blue california
Promise Health Plan

3840 Kilroy Airport Way
Long Beach, CA 90806

April 24, 2024

Subject: **Notification of required regulatory updates and July 2024 updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

Blue Shield Promise is revising the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* (Manual). The changes in each provider manual section listed below are effective July 1, 2024.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at www.blueshieldca.com/en/bsp/providers in the *Provider manuals* section under *policies & guidelines*.

You may also request a PDF version of the revised *Blue Shield Promise Health Plan Medi-Cal Provider Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is included by reference in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice or about the revisions that will be published in the July 2024 version of this Manual, please contact Blue Shield Promise Provider Customer Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Section 3: Benefit Plans and Programs

3.4: Home-Based Palliative Care Program

3.4.1: Enrolling/Disenrolling members in the Home-Based Palliative Care Program

Updated the sub-section regarding conditions that are eligible for the Palliative Care Program, to the following:

Member Eligibility

Members with either of the following conditions are eligible for the Palliative Care Program:

- Advanced medical conditions including, but not limited to congestive heart failure, chronic obstructive pulmonary disease, liver disease, and advanced cancer;
- The member is likely to, or has started to use the hospital or emergency department as a means to manage their advanced disease;
- The member's death within a year would not be unexpected based on clinical status;
- The member is not enrolled in Hospice, or has declined Hospice;
- The member and/or medical decision maker is willing to:
    - Participate in Advance Care Planning discussions
    - Attempt care in home or outpatient setting, when appropriate, prior to going to the Emergency Department
- Children, defined as members under the age of 21, with serious medical conditions.

Updated the following bullet in list of ways for a member to learn about and receive a referral to the Home-Based Palliative Care Program, in strike-through and boldface type:

Member Referral

Members have several ways to learn about and receive a referral to the Program.

- PCPs and Specialists can refer members for a full Palliative Care Program Evaluation by completing the Palliative Care Patient Eligibility Screening Tool form. The form can be found on the Blue Shield Promise provider website at blueshieldca.com/en/bsp/providers in the *Policies, Guidelines, Standards and Forms* section, then *Other patient care forms*. Submit the completed form to Blue Shield Promise by fax at (323) 889-2109 or secure email at BSCpalliativecare@blueshieldca.com

Member Disenrollment

Added "or member has died" to list of reasons for which a member can be disenrolled.

3.7: Doula Services

Added the following language concerning prior-authorizations and recommendations for doula services:

Please note that while a recommendation for doula services is required, Blue Shield Promise does not require prior authorization for doula services as a preventive service.

Added sub-sections, under the headings of "Claims and Billing" and "Doula Transaction Log," discussing the three options for submitting claims, requirement to submit all encounters electronically, encouragement to submit all claims electronically, and method of submitting paper claims. This sub-section contained language regarding the Doula Transaction Log Process and the timing of either paying, denying, or contesting claims.

Added the following language, concerning Blue Shield Promise's request for doulas to provide the Birth Outcomes Report, which tracks specific post-birth outcome data elements for each assigned member:

Birth Outcome Report

Blue Shield Promise requests that doulas track specific post-birth outcome data elements for each assigned member and submit a Birth Outcome Report.

How to submit Birth Outcome Report

- Doulas must submit the Birth Outcome Report within 60 Days of member's birth.

  Blue Shield Promise will provide doulas with a Birth Outcomes Report form. Doulas can complete and submit the report to the Blue Shield Promise Doula Program office via secured email BSCPromiseDoula@blueshieldca.com.

3.10: Non-Specialty Mental Health Services (Medi-Cal Managed Care)

Added Section 3.10, which discusses how members can gain access to non-specialty mental health services and Blue Shield Promise's responsibility to provide Medi-Cal Managed Care Plan (MMCP) Mental Health Benefits for members.

Section 6: Grievances, Appeals, and Disputes

6.4: Provider Disputes – Claims Processing

6.4.3: Provider Disputes Policy and Procedure

Updated paragraph discussing the methods by which providers submit disputes, to the following:

If a provider needs to submit a dispute, they can either submit in writing to the Blue Shield Promise Provider Dispute Department or via Blue Shield Provider Connection website at blueshieldca.com/provider-dispute. Disputes may pertain to issues such as post-service authorization or denial of a service; non-payment or underpayment of a claim; or disputes with our delegated entities. If a provider attempts to file a provider dispute via telephone or via digital media such as compact discs, USB data keys, flash drives, Blue Shield Promise staff will instruct the provider to submit the provider dispute to Blue Shield Promise in writing. Any digital

media received by Blue Shield Promise will be destroyed without review or further notice to the submitting party.

Section 7: Utilization Management

7.1: Utilization Management Program

Renumerated Sections to account for the movement of Sections 7.9.2, 7.9.3 and 7.9.4.

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Deleted and ***replaced*** the following section, regarding the processing of authorization logs:

Authorization logs must be sent to Blue Shield, based on the criteria below:

- **Hospital**: Authorization Logs are to be submitted to Blue Shield either immediately prior to, or at the time of a Hospital admission, discharge, or transfer for all Promise members and Blue Shield Dual Special needs Plan (DSNP) members.
- **IPA Medical Groups**: IPA/medical group approvals, denials and partial denials should be delivered weekly together on one file.
- **Approval/denial data files** ("Authorization Logs") must be delivered via secure email or Secure File Transfer Protocol (SFTP) file to Blue Shield using either the IPA9 or IPA10 file layout. The preferred file is the IPA10 which provides a feedback loop notifying the IPA/medical group if the submitted logs were accepted or rejected by Blue Shield.
- **SNF**: Authorization Logs are to be submitted to Blue Shield within 48 hours of a SNF admission for all Promise members and Blue Shield Dual Special Needs Plan (DSNP) members. Authorization Logs are to be submitted to Blue Shield in advance or at time of a members SNF discharge or transfer for all Promise members and Blue Shield Dual Special Needs Plan (DSNP) members.
- **Future State**: The required method to submit will be either IPA10 through SFTP or IPA9 which will be an upload via Provider Connect Portal. Your Provider Relations contact will reach out to you if you need assistance.
- To initiate the delivery of authorization logs by means of a SFTP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com

Removed the "Monthly Reporting Requirements" sub-section to avoid confusing the IPAs on where to send reports.

7.4 Primary Care Physician Scope of Care

Updated the following bullet point in list of PCP guidelines, in strike-through and boldface type:

Behavioral Health ~~Assessments~~ **Screening and Brief Counseling**:

- **Annual cognitive health assessments for eligible members 65 years of age or older to identify signs of Alzheimer's disease or related dementias**
- **Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders as appropriate to provider's scope of practice**
- **Prescribing of psychotherapeutic drugs**
- **Referrals for additional assessment and treatment**
- **Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT): Screen**

members ages 11 and older, including pregnant women, for unhealthy alcohol and drug use using validated screening tools. Brief behavioral/counseling intervention(s) and appropriate referrals for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable alcohol use disorder (AUD) or Substance Use Disorder (SUD).
- Screening for depression
- Screening for mental health conditions
- Screening for prenatal and postpartum mental health conditions and referrals for mental health services for all pregnant women or women who have delivered in the previous 12 months, as appropriate. Refer to Section 7.8.3: Direct OB/GYN Access for additional information.
- Trauma screenings: As required by the DHCS, PCPs must screen children and adults for Adverse Childhood Experiences (ACEs) which research shows are strongly associated with increased health and social risks. Early detection of ACEs and timely intervention can help prevent or reduce these risks and support healing. Screen children for ACEs using a clinically appropriate trauma screening tool at least once per year, and adults at least once per lifetime, in accordance with DHCS' trauma screening guidelines. For more detailed information, visit, acesaware.org and the Blue Shield Promise provider website at https://www.blueshieldca.com/provider.
- ~~Annual cognitive health assessments for eligible members 65 years of age or older to identify signs of Alzheimer's disease or related dementias~~
- ~~Developmental screening~~
- ~~Screening for depression~~
- ~~Screening for substance abuse~~
- ~~Screening for Adverse Childhood Experiences~~

7.4.1: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) / Medi-Cal for Kids & Teens

Updated and moved Section 7.9.4 to the newly created Section 7.4.1.

7.4.2: Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA)

Updated and moved Section 7.9.4 to the newly created Section 7.4.2.

7.4.3: Child Health and Disability Prevention Program (CHDP)

Moved Section 7.9.2 to the newly created Section 7.4.3.

7.4.4: California Regulatory Required Programs

Moved Section 7.9.3 to the newly created Section 7.4.4.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information

7.9.1: California Children's Services (CCS)

Updated the following sub-section, which describes the CCS Program, to the following:

California Children's Services (CCS) is a Medi-Cal benefit provided by the County. Blue Shield Promise coordinates the benefits for eligible members. The CCS program provides medical case management, diagnostic and treatment services, and physical and occupational therapy

services to children under the age 21 with CCS eligible medical conditions managed by CCS paneled providers. The program's goal is to provide medical and allied services necessary to achieve maximum physical and social function for children. Members identified with CCS-eligible conditions are referred to the County CCS program immediately upon identification.

When a member is identified as meeting the criteria for the CCS Program, the member/ member's family or designee will be contacted by a Blue Shield Promise employee to discuss the CCS Program.

7.9.1.3 CCS Program Referrals

Updated the following sub-section, which describes the CCS Program referral process, to the following:

Blue Shield Promise's contracted physicians or IPA Health Services staff shall assist in the coordination of care between PCP's, CCS Specialty providers, and the local CCS program. All members who are referred to CCS or confirmed to have a CCS-eligible condition shall be managed by Case Management. The CCS program authorizes payments to Blue Shield Promise network physicians who are CCS Paneled and provide services related to the CCS eligible condition. Blue Shield Promise shall submit information to the CCS program of those members who have a CCS-eligible condition.

7.9.1.4 CCS Care Management

Updated the following sub-section, which describes the CCS Program case management process, in boldface type:

… The Blue Shield Promise UM Department **and Population Health Management Children's Services** can serve as a link between Blue Shield Promise PCPs, providers, and specialists as appropriate and the CCS Program. This will be done by appropriately identifying and channeling all potential/applicable referrals to CCS in accordance with the specified program standards.

7.9.8: Specialty Mental Health Services (Medi-Cal Managed Care)

Changed name of sub-section from "Mental Health (Medi-Cal Managed Care)" to "Specialty Mental Health Services (Medi-Cal Managed Care)."

Deleted and *replaced* with the following:

Inpatient and specialty outpatient mental health services are carved-out of the Blue Shield Promise Medi-Cal benefit agreement. Blue Shield Promise members may directly access specialty mental health services through Los Angeles or San Diego County Department of Mental Health.

If the PCP determines that the members need access to specialty mental health services, often evidenced by severe mental impairment, the PCP should refer directly to the county mental health plan. The PCP may also refer to the Blue Shield Promise Social Services team for screening to determine the most appropriate level of care.

7.9.9: Alcohol and Drug Treatment

Deleted the previous 7.9.16: Alcohol and Drug and ***replaced*** it with the following:

Any member identified with possible alcohol or substance use disorders shall be referred to the County Alcohol and Drug Program in the county where the member resides for evaluation and treatment.

Resources for Substance Use Disorder (SUD) Services

- SUD Directories www.dhcs.ca.gov/provgovpart/Pages/sud-directories.aspx
- Los Angeles County Substance Abuse Service Helpline: (844) 804-7500
- San Diego County Drug-Medi-Cal Organized Delivery System: (888) 724-7240 TTY 711

7.9.18: Cancer Clinical Trials

Corrected language to indicate that Blue Shield Promise covers services related to clinical trials for members diagnosed with cancer and accepted into a phase I, II or III clinical trial for cancer. It previously listed phase I, II and IV clinical trials.

7.10: Delegated UM Reporting Requirements (IPA/Medical Groups Only)

Deleted the following reports from this section as they have been retired as of 1/1/24:

- HIV/ABR Report
- Quarterly Supplemental Report
- Sterilization Log

Section 9: Quality Improvement

9.1: Quality Improvement Program

Deleted and ***replaced*** sub-section, delineating the 2024 Quality Program Goals to deliver an exceptional quality program, improve the quality, safety, and efficiency of health care services, improve members' experiences, and ensure care is provided in an equitably and culturally and linguistically appropriate manner.

9.1.1: Program Structure Governing Body

Deleted and ***replaced*** with the following paragraph explaining the Blue Shield Board of Director's responsibility for the Quality Program:

The Blue Shield Board of Directors is ultimately responsible for the Quality Program. The Board provides oversight on performance against the quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of all quality activities to the Board Quality Improvement Committee (BQIC).

Updated, in strike-through, Number 8, in the following list of scopes for the sub-committees reporting to the Quality Management Committee:

The following sub-committees report to Quality Management Committee:

- Access and Availability Committee
- Medical Services Committee

Scope (includes but not limited to):

8. Reviewing reports of subcommittees (Medical Services)~~, Promise Behavioral Health~~ and Access & Availability, others reporting as necessary).

9.1.2: Standards of Practice

Deleted language stating that Providers are sent an annual notice with key information and links to online resources.

9.1.3: Quality Improvement Process

Updated the following bullet points in the list of data sources that Blue Shield Promise uses to monitor, analyze, and evaluate quality improvement goals and objectives., in strikethrough and boldface type:

Quality improvement is a data-driven process. Blue Shield Promise uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives. These data sources include, but are not limited to:

- **Centers for Medicare & Medicaid Service (CMS) Core Measures**
- **Dental Quality Alliance Measure (DQA)**
- **Provider access and availability data, and satisfaction surveys**
- **Clinical Action Registry Report**
- **Laboratory data**
- **Health Information Exchanges**~~, and behavioral health data.~~
- ~~Member grievances and quality of care issues (see more below)~~
- ~~Practitioner/Provider Satisfaction Surveys~~

9.3: Clinician and Member Satisfaction Surveys

Deleted and ***replaced*** the following paragraph with information about the Clinician Satisfaction Survey, which uses the survey results to improve satisfaction with Blue Shield Promise's performance in:

Clinician Satisfaction Survey

Blue Shield Promise conducts an annual Clinician Satisfaction Survey to assess and improve participating clinicians' satisfaction with Blue Shield Promise's performance. The overall objective of the Clinician Satisfaction Survey is to use the results to improve satisfaction with Blue Shield Promise's performance in Network Management, Utilization Management (UM), Coordination of Care (CoC), Access to Care, Translation and Interpretation Services, as well as other functions that are assessed in the survey. Opportunities are gleaned with each annual survey that allows Blue Shield Promise to demonstrate subsequent improvements in most measured categories. Blue Shield Promise conducts the annual Clinician Satisfaction Survey using a statistically valid random sample of participating primary care physicians, specialists, and behavioral health professionals. The consultant that performs the Clinician Satisfaction Survey is NCQA-certified and CMS-approved. Results of the annual Clinician Satisfaction

Survey are summarized and reported internally to appropriate departments and committees for follow-up and action as well as externally with state regulators.

9.12: HEDIS Measurements

Updated, per DHCS contract requirements, the following paragraph about how providers' performance data can be used for quality improvement, in boldface type:

Use of Practitioners/Providers Performance Data

Practitioners and providers will allow Blue Shield Promise to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). **Providers are expected to meet or exceed the 50th percentile for all DHCS Managed Care Accountability Set (MCAS).** Blue Shield Promise will also share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your Quality Program Manager.

9.13: Credentialing Program

9.13.2: Minimum Credentials Criteria

Added sub-section, which discusses the ICF/DD credentialing requirements.

9.13.3: Specialty Credentialing Specifications

Added sub-section, which explains California SB 487, which protects providers from being penalized for performing treatment that is within the rules of California but against the rules in another state.

9.13.4: Credentials Process for IPA/Medical Groups

Deleted and ***replaced*** details in Number 5, which explain how the IPA/medical group monitors compliance with the policies and procedures in describing its credentialing system controls and monitoring process.

Updated the following Number 11 in the list of credentialing system controls policy and procedures, in boldface type:

11. The IPA/medical group is required to review all Blue Shield Promise practitioners/ providers sanction activities within the 30 calendar days of the report's release by the reporting entity and report the findings to Blue Shield Promise as Blue Shield Promise practitioners/providers are identified **that require action to be taken.**

Updated the following paragraph explaining how the group documents corrective actions, in boldface type:

The IPA/medical group identifies and documents all actions it has taken, or plans to take, to address all modifications (findings from **NCQA, CR 8, Element C,** factor 5) that did not meet the delegation agreement or the delegate's policies and procedures, if applicable. One action may be used to address more than one finding for each delegate or across multiple delegates, if appropriate.

14.1: Claim Submission

Updated the following sub-section with information about claims processing regulatory requirements, to the following:

Blue Shield Promise) applies the appropriate regulatory requirements related to claims processing.

A. Blue Shield Promise requires that providers submit all encounters electronically and encourage providers to submit all claims and receive payments electronically as well, for faster processing and payment, using electronic data interchange (EDI). To enroll in electronic claim submission, providers can use Office Ally or Change Healthcare. To enroll in electronic encounter submission, providers can use FinThrive or Office Ally.

Approved Clearinghouse	Website	Phone Number
Office Ally	cms.officeally.com	(360) 975-7000
Change Healthcare	www.changehealthcare.com	(866) 371-9066
FinThrive (Encounters only)	www.finthrive.com	(800) 390-7459

Paper claims must be submitted using the current versions of UB-04 CMS-1450 and CMS 1500 forms. Paper claims, invoices, and additional information such as medical records, daily summary charges and invoices must be submitted at the following address to avoid processing and payment delay:

Blue Shield Promise Health Plan
P.O. Box 272660
Chico, CA 95927-2660

B. Providers must follow the most recently updated Current Procedural Terminology (CPT) coding guidelines, National Drug Code (NDC) for drugs as well as the Healthcare Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, and Department of Health Care Services (DHCS) coding guidelines.

14.2: Claims Processing Overview

Updated the following item in list of claims processes, in strike-through and boldface type:

A. Blue Shield Promise makes every effort to ensure claims that are the Blue Shield Promise financial responsibility are paid, denied, or contested within 30 calendar days of receipt. At least 90% of claims that are the Blue Shield Promise financial responsibility to pay are processed within 30 calendar days of receipt~~, or~~ 95% within 45 working days **of receipt, or 99% within 90 calendar days of receipt**.

Updated the following item describing the Emergency Claims Process, in strike-through:

G. Emergency Claims

Emergency claims are paid without prior authorization. ~~Legible emergency department reports must be submitted when billing with ER level 5.~~

Added the following language to comply with the Public Provider Ground Emergency Medical Transportation (PP-GEMT) Program APL:

K. Outpatient and Other Claims

4. Public Provider Ground Emergency Medical Transportation (PP-GEMT) Program is effective January 1, 2023. Refer to PPGEMTIGT (ca.gov) webpage for published guidance regarding program background and eligibility criteria.
    - The PP-GEMT add-on is applicable to public providers of ground emergency medical transportation, as defined in Welfare and Institutions (W&I) Code section 14105.945(a)(1).
    - Eligible public providers will be identified and reimbursed appropriately.

Section 15: Accounting

Deleted and ***replaced*** the entire Section 15, which explains the financial reporting and capitation payment processes.

Appendices

Appendix 1: Delegation of Utilization Management Responsibilities

Replaced previous Appendix 1 with a new chart that delineates the delegation of utilization management responsibilities.

Appendix 2: Delegation of Credentialing Responsibilities

Updated the "Delegation of Credentialing Activities" Chart, which details delegated credentialing activity, group responsibility as it relates to credentialing activity, plan responsibility as it relates to credentialing activity, the credentialing reporting procedures, and the credentialing improvement process.

Appendix 3: Delegation of Claims Processing Responsibilities

Updated the "Delegation of Claims Processing Responsibilities" Chart, which details delegated claims activity, group responsibility as it relates to claims activity, plan responsibility as it relates to claims activity, the claims reporting procedures, and the claims improvement process.

Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

Updated the following ambulatory procedures for APG Payment Rate, in strike-through and boldface type:

CPT	DESCRIPTION
31242	**Nasal/Sinus Ablation**
31243	**Nasal/Sinus Cryoablation**
52284	**Cysto Cath Sten Male**
58580	**Transcervical ablation uterine fibroid**
64596	**Insj/rplcmnt perq eltrd**
~~0465T~~	~~Supchrdl njx rx w/o supply~~

Appendix 9: Delegation Oversight Claims, Compliance, IT System Integrity - Auditing and Monitoring

Changed "Delegated Entity" to "Delegated Entity/Specialty Health Plan," throughout Appendix 9.

Changed sub-section entitled "Claims Oversight Audit Review Process" to "Claims, Compliance, IT System Integrity Oversight Audit Review Process."

Claims, Compliance, IT System Integrity Oversight Audit Review Process

Audits and Audit Preparation

Deleted and ***replaced*** entire section which contains information about how Blue Shield Promise and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements.

Regulatory Audit

Updated the following sub-section, which discusses the requirement to participate in compliance oversight:

Regulatory Audit

In the event Department of Managed Health Care (DMHC) and Department Health Care Services (DHCS) requires that Blue Shield Promise conducts additional compliance oversight, Blue Shield Promise will require the Delegated Entity/Specialty Health Plan to participate within the regulator-specified time schedules or deadlines. Blue Shield Promise requires the Delegated Entity/Specialty Health Plan to provide the material in the format requested in the timeframe as stipulated by the regulators. Refusal to do so will result in an escalation to Blue Shield Promise Contracting/Network Management.

Date Stamping

Added the following sentence to the "Date Stamping" sub-section, which discusses the requirement for Delegated Entities to date-stamp all paper claims:

This would also apply to Electronic Data Interchange (EDI) claims.

Payment Accuracy

Updated the following language regarding interest and penalties, in boldface type:

Payment accuracy includes: (1) proper payment of interest, (2) proper use of a reasonable and customary fee schedule for non-contracted providers, (3) applying appropriate contract fee schedules **as demonstrated by submitted documentation or shared via audit webinar**, and (4) system configuration**.** All four criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Interest and Penalty: Applies to paid claims, adjustments, and Provider Disputes (CCR Title 28 Section1300.71(i)).

Interest is applicable for contracted and non-contracted provider claims paid later than the regulatory requirement. Interest must be paid beginning on the 46th working day which is the

first day after the regulatory requirement of the 45th working day through **the day the check is mailed and/or electronic payment is issued.**

Added the following language, containing definitions related to the determination of financial responsibility:

Note: As defined by CCR Title 28, Sectio n 1300.71(a)(9)- (12) DMHC clarification regarding the determination of financial responsibility between the Delegate and the Health Plan is not related to Medical Necessity per the below requirements.

(9) "Health Maintenance Organization'' or ''HMO'' means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).
(10) "Reasonably relevant information'' means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
(11) "Information necessary to determine payer liability'' means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
(12) "Plan'' for the purposes of this section means a licensed health care service plan and its contracted claims processing organization.

Evidence of Payment (EOP)/Remittance Advice (RA)

Changed the "Family Planning Sensitive Services" sub-title to "Family Planning/State Supported Services," which discusses members' rights to family planning services.

Updated the following bullet point, which contains information about family planning claims processing, in strike-through and boldface type:

b. 95% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities within 45 working days after the date of receipt of the claim. (CCR Title 28 Section 1300.71 (g)~~)~~

   ~~Claim paid at Medi-Cal rate or appropriate clinic rates per SB 94.~~

   DHCS requires Blue Shield Promise and their Delegated Entities to reimburse non-contracting Family Planning providers at no less than the appropriate Medi-Cal Fee-For-Service (FFS) rate. This requirement supersedes APLs 10-003 and 10-014, resulting in paying non-contracted providers the appropriate Medi-Cal fee schedule base rate plus any applicable Center for Medicare and Medicaid Services approved directed payments as outlined in federal regulation (i.e., 2016 Final Rule and Title 42, Code of Federal Regulations section 438.6(c)) - not the augmented rates in APL 10-003 and 10-014, e.g. DHCS has retired APLs 10-003 and 10-014.

Updated this sub-section, which explains the corrective action plan and auditing processes, to the following:

Corrective Action (CAP)/Follow Up Audits

Blue Shield Promise performs, at a minimum, an annual claims and PDR audit. A follow-up audit will be scheduled by the assigned auditor if the Delegated Entity/Specialty Health Plan fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, a remediation plan (Excel worksheet) will be requested from the Delegated Entity/Specialty Health Plan who must submit by assigned due date from auditor. Based upon Blue Shield Promise's tracking of remediation plan additional monitoring and/or remediation (follow up) validation audits will be performed. Based upon Blue Shield Promise's tracking and outcome of the remediation plan the Delegated Entity/Specialty Health Plan will be escalated to the Delegation Oversight Committee. This would include on-site visits, scheduled meetings, focal audits, and remediation project plan oversight.

Blue Shield Promise's corrective action plan requires a Delegated Entity/Specialty Health Plan to submit by the date indicated (10 Business Days) from audit result letter. Blue Shield Promise will review and provide a response to corrective action plan. If the CAP is not accepted, the Delegated Entity/Specialty Health Plan has five (5) business days to submit a second CAP response. If the delegated entity remains non-compliant after two CAPs have been submitted and/or no response to CAP, the delegated entity will be escalated to the Delegation Oversight Committee (DOC).

For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield Promise by the date provided by the Blue Shield Promise and DMHC auditors. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators.

Newly Contracted Provider Training Oversight Audit

Added the following language to the paragraph discussing Delegated Entities' requirement to provide all newly contracted network providers new provider orientation training:

When a Delegated Entity/Specialty Health Plan has a provider with an existing Medi-Cal contract, but who is not participating in Blue Shield Promise Network, the Delegated Entity/Specialty Health Plan can submit evidence of Newly Contracted Provider Training. Upon the provider becoming a participant in Blue Shield Promise Network, an attestation of completion of such training is allowed as far back as 1 year from Blue Shield Promise Network effective date.

Deleted and ***replaced*** the following bullet points, in list of items that are a part of the New and Biennial training:

- All Member rights specified in DHCS Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment III, Section 5.1 (Member Services).
- Diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in DHCS Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training).

Deleted and ***replaced*** the following language, regarding evidence of training:

Evidence of training must be demonstrated in the form of a universe report and signed training attestation from each trained provider and submitted to the Blue Shield Promise Delegation Oversight Compliance Team. To download a copy of the Delegation Oversight Newly Contracted Provider Training Attestation form, go to the Blue Shield Promise provider website at Blue Shield Promise Provider Portal under Delegation oversight forms. The reports are due every quarter by the 15th day of the month following quarter end to the following dedicated email address BSCProviderTraining@blueshieldca.com. Providers will not be uploaded into the Blue Shield's provider directory for members to access or approval for any authorized services until your organization provides evidence that the provider has completed the training.

Delegation Oversight performs monthly review audits on Specialized Health Plans requiring submission of monthly universe reports and signed attestations by the 15th of the following month to the dedicated email address BSCProviderTraining@blueshieldca.com. Blue Shield Promise Delegation Oversight Compliance team will review attestations, and universe content against what is in the Specialized Health Plan website provider directory.

As a reminder, the Delegated Entity/Specialty Health Plan is responsible for providing unrestricted access to provider manuals, clinical protocols, evidence-based guidelines, and any other pertinent information to out-of-network providers. Unrestricted access means Delegated Entities website allowing the out of network provider access to Delegated Entities website/portal to obtain these training material, protocols, and guidelines. Requiring an out of network provider to call a Delegated Entity/Specialty Health Plan in order to request the aforementioned information and/or documentation would be an automatic deficiency for unrestricted access.

Added outline and sub-section delineating the Corrective Action Plan (CAP) Process.

Compliance Program Effectiveness Oversight Audit

Added sub-section which details the requirement that each health plan and its Delegated Entities/Specialty Health Plans have a Compliance, Fraud, Waste, and Abuse program.

Added outline and sub-section delineating the Corrective Action Plan (CAP) Process.

IT System Integrity Oversight

Added sub-section which details the audit which performs oversight of delegated entities to ensure data is secure and cannot be manipulated or breached, and that the Delegated Entity/Specialty Health Plan has a process in place to address any fraudulent activities.

Oversight Monitoring-System Integrity, Compliance, Organizational Oversight

Updated the following language and bullet points that describe implementation of controls to ensure integrity of mechanisms and procedures to promote accountability and prevent fraud, in boldface type:

Delegated Entity/Specialty Health Plan shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

- Group shall not allow the same person or departments to have the ability to pay claims and enter or update new providers, vendors and/or eligibility.
- Group shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times.
- Group shall maintain a compliance program, and that the program is independent of fiscal and administrative management. **Group shall provide a copy to Blue Shield Promise.**
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements.
- Group shall ensure that any and all changes made to data contained in entities; databases are logged and audited.
- **Group shall maintain a disaster recovery plan and ensure that it is reviewed and/or updated annually. Group shall provide a copy to Blue Shield Promise.**

Blue Shield Promise recommends the following IT Security Certification, HITRUST Risk-based r2 level certification. Secondarily, Blue Shield Promise will accept SOC 2 Type II certification.

Added outline and sub-section delineating the Corrective Action Plan (CAP) Process.

Oversight Monitoring-System Integrity, Compliance, Organizational Oversight

Added sub-section which details the audit which monitors and ensures data is secure and cannot be manipulated or breached, and that the Delegated Entity/Specialty Health Plan has a process in place to address any fraudulent activities.

Claims Delegate Reporting Instructions

Noted that the Principal Officer Form **must** be submitted to Blue Shield/Blue Shield Promise when changes occur.

Appendix 14: HEDIS Guidelines

Updated the HEDIS Measurements chart, with information about measure, criteria, and description.