health care and specific treatment preferences if expressed. Providers and staff members who make entries on member charts regarding this subject should identify themselves by signing or initialing each entry.

To ensure our member's wishes are met concerning the provision of health care if the member becomes incapacitated and is unable to make those wishes known, providers and facilities should comply with the following:

- The office or facility should either have copies of advance directives available for their patients to complete or advise the patient how to obtain one from the hospital or their attorney.
- If the office has received a signed advance directive, a copy of the document must be prominently displayed in the patient's chart so that it is easy to see.
- The provider must document in a prominent location within the patient's medical record **whether or not** the patient has executed an advance directive.

## Member rights and responsibilities

We are committed to providing Medicare Advantage members with the best possible health care coverage. Members are entitled to be treated in a manner that respects their rights and addresses their responsibilities.

We have developed a written policy based on regulatory requirements for entities such as CMS and Federal and State Patient Protection Acts.

Enrolled members are responsible for protecting these rights. Our participating physicians, other health care professionals and facilities are also contractually obligated to respect these rights.

Member rights

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Although we establish guidelines that affect how benefits are paid, no one can deny beneficiaries the right to make their own decisions. Medicare Advantage members have the right to:

*Timely and quality care*

- Access to emergency services
- Timely access to all covered services
- Access to a network of qualified physicians
- Access to urgently needed services when traveling outside the service area or in the service area
- Receive care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- Participate with physicians and other health care professionals in decision making regarding their care and treatment planning
- Continuity of care, and to know in advance the time and location of an appointment, as well as the provider who will render care
- Participate in a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage

*Treatment with dignity and respect*

- Be treated with respect, dignity and compassion
- Timely access to medical records, except as authorized by state law
- Confidential treatment of all communications and records pertaining to their care
- Expect these rights be observed by the Plan, contracted physicians, and other health care professionals
- Be involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment
- Complete an advance directive (living will) or other directive to their physician(s) and other health care professional(s)
- Extension of the member's rights to any person who may have legal responsibility to make decisions on the member's behalf
- Understand the reason for tests, treatments, or procedures, know the identity of the person who provides them, and the associated risks
- Refuse treatment or leave a medical facility, even against the advice of physicians, provided the member accepts the responsibility and consequences of the decision
- Refuse to sign a consent form if they feel they do not understand its purpose, or to cross out any part of the form they do not want applied to their care, or to change their mind about any treatment for which they have previously given consent
- Exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for their care

*Health plan and other important information*

- Understand utilization control procedures
- Receive statistical data on grievances and appeals
- Receive general coverage and plan comparison information
- Receive information on the financial condition of their health plan
- Expect a clear explanation regarding benefits and exclusions of their policy
- Summary of physician and other health care professional's compensation agreements
- Examine and receive an explanation of any bills for non-covered services, regardless of payment source
- Be informed of continuing care requirements following discharge from inpatient or outpatient facilities
- Receive information about their medications – what they are, how to take them and possible side effects
- Know the name and qualifications of the physicians, nurses or other health care professionals providing care
- Receive information about illness, the course of treatment and prospects for recovery in terms they can understand
- Receive as much information as needed about a proposed treatment or procedure to give or refuse informed consent about a course of treatment
- Receive information regarding how medical treatment decisions are made by the health plan or contracted medical groups, including payment structure
- Be advised if a provider proposes to engage in experimentation affecting their care or treatment, and the right to refuse or participate in such research projects
- Receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements
- Except in cases of emergency services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks

*Timely problem resolution*

- Receive timely responses to reasonable requests made for covered services
- Make recommendations regarding the health plan members' rights and responsibilities policies
- Be informed of their right to voice a complaint about their health plan or the care provided including the right to appeal, and the process involved
- Present questions, concerns, or complaints to Customer Service without discrimination and expect problems to be fairly examined and appropriately addressed

<u>Member responsibilities</u>

We are committed to providing our Medicare Advantage members with the best possible health care coverage. Members are entitled to be treated in a manner that respects their rights and addresses their responsibilities.

We have developed a written policy based on regulatory requirements for entities such as CMS and Federal and State Patient Protection Acts.

Enrolled members are responsible for protecting these rights. Our participating physicians, other health care professionals and facilities are also contractually obligated to respect these rights.

In addition to their rights, Medicare Advantage members have the responsibility to:

- Be on time for appointments
- Read and understand all material concerning their health benefits
- Call Customer Service if a question arises or there is a payment issue
- Ask questions of their physician, other health care professional or Regence
- Call their provider if they are going to be late for an appointment
- Pay their provider applicable fees for a missed appointment
- Contact Customer Service by phone or in writing if they feel they are not receiving adequate care
- Follow Plan requirements to have services properly authorized before receiving medical attention
- Notify their provider as soon as there is a need to cancel an appointment
- Accept the financial responsibility for any premiums associated with membership in a Medicare Advantage plan
- Act in a manner that supports the care provided to other patients and the general functioning of the office or facility
- Let us know if they have any concerns, or if they feel their rights are being compromised so we may act on their behalf
- Do their part to improve their health condition by following the plans and instructions that are recommended by those providing care
- Identify themselves as a member Medicare Advantage member and present their member card when requesting health care services
- Review information regarding covered services and policies and procedures as stated in their Evidence of Coverage or Member Handbook
- Participate, to the degree possible, in understanding their health problems including behavioral health, and developing mutually agreed upon treatment goals
- Provide complete health information to their provider to assist in an accurate diagnosis and appropriate treatment
- Provide, to the extent possible, information that their health care organization and its physicians and other health care professionals need in order to provide care
- Check their Evidence of Coverage or Member Handbook and follow proper procedures for illness or accidents needing medical attention after business hours
- Accept the financial responsibility for any copayment or coinsurance associated with covered services while under the care of a provider or while a patient at a facility

## Appeal and grievance procedures

There are several levels of appeal and grievance rights available to Medicare Advantage members:

Appeal procedures
Medicare Advantage members have a legal right to file an appeal if they do not agree with the Plan's decision regarding medical claims, or if they think:

- The Plan has not paid a claim
- The Plan has not paid a claim in full
- The Plan did not approve benefits for services that the member believes should be covered

*Standard appeal process*
A member must request an appeal of an adverse determination in writing within 60 days of the date of the Plan's determination. Appeal requests may be accepted beyond this 60-day guideline if the member can provide documentation for "good cause" as to why the appeal request is late. It is the Plan's responsibility to decide whether or not to accept an appeal request beyond the 60-day guideline, and if so, to fully document the reason.

An appeal request must be made in writing and signed by the member or their appointed representative for pre-service and post-service denials, or by a treating physician or prescribing physician or other provider, for pre-service denials.

If the appeal request is made by anyone other than the member or their provider, the Plan must have the enrollee's written permission for that person to act on their behalf. The Plan must have a signed Appointment of Authorized Representative form or a copy of the Power of Attorney in order to proceed with an appeal from someone other than the enrollee.

A non-participating provider may become a party to an appeal only if the provider has executed a waiver of liability form. This form ensures that the enrollee will not be held financially responsible for any charges should the provider lose the appeal. A sample waiver of liability form is available with other Medicare forms in the Forms & Documents section on our provider website. The form is also available from CMS at **cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms**.

*How to file an appeal*
If a member wishes to file an appeal, they may call Customer Service and request an appeal form. The member may also print an appeal form from our website, complete it, and send it to the following address:

Medicare Advantage
ATTN: Appeals and Grievances
P.O. Box 1827
Medford, OR 97501

The member may also fax the written request to 1 (888) 309-8784.

*Support for an appeal*
The member has the opportunity to provide additional information in support of an appeal in person or in writing. In the case of the expedited appeal, the member or their authorized representative may submit evidence in person, via telephone, or in writing via fax at the address and telephone number referenced above under "How to File an Appeal".

*Expedited appeal process*
Members who believe that waiting for a reconsideration of a pre-service denial under the standard 30-day appeal process could jeopardize their life, health or ability to regain or maintain maximum function may request an expedited appeal.

The expedited appeal process is for pre-service denials only. Claim denial issues are not eligible for the expedited appeal process.

A member, member's authorized representative or physician may request an expedited appeal verbally or in writing. Issues that may be expedited include, but are not limited to, any request for an expedited appeal from a physician or an appeal of a pre-service denial for:

- A terminally ill patient
- An experimental and/or investigational treatment (depending on the patient's condition)
- A refusal by the provider to proceed with a scheduled service because the Plan has failed to give an authorization

Upon receipt of an expedited appeal request, a response must be made to the appealing party within 72 hours, or as expeditiously as the member's health requires. This can be extended by up to 14 calendar days, if the extension is in the member's best interest.

*Second-level appeals – MAXIMUS Federal Services*
If the Plan's initial decision is adverse, the appeal is prepared for review by MAXIMUS Federal Services (a CMS contractor). MAXIMUS will make a determination and notify the Plan and the member in writing. MAXIMUS must adhere to the same timeliness guidelines as the Plan in making their determination:

- For expedited cases, a decision must be rendered within 72 hours, with a 14 calendar day extension if it is in member's interest, or sooner if warranted by the member's medical condition.
- For standard pre-service cases, a decision must be rendered within 30 calendar days, with a 14 calendar day extension if it is in the member's interest, or sooner if warranted by the member's health condition.
- For standard claim cases, a decision must be rendered within 60 calendar days.

If the Plan is overturned by MAXIMUS, the Plan must effectuate, authorize or provide the service within 72 hours for expedited cases. For standard pre-service cases, the Plan must effectuate, authorize the service, within 72 hours, or provide the service within 14 days. For standard post-service cases, the Plan must pay the claim within 30 days of notification from MAXIMUS.

*Additional appeal rights for members*
Additional appeal rights exist for members beyond the MAXIMUS Federal Services process:

- If MAXIMUS Federal Services decision is not in the member's favor and the dollar value of the medical care is at least $130, the member may ask an administrative law judge (ALJ) to consider the case.
- If the member or the Plan is unsatisfied with the decision made by the ALJ, a review request may be made to the Medicare Appeals Council. If the member or the Plan is unsatisfied with the decision made by the Medicare
  Appeals Council, the case may be taken to a Federal Court in which case the dollar value of the medical care must be at least $1,260.

*Fast-track appeals*
Medicare Advantage members have the right to an expedited review by a Quality Improvement Organization (QIO) if they disagree with the Plan's decision to discontinue coverage of skilled nursing facility (SNF), home health agency (HHA), or certified outpatient rehabilitation facility (CORF) services. QIOs are contracted with CMS to direct and review fast track appeals.

Upon notification from the QIO that a member is requesting a fast-track appeal, the Plan's appeal coordinator requests a copy of the Notice of Medicare Non-Coverage (NOMNC) notice from the provider. If the notice is valid, the appeal coordinator will provide the QIO with pertinent medical records and a Detailed Explanation of Non-Coverage (DENC). If the notice is invalid, the appeal coordinator will rescind the NOMNC and require the provider to issue a valid NOMNC.

If the QIO concurs with the Plan's decision to discontinue coverage, the member is responsible for any and all charges after the date given on the NOMNC. If the QIO overturns the Plan's decision to discontinue coverage, the member's services are covered until the Plan issues another NOMNC.

If the member or member's authorized representative disagrees with a QIO's decision to concur with the Plan, reconsideration may be requested from the QIO within 60 days of the date of the decision. The QIO will have 14 days to have another physician review the case and render a decision.

If the QIO's reconsideration again concurs with the Plan's decision, the member or member's authorized representative may request an ALJ hearing within 60 days of the date of the reconsideration decision by the QIO. If the ALJ upholds the Plan denial, the member or member's authorized representative may request a review by the Departmental Appeals Board (DAB). If the DAB concurs with the Plan's decision, the final level of appeal is to the Federal District Court.

Grievance procedures

Medicare Advantage members have a legal right to file a grievance if they are dissatisfied with any action of the Plan, Plan staff, and/or a contracted physician or other health care professional. A member may file a grievance verbally or in writing about problems they observe or experience, including:

- Physician or medical facility issues
- Involuntary disenrollment situations
- If the member disagrees with the decision to process their appeal request under the standard 30-day time frame rather than the expedited 72-hour time frame

If the request is made by anyone other than the enrollee, the Plan must have the member's written permission for that person to act on their behalf. The Plan must have a signed Appointment of Authorized Representative form or a copy of the Power of Attorney in order to proceed.

*Standard grievance process*

All grievances are investigated and responded to within 30 days from the date the grievance is received. The Plan may take an extension of up to 14 days if it notifies member.

A Grievance that is defined as a quality of care issue or has the potential to be a quality of care issue will be routed to the appropriate Plan staff for review. The quality of care grievance response includes information about how the member may file a separate complaint with the QIO.

We fully cooperate with the QIO on resolving the complaint.

*Expedited grievance process*

The Plan will identify grievances that must be processed in an expedited timeframe.

Expedited grievances will be resolved and the member will be notified within 24 hours of receipt of the verbal or written grievance.

*How to file a grievance*

If a member would like to file a grievance, they may call Customer Service at 1 (800) 541-8981. Our staff will attempt to resolve the dispute on an informal basis. If informal attempts do not resolve the problem, and the member wishes to file their complaint verbally, the complaint information will be taken over the phone, repeated back to the member and documented. The member must file the grievance within 60 days of the event or incident that precipitated the grievance. The member may also print a grievance form from our website, complete it, and send it to the following address:

Medicare Advantage
ATTN: Appeals and Grievances
P.O. Box 1827
Medford, OR 97501

The member may also fax the grievance to 1 (888) 309-8784. The request should be filed with us as soon as possible after any action taken by the Plan, the Plan's contracted physician or other health care professional, or a Plan's representative has left the member dissatisfied.

## HMO primary care providers

Our Medicare Advantage HMO plans require members to select a primary care provider (PCP) at the time of enrollment. If the member does not select a PCP, we will assign one for him or her. PCPs in our network may include family practice, general practice, geriatric, and internal medicine physicians, nurse practitioners and physician assistants/physician associates. Pediatricians may also be used as a PCP if appropriate for the member. Our Provider Directory includes a full list of providers who may act as PCPs.

Changing PCPs

Members may change their PCP selection by contacting us. The change will be effective the first of the following month.

Responsibilities of PCPs

The PCP is responsible for serving as the manager for all health care provided to the member who has selected them. This includes:

- Providing all primary health care services and screenings.
- Pre-authorizing all services listed on the Medicare Products Pre-authorization List.
- Ordering all lab and x-ray services to be performed either in the PCP's office, or at an office of a participating specialty physician, other referral provider, laboratory or health care facility.
- Maintaining the member's medical record and documentation in accordance with our standards and ensuring that information from specialty physician or other referral providers is reviewed and included in the medical record.
- Providing or arranging for health care 24 hours a day, seven days a week. Members are instructed to contact their PCP prior to seeking medical care in all cases except emergencies. In the event of an emergency, members are asked to contact their PCP as soon as possible.
- Entering referrals to participating specialty physicians or other referral providers when specialized care is needed. PCPs are responsible for entering the referral in a timely manner prior to the member receiving services. If a referral is needed for care that can only be provided outside the HMO network, the PCP must obtain prior authorization for this. See the Referrals section of this manual for details about the services that require referrals and the procedures to follow.

Transition of Care

If a new Medicare Advantage HMO member is currently in a course of treatment with an out-of-network provider, they may request assistance with their transition of care by calling Customer Service. We will review for medical necessity. If the review supports it, we will pay their out-of-network provider as in-network for up to 90 days to avoid increased risk to the members' health.

## Medicare Star Ratings

CMS assigns Medicare Advantage plans with a quality rating on an annual basis using a five-Star Rating system.

Star Ratings give Medicare beneficiaries a standardized way to compare Medicare health plans on overall quality and service - and determine the highest quality plans in their area.

Each Medicare Advantage plan is assigned an overall rating from one to five stars, based on the plan's performance in more than 50 specific areas across several general categories.

- **Staying healthy:** How often members receive screening tests, vaccines, physical examinations and other preventive services to help them stay healthy. This reflects how well the plan keeps members healthy through checkup reminders and general communication.
- **Managing chronic conditions:** How often members get recommended tests and treatments for long-term health issues. This reflects how well the plan helps members get these recommended tests and treatments.
- **Member experience:** How satisfied members are with their health plan and how they feel about the quality of care they receive from the health plan and providers.
- **Customer service:** How responsive and helpful the plan's customer service is, the accuracy of information given to members, appeals processing and enrollment timeliness.
- **Member complaints:** How often members found problems with the plan. It also measures how much the plan's performance improved year over year.
- **Pharmacy benefits:** How often members are prescribed medications that are safe and clinically recommended, how accurate medication pricing is and member experience.

The ratings, updated annually, are based on ongoing monitoring and analysis to represent:

★★★★★ Excellent performance

★★★★ Above average performance

★★★ Average performance

★★ Below average performance

★ Poor performance

**Star Rating measures**

Star Ratings reflect the performance of each Medicare Advantage plan in individual measures consisting of:

- Clinical quality standards
- Member satisfaction surveys
- Health plan administrative performance
- Compliance with CMS operational standards

The data sources used to create the Star Ratings include:

- Clinical quality standards and member satisfaction surveys:
  - Health Outcomes Survey (HOS)
  - Health Effectiveness Data and Information Set (HEDIS®)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Administrative performance and compliance standards:
  - CMS audits
  - Part D data integrity
  - Grievance and appeals
  - Call center performance
  - Member complaint tracking

**Our initiatives to maintain or improve Star Ratings**

We remain focused on achieving the highest possible scores in order to improve the health of our members, attract new members to our high-quality plans and continue offering competitive reimbursement to our providers.

We continually evaluate our overall ratings and the individual measures that comprise them. This may result in increased focus on quality program initiatives, such as HEDIS measures and risk adjustment reviews.

**Medicare Advantage incentive programs**

Our Medicare Advantage incentive programs are designed to reward providers who ensure that identified medical care or diagnosis gaps for Medicare Advantage patients are addressed and closed prior to the end of each year.

**How can you support and improve Star Ratings?**

We encourage all of our providers to provide five-star level services to our members. You help impact our Star Ratings by:

- Submitting claims and documenting all services thoroughly and accurately.
- Ensuring your patients receive appropriate screening tests and preventive services. We encourage our members to have an annual wellness visit each year.
- Helping your patients manage their chronic conditions, such as high blood pressure, arthritis and diabetes. Our care management program can provide additional support for patients with complex needs.
- Avoiding high-risk medications for your elderly patients. We will notify providers who have patients on high-risk medications and encourage the use of alternatives wherever possible.
- Meeting the requirements for Medicare Advantage providers, including advance directives and access and availability standards.
- Understanding the impact that you and your office staff have on member satisfaction with their health care experience, which is reflected in the CAHPS and HOS surveys. Use our *Provider checklist for member surveys* to promote a positive experience for members. The checklist is available in the Forms & Documents section on our provider website.