BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois
Provider Manual

Blue Cross Community MMAI (Medicare-Medicaid Plan)SM

2024

Blue Cross Community MMAI (Medicare-Medicaid Plan) is provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC's plan depends on contract renewal.

Table of Contents

Overview

The State of Illinois has been designated by the Centers for Medicare & Medicaid Services (CMS) to participate in a demonstration program designed to help better service individuals who are eligible for both Medicare and Medicaid. This partnership will include a three-way contract with CMS, the State of Illinois and Blue Cross and Blue Shield of Illinois (BCBSIL) to provide integrated benefits to Medicare-Medicaid enrollees. The network will consist of independently contracted providers including physicians, hospitals, skilled nursing facilities, ancillary providers, long-term services and support and other health care providers (hereafter referred to as “Providers”) through which Members may obtain Covered Services.

MMAI is available to individuals eligible for Medicare and Medicaid in the approved service area in the State of Illinois. BCBSIL will furnish Members with a Member Handbook that will include a summary of the terms and conditions of its plan.

BCBSIL is committed to working with Providers and Members to achieve a high level of satisfaction with the delivery of quality healthcare services. One of the goals of BCBSIL is to break down the financial, cultural, and linguistic barriers preventing low-income families and individuals from accessing health care.

About the Provider Manual

This Provider Manual and related Policies and Procedures are designed to provide information regarding MMAI operations and plan benefits. BCBSIL shall notify Providers of any changes to the Provider Manual.

Questions regarding the information outlined in this Provider Manual may be directed to Provider Network Services

Key Contact Information

The Provider Manual is a reference for Contracted Providers to use while working with BCBSIL. Providers who have questions may refer to the following chart for a listing of additional resources and related information, such as important telephone, website, and fax numbers. Additional detail may be located on our website at https://www.bcbsil.com/provider/network/network/medicaid.

MMAI Contact Information		
Department	**Telephone Number**	**Fax Number and/or Link**
Availity	1-800-AVAILITY	www.availity.com
ERA/EOB/EOP *if unable to locate in Availity*		https://www.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=7d08cfc4-b2f7-4508-9656-9fd13149f58e&env=na1&acct=beab3a5b-1a85-4b70-bccf-c7372074b491&v=2
Customer Services and Eligibility Verification	877-723-7702 Available Weekdays: 8am – 5pm CST	855-674-9193
Provider Data Management: Demographic Change Form Provider Onboarding Form Roster Requests and Submissions		https://www.bcbsil.com/provider/network/network/information-update
Provider Network Services	877-723-7702	855-674-9193
Electronic Claims Submission Facility and Professional claims Payer ID: MCDIL	877-723-7702	
Provider Claims Dispute	877-723-7702	Dispute: 855-322-0717 Claims Inquiry: 855-756-8727
Prior Authorizations: eviCore	855-252-1117 Available Weekdays: 7am-7pm CST	https://www.evicore.com/provider
Medical Management *(Including prior authorization requests, care management and discharge planning)*	877-723-7702	312-233-4060
Inpatient Admissions	877-723-7702	312-233-4060
Medical Appeals and Grievances Blue Cross Community MMAI PO Box 660717 Dallas TX, 75266-0717	877-723-7702	866-643-7069 Expedited Appeals: 800-338-2227
BCBSIL Medicaid Quality Dept		Il_medicaid_qui@bcbsil.com
Pharmacy Prior Authorization	800-693-6651	800-693-6703
Pharmacy Help Desk	888-840-3068	
Behavioral Health	877-723-7702	Utilization Management 312-233-4099
Dental Care	888-875-7482	855-674-9192
Transportation Provider Modivcare Inc	877-917-4149	
Vision Care	800-584-3140	800-328-4788
TTY number for the Hearing Impaired	711	711

MMAI Contact Information (Con't)		
Department	**Telephone Number**	**Fax Number and/or Link**
Language Interpreter Services *(Including sign language and special services for the hearing impaired.)*	877-723-7702	855-674-9193
BCBSIL Secured Email Lockout Assistance	888-706-0583	
Additional Helpful Contacts		
Adult and Children's Mental Health Crisis Hotline	CARES Hotline 800-345-9045 TTY (Toll Free) 866-794-0374	
HFS Provider notices	https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx	
IAMHP (Illinois Association of Medicaid Health Plans)	https://iamhp.net/providers	
State of Illinois Client Enrollment Services	1-877-912-8880	
Compliance Reporting		
Fraud, Waste, and Abuse Reporting	800-543-0867	
Department of Public Health	800-252-4343	
Illinois Office of Inspector General	800-368-1463	
Elder Abuse Hotline	866-800-1409	

Member's Rights and Responsibilities

BCBSIL is committed to ensuring that enrolled Members are treated in a manner that respects their rights as individuals entitled to receive health care services. BCBSIL also strives to support the cultural, linguistic, and ethnic preferences and needs of our Members. BCBSIL policies are designed to help address the issues of Members participating in decision-making regarding their treatment, confidentiality of information, treatment of Members with dignity, courtesy, and a respect for privacy, and Members' responsibilities in the practitioner-patient relationship and the health care delivery process.

BCBSIL also holds forth certain expectations of Members with respect to their relationship to the managed care organization and the Providers participating in MMAI. These rights and responsibilities are reinforced in Member and Provider communications, such as the BCBSIL website. As a Provider, you need to be aware of what BCBSIL communicates to Members in the Member Handbook. These rights, as stated below, should be enforced by Provider and Provider's staff.

Member's Rights and Responsibilities

Various components of the BCBSIL Quality Improvement (QI) Program incorporate elements of Member rights (See the Benefits and Beneficiary Rights section of this Provider Manual), which may include:

- Policies on inquiries and complaints
- Policies on appeals
- Policies on quality-of-care complaints
- Access and availability standards
- Member involvement in satisfaction surveys
- Member involvement in the development of their care plan and in their Interdisciplinary Care Team

In addition, the policy on Member Rights and Responsibilities further defines the relationship between the Member, the practitioner, and MMAI.

Member Rights:

- The right to receive information about the organization, its services, its practitioners and providers and Member rights and responsibilities.
- The right to be treated with dignity and respect.
- The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
- The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition, Functional Status, and language needs.
- The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
- The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
- Access to an adequate network of primary and specialty Providers who are capable of meeting the Member's needs with respect to physical access and communication and scheduling needs and are subject to ongoing assessment of clinical quality including required reporting.

- The right to receive a second opinion on a medical procedure and have MMAI pay for the second opinion consultation visit.
- The right to choose a plan and Provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month.
- The right to have a voice in the governance and operation of the integrated system, Provider, or health plan, as detailed in the Three-way Contract.
- The right to participate in all aspects of care and to exercise all rights of appeal. Members have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Members must:
    a. Receive an in-person Comprehensive Assessment upon enrollment in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Member's strengths and weaknesses, and a plan for managing and coordination of Member's care. Members, or their designated representative, also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.
    b. Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.
    c. Be provided the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
    d. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration Member's condition and ability to understand. A Member who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
        i. Before enrollment.
        ii. At enrollment.
        iii. At the time a potential Member or Member's needs necessitate the disclosure and delivery of such information in order to allow the potential Member or Member to make an informed choice.
    d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
    e. Have Advance Directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102.
    f. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
    g. Be afforded the opportunity file an Appeal if services are denied that the Member thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.
- The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each Member is free to exercise the Member's rights and that the exercise of those rights does not adversely affect the way MMAI and its Providers or the State Agency or CMS provide, or arrange for the provision of, medical services to the Member.
- The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year and the right to receive notice of any significant change in the information provided in the Orientation materials at least thirty (30) days prior to the intended effective date of the change. See 438.10(g),(h).
- The right to be protected from liability for payment of any fees that are the obligation of MMAI.
- The right not to be charged any cost sharing for Medicare Parts A and B services.
- The right to make recommendations regarding the organization's Member rights and responsibilities policy.

Member Responsibilities:

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and Providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- A responsibility to show their ID card before getting health care service.
- A responsibility to keep their appointment or call at least 24 hours in advance if they need to reschedule or cancel.

Nondiscrimination

BCBSIL and the Provider may not deny, limit, or condition enrollment to individuals eligible to enroll in the MMAI plan offered on the basis of any factor that is related to health status, including, but not limited to the following:

- Claims experience
- Receipt of health care
- Medical history
- Medical conditions arising out of acts of domestic violence
- Evidence of insurability including conditions arising out of acts of domestic violence and disability

Additionally, BCBSIL and its Providers must:

- Comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act (ADA), and the Genetic Information Nondiscrimination Act of 2008.
- Confirm that procedures are in place to ensure that Members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Not close their panel or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured patients.

Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with federal guidance, BCBSIL will accept third-party payment for premium directly from the following entities:

(5) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations, or urban Indian organizations; and (3) state and federal government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the covered persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all of an enrollee's premium.

Confidentiality of Member Information

Providers must comply with all state and federal Laws concerning minor consent and confidentiality of health and other information about Members. Providers must have policies and procedures in place regarding use and disclosure of health information that comply with applicable Laws. BCBSIL Members have the right to privacy and confidentiality regarding their health care records and information. Providers and each member of their staff must sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Basic Rule
BCBSIL and its Providers must provide Members with all Original Medicare and Medicaid services. The following requirements apply:

- Benefits: must provide or arrange for medically necessary Part A (for those entitled), Part B and Part D (prescription drugs) covered items and services as set forth in the MMAI Plan.
- Access: Members must have access to all covered medically necessary items and services.

Uniform Benefits
All plan benefits must be offered uniformly to all Members residing in the Service Area of the plan.

Benefits During Disasters and Catastrophic Events
In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a governor or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent an 1135 waiver by the Secretary, Medicare Medicaid Plans are expected to:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities;
- Waive in full, requirements for gatekeeper referrals where applicable;
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost-sharing amounts; and
- Waive the 30-day notification requirement to Members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the Member.

Access and Availability

Providers are expected to provide coverage for Members twenty-four (24) hours a day, seven (7) days a week. In addition, Providers must maintain a twenty-four (24)-hour answering service and ensure that each PCP provides a twenty-four (24)-hour answering arrangement, including a twenty-four (24)-hour on-call PCP arrangement for all Members. An answering machine does not meet the requirements for a twenty-four (24)-hour answering service arrangement. Hospital emergency rooms or urgent care centers are not substitutes for covering providers.

After-hours access shall be provided to help ensure a response to after-hours phone calls. Members who believe they have an Emergency Medical Condition should be directed to seek Emergency Services immediately.

The following appointment availability and access guidelines should be followed by Providers to ensure timely access to medical care. Members requesting other than routine/preventive services will be triaged by the Provider(s) medical staff to determine which appointment type is needed.

Overall Compliance Appointment Type	Provider Type (can be matched to data file)	Compliance
Routine/Preventive	PCP (Adult)	5 weeks
Routine/Preventive	PCP Ped (<6 Months)	2 weeks
Non-urgent / Requires Medical Attention	PCP (Adult)	7 Business Days
Non-urgent / Requires Medical Attention	PCP Ped	7 Business Days
Urgent/ Medically Necessary	PCP (Adult)	1 Business Day
Urgent/ Medically Necessary	PCP (Ped)	1 Business Day
Next Available Appointment (Non-Urgent)	All HV/HI	3 weeks
Next Available Appointment (1st Trimester)	HI/HV OBGYN	2 weeks
Next Available Appointment (2nd Trimester)	HI/HV OBGYN	1 week
Next Available Appointment (3rd Trimester)	HI/HV OBGYN	3 days
Emergency Care BH	All BH	Immediately
Initial Visit for Routine Care BH	All BH	10 Business Days
Follow-Up Routine Care BH	All BH	20 Business Days
Urgent / Non-emergent BH	BH Non-Prescribing	48 hours
Urgent / Non-emergent BH	BH Prescribing	48 hours

- BH = Behavioral Health
- HI = Endocrinology, Hematology/Oncology, Infectious Disease
- HV = Cardiovascular, OB/Gyn, Ophthalmology, Orthopedic Surgery

Additionally:

- There shall be a response to the Member by the Provider within 30 minutes of an emergency call.
- An after-hours phone call shall be made to the Member from an appropriate practitioner within an hour of the Member contacting the Provider.
- Provider shall offer hours of operation that are no less favorable than the hours of operation offered to persons who are not Members.
- In addition, to help ensure that Members enrolled with the Providers have reasonable access to the Provider, hours of operation must include:
    - Evening or early morning office hours three or more times per week;
    - Weekend office hours two or more times per month; and
    - Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed 30 minutes.

BCBSIL requires Providers to provide access to necessary specialist care, and in particular, gives Members the option of direct access to a women's health specialist within the MMAI network for women's routine and preventive health care services.

Adherence to Member access guidelines will be monitored through follow up regarding complaints/grievances related to access and availability, which are reviewed by the Clinical Quality Improvement Committee. Such follow up may occur via phone, email, US Mail and/or an in-person evaluation of the physical location. If you have any questions regarding your site visit, please contact Provider Network Services.

Services Provided in a Linguistically and Culturally Competent Manner

BCBSIL is obligated to ensure that services are provided in a linguistic and culturally competent manner to all Members, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds, physical disabilities, developmental disabilities, and differential abilities. BCBSIL is committed to the development, strengthening and sustainability of healthy Provider and Member relationships. Providers are obligated to meet this requirement and can direct Members to MMAI resources when in need of cultural and linguistic support and services. The MMAI Customer Service Department (phone number is listed on the back of the Member's ID card) has available the following services for MMAI Members:

- Teletypewriter (TTY) services
- Language services
- Bi-lingual-speaking Customer Service Representatives

Preventive Services

Members may access certain preventive services from any Provider. MMAI covers, without cost sharing, all covered preventive services for which there is no cost sharing under Original Medicare. Members may directly access in-network screening mammography and administration of influenza vaccine.

Out-of-Area Renal Dialysis Services

A Member may obtain medically necessary dialysis services from any qualified and appropriately licensed provider the Member selects when he/she is temporarily absent from the MMAI Service Area and cannot reasonably access an MMAI dialysis Provider. No prior authorization or notification is required. However, a Member may voluntarily advise MMAI that he/she will temporarily be out of the Service Area. MMAI may assist the Member in locating a qualified dialysis provider.

Drugs Covered Under Original Medicare Part B

Subject to coverage requirements and regulatory and statutory limitations, the following broad category of drugs may be covered under Medicare Part B:

- Injectable drugs that have been determined by Medicare Administrative Contractors (MAC) to be "not usually self-administered" and are administered incidental to physician services
- Drugs that the Member takes through durable medical equipment (i.e., nebulizers)
- Certain vaccines including pneumococcal, hepatitis B (high or intermediate risk), influenza and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition
- Certain oral anti-cancer drugs and anti-nausea drugs
- Hemophilia clotting factors
- Immunosuppressive drugs
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of End Stage Renal Disease (ESRD)

Medical Supplies Associated with the Delivery of Insulin

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, such as insulin pens, pen supplies, and needle-free syringes, can satisfy the definition of a Part D drug. However, test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D.

Advance Directives

Advanced Directives are an individual's written directive or instruction, such as a durable power of attorney for health care, a living will or a mental health treatment preference declaration, recognized under the laws of the State of Illinois and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

BCBSIL is committed to ensure its Members are aware of and are able to avail themselves of their right to execute an Advance Directive. BCBSIL is equally committed to ensuring that Providers and staff are aware of and comply with their responsibilities under federal and state Law regarding Advance Directives.

Providers delivering care to BCBSIL Members must ensure that all Members receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers must document in a prominent part of the Member's current medical record whether or not the Member has executed an Advance Directive.

If an Advance Directive exists, the Provider should discuss potential medical emergencies with the Member as well as a designated family member/significant other (if named in the Advance Directive and if available) and with the referring physician, if applicable. Any such discussion should also be documented in the medical record.

Americans with Disabilities Act (ADA) and Civil Rights Act of 1964

Providers are required to comply with the ADA and the Civil Rights Act of 1964 to promote the success of MMAI and support better health outcomes for Members. In particular, successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. BCBSIL also recognizes that access includes effective communication. BCBSIL requires that Providers communicate with Members in a manner that accommodates their individual needs, which includes

- Providing interpreters for those who are deaf or hard of hearing or who do not speak English;
- Accommodating Members with cognitive limitations; and
- Utilizing clear signage and way finding, such as color and symbol signage, throughout facilities.

In addition, BCBSIL recognizes the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. BCBSIL will continue to work with Providers to help further develop learning opportunities, monitoring mechanisms and quality measures to promote compliance with all requirements of the ADA.

For more information about the ADA, please visit the ADA website or call the toll-free ADA information line Monday, Tuesday, Wednesday, and Friday 9:30am - 12:00pm and 3:00pm – 5:30pm, or Thursday 12:30pm - 5:30pm. (ET) to speak with an ADA Specialist. All calls are confidential.

ADA Website
www.ada.gov

ADA Information Line
800-514-0301 (voice)
1-833-610-1264 (TTY)

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. For more information about Section 504, visit the Department of Health and Human Services (HHS) Office for Civil Rights website at www.hhs.gov/ocr.

A list of HHS Office for Civil Rights regional offices near you can be found at https://www.hhs.gov/about/agencies/regional-offices/index.html.

Section 504's requirements for new construction and alterations to buildings and facilities are found at 45 C.F.R. Part 84, Subpart C for recipients of federal financial assistance. The regulations are available at https://www.hhs.gov/ocr/index.html.

Provider Orientation and Training

BCBSIL will make available orientation and training to all Providers and their office staffs regarding the requirements of MMAI.

Provider Orientation

BCBSIL will make available an initial Provider orientation within 30 calendar days of the Provider becoming effective with MMAI. Ongoing educational opportunities will be provided to help ensure compliance with plan program requirements. Providers will be made aware of these ongoing educational opportunities through correspondences, website postings and Provider Network Consultant meetings. The sessions may cover, but are not limited to, the following topics:

- Program Overview
- Care Model Overview
- Member Information
- Benefits and Beneficiary Rights
- MMAI Primary Care Medical Home Program
- MMAI Policies and Procedures
- Performance Standards and Compliance
- Coding Compliance
- Annual Health Assessments
- Patient Care Plan Participation
- Quality Improvement Program
- Utilization Management
- Prior Authorization
- Claims submission and Payments
- Education and Training Requirements

Provider Education and Training

BCBSIL will make available cultural competency, cross cultural communication, and disability literacy training programs to all Providers. The goals of the training programs include, but are not limited to:

- Improve the care and simplify the processes for Members to access the items and services they are entitled to under the Medicare-Medicaid program.
- Improve care continuity and help ensure safe and effective care for both Acute and Long-Term Supports and Services (LTSS).

BCBSIL is committed to helping to ensure that Providers and their office staffs are culturally competent to work with and address the diverse needs of MMAI Members. BCBSIL will make available ongoing education and training workshops, including but not limited to the topics outlined below, and will require all Providers and their office staffs to participate in training at least once per calendar year. Such training may include, but is not limited to the following topics:

- Medicare and Medicaid Overview
- Model of Care / Medical Home (Person Centered Practice)
- Fraud, Waste, and Abuse (FWA)
- Abuse, Neglect, Exploitation / Critical Incidents
- Cultural Competency
- Americans with Disabilities Act (ADA) / Independent Living
- Medicare Part C and D General Compliance Training

The Provider can complete the required annual compliance training online at https://www.bcbsil.com/provider/network/training_medicaid.html or submit an online or paper BCBSIL/Illinois Association of Medicaid Health Plans (IAMHP) Attestation that certifies completion of the annual compliance training from another Managed Care Organization (MCO). The online attestation can be found here: https://forms.office.com/Pages/ResponsePage.aspx?id=RLYMLpTA10GrPUMgHaJEOAX1cUBQw_NNqhHbW8a0yFlUQjBSVFpZU1dTMFJDMUdPNlFRV0k3MUVLNiQlQCN0Pwcu

Health Education for Members
BCBSIL encourages Providers to provide health education to Medicare, Medicaid and MMAI Members. Provider Network Consultants will make available training to help support Member education on topics such as preventive care, disease-specific and plan services information. The goal of this education will be to promote compliance with treatment and encourage self-direction from Members.

Coordination with Other Service Providers
BCBSIL encourages Providers to cooperate and communicate with other service providers who serve Medicare, Medicaid, and MMAI Members.

Provider and Health Plan Education at Provider Locations
Providers and their staff shall ensure that a client is aware of all plan choices and shall use materials approved by BCBSIL and HFS in educating individuals. At the request of a Provider, a flyer/letter template will be provided to Providers to use in their offices which will require the Provider to include all health plans that they are contracted with.

If a Provider chooses to *prefer* a health plan in the flyer/letter (the preference must be a benefit to the recipient, not only to the Provider), Providers may add a paragraph to the flyer/letter indicating their preference. The paragraph must make no false or disparaging statements about other health plans and must be presented in a positive way. Any flyer/letter that has a preferred Provider paragraph must be submitted through BCBSIL for HFS approval. You may contact your Provider Network Consultant (PNC) to assist with the approval process.

The Provider template flyer/letter, including those with a preferred health plan paragraph, must have a statement at the bottom that states, "Illinois Client Enrollment Services will send you information about your health plan choices when it is time for you to make a health plan choice and during your Open Enrollment period."

Provider offices are prohibited from providing client access to the Client Enrollment Services Enrollment Portal to make an online enrollment choice within any provider setting. This includes all Health Plan primary care Provider offices, health fairs, or other health plan functions where enrollment may be discussed. If a potential enrollee is not currently enrolled with a Health Plan, you may refer them to the Illinois Client Enrollment Services at 877-912-8880 for information about their health plan choices. An individual that is not enrolled in a health plan may also be excluded from participating in a managed care program. These individuals should be referred to HealthChoice Illinois (https://enrollhfs.illinois.gov/en/contact) for assistance in finding providers for needed services.

In addition to the above guidelines and in accordance with the Provider Agreement, Providers may not utilize BCBSIL name(s) or symbol(s) without prior written approval by BCBSIL.

Provider Data Management
It is the responsibility of the Provider to submit accurate demographic and indicative data upon request for participation, to submit any changes 90 days prior to the effective date of those changes, and to periodically review, correct and/or attest to the accuracy of their data in our systems through roster reconciliations or other means of verification as directed by BCBSIL. Such data will include but is not limited to all fields included on the Universal Standardized Roster as well as additional telehealth data.

Information about the ways to submit and verify Provider demographic and indicative data can be found here: **https://www.bcbsil.com/provider/network/network/information-update**

In event of practice closure, Providers may submit with at least 90 days' notice the details of that closure in writing, on letterhead. Letter should include the circumstances and effective date of closure, the practicing address(es), TIN(s), and NPI(s) affected, as well as the name, title, email and contact phone for the submitter as well as the practice's contract signatory.

Program Compliance

Providers are required to cooperate and comply with BCBSIL medical policies as well as BCBSIL policies, procedures and programs for quality improvement, performance improvement and medical management, including, as applicable, drug utilization management, medication therapy management and e-prescribing programs. Cooperation and compliance includes, but is not limited to, making all records and information regarding medical services rendered, medical management and quality improvement activities available to BCBSIL, Illinois Department of Healthcare and Family Services (HFS) and Centers for Medicare & Medicaid Services (CMS) upon request, and providing MMAI data as may be necessary for BCBSIL to implement and operate any and all quality improvement and medical management programs and credentialing and re-credentialing requirements. Providers will supply data in standardized formats to BCBSIL to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

Cultural Competency and Diversity

Providers must understand cultural competency as it pertains to Members they may see in their practice. Cultural competency refers to a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and which are intended to increase the quality and appropriateness of health care and outcomes. Providers are expected to take into consideration the Member's racial and ethnic group, including their language, histories, traditions, beliefs, and values when rendering or referring Members for medical services.

Providers are also encouraged to respect and value human diversity and make a good faith, reasonable effort to utilize minority, women, and disabled owner business enterprises in the performance of services provided under MMAI.

Providers are expected to provide an interpreter when the Member does not speak or understand the language that is being spoken. BCBSIL offers Language Interpreter Services to support Members and Providers in this requirement.

Compliance with Federal Electronic Data Interchange Standards

Providers are required to transmit data to and receive data from BCBSIL, which information includes, but is not limited to, data relating to health care claims and equivalent encounter information, health care claims status, Member enrollment and eligibility, health care payment and remittance advice, premium payments, referral certification and authorization, coordination of benefits, first report of injury and health claims attachments using only the code sets and data transmission standards as issued and in effect by the United States Department of Health and Human Services as published in 45 Code of Federal Regulations Part 142; and comply and ensure compliance by its officers, employees and Physicians, with all electronic data security standards as issued and in effect by the United States Department of Health and Human Services as published in 45 Code of Federal Regulations Part 142; and accept electronic claims and encounter data that may be routed to the Provider by BCBSIL, a physician or other health care provider or clearinghouse.

Protected Health Information (PHI)

Providers must follow all laws regarding privacy and confidentiality including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provisions for the use of PHI and the provisions identified below and must require any sub-delegates to follow those same provisions:

- Use PHI (any Member identifiers that can be linked to a Member) only to provide or arrange for the provision of medical and behavioral health benefits administration and services;
- Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
- Ensure that sub-delegates have similar safeguards;
- Provide individuals with access to their PHI;
- Inform all affected parties, including the Provider, if inappropriate use of the PHI occurs; and
- Ensure that PHI is returned, destroyed, or protected if the contract ends.

Medical Records

For the purposes of CMS audits, and for the purposes set forth below, Providers are required under the Medical Service Agreement (MSA) to provide medical records requested by BCBSIL. Purposes for which medical records from Providers are used by BCBSIL include, but are not limited to:

- Advance determinations of coverage
- Plan coverage
- Medical necessity
- Proper billing
- Quality reporting
- Fraud and abuse investigations
- Plan initiated internal risk adjustment validation

Additionally, Providers furnishing Covered Services to an Member shall maintain and share, as appropriate, an Enrollee health record in accordance with professional standards.

Providers are required to maintain and share medical records, mental-health records, and any other information about Member for the Department upon request and in accordance with professional standards.

Initial Health Risk Assessment

The Health Risk Assessment (HRA) is a clinician- or paraprofessional-directed annual Member questionnaire that is used to help determine the care coordination stratification level for purposes of Member engagement into the appropriate care coordination/complex case management stratified program and used in the initial creation of the individualized Member Care Plan. The HRA is conducted either telephonically or face to face, normally within 30 days of the Member's enrollment into the plan. These assessments will be completed annually for Members. During the HRA process the Member's demographic information is verified, the Member is provided important information such as benefits, Care Coordinator, finding a PCP or specialist and, if a comprehensive health assessment is warranted at home, when to expect a clinician home or long-term care facility visit. BCBSIL offers a version of the HRA form here: https://www.bcbsil.com/docs/provider/il/clinical/preventive-care/ma-annual-wellness-visit-form.pdf

Annual Health Assessment

The BCBSIL Annual Health Assessment (AHA) serves as a platform to help identify essential clinical and care management needs of Members and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the Member's past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings and chronic disease monitoring. These assessments can occur in the Provider's office, Member's home, or through approved virtual options. The AHA is a part of the Quality Program. Documentation on the forms must be accurate, completed to the satisfaction of BCBSIL and appropriately supported by information contained within the Provider's medical record.

Process for Submitting AHA – Paper Submission Procedure

1. The Provider conducts a face-to-face annual visit with the Member and completes the AHA form according to the instructions provided.

2. The Provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission.

    a) The Provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes:
        i. **G0402 – Initial Preventive Physical Examination**
        Code is limited to new beneficiary during the first 12 months of Medicare enrollment.
        ii. **G0438 – Annual Wellness Visit (AWV), Initial**
        The initial AWV, G0438, is performed on patients that have been enrolled with Medicare for more than one year, including new or established patients.
        iii. **G0439 – Annual Wellness Visit (AWV), Subsequent**
        The subsequent AWV occurs one year after the patient initial visit.

3. The Provider ensures all required fields are completed on the AHA form and shall fax the completed AHA to the attention of Enterprise Medicare at 918-551-2297 or email MCO_Reporting@hcsc.net.

Process for Submitting AHA – Electronic Medical Record (EMR) Procedure

1. The Provider conducts a face-to-face annual visit with the Member and completes the AHA form according to the instructions provided.

2. The Provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission:

    a) The independently contracted provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes.
        i. **G0402 – Initial Preventive Physical Examination**
        Code is limited to new beneficiary during the first 12 months of Medicare enrollment.
        ii. **G0438 – Annual Wellness Visit (AWV), Initial**
        The initial AWV, G0438, is performed on patients that have been enrolled with Medicare for more than one year, including new or established patients.
        iii. **G0439 – Annual Wellness Visit (AWV), Subsequent** The subsequent AWV occurs one year after the patient initial visit.

BCBSIL will reimburse the Provider for both the annual wellness visit and the medically necessary evaluation and management (E/M) service when billed at the same time as the E/M procedure code with the modifier-25. The E/M code must be medically necessary to treat an illness or injury.

Since there are no Member copayments or co-insurances for MMAI Members, there are no copayments or co-insurances for these visits when an additional E&M code is billed for the physical exam in addition to the annual health visit.

The full AHA manual can be located here: https://www.bcbsil.com/docs/provider/il/clinical/preventive-care/ma-annual-wellness-visit-guide.pdf

Quality Improvement

Quality Improvement (QI) is an essential element in the delivery of care and services to Members. To help define and assist in monitoring quality improvement, the BCBSIL QI Program focuses on measurement of clinical care and service delivered by Providers against established goals. The QI Program is described in the Quality Management and Improvement section of this manual.

Providers are required to cooperate with BCBSIL's quality improvement activities and participate in the BCBSIL QI Program. Providers' cooperation with the QI Program includes, but is not limited to:

1. Cooperate with the BCBSIL data collection process by reviewing medical and administrative records for identified Members and submitting requested documentation to BCBSIL.
2. Permit BCBSIL to publish results related to Provider's clinical performance.
3. Permit BCBSIL Medical Director(s) and/or BCBSIL staff to inspect, at mutually agreed upon times, but no later than seven days after a request, the premises used by the Provider for Members, as well as to study all phases of the medical services provided by the Provider to Members. Study may include the inspection of medical records.
4. Facilitate access to Provider's medical records, including electronic medical records, for Quality Improvement Program (QIP) reporting and other BCBSIL quality improvement initiatives;
5. Should a site visit be requested by BCBSIL, Provider will maintain an ADA physical site review score of 90 percent or better, which includes accessibility and facility inspection.

Utilization Management (UM)

The BCBSIL Utilization Management (UM) program includes:

- Prospective review (preauthorization and precertification)
- Concurrent review
- Discharge planning
- Retrospective review

The Utilization Management Program is described in the Utilization Management, Case Management and Condition Management section of this Provider Manual.

Providers are required to cooperate with BCBSIL's UM policies and procedures and participate in BCBSIL's UM Program concerning MMAI Members as the policies and procedures are developed and implemented. Provider cooperation with the UM program includes, but is not limited to:

1. Cooperate with the BCBSIL UM program for hospital, skilled nursing facility and other inpatient facility admissions, home health care, outpatient surgery, and outpatient specialist services;
2. Adhere to BCBSIL requirements for pre-admission certification, concurrent review, and case management activities;
3. Participate in BCBSIL disease and case management programs;
4. Designate a staff member employed by the Provider who will serve as the primary contact for BCBSIL and will be responsible for care coordination activities including, but not limited to the following;
    a. Facilitate physician involvement in the development and ongoing monitoring of the Member's individualized care plan;
    b. Cooperate with the BCBSIL care coordination team and quality team in arranging or scheduling Provider services, and
    c. Submit to BCBSIL all physician orders for MMAI Members that require prior authorized services.
5. Communicate appropriate treatment alternatives, regardless of cost or benefit coverage.
6. Distribute within their group or facility BCBSIL information to all Providers, which includes, but is not limited to:
    a. Designated UM reports;
    b. Pharmacy reports;
    c. Quality reports including reports identifying Members with gaps in care for targeted quality metrics;
    d. *Blue Review* Provider newsletter;
    e. Any network survey results as requested by BCBSIL.

Compliance, Fraud, Waste, and Abuse Program and Reporting

Compliance Program

Providers are required to implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that addresses the scope of services under MMAI. The Provider's compliance program must require cooperation with BCBSIL's compliance plan and policies and include, at minimum, the following:

1. A code of conduct specific to the Provider that reflects a commitment to preventing, detecting, and correcting fraud, waste and abuse in the administration or delivery of Covered Services to Members. BCBSIL's code of conduct is available at http://www.hisccompliance.com.

2. Compliance training for all employees, subcontractors, any affiliated party, or any Downstream Entity involved in the administration or delivery of Covered Services to Members or involved in the provision of Delegated Activities, such as:

    a. Provider will provide general compliance training to employees, subcontractors, any affiliated party, or any Downstream Entity involved in the administration or delivery of Covered Services to Members or involved in the provision of Delegated Activities at the time of initial hiring (or contracted) and annually thereafter. General compliance training must address matters related to Provider's compliance responsibilities, including, without limitation, a) Provider's code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues; (b) Provider's obligations to comply with Laws; (c) common issues of non-compliance in connection with the provision of health care services to Members; and (d) common fraud, waste and abuse schemes and techniques in connection with the provision of health care services to Members.

    b. Providers will also provide specialized compliance training to personnel whose job function directly relates to the administration or delivery of Covered Services to Members on issues particular to such personnel's job function. Such specialized training shall be provided (i) upon each individual's initial hire (or contracted); (ii) annually; (iii) upon any change in the individual's job function or job requirements; and (iv) upon Provider's determination that additional training is required because of issues of non-compliance.

    c. Providers must maintain records of the date, time, attendance, topics, training materials and results of all training and related testing. Upon request, Providers will provide to BCBSIL annually a written attestation certifying that Provider has provided compliance training in accordance with this section.

3. Policies and procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and Provider's compliance and anti-fraud, anti-waste, and anti-abuse initiatives. The program must include implementation and publication to Provider's directors, officers, employees, agents, and contractors of a compliance hotline, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and Provider's anti- fraud, anti-waste, and anti-abuse initiatives;
4. Annual compliance risk assessments, performed at Provider's sole expense. Upon request, the Provider will share the results of the assessments with BCBSIL to the extent any part of the assessment directly, or indirectly, relates to BCBSIL.

5. Routine monitoring and auditing of Provider's responsibilities and activities with respect to the administration or delivery of Covered Services to Members.
6. Upon request, provide to BCBSIL reports of the activities of Provider's compliance program required by BCBSIL, including reports and investigations, if any, of alleged failures to comply with laws, regulations, the terms and conditions of the HFS and CMS Contract, or the BCBSIL Medical Service Agreement (MSA) so that BCBSIL can fulfill its reporting obligations under Laws and the CMS Contract.
7. Upon request, provide BCBSIL the results of any audits related to the administration or delivery of Covered Services to Members.
8. Make appropriate personnel available for interviews related to any audit or monitoring activity.

Incidents of Suspected Non-Compliance, Fraud, Waste or Abuse

Providers must promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the BCBSIL Medical Service Agreement and/or the administration or delivery of Covered Services to Members and report any incident to BCBSIL as soon as reasonably possible, but in no instance later than 30 calendar days after Provider becomes aware of such incident. Notice to BCBSIL must include a statement regarding Provider's efforts to conduct a timely, reasonable inquiry into the incident, proposed or implemented corrective actions in response to the incident and any other information that may be relevant to BCBSIL in making its decision regarding self-reporting of such Incident.

Providers must cooperate with any investigation by BCBSIL, HFS, HHS or their authorized designees relating to the incident. Failure to cooperate with any investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

Providers must require its Downstream Entities to promptly report to the Provider, who shall report to BCBSIL, any incidents in accordance with this section.

Conflicts of Interest

The Provider shall require any manager, officer, director, or employee associated with the administration or delivery of Covered Services to Members to sign a conflict-of-interest statement, attestation, or certification at the time of hire and annually thereafter, certifying that such individual is free from any conflict of interest in administering or delivering Covered Services to Members. Providers shall supply the form of such statement, attestation, or certification to BCBSIL upon request.

Compliance Reviews

Providers must provide BCBSIL with access to Provider records, physical premises and facilities, equipment, and personnel in order for BCBSIL, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the BCBSIL Medical Service Agreement.

Sanctions under Federal Health Programs and State Law

Providers are required to check the appropriate databases specified in the Provider Contract at least monthly to ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement with Medicaid, Medicare or other federal health care programs are employed or subcontracted by the Provider.

Providers must disclose to BCBSIL whether the Provider or any staff member or subcontractor has any prior violation, fine, suspension, termination, or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of the State of Illinois, the federal government, or any public insurer. Providers must notify BCBSIL immediately if any such sanction is imposed on a Provider, a staff member, or subcontractor.

Membership Information

Primary Care Physician Selection
BCBSIL requires that all Members enrolled with MMAI select a Primary Care Physician (PCP).

Assignment to Primary Care Provider (PCP)
Members are required to have a Primary Care Physician. Members who have not selected a PCP within 30 days of their enrollment date will be assigned a PCP by BCBSIL. BCBSIL may consider the following in the assignment process:

1. Prior history with a PCP, if available.
2. Ability of PCP to meet the needs of the Member
3. Location of PCP to Member residence.

Identification Cards
All eligible MMAI Members are issued an identification card.

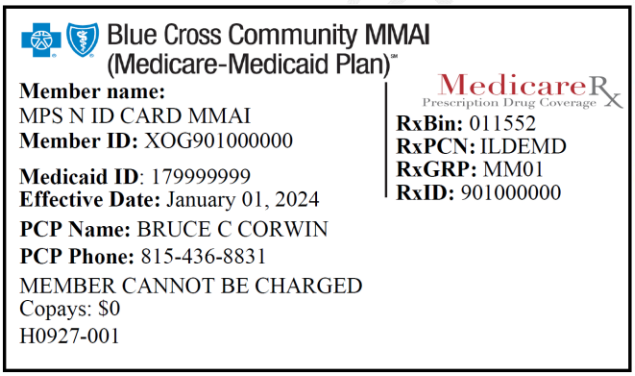
Identification cards are generated when:

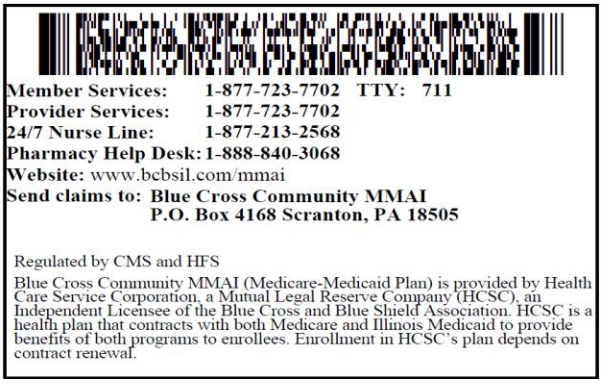
- Member becomes eligible
- Member name changes
- Member changes PCP
- PCP phone number change
- Requested by contacting Member Services
- Requested after login to Blue Access for Members (BAM) at www.bcbsil.com

Each identification card contains the following information:

- Product name – Blue Cross Community MMAI
- Member name
- Effective date – The Member's most current effective date
- PCP name
- PCP phone number
- Prescription drug benefit information
- The 24-hour telephone number to confirm eligibility and for benefits and benefit preauthorization for services

Below is an example of a typical MMAI identification card. Note: BCBSIL reserves the right to change the ID cards without advance notice.





Verifying Membership
Providers can check MMAI Member eligibility via Availity (www.availity.com) or by phone at 877-723-7702. Remember to always check the Member's ID card before services are rendered.

MMAI Eligibility List and Care Coordination Fee Report

The MMAI Eligibility List and Care Coordination Fee Report is posted on MXOtech. MXOtech allows MMAI Providers to view their eligibility list and Care Coordination Fee report.

MXOTech makes available the MMAI eligibility list online, with the ability to view an eligibility list in its entirety, or to make certain selections such as to view all Members that have changes since the last eligibility list. Providers have access to the three most recent eligibility lists and the ability to view the most current Member information that is stored on our membership file in the format of the eligibility list. The address listings for all new Members can also be viewed for the three most recent eligibility periods.

The application for Care Coordination Fee Reports includes the following: reconciliation, summary, activity count, Member counts and Care Coordination Fee.

Most reports can be filtered using search criteria functionality; this includes the detail reports. Summary reports cannot be filtered. Several reports can be downloaded in a .txt format.

Data definitions can be viewed for all files available for download.

Introduction and Guidelines for Benefits Interpretation

The Scope of Benefits outlined in this Provider Manual is based in part on:

- Medicare benefits as set forth in 42 C.F.R. 422.101, or its succeeding regulations; and
- Medicaid State Plan benefits and services including, but not limited to, home and community-based waiver services; and,
- MMAI Member Handbook.

Each MMAI Member receives a MMAI Member Handbook upon enrollment. Information in the Member Handbook is also available online via the secure Member portal (BAM: Blue Access for Members), and member forms can be located at https://www.bcbsil.com/mmai/member-resources/forms.

The Provider is responsible for providing or arranging for all covered physician services, provider- approved inpatient and outpatient hospital services, ancillary services, long-term care support services and non- hospital-based emergency services within the scope of benefits of the Member Handbook.

All inpatient hospital admissions (except out-of-area admissions), skilled nursing facility (SNF) days and home health visits must be approved by the Provider to be covered.

Covered services to a Member will cease upon the effective date of disenrollment. Under special circumstances, the Provider can request an exception from the Customer Services Department before the service is rendered.

This section is intended to provide a quick reference of covered and non-covered services. It includes frequently asked benefit questions and clarification on some issues that may be misinterpreted based upon past experience. However, it is not possible to include everything. Eligibility and Benefit information may also be obtained via Availity (www.Availity.com). If you have additional questions regarding covered services, please contact the Customer Service Department. (see Key Contact Information)

Medicare Covered Services

For Medicare covered services, Providers in the MMAI network may refer directly to Medicare coverage policies. There are two types of Medicare coverage policies that apply:

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

MMAI must cover all services and benefits covered by Medicare and Medicaid. Coverage information that you receive concerning Original Medicare also applies to MMAI.

National Coverage Determinations (NCDs)

The Centers for Medicare & Medicaid Services (CMS) explains NCDs through program manuals, which are found on the CMS Manual page at **http://cms.hhs.gov/manuals/**. Key manuals for coverage include:

- Medicare National Coverage Determinations Manual
- Medicare Program Integrity Manual
- Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and sends updated information via articles through the Medicare Learning Network. These articles can be found on the MLN Matters articles page at www.cms.hhs.gov/MLNMattersArticles/.

Local Coverage Determinations (LCDs)

CMS contractors (e.g., carriers and fiscal intermediaries) develop and issue local coverage determinations (LCDs) to provide guidance to the public and provider community within a specific geographical area. LCDs supplement a NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

Providers may access our region's LCDs at the following website addresses:

- Medicare Part B: www.wpsmedicare.com

- Medicare Part A: www.wpsmedicare.com
- http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Providers are encouraged to join mailing lists at the above Medicare contractors' websites for LCD policy publications and at CMS's website for NCD policy publications. This can be done by going to each contractor's website (and CMS's website) and subscribing to their mailing lists.

Medicare Coverage Database

CMS launched the Medicare Coverage Database in 2002. The Medicare Coverage Database can be accessed at www.cms.hhs.gov/CoverageGenInfo/.
The following areas may be searched:

- National Coverage Determinations (NCDs)
- National Coverage Analyses (NCAs) – These documents support the NCD process.

Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is normally updated on a monthly basis. Therefore, the most current information on LCDs should be accessed through the local websites listed above.

Medicare Covered Services

Covered Services eligible for benefits under Medicare are in accordance with the terms of the Medicare program. For complete details, including benefits, limitations and exclusions, Members should refer to their Member Handbook.

Medicaid Covered Services for Adults

For MMAI Members, Medicare is usually the primary payer for many of the Covered Services. For more complete details, including benefits, limitations and exclusions, Members should refer to their Member Handbook.

Covered Dental Services for Adults Aged 21 and Over

Medically Necessary Dental Services (e.g., tooth extractions prior to radiation treatment for cancer involving jaw.)	Covered
Preventive Dental Services	2 oral exams/calendar year 2 cleanings/calendar year 1 set dental x-rays/calendar year
Comprehensive Dental Services	Coverage limited to urgent/emergency care.

The plan offers an $800 allowance as a supplemental benefit each year to help pay for dental services that would not otherwise be covered by Medicare or Medicaid. Member would be responsible for any charges for services that exceed the annual $800 supplemental benefit allowance.

This is a brief summary of some of the services that may be eligible for benefits under Medicare. For more complete details, including benefits, limitations and exclusions, Members should refer to their Member Handbook.

Home and Community Based Waiver Services

Home and Community Based Services (HCBS) waivers are granted under the authority of Section 1915c of the Social Security Act, enabling states to provide services (other than room and board) to individuals as an institutional alternative.

Individuals served by waivers are most commonly disabled and/or over age 65.
In order to be eligible for a waiver, persons usually must require a level of care that, in the absence of community services, would require placement in one or more of these institutional settings:

- Hospital,
- Nursing Facility or
- Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)

States can offer a combination of standard medical and non-medical community services to divert or move individuals from institutional settings into their homes and community. Illinois HCBS waivers may be granted in

the following situations:

- **Aging Waiver** – For individuals 60 years and older that live in the community.
- **Individuals with Disabilities Waiver** – For individuals who have a physical disability and are between the ages of 19-59.
- **HIV/AIDS Waiver** – For individuals that have been diagnosed with HIV or AIDS.
- **Individuals with Brain Injury Waiver** – For individuals with an injury to the brain.
- **Supportive Living Facilities** – For individuals that need assistance with the activities of daily living but do not require the care of a nursing facility.

Medicaid Covered Home and Community Based Waiver Services

Members may qualify for home and community-based services waiver (HCBS), Supportive Living Facility (SLF) or Long-Term Care (LTC). Eligibility for these waiver benefits is determined solely by the State of Illinois. This is usually done through an assessment tool, the Determination of Need (DON). In this process, the Member will be asked a series of questions and given an overall score. Based on the Member's DON score, the state will determine if the Member is eligible for a waiver service or benefits to reside in a SLF or LTC facility. The table below is an outline of services available under a HCBS waiver.

Service	Waiver			
	Elderly	Disability	HIV/AIDS	Brain Injury
Adult Day Service	√	√	√	√
Adult Day Service Transportation	√	√	√	√
Environmental Modification		√	√	√
Supported Employment				√
Home Health Aide		√	√	√
Nursing, Intermittent		√	√	√
Nursing, Skilled		√	√	√
Occupational Therapy		√	√	√
Personal Assistant		√	√	√
Physical Therapy		√	√	√
Speech Therapy		√	√	√
Prevocational Services				√
Day Habilitation				√
Homemaker	√	√	√	√
Home Delivered Meals		√	√	√
Emergency Home Response System	√	√	√	√
Respite		√	√	√
Adaptive Equipment		√	√	√
Behavioral Services				√

This table is provided for informational purposes only and is not a guarantee that an individual will receive a waiver. Waiver determinations are made by the State of Illinois.

MMAI Utilization Management Program

The Utilization Management (UM) Plan is developed by BCBSIL in accordance with the requirements prescribed by the Centers for Medicare & Medicaid Services (CMS), the Illinois Department of Healthcare and Family Services (HFS), the Illinois Department of Insurance and other regulatory and accrediting agencies. The UM Plan is evaluated and may be revised annually by BCBSIL.

The MMAI UM Plan incorporates standards related to the monitoring of care and services rendered to MMAI Members. BCBSIL is responsible, unless delegated to another party, for the performance of UM and Case Management (CM) including complex and intensive case management, for Members receiving physical health care, Long Term Services and Supports (LTSS) and Behavioral Health services

Physician Responsibility for Care
Providers are solely responsible for the provision of all health care services to MMAI Members. All decisions regarding Member treatment and care are the sole responsibility of the Provider. Such decisions are not directed or controlled by BCBSIL. BCBSIL's decision about whether any medical service or supply is a covered benefit under the Member's MMAI benefit plan are benefit decisions only and are not the provisions of medical care. It is the Provider's responsibility to discuss all treatment options with the Member, regardless of whether such treatment is a covered benefit under the Member's benefit plan. Providers and subcontractors are encouraged to cooperate and communicate with other service providers who serve Members. Providers are required to provide services to Members in the same manner and quality as those services that are provided to other patients who are not MMAI Members.

Program Scope
The UM Program is applicable to all Members in MMAI living in the Service Area. The UM Program is under the direction of the BCBSIL Medical Director. The goal of the UM process is to integrate the admission, ongoing prior authorization of benefits for inpatient hospital, residential treatment, skilled nursing facility care, long-term acute care (LTAC), outpatient care, office and home care, and discharge planning functions and to assist Members with receiving benefits for continuity of service across the continuum. UM helps ensure that the assessment process identifies specific health care needs and works with the Member, family, and physician in order to help meet the assessed needs.

The BCBSIL Health Services staff completes prior benefit approval/determinations, concurrent review of benefits for inpatient services, application of clinical criteria including NCD (National Coverage Determinations) and LCD (Local Coverage Determinations), timelines for decision making, physician involvement for medical, pharmaceutical, and behavioral health care services and procedures for communication denial decisions and appeal rights.

Overview of Care Coordination

At the core of the Care Model is an ongoing relationship between the Member, his/her family or caregivers, the Provider, and the Care Coordinator. Each Member has an assigned Care Coordinator who helps facilitate and coordinate the delivery of care and services for the Member. The Interdisciplinary Care Team (ICT), led by the Case Manager and supported by the Care Coordinator, seeks to have regular interface with the Members and involve the Member, his/her family or caregivers, and community liaisons in care coordination. Likewise, the Member's Primary Care Physician (PCP) and other physicians or providers are consulted in the Member's care planning and management, sometimes participating in ICT rounds and discussions about the Member when appropriate. The transition period concludes when the care plan including required services have been reviewed in the context of the ICT which includes Member and community liaison involvement. The Care Coordinator serves as the point of contact for notification to the Member.

Care Coordination

Care coordination is an MMAI service that is designed to assist Members (and their families and caregivers) with multiple, complex, cognitive, physical, behavioral, and special health care needs. Care Coordination seeks to integrate service Providers involved in addressing all aspects of a Member's needs.

Care Coordination is designed to help ensure the Member's medical, behavioral health and social needs and seeks to have necessary services provided and coordinated by:

- Providing a designated person who is primarily responsible for coordinating the Member's health care services;
- Assisting with access to Providers who are experts for Members with special needs;
- Assisting with coordination of medical and behavioral health services; and
- Interfacing and collaborating with a Member's case manager, if applicable. The Care Coordinator may also refer the Member to Case Management as needed.

Health Assessments

The Health Services care coordination staff will contact new Members via telephone to complete a health assessment. In addition to telephonic care coordination, Members may participate and receive face-to-face assessments (Annual Health Assessment) completed by the PCP and home-based clinicians. These assessments seek to identify Member's unique needs. The goal of the assessments is to have BCBSIL Care Coordination staff evaluate results and:

- Identify possible health care needs,
- Assist with access to health care services,
- Assist with coordination of care,
- Provide telephonic educational or written materials via mail as needed, and
- Refer Members to appropriate case and condition management/disease management programs as may be needed

Individual Care Plan

BCBSIL Care Coordination staff provides an Individual Care Plan for Members based upon the recommendations of the ICT. The Individual Care Plan is not a substitute for the care plan established between the Member and their health care provider. Providers are required to exercise their independent medical judgment in establishing care plans for their patients.

Benefit Prior Authorization and Referral Process

- Prior benefit authorization is not required for emergency and urgent care services. Providers do not need to obtain benefit preauthorization from BCBSIL for referrals to in-network specialists.
- Obstetrical/Gynecological Services – Members can self-refer to in-network providers for routine OB/GYN services.
- Prior benefit authorization is not required for substance abuse services when the Provider notifies BCBSIL within 24 hours of initiation of treatment. All services are subject to establishment of medical necessity and may require a medical necessity review.
    - Applicable substance abuse services include the following: American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services

- Non-contracted providers must be registered with IMPACT to be eligible for claims payment.
- Additionally, benefit preauthorization is required from BCBSIL for services rendered by all non-contracted providers before the services are rendered.
- Services rendered to Members by non-contracted providers without appropriate medical referral, prior benefit preauthorization or IMPACT registration will not be considered for reimbursement.
- Approved referrals to non-contracted providers are valid for one visit within six months from the date the request is entered into the information system.

Unless otherwise prohibited by law, benefit preauthorization, also referred to as prior benefit authorization, prior approval, or precertification, are required for certain services before they are rendered. Benefit preauthorizations are based on benefits, limitations and exclusions as well as meeting the definition of medical necessity defined in the Member Handbook and supported through clinical information supplied by requesting physicians. Prior authorizations can be obtained by calling the Medical Management Department at 877-723-7702 or or by faxing a completed Medicaid Prior Authorization Request Form. (https://www.bcbsil.com/provider/education/education-reference/forms)

The fact that a benefit prior authorization has been granted is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon the Member's coverage in effect on the date of service, including, eligibility, exclusions, limitations, and the terms of coverage.

Prior Authorization Code List
The MMAI Prior Auth Requirements Summary and Prior Authorization Code List can be found on our website here: https://www.bcbsil.com/provider/claims/claims-eligibility/utilization-management/government-support-materials

BCBSIL has contracted with eviCore healthcare (eviCore) to manage benefit preauthorization requests for certain specialized clinical services for BCBSIL MMAI Members. eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

Medical Benefit Preauthorization Form

https://www.bcbsil.com/docs/provider/il/network/26raumati/mmai-bcchp-preauth-form.pdf

BlueCross BlueShield of Illinois

FOR INTERNAL US ONLY
UMC
(WORK ITEM TYPE)

Medicaid Prior Authorization Request Form

Please fax completed form to 312-233-4060

This information applies to Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members.

☐ **URGENT** (If checked, please provide anticipated date of service below)

Please attach supporting documentation to facilitate your request (e.g., the history & physical, letter of medical necessity, original photographs, etc.) This form must be placed on top of the information you are submitting.

MEMBER / PATIENT DATA	
ID # (INCLUDE THREE-CHARACTER PREFIX):	GROUP #
MEMBER NAME	DATE OF SERVICE
PATIENT NAME	DATE OF BIRTH
PROCEDURE CODE(S)	
DIAGNOSIS CODE(S) (IF A MEDICAL SERVICE ONLY) (LIST PRIMARY FIRST)	CPT4/HCPC CODES(S) INCLUDE UNIT OF MEASURE/FREQUENCY FOR SUPPLIES & SERVICES
SERVICES RENDERED	PLEASE CHECK ONE: ☐ PROVIDER OFFICE ☐ OUTPATIENT FACILITY ☐ INPATIENT FACILITY
	OFFICE OR FACILITY NAME
	ADDRESS/CITY/STATE/ZIP
	PHONE
	NPI(S)
PLEASE ATTACH OR INCLUDE ANY ADDITIONAL SUPPORTING CLINICAL INFORMATION IN THE SPACE BELOW.	

PROVIDER DATA	
NPI, IF APPLICABLE	DATE
PHYSICIAN/PROFESSIONAL PROVIDER NAME	
ADDRESS/CITY/STATE/ZIP	

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

242129.0121

Behavioral Health Benefit Preauthorization Form

For behavioral health outpatient service preauthorization forms, please visit https://www.bcbsil.com/provider/education/education-reference/forms#bh_medicaid

Prior Authorization List

Always check eligibility and benefits first through Availity (www.availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization requirements and vendors, if applicable. For some services/Members, prior authorization may be required through BCBSIL. For other services/Members, BCBSIL has contracted with eviCore healthcare (eviCore) for utilization management and related services.

Check the Support Materials (Government Programs) page for summary and procedure code lists to help you navigate prior authorization requirements for our Illinois Medicaid Members.

Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the Member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

Timeliness of Decisions and Notifications

Routine Prior authorization (Standard)	**Decision** – To be completed no later than 14 calendar days from receipt of request for benefits for services for which Medicare is the primary payor and five (5) calendars days from the date of receipt of all Necessary Information for benefits for which Medicaid is the primary payor (or additional 14 days when an extension is granted). **Part B Medications –** Routine/Standard decisions will be rendered within 72 hours of the request. **Notification** – Provider shall be notified within 14 working days of making the decision for benefit prior authorization or denial of non-urgent (routine) care or within 72 hours of the Part B Medication decision. **Denial confirmation** – For non-urgent (routine) care, the Member and Provider will be given written or electronic confirmation for the decision within 14 working days of making the decision or within 72 hours of the Part B Medication decision.
Urgent Prior authorization (Expedited)	**Decision –** Coverage decisions for expedited requests for services or DME will be completed, and notification provided either by phone or fax within 72 hours of receipt of the request for which Medicare is the primary payor and seventy two (72) hours from the date of receipt of all Necessary Information for benefits for which Medicaid is the primary payor. **Durable Medical Equipment (DME) –** supplies or DME benefit prior authorization or denials will be completed within seven days **Part B Medications –** Expedited request decisions for Part B Medications will be rendered and notification provided within 24 hours of receipt of the request. **Notification:** Written notification will follow within two working days of the decision **Denial confirmation** – The Member and Provider written notification shall be postmarked within 72 hours of receipt of the request to provide confirmation of the decision.

Member Complaints, Grievances and Appeals

A Member or their authorized representative may submit a complaint, orally or in writing, through the Medical Appeals and Grievances: MMAI Customer Service Department at 877-723-7702, or mail to:

Blue Cross Community MMAI
Attn: Appeals & Grievances
PO Box 660717
Dallas TX, 75266-0717

BCBSIL Appeals and Grievances Process

The MMAI Customer Service Department will evaluate the complaint and determine if the complaint is a grievance (dissatisfaction with health care services), appeal (dissatisfaction with an adverse organization determination) or both a grievance and an appeal.

1. Grievance
   BCBSIL has written policies and procedures regarding grievances that address the following:
   a) Acceptance of any information or evidence concerning the grievance orally or in writing not later than 60 calendar days after the event occurred;
   b) The ability to respond within 24 hours to a Member's expedited grievance whenever it is filed because the MMAI plan extended the time frame to make a decision or reconsideration, or refused to grant a request for an expedited determination or reconsideration;
   c) Use of the model notice to notify the Member of their right to file an expedited grievance;
   d) The prompt and appropriate action as quickly as the case requires, including completion of a full investigation of the grievance, no later than 30 calendar days from the date the oral or written request is received, unless extension is permitted
   e) Prompt notification to the Member or their representative regarding an organization's plan to take up to a 14-calendar day extension
   f) Documentation of the need for any extension taken (other than one requested by the Member) that explains how the extension is in the best interest of the Member
   g) Notification of all concerned parties upon completion of the investigation.

2. Pre- and Post-Service Appeals – BCBSIL has written policies and procedures regarding appeals that address the following:
   a) Allowing at least 60 calendar days after notification of the denial for the Member or authorized representative to file an appeal;
   b) Documentation of the substance of the appeal and action taken;
   c) Full investigation of the appeal, including aspects of any clinical care involved;
   d) The opportunity for the Member or authorized representative to submit written comments, documents or other information relating to the appeal;
   e) Submit all relevant clinical information when you request an appeal. Insufficient clinical information may result in a delay in review or an inability to make a fully informed decision.
   f) Appointment of a new person for review of the appeal who was not involved in the previous review;
   g) For medical necessity appeals, the case must be reviewed by a Practitioner with expertise in the field of medicine appropriate to the service(s) under review;
   h) The decision and notification to the Member within 15 business days unless a 14-day extension is requested (pre-service) and 60 calendar days (post-service) of receipt of the request;
   i) Notification about further appeal rights including the appeal process and notification of the contact information;
   j) Providing the Member access and copies of all documents relevant to the appeal;
   k) An authorized representative's ability must be able to act on the Member's behalf;
   l) Expedited pre-service appeals, which include the initiation, decision, and notification process;
   m) Member requests and receives appeal data from Medicare health plans;
   n) Accepting post-service appeals from non-contracted Providers upon receipt of executed waiver of liability;
   o) Appeal process extensions; and
   p) Providing notices of the appeals process to Members in a culturally and linguistically appropriate manner.

3. Expedited Reconsideration (Appeal)
   An expedited appeal may occur if proposed or continued services pertain to a medical condition that may seriously jeopardize the life or health of a Member or if the Member has received emergency services and remains hospitalized.

   If the Member is hospitalized, the Member may continue to receive services with no financial liability until notified of the decision.

   BCBSIL has procedures for registering and responding to expedited appeals, which include:
   a) Allow oral or written initiation of an expedited appeal by the Member, a Member's representative or practitioner acting on behalf of the Member;
   b) When a request for an expedited appeal is received, the Member will be verbally notified within 24 hours of receipt of Member's request and/or the receipt of all information necessary to evaluate the appeal;
   c) Request for necessary information from non-contracted providers;
   d) Electronic or written confirmation of the decision must be made within 72 hours; and
   e) Notification of further appeal rights and the right to file an expedited grievance if the Member disagrees with the decision not to expedite the determination.

4. Additional Appeal Rights
   Requests from the Provider(s) and/or Member for further information on an appeal should be directed to the MMAI Customer Service Department at 877-723-7702.

5. Continued Coverage
   Continued coverage must be provided to the Member pending the outcome of an internal appeal for covered services.

Medical Policies, New and Existing Medical Technology
Medical policies represent guidelines for use in making health care benefit coverage determinations on particular clinical issues, including new treatment approaches and medical technologies. BCBSIL evaluates emerging medical technologies as well as new applications of existing technologies through BCBSIL's corporate medical policy development process. The evaluation process is applied to new technologies, products, drugs, medical and surgical procedures, behavioral health procedures, medical devices and any other such services as may come under policy and claims review.

Medical policy guidelines are solely intended to assist in making benefit determinations. The final decision about any service or treatment, regardless of any benefit determinations, is between a Member and their health care provider.

Satisfaction with the UM Process
BCBSIL relies upon the CAHPS survey to identify areas of concern expressed by Members with accessing needed care. The results of the annual survey are used to identify issues and outline action plans.

The BCBSIL QI Department conducts a Provider satisfaction survey annually. Results are monitored, and the findings are reported to the QI Committee for review, discussion, and the development of an action plan, if deemed appropriate.

Pharmaceutical Management
Pharmacy benefits are administered by Prime Therapeutics LLC ("Prime"), BCBSIL's Pharmacy Benefit Manager.

Ensuring Appropriate Utilization
BCBSIL reviews and evaluates the following data, and such other information as BCBSIL deems appropriate, in order to identify any patterns of potentially inappropriate utilization:

a) Inpatient admissions/1000 (including acute and long-term acute care);
b) Inpatient days/1000;
c) Average length of stay (LOS);
d) Outpatient surgery/1000;
e) ER visits;
f) BH and CD days/1000; and
g) Member satisfaction data from annual surveys

Data is collected at the provider level. Thresholds for intensified review by the BCBSIL UM Workgroup are established based on a statistical analysis of Provider performance in relation to overall network performance. The BCBSIL QI Plan contains utilization goal benchmarks that are set based on all MMAI products. In addition, Milliman benchmark performance data (for moderately managed health plans) are used as a guide. In addition, Member survey and PCP survey data are reviewed for each identified Provider. The BCBSIL UM Workgroup reviews reports and identifies potential issues. Also, claims payment data, denial files, customer service issues, quality of care issues, diagnosis, referrals, case detail, Member satisfaction and appeals are also utilized to identify potential problems. When deemed appropriate, a corrective action plan is requested from the Provider. It may include any of the following components: further data collection, written requests for action, meeting with the Provider Network Consultant and the Provider.

Transition of Care
BCBSIL will help facilitate transition of care when a Member needs assistance in moving from one level of care to another or from one provider to another. Transitions of care protocols are applicable when a Member is displaced by physician de-participation or is displaced by termination of a provider contract. The Care Coordinator facilitates location of new in-network providers for the Member. New Members are assigned a Care Coordinator who will work with the Member to identify in-network providers within 180 days of enrollment. Members in one of these situations who are receiving frequent or ongoing care for a medical condition or pregnancy beyond the first trimester may request assistance to continue with established specialists for a defined time. Such Members should be directed to the MMAI Customer Service Department at 877-723-7702 for help in this matter.

Protected Health Information (PHI)

Providers must follow all laws including, but not limited to, the HIPAA provisions for the use of protected health information (PHI) and the provisions identified below and require any sub-delegates to follow those same provisions:

- Use PHI (any Member identifiers that can be linked to a Member) only to provide or arrange for the provision of medical and behavioral health benefits administration and services;
- Provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure;
- Ensure that sub-delegates have similar safeguards;
- Provide individuals with access to their PHI;
- Inform all affected parties, including the Provider, if inappropriate use of PHI occurs; and
- Ensure that PHI is returned, destroyed, or protected if the contract ends.

Emergency Medical Treatment and Labor Act (EMTALA)

- Medicare participating hospitals that offer emergency services are required to provide a medical screening examination (MSE) when a request is made for the examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.
- Nothing in this Provider Manual is construed to conflict with provider's obligations under EMTALA.

Quality Improvement Program

Quality Monitoring Activities

Ongoing monitoring of specific quality indicators is an important component of the BCBSIL Quality Improvement (QI) program. Indicators are selected based on important aspects of care for MMAI Members including, but not limited to, utilizing medical/surgical, behavioral health and chemical dependency data. These indicators are relevant to the enrolled population; are designed to be reflective of high volume or high-risk services; encompass preventive, acute and chronic care and span a variety of delivery settings. Categories of indicators may include the following:

- Effectiveness of care and services for preventive health, BH, chronic and complex conditions.
- Clinical QI Program effectiveness
- Service QI Program effectiveness including Appeals and Grievances
- Member and Provider experience of clinical and BH care and services
- UM, complex case management, and disease management program effectiveness
- Adult and adolescent experience of and benefit from clinical and BH care coordination and services
- Patient safety and critical incidents
- Continuity and quality of care between medical practitioners and transitions and settings of care
- Continuity and quality of care between medical and behavioral health practitioners
- Practitioner and Provider contracting, credentialing, and re-credentialing
- Effectiveness of care and services to Members at-risk due to specific age, racial, cultural, ethnic, and linguistic needs
- Performance against clinical practice guidelines for acute, chronic, BH medical conditions, and adult preventive guidelines

Quality indicators are usually selected on the basis of their objectivity, measurability, and validity. Performance goals or benchmarks may exist or may be established after baseline measurements have been completed. Quality indicators are reported to the Quality Committee(s) for review and recommendations, including the development of corrective action and/or performance improvement plans.

MMAI Quality Ratings

The Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS) will evaluate the Illinois MMAI Demonstration Program on the basis of quality metrics. Provider involvement is an integral piece to the success of this program.

CMS and HFS will withhold a percentage of the payment to MMAI each calendar year (CY). The withhold is paid back to MMAI, if the quality metrics are met.

The withhold quality metrics are for calendar years after the initial calendar year of the MMAI program, where Provider involvement is essential. Please refer to your Provider contract for measure specific information. If you have any questions, please contact your Provider Network Consultant.

In addition to the withhold quality metrics, there are more than ninety additional core quality measures for the MMAI program.

The quality scores for MMAI plans are based on performance measures that are derived from seven sources:

- Healthcare Effective Data and Information Set (HEDIS), including pharmacy clinical data
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)-Member survey
- Health Outcomes Survey (HOS)-Member survey
- CMS administrative data, including information about Member satisfaction, plans' appeals processes, audit results and customer service
- Internal plan process and outcomes measures related to implementation of the Model of Care
- Internal plan process and outcomes measures specifically focused on institutional and LTSS Members

Oversight for the MMAI Quality Improvement Program

The Quality Assurance Committee (QAC) is responsible for providing oversight and direction to the BCBSIL Quality Improvement Program. The QAC brings multidivisional staff together with Providers and Members for the purpose of reflecting customer values.

Responsibilities of the QAC include:

- Review and approval of the annual Quality Improvement Program Description
- Review and approval of the annual Quality Improvement Work Plan
- Monitoring and analysis of reports on QI activities from subcommittees
- Review and approval of annual Quality Improvement Program Evaluation, review, and approval of Quality Improvement Projects
- Recommendation of policy decisions
- Analysis and evaluation of the results of QI activities
- Review of analysis of significant health care disparities in clinical areas
- Review of analysis of information, training and tools to staff and practitioners to support culturally competent communication
- Review of analysis of on-site audit results to understand the differences in care provided and outcomes achieved
- Review of analysis and evaluation of Member complaints and appeals
- Review of analysis and evaluation of populations with complex health needs
- Ensuring practitioner participation in the QI Program through project planning, design, implementation and/or review
- Institution of needed actions
- Ensuring follow-up, as appropriate

Chronic Care Improvement Program (CCIP)

Chronic Care Improvement Program (CCIP) is a set of interventions designed to help improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians, as well as support services for Providers and patient self-management techniques.

Quality Improvement Project (QIP) and Performance Improvement Project (PIP)

An organization's initiative(s) that focuses on specified clinical and non-clinical areas.

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trends for possible quality of care issues. All Member grievances regarding quality of care, regardless of whether they are filed orally or in writing, are responded to in writing. A quality-of-care complaint may be filed through the MMAI's grievance process and/or a Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided or arranged by MMAI meet professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings. MMAI is required to cooperate with the QIO in obtaining documentation and in resolving the grievance in situations where the Member files a quality-of-care grievance with both the QIO and MMAI.

The QIO is comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare-Medicaid Members. QIOs review complaints raised by Members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs) and ambulatory surgical centers. The QIOs also review continued stay denials for Members receiving care in acute inpatient hospital facilities, as well as coverage terminations in SNFs, HHAs and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

All quality-of-care grievances filed with MMAI are investigated. Based on the investigation, if there is validation of quality concerns, a Medical Director will assign a level of severity and specific actions that may be taken.

Ombudsman Program

Mandated by the Federal Older Americans Act and the Illinois Act on Aging, the Illinois Long-Term Care Ombudsman Program (LTCOP) is a resident-directed advocacy program which protects and improves the quality of life for residents in a variety of long-term care settings. Ombudsmen work to resolve problems of individual residents and to bring about changes at the local, state, and national levels to improve care. For more information, visit https://ilaging.illinois.gov/programs/ltcombudsman.html

Member and Provider Satisfaction

The monitoring, evaluation and improvement of Member satisfaction are important components of the BCBSIL QI Program. This is accomplished through the use of surveys, as well as through the aggregation, trending and analysis of Member complaint and appeal data including the following categories: quality of care, access, attitude and service, billing and financial issues, and quality of the practitioner's office site. In addition to the administration of surveys, BCBSIL encourages Members to offer suggestions and express concerns utilizing customer service telephone lines and request for comments in survey instruments.

The following surveys are some of the tools utilized in the assessment of Member satisfaction:

- CAHPS Survey
- Quality of Life Survey
- Health Outcomes Survey (HOS)
- Condition Management Surveys
- Behavioral Health Survey, if applicable

In addition to assessment of Member satisfaction, Providers are surveyed to assess their satisfaction with various aspects of the MMAI program including Utilization Management and Case Management. In addition, MMAI IPAs and practitioner needs and expectations may be voiced at regular open meetings, including MMAI Administrative Forums and Managed Care Roundtables. BCBSIL uses information from practitioner surveys in ongoing program evaluation.

MMAI IPAs may be surveyed to assess their overall satisfaction with the networks' administration. For example, they may be asked about their satisfaction with MMAI support staff (e.g., Provider Network Consultants, Clinical Practice Consultants) as well as other questions related to network support. Information obtained through IPA surveys is utilized in network development and planning.

MMAI also solicits input from Providers and facilities by the following means:

- MMAI Member Advisory Committee
- Telephonic encounters
- Ad hoc advisory groups
- Face-to-face meetings

HEDIS

*Health Care Effectiveness Data and Information Set (*HEDIS) Performance Measures results are evaluated on an annual basis to monitor improvement. HEDIS data are collected from claims, encounters and may be supplemented with medical chart review. HEDIS data submitted to National Committee for Quality Assurance (NCQA) and other entities are audited by an NCQA certified HEDIS auditor. HEDIS is a registered trademark of NCQA.

Missed or Cancelled Appointments

Providers must:

- Document in the Member's medical record, and follow-up on missed or cancelled appointments.
- Conduct affirmative outreach to a Member who misses an appointment by performing the reasonable efforts to contact the enrollee. Providers may also contact Provider Services and request outreach from Care Coordination for Members with missed appointments.
- Not bill Members for missed appointments or refuse to provide services to Members who have missed appointments.

Continuity and Coordination of Care

Continuity and coordination of care are important elements of care and as such are monitored through the BCBSIL QI Program. Opportunities for improvement in the continuity and coordination of medical care may be selected from across the delivery system, including settings, transitions in care and patient safety. In addition, coordination between medical and behavioral health care is also monitored.

Practice Guidelines
Development and Updates

BCBSIL has developed and implemented evidenced-based preventive and clinical practice guidelines and criteria to assist clinical decision-making by patients and practitioners, provide standards and measures to help assess and improve the quality of care and encourage uniformity and consistency in the provision of care. Clinical practice guidelines and clinical criteria are developed and derived from a variety of sources, including recommendations from specialty and professional societies, consensus panels and national task forces and agencies, reviews of medical literature and recommendations from ad hoc committees.

> Clinical practice guidelines and clinical criteria are provided for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are required to exercise their own medical judgment in providing health care to Members.

The BCBSIL Clinical Management Committee will review and, as necessary, update clinical criteria annually and practice guidelines at least every two years. These guidelines are also updated when new significant findings or major advancements in evidence-based best practices and standards of care are established. Providers may be educated about Practice Guidelines through provider newsletters and this Provider Manual. Providers are informed they may receive copies of the Practice Guidelines free of charge upon verbal or written request. Questions and feedback about the guidelines can be directed to il_medicaid_qui@bcbsil.com.

Service Quality Improvement

The ability to provide valuable health care correlates strongly with services that support the managed care organization and health care delivery system. Further, satisfaction with BCBSIL is often derived from the quality of service the Members receive. Service standards have been established to help prevent issues whenever possible, and provide consistent, timely and accurate information and assistance to Members, physicians, Providers, and other customers. The standards are routinely monitored. Surveys and complaints are monitored to help ensure the standards established are appropriate and meet the needs of the organization and customers. Service indicators include:

- Inquiry and complaint rates
- Telephone access standards
- Results from Member and Provider appeals
- Compliance with Provider and practitioner access standards
- Results from Member and Provider surveys
- ADA Compliance

Each of the standards allows Member satisfaction with key service indicators to be assessed and interventions implemented as necessary. The key areas of focus are likely to include, but are not limited to:

- Customer service
- Claims payment

External Accountabilities

The MMAI QI Program is designed to meet all applicable state and federal requirements (e.g., HIPAA, etc.). MMAI staff monitors state and federal requirements related to quality improvement and reviews program activities to help assure compliance. In addition, if MMAI achieves external accreditation/certification, maintenance of such accreditation/certification is monitored through the MMAI QI Program.

Quality Improvement Program Documents

MMAI QI Program Description
The QI Program description is reviewed annually and is updated as needed.

QI Work Plan
The QI Program Work Plan is initiated annually based upon the planned activities for the year and includes improvement plans for issues identified through the evaluation of the previous year's program. The scope of the MMAI Work Plan includes aspects of the MMAI QI Program and the activities appropriately linked to the established goals and objectives. The Work Plan will include time frames for accomplishing each planned activity. The document is updated throughout the year to reflect the progress on QI activities and new initiatives as they are identified.

MMAI QI Program Evaluation
On an annual basis there is a written evaluation of the MMAI QI Program. The evaluation includes an assessment of progress made in meeting identified QI initiatives and goals and an evaluation of the overall effectiveness of the QI Program. The MMAI QI Program is then updated accordingly.

The MMAI evaluation process includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- Analysis of the results of QI initiatives, including barrier analysis
- Evaluation of the overall effectiveness of the MMAI QI Program, including progress toward influencing network-wide safe clinical practices.

Disclosure of the MMAI QI Program Information
Information regarding the MMAI QI Program is made available to MMAI Providers and to Members, upon request.

Reporting Incidents of Abuse, Neglect and Exploitation

- It is important to report abuse, neglect, and exploitation to the appropriate authorities to ensure the health, safety and well-being of vulnerable adults and children.
- Please call 855-334-4780 to inform MMAI of the report.

Reporting of Critical Incidents

- To report critical incidents to MMAI Members, Providers may call 855-334-4780 or complete the Critical Incident Reporting Form located on our website at https://www.bcbsil.com/pdf/education/forms/critical_incident_form.pdf
- When calling, please have the following information available:
    - The name and identification number of the Member;
    - A brief synopsis of the incident; and
    - The steps taken to ensure the health and safety of the Member.

Mandated and Voluntary Reporters of Abuse, Neglect, Exploitation or Critical Incidents

- Mandated reporters can be employees of facilities, community agencies, and certain professionals and are required by law to report abuse, neglect, exploitation, and critical incidents. These professionals include doctors, nurses, psychologists, dentists, social service workers, and law enforcement personnel.
- Everyone is encouraged, even when not required to report any suspected case of abuse, neglect, exploitation, and critical incidents. It is not necessary to provide your name should you wish to remain anonymous. No matter who reports, the identity of the reporter is not disclosed without the written permission of the reporter or by order of a court.

Claim Submission

Effective Jan. 1, 2023, Blue Cross and Blue Shield of Illinois (BCBSIL) will require electronic submission of all claims which do not require attachments for services provided to BCCHP and MMAI Members. This change aligns with the Illinois Department of Healthcare and Family Services (HFS) transition toward paperless claim filing, as outlined in their provider notice from November 2021. (https://hfs.illinois.gov/medicalproviders/notice.prn211124c.html)

Facility and Professional claims – **Payer ID: MCDIL**

Please note that the alpha prefix for BCCHP Members is **XOG**. The alpha prefix must be included as part of the Member ID number.

Paper claims requiring attachments should be sent to the following address:
Blue Cross Community Health Plans
c/o Provider Services
P.O. Box 3418
Scranton, PA 18505

Providers are required to prepare and submit to BCBSIL, according to the billing procedures established by BCBSIL, billing and encounter information for Members who have received covered services from a Provider. Providers are required to submit all claims eligible for reimbursement within 180 days from the date of service. BCBSIL may, at its sole discretion, deny payment for any such fee for service claim(s) received after 180 days from the date of service.

Claims must be submitted in a format that complies with the transaction and code set standards established by the Health Insurance Portability and Accountability Act of 1996 and the Act's implementing regulations (collectively "HIPAA"). Claims not submitted via the defined formats are subject to rejection.

Refer to our claim submission page for tips on how to get started with electronic claim filing.
https://www.bcbsil.com/provider/claims/claims-eligibility/claim-submission

Non-Contracted Providers (Nonpar)
Providers who are registered in IMPACT but not contracted with BCCHP may see Members and submit claims for reimbursement. All services may require preauthorization. If the Member belongs to a Blue Plan in a state other than your locally contracted Blue Plan, you must file the claim to your local Blue Plan. The two states will communicate through BlueCard to finalize the claim.

Dually Contracted Providers
Providers who are directly contracted with Blue Plans in multiple states, usually due to contiguous county contracting, are sometimes considered to have two "local" plans: one is their geographic local plan (Plan A), the other is a local plan due to contractual obligation (Plan B). In this circumstance, Providers must file Member claims from Plan B with that state, regardless of the state where services were rendered. Providers file all other Member claims to their geographic local / state where services were rendered (Plan A).

Treating Family Members

Participating Providers may not bill BCBSIL for health care services rendered to themselves or their Immediate Family Members, or designate themselves as a primary care physician, for any purpose, for themselves or their Immediate Family Members. An "Immediate Family Member" is defined as: (i) current spouse; (ii) eligible domestic partner; (iii) parents and stepparents of themselves, their spouse or domestic partner; (iv) children and grandchildren (biological, adopted, or other legally placed children) of themselves, their spouse or domestic partner; and (v) siblings (including biological, adopted, step, half, or other legally placed children) of themselves, their spouse or domestic partner. BCBSIL will not process any claims for services, nor make payment for any claims for services, rendered by a Participating Provider to him or herself, or to his or her Immediate Family Members. In the event that BCBSIL determines that a benefit was paid in error, BCBSIL has the right to request and receive a refund of the payment from the Participating Provider.

Transportation Claim Administration

To view detailed billing guidelines for transport services, view the IAMHP Comprehensive Billing Manual on their website at: https://iamhp.net/providers

To learn more about PCS form guidelines, go to:
https://hfs.illinois.gov/medicalproviders/noninstitutional/physiciancertificationstatement.html

Claim Payment

BCBSIL shall pay Providers for Covered Services authorized by MMAI and provided to eligible Members. Providers agree to accept payment from BCBSIL as payment in full for the provision of covered services to Members, as per the Medical Service Agreement, less any applicable copayments, deductibles, coinsurance, and/or cost-share amounts required directly from the Member, if any.

As a reminder, checking eligibility and benefits is an important first step, prior to rendering services and submitting claims, as some services may require benefit prior authorization by BCBSIL. Additional information on services requiring benefit prior authorization may be found in the Utilization Management section of this manual.

Claim Payment Adjustments

MMAI will process accurate and complete Provider claims according to MMAI claims processing procedures and applicable Laws, rules, and regulations. Such claims processing procedures may include, but are not limited to, system applications which review compliance with standards for claims coding.

In addition, Providers should be aware that MMAI may make retroactive adjustments to the payment arrangements outlined in the Medical Service Agreement for reasons including, but not limited to, changes to Member enrollment status and claims payment errors.

Provider Claim Disputes

BCBSIL gives network and non-network providers at least sixty (60) days to dispute a BCCHP claim after BCBSIL has partially paid or denied it. You may also dispute recovery requests initiated by BCBSIL via this process if you believe the associated claim adjustment was incorrect.

Providers may file a dispute by contacting BCBSIL at 877-860-2837 or by completing the Medicaid Claims Inquiry and Dispute Form and submitting it along with supporting documentation by fax to 855-322-0717 or by mail to:

Blue Cross Community Health Plans
c/o Provider Services
PO Box 4168
Scranton, PA 18505

The Provider Claims Inquiry or Dispute Request Form can be found on our website at
https://www.bcbsil.com/pdf/network/medicaid_claims_inquiry_dispute_request_form.pdf

Providers who call Customer Service to file a Provider Dispute are assigned a 12-digit unique tracking ID number. The Tracking ID Number will appear in the following format: 193450004656

- The first two digits represent the year of receipt: 19
- Digits 3-6 are the date within the year, for instance 345= December 11th
- The remaining digits uniquely identify the dispute in our system

Written notification of payment contestation must include at a minimum the following information: Member name and identification number, date of service, claim number, name of the provider of service, charge amount, payment amount and an explanation of the basis for the contestation. BCBSIL will review such contestation(s) and usually will respond to Providers within 45 days of the date of receipt by BCBSIL of such contestation. BCBSIL's decision on the matter will be final unless the provider elects to appeal in accordance with the terms of the Medical Service Agreement. Failure to contest the amount of any claim hereunder within the time specified above will result in a waiver of the Provider's right to contest such claims payment.

Claims to State or Federal Government Prohibited

Providers shall not request payment for Covered Services provided in any form from HFS, CMS, HHS or any other agency of the State of Illinois or the United States of America or their designees for items and services furnished in accordance with the Medical Service Agreement, unless approved in advanced by MMAI and HFS or CMS.

Coding Related Updates

Provider acknowledges and agrees that BCBSIL may apply claim editing rules or processes, in accordance with correct coding guidelines and other industry-standard methodologies, including, but not limited to, CMS, CPT, McKesson and Cotiviti coding process edits and rules.

Recovery of Overpayments

Providers are required to provide notice to MMAI of any overpayment(s) identified by Providers, including duplicate payments, within 10 calendar days of identifying such overpayment, and unless otherwise instructed by MMAI in writing, Providers are required to refund any amounts due to MMAI within 30 calendar days of identifying such overpayment.

In the event of any overpayment, duplicate payment, or other payment in excess of that to which the Provider is entitled for Covered Services furnished to a Member, MMAI may recover the amounts owed by way of offset or recoupment from current or future amounts due from MMAI to the Provider.

Balance Billing

An important protection for Members when they obtain plan-covered services in a MMAI Plan is that they do not pay more than MMAI-allowed cost sharing.

Payment will not be made by MMAI for services rendered to Members, which are determined by MMAI not to be medically necessary, as defined in the Member Handbook. In the event of a denial of payment for services provided to Members that are determined by MMAI not to be medically necessary, the Provider shall not bill, charge, seek payment or have any recourse against a Member for such services.

Providers may bill the Member for services that are determined not to be medically necessary if the Provider provides the Member with advance written notice that informs the Member that such services may be deemed by MMAI to be not medically necessary and provides Member with an estimate of the cost to the Member for such services and the Member agrees, in writing that is signed and dated, to assume financial responsibility in advance of receiving such services.

Defined Member Populations

The following table defines all Member populations for MMAI.

Member Population Name	Definition	Effective date by HFS and/or CMS
Community Members	A Member that meets one of the following qualifications: 1. has been placed in rate cell W7046 and is not a resident of a supportive living facility (SLF); 2. has been placed in rate cell W7047; 3. has been placed in rate cell W7049 and is not a resident of a SLF; and 4. has been placed in rate cell W7050.	3/1/2014
SLF Custodial Member	A Member that meets one of the following qualifications: 1. has been placed in rate cell W7046 and is a resident of a SLF; or 2. has been placed in rate cell W7049 and is a resident of a SLF.	3/1/2014
SNF Custodial Member	A Member that meets one of the following qualifications: 1. has been placed in rate cell W7045; or 2. has been placed in rate cell W7048;	3/1/2014

Annual Health Assessment (AHA) Payment

The AHA serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the Member's past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings and chronic disease monitoring. These assessments can occur in the Provider's office or Member's home to remove barriers to completion.

MMAI shall reimburse the Primary Care Physician (PCP) for the completion of an AHA as set forth in the Medical Service Agreement for Eligible Members as defined in Table A below. AHA reimbursement shall be limited to one member per calendar year. AHA reimbursement for Eligible Members is defined in Table B below. The AHA must be accurate, completed to the satisfaction of MMAI and appropriately supported by information contained within the PCP medical record. The PCP agrees to provide MMAI with such documentation as is required by MMAI to substantiate any claim by PCP for reimbursement.

Table A

Eligible Members	Effective Date Within Annual Health Assessment (AHA) Program
Community Members	1/1/2019
SLF Custodial Member	1/1/2019
Custodial Member	1/1/2019

Table B

Date	Reimbursement Amount
Prior to June 1, 2020	$100
June 1, 2020 to December 31, 2020	$150
January 1, 2021	$100

MMAI Primary Care Medical Home Program (PCMH)

MMAI supports the concept of medical home by offering PCPs an opportunity to participate in the MMAI Primary Care Medical Home Program (PCMH). PCPs meeting the PCMH requirements as outlined below are eligible to receive a monthly Care Coordination Fee for each Member assigned to the PCP.

To be eligible for the PCMH Care Coordination Fee, PCPs must:

1. Provide Members with comprehensive primary care services and covered preventive services, including but not limited to, medically indicated physical examinations, health education, laboratory services, referrals for Medically Necessary Covered Services;
2. Provide or arrange for all appropriate immunizations;
3. Participate in or coordinate the Members' care including inpatient admission and collaborate with MMAI Care Managers as requested;
4. Participate in and collaborate with the MMAI Care Managers in Member Care Plan;
5. Maintain access to care and appointment accessibility standards defined by MMAI;
6. Outreach to Members missing an appointment to reschedule the appointment as needed;
7. Outreach to Members for preventive and immunization services.

Care Coordination Fee

PCPs shall receive a monthly Care Coordination Fee payment for each eligible Member assigned to the PCP as defined in Table A below. The Care Coordination Fee is paid on a per Member per month basis regardless of the number of times the Member visits their PCP.

Table A

Eligible Members	Effective Date Within Care Coordination Fee Program
Community Members	1/1/2019
SLF Custodial Member	1/1/2021

Calculation of Care Coordination Fee Payment

MMAI calculates current Care Coordination Fee amounts paid to PCPs which is based on the Member's effective date of enrollment in the MMAI Plan and the PCP. The Care Coordination Fee payment amount is defined in Table A below.

Calculations are listed in the Care Coordination Fee Summary report. The Care Coordination Fee Summary is available on a monthly basis to the PCP along with their Care Coordination Fee. If the PCP has any questions about the calculation of its monthly Care Coordination Fee check, this Summary should be consulted first.

Table A

Eligible Members Reimbursement Thresholds	PMPM
< 100	$10.00
100-200	$12.00
> 200	$15.00

The Care Coordination Fee Payment Summary Key

Use the following key to understand the MMAI Capitation Payment Summary.

- **Month:** Month for which Care Coordination Fee is being paid
- **Provider Number and Provider NPI Number:** Identification number and the National Provider Identifier (NPI) of the Provider to whom Care Coordination Fee is being paid
- **Current Capitation:** Dollar amount of current calculated Care Coordination Fee
- **Additional Adjustments/Payments:** Dollar amount (positive or negative) of manual adjustments to the month's Care Coordination Fee.
- **Description:** A brief description of the Additional Adjustment/Payment

Part D Vaccines Claims Submission Process

Providers, if providing Part D vaccines in their office, must submit the claim encounter through TransActRX. To enroll, Providers should go to https://www.transactrx.com/. TransActRX FAQ and applicable drugs can be found on the MMAI Resource section on the Provider website.

Quality Improvement Program (QIP)

The MMAI Quality Improvement Program (QIP) is intended to provide incentives to the Provider for maintaining high quality and patient satisfaction standards in the delivery of covered services.

QIP Clinical Measures and performance thresholds will be established by MMAI on an annual basis. QIP Clinical Measures and performance thresholds may be modified by MMAI to comply with the contractual requirements from CMS and HFS. The current QIP Clinical Measures are defined in the table below:

Influenza Immunizations	**QIP Incentive Payment**	**Per compliant influenza vaccination for members 18 years and older** who received the vaccination between September 1 and December 31.	
	$25	**CPT**	90630, 90653-90657, 90660, 90661, 90662, 90672- 90674, 90682, 90685-90688, 90756
		HCPCS	Q2034 – Q2039

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	**QIP Incentive Payment**	**The percentage of adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:** **1. Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within fourteen (14) days of the diagnosis.** **AND** **2. Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within thirty (30) days of the initiation visit.**	
	$25	**Initiation of AOD Treatment** Member had one substance abuse treatment encounter within fourteen (14) days of the initial AOD diagnosis. The treatment encounter could be an inpatient admit, partial hospitalization or outpatient visit or encounter.	**ICD-10-CM:** Use the appropriate code family – F **CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510 **HCPCS**: G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015

			CPT with POS: **CPT**: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876 **POS**: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72 **CPT with POS with or without Telehealth Modifier** **CPT**: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **POS**: 52, 53 **Telehealth Modifier:** 95, GT **Telephone Visit with POS** **Telephone Visit:** 98966-98968, 99441-99443 **POS**: 52, 53 **Online Assessment CPT:** 98969, 99444 POS: 52, 53
	$25	**Engagement of AOD Treatment** Member had at least two substance abuse treatment encounters within thirty (30) days of the initiation visit described above.	

Care of Older Adults	**QIP**	**The percentage of adults 66 years of age or older who had the following during the measurement year:** **1. Advance Care Planning** **2. Medication Review** **3. Functional Status Review** **4. Pain Assessment**	
	$10	**Advance Care Planning**	**CPT:** 99483 **CPT II:** 1123F, 1124F, 1157F, 1158F **HCPCS:** S0257
	$10	**Medication Review**	**CPT:** 90863, 99483, 99605, 99606 ***OR*** **CPT II:**1160F ***AND***
		Medication List	**CPT:** 1159F, 99483 **OR** **HCPCS: G0438, G0439,** G8427
		Transitional care management (TCM) TCM 7-Day TCM 14 Day	**OR** **CPT:** 99495 **OR** **CPT:** 99496
	$10	Functional Status Review	**CPT II:** 1170F
	$10	Pain Assessment	**CPT II:** 1125F, 1126F

Quality Improvement Program Payment

MMAI shall reimburse the PCP for each eligible Member enrolled with the PCP as defined in the table below who received either a targeted Clinical Measure service or achieved the targeted outcome according to the payment terms of the Medical Service Agreement.

Eligible Members	Effective Date Within Quality Improvement Program
Community Members	1/1/2019
SLF Custodial Member	1/1/2021

Quality Improvement Program Data Submission and Calculation

QIP Clinical Measures shall be based, amongst other things, on MMAI claims data and medical record review. The PCP is required to submit complete and accurate data and supporting documentation for each of the QIP Clinical Measures as requested by MMAI. The data must be submitted in a format acceptable to MMAI and within the time period established in the annual QIP instructions. Data submission must be accompanied by an attestation of accuracy and completeness signed by the PCP.

If it is necessary for MMAI to perform a site visit to obtain the required documentation, no QIP payment will be made to the PCP.

All documentation requested by MMAI to support any claims for payment must be received by MMAI within seven days of the request for documentation, unless the QIP instructions allow more time for the PCP to provide such documentation. MMAI may reduce or eliminate any payments that the PCP may be eligible for if the Provider either refuses or delays providing such documentation to MMAI.

Shared Savings and Shared Loss Program Calculation

MMAI shall calculate the MLR of the PCP for each eligible Member enrolled with the PCP, as defined in the table below, according to the payment terms of the Medical Service Agreement. The Practice must have a minimum of 250 Eligible Members on or before May 1 of the current calendar year to be enrolled in the Shared Savings and Shared Loss Program.

Eligible Members	Effective Date Within Shared Savings and Shared Loss Program
Community Members	1/1/2019
SLF Custodial Member	1/1/2021

Coordination of Benefits

If a Member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by MMAI will be governed by the amount paid by the primary plan and Medicare Secondary Payer law, regulations, and policies.

If MMAI is not the primary payer, the Provider must bill payer(s) with the primary liability prior to submitting bills for the same services to MMAI. The Provider must also provide MMAI with relevant information it has collected from Members regarding coordination of benefits. If MMAI is not Member's primary payer, the Provider's compensation by MMAI shall be no more than the difference between the amount paid by the primary payer(s) and the applicable rate under this Medical Service Agreement, less any applicable co-payments or coinsurance.

Medicare Secondary Payer Demand Letter

The Medicare Secondary Payer law is a provision of the Social Security Act. It refers to those instances in which Medicare does not have the primary responsibility for paying the medical expenses of a Medicare beneficiary because the beneficiary is entitled to other coverage that should pay primary health benefits.

There are times when the Centers for Medicare & Medicaid Services (CMS) will send a Medicare Demand Letter if Medicare has paid claims as Medicare primary in error. This letter contains a summary data sheet, a payment record summary and the claims that are involved in the reimbursement to Medicare. This Demand Letter requires that MMAI reimburse Medicare in full for their expenses for the health care services that it paid as primary in error.

MMAI reviews the Medicare Demand Letter and verifies the eligibility and claim information and identifies the appropriate Provider. The MMAI will use its resources to obtain any claim contracting data present. MMAI will send a Medicare Secondary Payment Request Letter to the Provider including a summary claims listing. The independently contracted provider will have five business days to respond to the request.

Worker's Compensation

The Illinois Workers' Compensation Act provides that an insured employee has the right to obtain medical care for treatment of a work-related injury. If the employee chooses to use the services of the chosen independently contracted provider, the charges or equivalents for these services should be recouped through the employer's Workers' Compensation carrier. The independently contracted provider must not bill the member. A Member can be questioned to determine whether the injury a) occurred at work or b) during the course of their work duties.

Regular follow up by the independently contracted provider, via certified mail, is recommended to ensure reimbursement. Liens should not be issued for Workers' Compensation claims.

Right to Recovery

The independently contracted provider has the right to recovery after they have rendered services for an injury and the member attempts to collect payments by an action at law, settlement or otherwise. Benefits provided must be for covered services under the Member Handbook.

In the event of accidental injury outside of work or when some party other than the employer or co-employees are responsible for the injury, there is a right to recovery of these monies from the responsible party (i.e., insurance carrier). A lien for medical or hospital treatment can be perfected against the insured, the responsible party and the responsible party's insurance carrier. This must be perfected by the medical Provider and not MMAI. No lien can be filed unless there is a claim or litigation pursued by the member.

Policies and Procedures

Inpatient Readmission Reduction Policy Background

The Blue Cross Blue Shield of Illinois (BCBSIL) Inpatient Readmission Reduction Program derives from the Centers for Medicare and Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS) guidelines. Implemented as part of the Affordable Care Act in 2010, CMS mandates various payment reduction incentives to hospitals in order to decrease potentially preventable readmissions (PPRs). This mandate is referred to as the Hospital Readmissions Reduction Program (HRRP), located in Section 3025 of section 1886(q) within the ACA. HRRP took effect on Oct. 1, 2012.

Following CMS, many state Medicaid programs are implementing readmission programs in an effort to reduce preventable inpatient hospital readmissions. Inpatient readmissions is a quality-of-care metric that incentivizes hospitals to bring their quality of care up to standard. The purpose of this policy is to promote the health of the member.

Application
This policy applies to hospitals.

Description
Upon BCBSIL's request, a hospital must forward to BCBSIL all medical records and related documents involving the admissions. These documents can be clinically reviewed to determine if readmission within 30-days of hospital discharge was clinically related. Following this review, the data will be further reviewed to determine whether the readmission was potentially preventable. This clinical review process analyzes the quality of the patient's discharge plan, the hospital's quality of care, and patient's condition. After the review process, if a readmission is determined to be clinically related and/or potentially preventable, BCBSIL can deny payment.

Definitions

Readmission
An Inpatient Readmission is defined as a hospital readmission within 30-days after the initial discharge. The readmission must be clinically related to the initial admission and meet the criteria for a potentially preventable readmission (PPR).

Clinically Related
A clinically related admission is an admission that resulted from related treatment as part of a prior inpatient stay. This may be due to the quality of care and treatment process during the initial admission or insufficient follow-up and transitional care post discharge. If the readmission is due to unrelated events following a prior admission, then the readmission is not considered clinically related.

Potentially Preventable
A readmission is considered potentially preventable if it is clinically related to the initial admission and could likely have been prevented with appropriate quality of care or discharge planning. Hospital claims will be determined to be potentially preventable after they have been classified as clinically related, based on the above criteria. The readmission could result in being potentially preventable based on a multitude of factors including, but not limited to:

- The readmission was a result of a previous premature discharge from the hospital setting
- The readmission was a result of inadequate discharge planning
- Inadequate transition of care processes
- The readmission was a result of inadequate coordination between the inpatient and outpatient providers
- Failure to address proper rehabilitation needs
- The readmission was NOT medically necessary

Readmission Review Processes

Pre-Payment Review

A pre-payment review process will be completed following the steps below:

1. All claim data for member within 30 days of initial discharge are submitted to BCBSIL for clinical review.
    a. If medical records for both the initial and subsequent admissions are not received, the second claim will be denied payment.
    b. Upon denial, the hospital may submit for a payment adjustment or appeal to BCBSIL with the necessary claims data included. If submitted data is insufficient, appeal or adjustment will be denied.
2. A qualified clinician will determine if the readmission was clinically related and/or potentially preventable based on the above guidelines.
3. If a readmission is determined to be clinically related and/or potentially preventable, the hospital will be notified by mail and the payment for the readmission can be denied.

Post-Payment Review

To minimize the need for post-payment review, BCBSIL may clinically review hospital claims submissions prior to payment. However, BCBSIL reserves the right to review post-payment if pre-payment review was not conducted. The post-payment review process will be conducted following the steps below:

1. If a hospital claim is considered clinically related during the initial clinical review process, and thus could be considered a PPR, the hospital(s) must send BCBSIL all medical records relating to the initial admission and all relevant readmissions upon BCBSIL's request.
2. A qualified clinician will then review all medical records and supporting documentation to determine if any readmission was unnecessary and/or potentially preventable based on the above guidelines.
3. If a readmission is determined to be unnecessary and/or potentially preventable, the hospital(s) will be notified by BCBSIL via written notification of this determination.
4. A request from BCBSIL to the hospital(s) for refund of the applicable payment(s) for the PPR will be sent within the written notification.
5. If the hospital fails to refund the necessary payment(s) for the readmission, BCBSIL may recover the necessary payment(s) by offsetting against future payments to the hospital(s), unless prohibited by law or expressed in the corresponding contract.

Exclusions

Readmissions under the following circumstances are excluded from 30-day readmission review, including but not limited to:

- Obstetrical readmissions
- Transfers of patients to receive care that was unable to be provided at the initial facility
- SNF and rehabilitation facility admissions
- Planned readmissions for repetitive health care treatments, including but not limited to: Chemotherapy, staged surgical procedures, procedures involving malignancies, burns procedures, cystic fibrosis procedures, and other treatments
- Patient non-compliance, ONLY if this is adequately documented in medical records

Required Documentation

Upon request from BCBSIL, hospital providers must supply all medical records and documentation related to relevant hospital stays.

References

1. Readmissions Reduction Program (HRRP). (2018, April 27). Retrieved from https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html
2. Patient Protection and Affordable Care Act Pub. L. No, 111-148 § 3025(a), 124 Stat. 119, 408 (2010). The Affordable Care Act, Section 3025, § 1886(q), requires the Secretary to establish a Hospital Readmissions Reduction program effective for discharges beginning on October 1, 2012.
3. Averill, R. F., McCullough, E. C., Hughes, J. S., Goldfield, N. I., Vertrees, J. C., & Fuller, R. L. (2009). Redesigning the Medicare Inpatient PPS to Reduce Payments to Hospitals with High Readmission Rates. *Health Care Financing Review*, *30*(4), 1–15.

Glossary

ADA Accessible
A term defined under the ADA that generally requires that any site, facility, work environment, service or program be easy to approach, enter, operate, participate in and/or use safely and with dignity by a person with a disability.

Adults with Disabilities
An individual who is 19 years of age or older, who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382), and who is eligible for Medicaid.

Advance Directive
An individual's written directive or instruction, such as a durable power of attorney for health care, a living will or a mental health treatment preference declaration, recognized under the laws of the State of Illinois and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Adverse Action
The denial or limitation of authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial of payment for a service; the failure to provide services in a timely manner; the failure to respond to an appeal in a timely manner, or solely with respect to an Demonstration Plan that is the only contractor serving a rural area, the denial of an member's request to obtain services outside of the service area for reasons other than medical necessity.

Americans with Disabilities Act (ADA)
A federal law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services.

Appeal
The procedure that deals with the review of adverse initial determinations made by the MMAI plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug.

Basic Benefits
All health care services covered under the Medicare Part A, Part B and MMAI Programs, except hospice services and additional benefits. All members of MMAI are eligible to receive all basic benefits.

Care Coordinator
Care Coordinator provides Care Management and, working with a member and care team, establishes a Care Plan for the member.

Care Management
Care Management is a program designed to assist members in gaining access to services, including medical, social, educational, and other services, regardless of the funding source for the services. Care Management is a collaborative process that is designed to assist members and their providers to assess, plan, implement, coordinate, monitor, and evaluate the options and services (both Medicare and Medicaid) required to meet a member's needs across the continuum of care.

Care Plan
A Care Plan is a member-centered, goal-oriented, culturally relevant, and logical written plan of care with a service plan component, if necessary, that is designed to assist the member to obtain access, to the extent applicable, to medical, medically related, social, behavioral, and necessary covered services, including long-term services and supports, in a supportive, effective, efficient, timely manner that emphasizes prevention and continuity of care.

Center for Health Dispute Resolution (CHDR)
An independent Centers for Medicare & Medicaid Services (CMS) contractor that reviews appeals by members of managed care plans, including MMAI.

Centers for Medicare & Medicaid Services (CMS)
CMS is the federal agency responsible for administering Medicare.

Chronic Health Condition
A health condition with an anticipated duration of at least 12 months.

CMS Contract
CMS Contract means all the contracts between an HMO and CMS pursuant to which HMO sponsors MA and Part D Plans.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of beneficiary experiences with health care.

Contracted Facility
Any independently contracted health facility, hospital, laboratory, or other institution licensed and/or certified by the State of Illinois and Medicare to deliver or furnish health care services and has a written agreement to provide services directly or indirectly to MMAI members pursuant to the terms of the Agreement for Facilities Services.

Contracted Pharmacy
Any independently contracted pharmacy that has an agreement to provide MMAI members with medication(s) prescribed by each member's contracted provider in accordance with MMAI.

Contracted Provider
Any independently contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, and any other provider of medical services, licensed and/or certified by CMS to deliver or furnish health care services. This individual has a written agreement to provide services directly or indirectly to MMAI members pursuant to the terms of the Medical Service Agreement.

Contractor
When referring to Medicare and Medicaid, the "Contractor" is the Managed Care Organization (MCO). For the purposes of this manual, that would be MMAI managed by BCBSIL.

Coverage Determination
Any initial determination with respect to any treatment or services that may be covered by MMAI including, but not limited to payment for pharmacy-benefits that are covered by Medicare Part D.

Covered Services
Those benefits, services or supplies that are covered under MMAI and approved for a member by MMAI as more fully set forth in the MMAI plan document.

Cultural Competence
Generally considered the understanding of those values, beliefs and needs that are associated with age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds of members receiving health care services. Cultural Competence also includes a set of competencies, which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

DCFS
The Illinois Department of Children and Family Services and any successor agency.
http://www.state.il.us/dcfs/index.shtml. 1.17.40

DCMS
The Illinois Department of Central Management Services and any successor agency.

DHHS
The United States Department of Health and Human Services and any successor agency.

DHS
The Illinois Department of Human Services and any successor agency.

DHS-SUPR
The Division of Substance Use Prevention and Recovery (SUPR), or its successor, within Illinois Department of Human Services (DHS) that operates treatment services for alcoholism & addiction through an extensive treatment provider network throughout the State of Illinois. http://www.dhs.state.il.us/page.aspx?item=29725

DHS-DDD
The Division of Developmental Disabilities within DHS that operates programs for persons with developmental disabilities.

DHS-DMH
The Division of Mental Health, and any successor agency, within DHS that is the state mental health authority.

DHS-DRS
The Division of Rehabilitation Services, and any successor agency, within DHS that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.

DHS-OIG
The Department of Human Service Office of Inspector General, and any successor agency, is the entity generally responsible to investigate allegations of abuse and neglect of people who receive mental health or developmental disability services in Illinois and to seek ways to prevent it.

Delegated Activities
Delegation occurs when an organization gives another entity the authority to carry out a function that it would otherwise perform. Delegation or Subcontracting is the process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities on behalf of the health plan, while the health plan retains final authority to provide oversight to the delegate.

Determination of Need (DON)
The tool used by the State of Illinois Department of Human Services or the Department's authorized representative to determine eligibility (level of care) for nursing facility and home and community-based services (HCBS) waivers for persons with disabilities, HIV/AIDS, brain injury, supportive living, and the elderly.

Disenrollment
The process by which a member's participation in MMAI is terminated. Reasons for disenrollment include, but are not limited to, death, loss of eligibility for MMAI or choice not to participate in MMAI. Disenrollment at the direction of the member may also be referred to as "opt-out."

DoA
The Illinois Department on Aging and any successor agency.

Downstream Entity
Downstream Entity has the same definition that is found in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this Agreement, means any person or entity that enters into a written arrangement with persons or entities involved in the MMAI, MA and/or Medicare Part D Programs, below the level of the arrangement between HMO and a First-Tier Entity, such as IPA.

DPH
The Illinois Department of Public Health, and any successor agency, the State Survey Agency responsible for promoting the health of the people of Illinois through various means, including, but not limited to, the prevention and control of disease, injury, licensure, and certification of Nursing Facilities (NF's) and Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) facilities.

Dual Eligible
A person who is eligible to receive services through both the Medicare and the Medicaid program.

Effectuation
Compliance with a reversal of MMAI original adverse organization determination. Compliance may entail payment of a claim, authorization for a service or provision of services.

Emergency Medical Condition
Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Emergency Services
Covered inpatient or outpatient services that are:

- Furnished by a Provider qualified and appropriately licensed to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Enrollment
The processes by which an individual who is eligible for MMAI is enrolled in MMAI including transfers from one participating MMAI plan to another. Such processes include the completion of a telephonic enrollment process or an enrollment form, when requested, in order to become a member of a participating MMAI plan.

Experimental Procedures and Items
Items and/or procedures determined not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, MMAI will consider CMS guidance, if applicable, and/or determinations already made by Medicare.

Explanation of Payment (EOP)
The statement provided to the Provider when payment is made that informs the Provider which procedures are being paid.

Facility
Hospital and ancillary providers, which include, but are not limited to: Durable Medical Equipment (DME) suppliers and Skilled Nursing Facilities (SNFs).

Fee-for-Service Medicare
A payment system by which physicians, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance
Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process may include waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Habilitation
An effort directed toward the alleviation of a disability or toward increasing a person's level of physical, mental, social, or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training, education, sheltered employment, protective services, counseling, and other services.

Healthcare Effectiveness Data and Information Set (HEDIS)
A tool developed and maintained by the National Committee for Quality Assurance and its successor organization that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality. Ensures that Members will receive optimal preventive and quality care. Annually, the Quality Improvement Department collects, analyzes, and evaluates performance measures. The results are used to evaluate our adherence to practice guidelines and improve Member outcomes. The results are reported to Healthcare and Family Services in June.

Health Outcomes Survey (HOS)
Beneficiary survey used by the Centers for Medicare & Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in various activities including, quality improvement activities, plan accountability, public reporting and improving health.

HHS
U.S. Department of Health and Human Services.

Home and Community Based Services (HCBS)
A combination of standard medical services and non-medical services that allow individuals to remain in their own home or live in a community setting including, but not limited to, case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care.

Home and Community Based Waiver
Waivers issued under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

Home Health Agency (HHA)
A Medicare-certified agency which provides intermittent skilled nursing care and other therapeutic services in the member’s home when medically necessary, when members are confined to their home and when authorized by their contracted provider.

Homemaker Service
General non-medical support by supervised and trained homemakers. Homemakers are trained to assist members with their activities of daily living, including personal care as well as other tasks such as laundry, shopping, and cleaning.

Hospice
An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital
A Medicare-certified institution licensed in the State of Illinois, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Hospital - Acquired Conditions
Conditions that are generally considered by CMS: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. These criteria are subject to change by CMS.

Illinois Client Enrollment Broker (ICEB)
The entity contracted by the Illinois Department of Healthcare and Family Services (HFS) to conduct enrollment activities for potential members, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of a health plan and PCP and processing requests to change health plans.**HFS**
Illinois Department of Healthcare and Family Services and its successor agency.

HFS Contract
HFS Contract means all the contracts between BCBSIL and HFS pursuant to which BCBSIL and Dual Plans as applicable.

Independent Physicians Association (IPA)
IPA means an Individual Practice Association, Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provision of professional medical services.

Institutionalized
Residency in a nursing facility, Intermediate Care Facility for Developmental Disabilities (ICF/DD) or state operated facility, but not including admission in an acute care or rehabilitation hospital setting.

Laws
Laws means any and all applicable laws, rules, regulations, statutes, orders, and standards of the United States of America, the states or any department or agency thereof with jurisdiction over any or all of the Parties, as such laws, rules, regulations, statutes, orders, and standards are adopted, amended, or issued from time to time. Laws include, without limitation, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations, including the HIPAA Privacy Rule and HIPAA Security Rule; Parts C and D of Title XVIII of the Social Security Act and its implementing regulations, including Parts 422 and 423 of Title 42 of the Code of Federal Regulations; all CMS guidance and instructions relating to the Medicare Advantage and Medicare Prescription Drug Programs; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the requirements applicable to individuals and entities receiving federal funds; the federal False Claims Act; any applicable state false claims statute, the federal anti-kickback statute; and the federal regulations prohibiting the offering of beneficiary inducements.

Long-Term Care (LTC) Facility or Nursing Facility (NF)
A facility that provides skilled nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the state of Illinois, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

Long Term Services and Support (LTSS)
See Home and Community Based Services (HCBS)

Medicaid
The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

Medically Necessary Services
A service, supply or medicine that is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, for the prevention of future disease, to assist in the member's ability to attain, maintain or regain functional capacity or to achieve age-appropriate growth or otherwise medically necessary and meets the standards of good medical practice in the medical community, as determined by the contracted Provider in accordance with MMAI guidelines, policies or procedures.

Medicare
Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities and people with End State Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Advantage (MA) Plan
A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit plan in the same service area.

Medicare Part A
Hospital insurance benefits including inpatient hospital care, SNF care, home health agency care and hospice care offered through Medicare.

Medicare Part A Premium
That portion of the premium required under Medicare to pay for Medicare Part A.

Medicare Part B
Medical insurance offered under Medicare that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, DME, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B Premium
A monthly premium paid to Medicare to cover Medicare Part B services. Members must pay this premium to Medicare to receive covered services whether members are covered by a Medicare Advantage Plan or by Original Medicare.

Medicare-Medicaid Enrollees
For the purposes of this MMAI Plan, individuals who are entitled to Medicare Part A and enrolled in Medicare Parts B and D and receive full benefits under the Illinois Medicaid State Plan and otherwise meet eligibility criteria for the MMAI Plan.

Member
The Medicare-Medicaid beneficiary, entitled to receive covered services, who has voluntarily elected to enroll in BCBSIL MMAI and whose enrollment has been confirmed by CMS and HFS. Member shall include the guardian where the member is an adult for whom a guardian has been named; provided, however, that the MMAI Program is not obligated to cover services for a guardian who is not otherwise eligible as a member.

Member Centered
A MMAI requirement that services and care are built on the member's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

Member Communications
Materials designed to communicate member's Covered Services and flexible benefits, policies, processes and/or member rights. This includes pre-enrollment, post-enrollment, and operational materials.

Member Handbook
A document that describes the health care benefits covered by MMAI. It provides the member with some form of documentation of what that insurance covers and how it works.

MMAI
Medicare-Medicaid Alignment Initiative (MMAI) – The Illinois name for the Capitated Financial Alignment Initiative.

Non-Participating Provider or Facility
Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the State of Illinois or Medicare to deliver or furnish health care services, and also being neither employed, owned, operated by, nor under contract with MMAI to deliver covered services to MMAI members.

Older Adult
An individual who is 65 years of age or older and who is eligible for Medicaid.

Organization Determination
Any initial determination with respect to any treatment or services that may be covered by MMAI including, but not limited to:

- Payment for pharmacy-benefits (e.g., diabetic testing supplies, continuous glucose monitors) that are covered by Medicare Part B.
- Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care or urgently needed services;
- Payment for any other health services furnished by a provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by MMAI;
- MMAI's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by MMAI;
- Reduction or early discontinuation of a previously authorized ongoing course of treatment; and/or
- Failure of MMAI to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Personal Assistant
Individuals who provide personal care to a member when it has been determined by the case manager that the member has the ability to supervise the personal care provider.

Personal Care
Assistance with meals, dressing, movement, bathing or other personal needs or maintenance or general supervision and oversight of the physical and mental well-being of a member.

Personal Emergency Response System (PERS)
An electronic device that enables a member at high risk of institutionalization to secure help in an emergency.

Post-stabilization Care Services
Post-stabilization care services are covered services defined under the MMAI Plan that generally are:

- Related to an emergency medical condition;
- Provided after a member is stabilized; and
- Provided to maintain the stabilized condition or under certain circumstances to improve or resolve the member's condition.

Primary Care Physician (PCP)
Any independently contracted physician who has been selected by the member to be primarily responsible for treating and coordinating the member's health care needs. A PCP may be a physician who is Board Certified or Board Eligible in Internal Medicine, Family Practice, General Practice or Geriatric Medicine.

Prime Therapeutics LLD (Prime)
Prime Therapeutics LLC is a pharmacy benefit management company. Blue Cross and Blue Shield of Illinois (BCBSIL) contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Provider / Independently Contracted Provider
Any physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, hospital facility, health care facility, laboratory, and any other provider of medical services, licensed in accordance with all applicable Laws.

Quality Improvement Organization (QIO)
Organizations comprising practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, SNFs, HHAs, Medicare health plans and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Quality of Care Issue
A quality-of-care complaint may be filed through MMAI's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration
A MMAI member's first step in the appeal process after an adverse organization determination. The MMAI Plan re-evaluates an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained. The term may refer to the first level review by the MMAI Plan or the second level of the appeals process in which an independent review entity reviews and adverse MMAI Plan decision.

Redetermination
A MMAI member's first step in the appeal process after an adverse coverage determination. MMAI or an independent review entity may re-evaluate an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative
An individual appointed by a MMAI member or other party, or authorized under state or other applicable law, to act on behalf of the member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the member or party in obtaining an organization determination, filing a grievance or in dealing with any of the levels of the appeal process, subject to the applicable rules described at 42 CFR Part 405.

Serious Reportable Adverse Events (SRAEs)
The MMAI Plan, consistent with CMS, will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the Provider erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. The MMAI Plan, consistent with Medicare, will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM), chapter 1, sections 10 and 180 and chapter 16, section 120.

Service Area
A geographic area approved by CMS within which an eligible individual may enroll in a participating MMAI Plan. Blue Cross Community MMAI (Medicare-Medicaid Plan) plans are available in all counties in Illinois.

Supportive Living Facility (SLF)
Residential apartment-style housing (assisted living) setting in Illinois that is certified by the Department of Healthcare and Family Services (HFS) that provides or coordinates flexible personal care services, 24 hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs; has an organizational mission, service programs and physical environment designed to maximize residents' dignity, autonomy, privacy and independence; and encourages family and community involvement. Services include temporary nursing care, social/recreational programming, health promotion and exercise, medication oversight, ancillary services, 24-hour response/security, personal care, laundry, housekeeping, and maintenance.

Three-way Contract
The participation agreement that CMS and HFS enter into with a health plan specifying the terms and conditions pursuant to which a health plan may participate in the MMAI Demonstration project.

Urgently Needed Services
Covered services provided that are not emergency services, as defined above, but that are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition.