October 11, 2019

Subject: **Notification of January 2020 Updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

We have revised our *HMO IPA/Medical Group Procedures Manual.* The changes listed on the following pages are effective January 1, 2020.

On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under *Guidelines & resources*.

You may also request a CD version of the revised *HMO IPA/Medical Group Procedures Manual* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is referenced in the agreement between Blue Shield of California (Blue Shield) and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO IPA/Medical Group Procedures Manual* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2020 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Vice President, Provider Network Management
Blue Shield of California

UPDATES TO THE JANUARY 2020
HMO IPA/MEDICAL GROUP PROCEDURES MANUAL

General Reminders

Please visit Provider Connection at blueshieldca.com/provider for updated Forms, Member Rights and Responsibilities, Authorizations, Claims information, Provider Manuals and much more.

Blue Shield 65 Plus (HMO) plan name change

The Blue Shield 65 Plus (HMO) plan has changed names. It is now called the **Blue Shield Medicare Advantage plan**. When this manual references Blue Shield Medicare Advantage, it refers to Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO) and Blue Shield Vital (HMO).

Section 2.3 Blue Shield Accountable Care Organizations (ACOs)

Added *the following to list of Added Benefits and expanded the Wellvolution benefit i*ncluded in Trio HMO:

- Lifestyle programs to support prevention, treatment and reversal
- On-demand doctor house calls with Heal™ add in $0 first visit copay and free Rx delivery with Heal visit
- 24/7 virtual consults with Teladoc for $0 copays
- Option to self-refer to specialists within the same medical group

Section 2.8 Benefits and Benefits Programs

CARE MANAGEMENT

Updated *the Prenatal Program language to support the AB 2193 mandate, as follows:*

Prenatal Program. This program is designed to improve the quality of care received before and during pregnancy and to reduce the costs associated with high-risk pregnancies, while helping women have healthy pregnancies and healthy babies. Our Prenatal Program utilizes a whole-person approach by addressing our members' physical health and mental well-being throughout her pregnancy.

WELLNESS AND PREVENTION PROGRAMS

The Daily Challenge, QuitNet, and Walkadoo Programs ***have been replaced*** *with Wellvolution:*

Wellvolution

Wellvolution has been redesigned to give members the tools for obtaining optimal health, whether that means staying fit, preventing disease, or treating existing conditions.

Here's how it works: A member creates a new account and sets health goals. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results.

At no extra cost, members get access to easy, customized plans and popular apps, like Pacifica, Yes Health and Weight Watchers, that fit their path. No matter where they are on their health journey, Wellvolution will help members reach their goals.

Visit www.wellvolution.com to get started.

Wellvolution *(cont'd.)*

Programs are broken into three categories:

1. Wellvolution Lifestyle programs – a hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better or quitting smoking. Many of these programs are available in their market 'free' version, with upgrades available at the member discretion.
2. Wellvolution Disease prevention programs – high touch programs, often incorporating in-person or digital coaching options, digital tools and frequent engagement are geared toward prevention of diseases like type 2 diabetes or heart disease using proven lifestyle medicine methodology. These programs are fully covered by Blue Shield of California.
3. Wellvolution Condition reversal programs – high touch programs, often incorporating in-person or digital coaching options, digital tools and frequent engagement are geared toward reversal and treatment of existing chronic conditions using proven lifestyle medicine methodology. These programs are fully covered by Blue Shield of California.

Diabetes Prevention Program

*The Diabetes Prevention Program **can now be accessed** through the Wellvolution platform at* www.wellvolution.com.

Wellness Discount Programs

***Removed** Weight Watchers, ClubSport, and 24-Hour Fitness and **added** Fitness Your Way by Tivity to wellness discount programs.*

PHARMACEUTICAL BENEFITS

DRUG FORMULARY

Specialty Drugs

***Added** language indicating that Specialty Pharmacies provide 30-day supply of Specialty Drugs:*

A Network Specialty Pharmacy provides **up to a 30-day supply of** Specialty Drugs by mail or, upon a member's request, at an associated retail pharmacy for pickup.

Pharmaceuticals in the Medical Benefit

***Updated** language in boldface type below:*

Drugs approved by the Food and Drug Administration (FDA) and covered under a Blue Shield member's medical benefit are generally those that are incident to a medical service, administered by a healthcare professional in a provider office, outpatient facility, infusion center, or by home health/home infusion (not self-administered by the patient). Some medical benefit drugs may require prior authorization **and step therapy** for coverage based on medical necessity. Additional authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site **in addition to authorization of coverage for the drug.**

Section 2.8 Benefits and Benefits Programs *(cont'd.)*

DRUG FORMULARY

Childhood Immunizations

Updated *language in boldface type below:*

All childhood immunizations first recommended for use by the Advisory Council on Immunization Practices (ACIP) or the American Academy of Pediatrics (AAP) on or after January 1, 2001 will become the full financial responsibility of Blue Shield. Childhood immunizations that were part of the ACIP recommendation schedule prior to January 1, 2001 and the cost of vaccine administration are both the financial responsibility of the IPA/medical group. Please note that new combination vaccines of previously recommended immunizations **or changes to dosing frequency or age restrictions** will not be included in this classification unless they represent a material change in cost under a current contract. Claims must be submitted by the IPA/medical group, not the individual participating providers, for reimbursement. Please refer to Section 4.4 for encounter and claims processing procedures.

Office/Facility-Administered Medications

Noted *that encounters or claims submitted by the IPA/medical group must include the appropriate National Drug Code (NDC) and HCPCS code.*

Updated *language to indicate that for reimbursement of medications administered at an outpatient facility, select drugs may require* ***medical necessity*** *authorization for coverage* ***in addition to the authorization of the drug.***

PATIENT ALLY

Removed *this section. Information about Patient Ally can be found on Provider Connection at blueshieldca.com/provider.*

Section 4.1 Network Administration

PRACTITIONER CREDENTIALING

Due to an updated Blue Shield policy, ***removed*** *the following requirement in order for providers to be credentialed:*

- Do not hold a restricted medical license in another state.

Updated *credentialing criteria for hospital admitting privileges, in boldface type below:*

Have staff privileges at a Blue Shield-contracted hospital affiliated with the practitioner's IPA/medical group. (Exceptions may be made for certain physicians who do not **require** hospital admitting privileges or in instances in which the IPA/medical group uses hospitalists to admit patients). **If the physician utilizes the hospitalist program, a letter of the coverage arrangement is required to be on file.**

LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

Blue Shield's threshold languages for 2020 are: ***Chinese – Traditional, Spanish and Vietnamese****.*

Updated *the fax number where Language Assistant Forms are sent to. The new fax number is* (248) 733-6331.

Section 4.2 Member Rights and Responsibilities

Updated *the Statement of Member Rights to align with Evidence of Coverage (EOC) language.*

MEMBER GRIEVANCE PROCESS - STANDARD, EXPEDITED, AND EXTERNAL REVIEW

Added *language to the Expedited Review process, indicating that the Blue Shield Grievance Process allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.*

Section 4.4 Claims Administration

CLAIMS PROCESSING

Claims for Outpatient Prescription Drugs

Noted *for Commercial Plans, prior authorization requests may be submitted electronically through the electronic health record, if available.*

Section 5.1 Utilization Management

Updated *multiple subsections within Section 5.1 relating to Blue Shield Medical & Medication Policies, with the language in boldface type below:*

Blue Shield requires that all delegated IPA/medical groups adhere to Blue Shield Medical & Medication Policies **which may include step therapy and site of administration criteria.**

DELEGATION OF UTILIZATION MANAGEMENT (UM)

Updated *the following activity that may be monitored and reviewed for the delegated entity, in boldface type below:*

- Policies and procedures for UM **that demonstrate adherence to Blue Shield Medical & Medication Policies**

UM CRITERIA AND GUIDELINES

Updated *language in boldface type below:*

Denials made by Blue Shield use nationally recognized evidence based criteria, internal medical policies established by the Blue Shield Medical Policy Committee, and MCG Care Guidelines for **inpatient and** mental health and substance abuse services, Center for Medicare & Medicaid Services (CMS), DME coverage criteria, National Imaging Associates (NIA) Radiology Clinical Guidelines, Advisory Committee on Immunization Practices (ACIP), and Medication Policies **(for non-self-administered drugs such as Injectable and Implantable drugs)** established by the Blue Shield Pharmacy and Therapeutics Committee. These criteria and guidelines are adopted with input from network physicians and are regularly reviewed for clinical appropriateness. It is the responsibility of the IPA/medical group to ensure that they are using the most current version of the policies **and updating their UM review processes.** These policies may be found on blueshieldca.com/provider **and may be updated quarterly as needed.**

BREAST PUMP ALLOWANCE

Removed *this section from the manual. For the most current language on this allowance, visit Provider Connection at blueshieldca.com/provider and go to Claims, Policies & guidelines, then Payment policies and rules.*

Section 5.1 Utilization Management *(cont'd.)*

HOME HEALTH CARE FOR BLUE SHIELD MEDICARE ADVANTAGE PLAN MEMBERS

Updated *the following covered service in boldface type below and noted that enterals that are not administered through a feeding tube will be denied for coverage.*

- Home infusion therapy, including enteral **tube feedings** and parenteral nutritional services and associated supplies and supplements.

OUTPATIENT PRESCRIPTION DRUGS

Noted *for Commercial Plans, prior authorization requests may be submitted electronically through the electronic health record, if available.*

Section 5.2 Quality Management Programs

ACCREDITATION

Expanded *the definition of the Health Plan Accreditation process, as below:*

Blue Shield maintains Health Plan Accreditation (HPA) status with National Committee for Quality Assurance (NCQA). Blue Shield of California takes the following product types through NCQA accreditation: Commercial HMO/POS, Commercial PPO, Marketplace HMO/POS (Covered CA/Exchange), Marketplace PPO (Covered CA/Exchange) and Medicare HMO. The NCQA review process is an ongoing quality assurance and improvement process that culminates in an audit of health plan performance on NCQA standards every three years. Health Plan scores are evaluated based on audit outcomes and yearly review of health plan scores relative to other plans on key HEDIS and CAHPS measures.

The current Quality of Care Reviews section ***has been changed*** *to Quality of Care Activities and a new Quality of Care Reviews section* ***added****, as follows:*

QUALITY OF CARE REVIEWS

Blue Shield has a comprehensive review system to address potential quality of care concerns. A potential quality issue arising from member grievances or internal departments is forwarded to the Blue Shield Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including a provider written response, if available. The case may then be forwarded to a Blue Shield Medical Director for review and determination of any quality of care issues. A case review may also include an opinion about the care rendered from a like-peer specialist and/or review by the Blue Shield Peer Review Committee.

During the review process, requests for additional information may be made to the IPA/Medical Group or directly to the involved provider. Upon review completion and dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a corrective action request or an educational letter outlining opportunities for improvement. Patient safety concerns or patterns of poor care can be considered during Blue Shield re-credentialing activities or reviewed in more detail by the Credentials Committee and may result in termination from the Blue Shield network.

Contracted providers are obligated to participate in quality of care reviews and provide requested documents. Peer review activities are considered privileged communication under California Health and Safety Code section 1370 and California Evidence Code 1157. As such, neither the proceedings or record of the review may be disclosed outside of the review process.

Section 6.1 Blue Shield Medicare Advantage plan Program Overview

BLUE SHIELD MEDICARE ADVANTAGE PLAN SERVICE AREAS

Added/removed *Medicare Advantage plan Service Areas in boldface type and strike through as follows:*

Individual Blue Shield Medicare Advantage plan Service Area

Alameda	**San Mateo**
Fresno	San Bernardino ~~(partial county coverage)~~
Kern ~~(partial county coverage)~~	San Diego
Los Angeles ~~(partial county coverage)~~	San Luis Obispo (partial county coverage)
Orange	Santa Barbara (partial county coverage)
Riverside ~~(partial county coverage)~~	Ventura ~~(partial county coverage)~~
Sacramento ~~(partial county coverage)~~	

Group Blue Shield Medicare Advantage plan Service Area

Contra Costa (partial county coverage)	San Diego
Fresno	San Francisco
Kern	San Joaquin
Los Angeles	San Luis Obispo
Madera (partial county coverage)	San Mateo
Nevada (partial county coverage)	Santa Barbara (partial county coverage)
Orange	Santa Clara
Riverside ~~(partial county coverage)~~	Santa Cruz
Sacramento	Ventura
San Bernardino ~~(partial county coverage)~~	

Section 6.2 Blue Shield 65 Plus (HMO) Benefits and Exclusions

MEDICATION THERAPY MANAGEMENT PROGRAM

Added *the following condition to chronic conditions that the MTMP addresses:*

- Dyslipidemia

NON-FORMULARY OUTPATIENT PRESCRIPTION DRUGS

Transition Policy

Updated *address to send supporting documents for prior authorization requests to:*

Blue Shield of California
Pharmacy Services
601 12th Street, 21st Floor
Oakland, CA 94607

Appendices

APPENDIX 3-A ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Removed *this form from the manual. This form can be found on Provider Connection at blueshieldca.com/provider under Guidelines & resources, Forms, then Patient care forms.*

APPENDIX 3-B BLUE SHIELD COMBINED ELIGIBILITY/CAPITATION REPORT

Updated *the appendix number to Appendix 3-A Blue Shield Combined Eligibility/Capitation Report.*

APPENDIX 3-C BLUE SHIELD HMO ELIGIBILITY ADDS AND TERMINATIONS REPORT

Updated *the appendix number to Appendix 3-B Blue Shield HMO Eligibility Adds and Terminations Report.*

APPENDIX 4-A CLAIMS COMPLIANCE AND MONITORING

This appendix was ***rewritten*** *for clarification. Duplicated sections were removed and language relating to regulations were expanded upon.*

APPENDIX 4-C ACTUARIAL COST MODEL

Updated *the model with 2020 data.*

APPENDIX 5-A UTILIZATION MANAGEMENT DELEGATION STANDARDS

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards

Non-Delegated Initial Determinations

Removed *Medicare expedited initial determinations (EIDs) from the list of non-delegated initial determinations as EIDs are a delegated function.*

Service Denial Letter Format Components

Added *the following to list of elements a service denial letter should include:*

- Blue Shield's Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Evaluation of Entities' Handling of Denials

Added the following to list of elements that were reviewed in the denial process:

- Blue Shield's Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

APPENDIX 5-A UTILIZATION MANAGEMENT DELEGATION STANDARDS *(cont'd.)*

Standards for Personal and Health Information (Protected Health Information)

Standards for Evidence of Oversight for Any Delegated (Sub-Delegated) Activity, When Applicable

Updated *the following:*

Entities that have a sub-delegated arrangement must have a mutually agreed upon delegation document defining the following:

- Describes the delegated activities and the responsibilities of the organization and the sub-delegated entity
- Requires at least semiannual reporting by the sub-delegated entity to the organization
- Describes the process by which the organization evaluates the sub-delegated entity's performance
- Describes the process for providing member experience and clinical performance data to its sub-delegates when requested
- Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement

Additionally, there must be evidence that the entities:

- Conduct an initial assessment prior to sub-delegation;
- Annually reviews the sub- delegates UM Program;
- Semi-annually evaluates required reports; and
- Annually evaluates sub-delegates performance.

Commercial Required Reporting to Health Plan

Added *the following two reports to* ***UM Work Plan Commercial Reporting****:*

- Total # of decisions compliant with TAT & % compliant (UM, BH, Pharmacy)
- Total # of notifications compliant with TAT & % compliant (UM, BH, Pharmacy)

APPENDIX 5-B CLINICAL PRACTICE GUIDELINES

Removed *this appendix from the manual. Clinical Practice Guidelines can be found on Provider Connection at blueshieldca.com/provider under Guidelines & resources, Guidelines & standards, then Clinical practice guidelines.*

APPENDIX 5-C CREDENTIALING/RECREDENTIALING STANDARDS

Updated *the appendix number to Appendix 5-B Credentialing/Recredentialing Standards.*

APPENDIX 6-D BLUE SHIELD MEDICARE ADVANTAGE PLAN REQUIRED BILLING ELEMENTS

Updated *steps #8, #9 and #10 of the Appeal Process for Notice of Non-Coverage HHA, SNF, CORF, in boldface and strike through font below:*

#	Responsible Party	Activity	Time Requirement
8.	IPA/MSO	Faxes records to: 1.) Health Services Advisory Group, Inc. Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee's medical records. ~~2.) Blue Shield 65 Plus (HMO):~~ ~~Cover sheet confirming documentation was sent to Health Services Advisory Group, Inc., copy of NOMNC with member's signature or documentation of refusal to sign & copy of DENC~~ **2.)** Member/representative: Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.	Day 1
9.	IPA/~~MSO~~	IPA makes decision to rescind the termination date and send new letter to member. Fax copy of letter to Health Services Advisory Group, Inc.	Resolved Go to step 14
10.	Health Services Advisory Group, Inc.	Reviews documents. Renders decision to uphold or overturn. Notifies ~~IPA &~~ Blue Shield **Medicare Advantage plan** of decision by phone or fax. Mails letters of determination to Blue Shield **Medicare Advantage plan** and enrollee.	Day 1 If Resolved Go to step 14