blue california
Promise Health Plan

# POLICY & PROCEDURE
## Medical Services

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| **Policy Title: Utilization Management Delegation and Monitoring** | | |
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| **Department Head: Date:** | **Medical Services/P&T Committee: Date:** | |
| **P&P Committee: Date:** | **Department(s): UM** | |

## PURPOSE:

To establish processes and mechanisms to delegate specific Utilization Management (UM) functions to Primary Medical Groups/Independent Practice Associations (PMG/IPA) that, by contract, retains financial risk for the healthcare management of Blue Shield Promise members.

## POLICY:

UM 1 – Program and Structure
The delegated PMG/IPA has a written description of the Um program outlining the program structure, accountability, scope and process used to make determinations of benefit coverage and medical necessity.

I. A delegated PMG/IPA shall have written policies and procedures establishing the process, by which the delegated group prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in a part on medical necessity, requests by providers of health care services for plan enrollees.
II. Involvement of a designated senior physician, or a Medical Director, who holds an unrestricted license to practice medicine in the State of California issues pursuant to Title 22, CCR, Section 53867, whose responsibilities include but not limited to: a) ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations; b) ensuring that medical care provided meets the standard for acceptable medical care; c) ensuring that medical protocols and rules of conduct for plan medical personnel are followed; d) developing and implementing medical policy; e) resolving grievances related to medical quality of care; f) actively participating in the function of the plan grievance procedures, and has g) direct involvement in the implementation of Utilization Management activities. The Senior Physician must also be involved in key aspects of the UM Program: 1) set UM policies and procedures; 2) review consistency of applying UM decision criteria and implement

corrective actions when needed; 3) review and decide UM cases; and 4) participate in UM Committee meetings.

III. A designated behavioral health practitioner (if applicable to Line of Business – LOB) is actively involved in implementing the behavioral health aspects of the UM program. The designated behavioral health practitioner could be a medical director, a clinical director, a participating practitioner from the organization or a participating practitioner from the behavioral health delegate.

The designated behavioral healthcare practitioner must have involvement in the UM program implementation, have a role in setting policies, and reviews cases and participate on the UM Committee.

The Medical Director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on member, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section. (For Medi-Cal Line of Business, Behavioral Health is a carve-out. For Medicare, Healthy Families, and Commercial Lines of Business, Behavioral Health is delegated to an approved Blue Shield Promise vendor).

IV. PMG/IPA's UM Committee membership must include a minimum of three practice physicians from the IPA, representing the appropriate specialties including OB/GYN, Pediatrics, Family Practice and other specialists as needed. The UM Committee meets at least quarterly and its responsibilities include, but are not limited to the following activities:
    a. Review and approve Annual UM Work Plan, Annual UM Evaluation, and Quarterly UM Report;
    b. Review and evaluate UM statistics and make recommendations for improvement;
    c. Review complex referrals requiring input beyond the expertise of the CMO or multiple physicians input;
    d. Coordinate educational opportunities for physicians regarding UM procedures and processes.

V. Pre-authorization and concurrent review decision processes are in place consistent with DMHC, DHCS, CMS, L.A. Care, Blue Shield Promise and NCQA standards, and are supervised by an appropriate qualified professional, such as the following:
    a. a physician reviewer conducts medical review on any denial
    b. Board-certified physician specialists are used as consultants to assist in determining medical necessity. Documentation is maintained to support their decisions
    c. Non-physician UM staff with specific level of utilization decision-making authority will be clinical nurses licensed to practice in California (RN or LVN) and staff ratios are to be appropriate to the level of review.

VI. Delegated PMG/IPA shall maintain access for providers to request authorization for health care services
VII. The PMG/IPA annually evaluates and updates the UM program, as necessary.

UM 2 – Criteria or Guidelines
The delegated PMG/IPA's UM policies and procedures ensure that decisions based on medical necessity of proposed health care services are consistent with criteria or guidelines supported by sound clinical principles and processes.

I. The criteria or guidelines used by the delegated PMG/IPA with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
    a. Be developed with involvement from actively practicing health care providers;
    b. Be based on medical evidence and objectivity;
    c. Be based on individual needs and shall have assessment of the local delivery system;
    d. Be evaluated, and updated, as necessary, at least annually and;
    e. Involve appropriate practitioners in developing, adopting and reviewing criteria. The appropriate practitioners will have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria. The delegate may solicit opinions through practitioner participation on a committee or by considering comments from practitioners to whom it has circulated the criteria.
II. Delegated PMG/IPA must use nationally recognized UM standards when making decisions related to medical care. Criteria sets approved by Blue Shield Promise include Milliman Care Guidelines, Interqual Review Criteria, Up to Date Guidelines, CMS, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, and other nationally accepted organizations. Other criteria sets used are L.A. Care and Medi-Cal Health Care guidelines and Benefit Interpretation, the Department of Health and Human Services Health Care Guidelines and requirements.

    The delegate may use their organization's clinical practice guidelines after they have been submitted to Blue Shield Promise and approved by the health plan's Medical Services Committee (MSC).

III. When applying criteria, individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment are taken into consideration. Additionally, criteria applied takes into consideration the characteristics of the local delivery system for specific patients, such as:
    a. Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.

b. Coverage of benefits for skilled nursing facilities, subacute care facilities or home care where needed.
c. Local hospital's ability to provide all recommended services within the estimated length of stay.

IV. Written decision protocols must be objective and based on medical evidence. Written documentation of the application of decision protocols must contain a mechanism for checking the consistency of the application of criteria by all reviewers including physicians and non-physicians (licensed and non-licensed UM staff) annually. The organization must also act on opportunities to improve consistency, if applicable.

The delegate may use assessment mechanisms such as:

- A supervisor's periodic review of determinations which could include side-by-side comparisons of how different UM staff members manage the same cases.
- Weekly UM "rounds" attended by UM staff members and physicians to evaluate determinations and problem cases.
- Periodic audits of determinations against criteria.

V. Delegated IPAs/Medical Groups must disclose to network providers, members, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the medical service requested. The following statement must be accompanied with the disclosure of criteria:

"The materials provided to you are guidelines used by (IPA name) to authorize, modify, or deny care for persons with similar illness or conditions."

Disclosure of UM Criteria upon Request:

I. The description of the process by which the plan reviews and approves, modifies, delays or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be disclosed by the delegated PMG/IPA to providers, and to enrollees and public upon request.
II. The delegated PMG/IPA shall disclose or provide for the disclosure to network providers the process which the delegated group uses to authorize, modify, or deny health care services under the benefits provided by the delegated group, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities, as applicable. The delegated PMG/IPA shall also disclose those processes to enrollees designated by an enrollee, or to any other persons in the organization, upon request.
III. The criteria will be available to the public upon request. Only the guideline for the requested procedure or conditions requested shall be disclosed.
IV. The delegated PMG/IPA may distribute criteria via the internet and it if does, it must also send written notification to all participating practitioners of the availability of the information on its web site and provide paper copies of the information upon request. The organization must use alternate approaches for practitioners without fax or email access.

Criteria may be available by making copies of criteria for each practitioner, by reading criteria over the phone, or making criteria available for review at the delegate's office.

V. The PMG/IPA must at least annually evaluate the consistency with which health care professionals involved in UM apply criteria in decision making and act on opportunities to improve consistency, if applicable.

**UM 3 – Communication Services**

The delegated PMG/IPA must meet the following communication requirements:

I. Only a qualified licensed physician or health care professional may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

II. The delegated PMG/IPA provides a clear and concise response with a description of the criteria or guidelines used.

III. The delegated PMG/IPA communicates clearly to the requesting physician or health care provider how to contact the professional responsible for any denial, delay, or modification of an authorization.

IV. Communication of denial to the enrollee includes appeal and independent medical review rights and process notification.

V. Denial based upon benefit coverage must include specific provisions of the contract that exclude coverage.

VI. The delegated PMG/IPA provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. It provides the following communication services for members and practitioners:
    a. Staff is available at least eight hours a day during and after normal business hours for inbound calls regarding UM issues.
    b. Staff can send outbound communication regarding UM inquiries during and after normal business hours.
    c. Staff members must identify themselves by name, title and IPA name when initiating or returning calls regarding UM issues.
    d. A toll-free number of staff who is able to accept collect calls regarding UM issues.
    e. Staff is accessible to callers who have questions about the UM process.
    f. The entity offers TDD/TTY services for deaf, hard of hearing or speech-impaired members.
    g. Delegate provides language assistance of members to discuss UM issues.

VII. Blue Shield Promise and delegated entities provide for accessibility of information in the members' preferred languages.

Interpretation service is available at Blue Shield Promise should a non-English speaking member request it.

- Member notification letters such as denials have an attachment that says in English and translated into threshold languages: "if you need this information in your language or in an alternative format (i.e. Braille, Large Print or Audio), please call our toll free number 1-800-605-2556" Notice of Action letters (denial letters) are also available in threshold languages.
- For Health Families, member notification letters are available in Spanish language. Each denial letter is accompanied by the following LAP verbiage that is translated in Spanish: "IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-800-605-2556"
- For Commercial members, the denial letter is always accompanied by the following verbiage, translated in Spanish and Chinese languages: **"IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-800-605-2556."**

**UM 4 – Appropriate Professionals**
The delegated PMG/IPA has appropriately licensed professionals to supervise all medical necessity decisions.

I. The PMG/IPA must have written procedures that specify the type of personnel responsible for each level and type of UM decision-making. They must have appropriately licensed professionals that are able to supervise all medical necessity decisions. Supervision may include activities such as ensuring consistent criteria application, participating in staff training, and monitoring documentation adequacy. Supervisors must have day-to-day involvement in UM activities and should be consistently available to staff, either on site or by telephone.

   Licensed physicians must oversee UM decisions to ensure consistent medical necessity decision making. Licensed mid-level clinical psychologists may oversee behavioral healthcare UM decisions.

   Licensed health care professionals must make Um decisions that require clinical judgment.

   Staff members who are not qualified health professionals may collect data for preauthorization and concurrent review under the supervision of appropriately licensed health professionals. They may also have the authority to approve (**but not to deny**) services for which there are explicit criteria.

**II. Use of practitioners for UM Decisions**

The PMG/IPA has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:

- Education, training or professional experience in medical practice.
- A current license to practice without restriction.

**III. Practitioner Review of Non-Behavioral Health Denials**

The PMG/IPA ensures that a physician or other health care professional, as appropriate, reviews any non-behavioral health denial based on medical necessity as defined by Blue Shield Promise.

Evidence of appropriate professional review by the delegate may consist of a handwritten signature, handwritten initials or unique electronic identifier on the letter of denial or on the notation of denial in the file. For electronic signatures, the delegate must demonstrate appropriate controls that only the individual indicated may enter a signature. Documentation of the denial may also consist of a signed or initialed note from a UM staff person who attributes the denial decision to the specific professional who reviewed and decided the case.

**IV. Practitioner Review of Behavioral Health Denials**

The PMG/IPA ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate for the line of business, reviews any behavioral health denial of care based on medical necessity if applicable to line of business.

(For Medi-Cal Line of Business, Behavioral Health is a carve-out. For Medicare, Health Families, and Commercial Lines of Business, Behavioral Health is delegated to an approved Blue Shield Promise vendor).

**Use of Board-Certified Consultants**

The PMG/IPA has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.

**Affirmative Statement About Incentives**

The PMG/IPA must distribute a statement to all its members and practitioners, providers and employees who make UM decisions affirming that:

- Um decision making is based only on appropriateness of care and service and existence of coverage
- Practitioners are not rewarded for issuing denials of coverage of care
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The delegate may distribute the statement in writing by mail, fax or email, or on the web.

**Reviewer Availability:**

I. The delegated PMG/IPA gives practitioners information about its policy for making appropriate practitioner reviewer available to discuss any UM denial decision and how to contact a reviewer.
II. The PMG/IPA provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate reviewer.

**Use of Board Certified Consultants**

The PMG/IPA has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.

**UM 5 – Timelines of UM Decisions**

The delegated PMG/IPA makes utilization decisions and sends notification of the decision within the timeframes set out by regulatory and accrediting bodies such as: DHS, DMHC, CMS, L.A. Care and NCQA.

(Refer to ICE UM Timeliness Standards for Healthy Families, Commercial and CMS, and L.A. Care Timeline for Medi-Cal LOB)

UM Assessment and Evaluation:

I. The delegated PMG/IPA's UM Plan has a process by which compliance with UM standards is assessed and evaluated. The process shall include a mechanism to evaluate complaints, except non-delegated member complaints, assess trends, implement actions to correct identified problems, mechanisms to communicate actions and results to group's employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.
II. For each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers. Compliance with UM processes include:
    a. Timeliness of decision-making, notification and appropriate use and application of criteria in the UM decision process;
    b. Turn-around times for UM functions;
    c. Inter-rater reliability among UM nurse reviewers and non-clinical staff;
    d. Use of appropriate and competent licensed health care provider in making denial and appeal decision;
    e. Availability of independent review process;
    f. Use of complaint and satisfaction data to identify issues with potential problems; and
    g. Trending of UM data, such as:
        i. Denial, appeal, and overturn rates;
        ii. Provider referral and specialist care patterns of practice; and

iii. Other UM indicators.

**UM 6 – Clinical Information**
The delegated PMG/IPA obtains relevant clinical information and consults with treating practitioner before making UM decisions. A written policy must be in place to guide the staff with this process, specifically, the process of obtaining missing clinical information. Policy may specify clinical information such as:

- Office records
- History of presenting problem
- Clinical exam
- Treatment plans and progress notes
- Diagnostic test results, operative and pathological reports
- Consultation reports, evaluations from other practitioners

The delegate must also have documentation that relevant clinical information is gathered consistently to support non-behavioral and behavioral healthcare UM decision making.

**Procedures for Onsite Facility Reviews:**
If the delegate provides onsite review services at facilities (e.g., hospital, skilled nursing facilities, rehabilitation facilities), it has a process that includes the following:

- Guideline for identifying organization staff at the facility, in accordance with facility procedures
- A process for scheduling the onsite review in advance unless, unless otherwise agreed upon
- A process or ensuring that staff follow facility rules

The delegate must also have a process that indicates how it informs its staff of facility rules such as:

- Staff training and orientation
- Staff review of applicable facility contract language
- Staff review of facility policies and procedures

UM 7 – Denial Notices
The delegated IPA/Medical Group must communicate clearly the reason for each non-behavioral or behavioral health denial. They must send sufficient information to both members and practitioners so that they can understand and decide whether to appeal a decision to deny care or coverage.

I. The delegated PMG/IPA must notify the practitioners about its policy for making an appropriate practitioner reviewer to discuss any UM denial decision and how to contact a reviewer. An appropriate practitioner is the delegate's representative who makes UM denial decisions and the reviewer may be a physician, pharmacist, chiropractor, and dentist or other practitioner type, as appropriate.

II. The delegated PMG/IPA must provide treating or attending practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate reviewer. It must also provide contact instructions to its provider network. Distribution of availability information may be done through one of the following methods:
    a. In writing by mail, fax, or e-mail
    b. On the web, if it notifies practitioners that the information is available

III. The PMG/IPA must provide written notification of the non-behavioral/behavioral health denial that contains the specific reasons for the denial that contains the following information:
    a. Specific reasons for the denial in a clear and understandable language
    b. Reference to the benefit provision, guidelines, protocol or other similar criterion on which the denial decision is based
    c. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol of other similar criterion on which the denial decision was based, upon request. This requirement is not required for the Medicare LOB

IV. The delegated PMG/IPA must also provide written notification of a non-behavioral/behavioral health denial which will contain:
    a. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
    b. An explanation of the appeal process, including the right to the member representation and time frames for decision appeals, and
    c. A description of the expedited appeal process for urgent pre-service urgent concurrent denials.

When the delegate issues notification of denial, it must inform members of their right to have a representative act on their behalf at all levels of appeal.

Blue Shield Promise is responsible for all levels of appeal.

**UM 8 – Resolutions of Appeals (Not Delegated)**

Blue Shield Promise has written policies and procedures for thorough, appropriate and timely resolution of member rights. (Refer to P&P 10.18.1, “Member Appeal Process” for Medi-Cal, Healthy Families and Commercial; and to P&P 50.18.05 “MA Enrollee Standard Appeals” for Medicare)

Blue Shield Promise has a full and fair process for resolving member’s disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service.

**UM 9 – Appropriate handling of Appeals (Not Delegated)**

Blue Shield Promise adjudicates member appeals in a thorough, appropriate and timely manner.

Blue Shield Promise has a full and fair process for resolving member's disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service.

**UM 10 – Evaluation of New Technology (Not Delegated)**

The delegated PMG/IPA relies on Blue Shield Promise for evaluation of new technology and application of existing technology to keep pace with the changes to ensure safe and effective member care. All related requests must be submitted to Blue Shield Promise for determination.

**UM 11 – Satisfaction with the UM Process (Not Delegated)**

Blue Shield Promise evaluates member and practitioner satisfaction with its UM process to identify areas of improvement and this process is not delegated.

**UM 12 – Emergency Services Authorization**

I. The delegated PMG/IPA ensures that health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week.
II. The PMG/IPA's emergency services P&Ps require:
    a. Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed; and
    b. Coverage of emergency services if an authorized representative, acting for the organization has authorized the provision of emergency services
        i. For Medi-Cal LOB, members are not held financially responsible for ER service.

**UM 13 – Procedures for Pharmaceutical Management (Not Delegated)**

Blue Shield Promise ensures that its procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and it develops regular reviews, and updates policies and procedures for pharmaceutical management based on sound clinical evidence. (Refer to Blue Shield Promise Pharmacy Department's Policies and Procedures)

**UM 14 – Triage and Referral for Behavioral Healthcare**

Blue Shield Promise approved Behavioral Health vendor has written standards to ensure that any centralized triage and referral functions for behavioral healthcare services are appropriately implemented, monitored and professionally managed.

Blue Shield Promise approved Behavioral Health vendor has a National Call Center and regional UM departments are accessible to practitioners and members for all UM related issues and question, including eligibility, co-pay and procedures for accessing services. They assure that members gain prompt access to behavioral healthcare programs and services.

For Medi-Cal LOB: Behavioral Health is a carve-out
For Commercial, Health Families, and Medicare LOBs: Behavioral Health is delegated to Blue Shield Promise approved Behavioral Health vendor.

Refer to Blue Shield Promise approved Behavioral Health vendor:
P&P 7.36.13v "Medicare Access and Referral"
P&P 07.36.14vCA "CA Access and Referral incl. Rescinding Authorizations"
P&P 07.51.00 "Access Staff for Communication and Receipt of Information"
P&P 07.44.00 "Access to a Psychiatrist for Medication Evaluation and Ongoing Management"
P&P 07.5.00 "Access to Psychological Testing"

**UM 15 – Delegation Oversight**
Blue Shield Promise remains accountable for and has appropriate structures and mechanisms to oversee delegated PMG/IPA are UM activities.

I. Written Delegation Agreement – written delegation agreement delineates the responsibilities of both Blue Shield Promise and the delegated entity. The written delegation agreement document:
    a. Is mutually agreed upon
        i. All delegates must adhere to CMS requirements
    b. Describes the responsibilities of Blue Shield Promise and the delegated group
    c. Describes the delegates activities
    d. Requires at least semi-annual reporting to Blue Shield Promise
        i. Document must specify the content and frequency of reporting to Blue Shield Promise; reporting may be in the form of joint meetings or conferences but must occur at least twice a year. It must also contain at least the following items:
            1. Number of complaints and appeals received
            2. Number of each type of complaint, using agreed-upon categories
            3. Disposition of complaints and appeals
            4. Complaint and appeal turnaround times
    e. Describes the process by which Blue Shield Promise evaluates the delegated entity's performance
        i. Performance measures and adherence to established procedures are determined by Blue Shield Promise and incorporated into Blue Shield Promise's or the PMG/IPA's UM Program
    f. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Blue Shield Promise IPA Compliance staff under the guidance of the Chief Medical Officer (CMO) and the VP of Medical Services will monitor and review reports submitted by PMG/IPAs on an ongoing basis as listed in their reporting requirements. Blue Shield Promise IPA Compliance staff will also conduct oversight activities as outlined in their delegation agreement **(Refer to UM Delegation Agreement/Delineation of UM Responsibilities).**

Failure by the delegate to meet the Blue Shield Promise requirements may result in a corrective action and if the delegate is unable to fulfill its obligations under the agreement after a specific period of time, may result in the following remedies as determined by the Capitated IPA/Primary Medical Group Agreement between Blue Shield Promise and IPA/Medical Group:

- Notice of material breach and specified cure period
- Capitation deduction
- De-delegation of certain UM activities as appropriate
- Termination from the network

## II. Attestation for Protected Health Information (PHI)

a. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), IPA/MG shall comply with the following provisions:
   i. The delegate has a list of the allowed uses of PHI
   ii. The delegate has a process in place for ensuring that members' and practitioners' information will remain protected
   iii. The delegate has a description for safeguarding the protected information from inappropriate use or further disclosure
   iv. The delegate has a written description stipulating that the delegate will ensure that sub-delegates have similar safeguards, when applicable.
   v. The delegate has a written description stipulating that the delegate will provide individuals with access to their protected health information
   vi. The delegate will ensure that its organization will inform the organization if inappropriate use of the information occurs.
   vii. The delegate will ensure that that protected health information is returned, destroyed or protected if the delegation agreement ends.

## III. Pre-Delegation Evaluation

a. Blue Shield Promise will conduct a pre-delegation evaluation of an entity prior to signing of the delegation agreement. Evaluation may involve site and desktop review and a review of the delegate's understanding of the accrediting, regulatory, and Blue Shield Promise's standards and the delegated tasks, staffing capabilities and performance records.
b. Pre-Delegation evaluations are reported on a quarterly basis to the Medical Service Committee QM/UM Committee. Once granted their delegation status, the PMG/IPA agrees to:
   i. Make available to Blue Shield Promise any requested data, documents, and reports
   ii. Allow site visits, evaluations, and audits by Blue Shield Promise or other agencies authorized by the health plan and state and federal agencies
   iii. Adhere to all their responsibilities outlined in the delegations agreement and participate in the monitoring activities conducted by the Blue Shield Promise's IPA Compliance staff

Refer to P&P #70.2.90 "IPA/PMG Delegated Oversight Evaluation, Scoring, and Reporting Requirements"

**IV. Annual UM Delegation Evaluation**

a. Blue Shield Promise will conduct an annual evaluation of all delegates. The evaluation may involve a site visit and may also be conducted through telephone consultation, documentation review or committee meetings, audit of the delegated entity's files and a review of meeting minutes. Findings may warrant a corrective action plan to improve their performance. Failure to meet its obligation may result in the following remedies as determined by the Capitated IPA/Primary Medical Group Agreement between Blue Shield Promise and IPA/Medical Group.
    i. Notice of material breach and specified cure period
    ii. Capitation deduction
    iii. De-delegation of certain UM activities as appropriate
    iv. Termination from the network

Refer to P&P #70.2.90 "IPA/PMG Delegated Oversight Evaluation, Scoring, and Reporting Requirements

**V. Opportunities for Improvement**

Blue Shield Promise will continuously identify opportunities for improvement based on findings from the delegate's pre-delegation evaluation, annual evaluation or ongoing file reviews such as denial file monitoring, review of case management files or any other file reviews determined. These opportunities may also include timeliness of report submission and findings that may have identified areas of improvement.

VI. Approval of the UM Program:

Annually, Blue Shield Promise approves each delegated PMG/IPA's UM program. Refer to P&P #70.2.90 "IPA/PMG Delegated Oversight Evaluation, Scoring, and Reporting Requirements"

VII. UM Reporting:

Blue Shield Promise receives reports from its delegated PMG/IPA at least semi-annually, from which evaluation occurs on the same basis as reporting. Each report shows evidence of substantive evaluation through review and analysis. (Refer to Reporting Requirements for each Line of Business)

**Services Requiring Prior Authorization**

**Overview:**

The delegation of UM affords broad authority for the PMG/IPAs to establish prior authorization requirements. These requirements must be reviewed and approved by Blue Shield Promise through the delegation process.

**Parameters**
The parameters below, and any future updates, must be followed by PMG/IPAs in developing prior-authorization requirements.

- Services that do not require prior authorization:
  - Emergency treatment
  - For Medi-Cal Line of Business:
    - Family Planning Services;
    - Abortions;
    - OB/GYN consultations within network;
    - STD services, including HIV testing; and
- Services that require prior authorization:
  - Transplant evaluation
  - Hospital admission (non-emergent)
  - Non-family planning elective surgical procedures (inpatient or outpatient)
  - Second opinions
  - Care by out-of-area providers (non-emergent)
  - DME/orthotics/prosthetics
  - Ambulance transport and other transport
  - Home health
    - OP, OT, PT, speech therapy and
    - Hospice

**Grievance and Appeals Process**
- The Member Grievance and Appeals Process is not delegated to PMG/IPAs. All grievances must be submitted to Blue Shield Promise for resolution. The PMG/IPA must maintain a monthly log of grievances received. (Refer to P&P 10.18.1 " Member Appeal Process" for Medi-Cal, Healthy Families and Commercial; and to P&P 50.18.05 "MA Enrollee Standard Appeals" for Medicare)
- The Clinical Grievance Coordinator will immediately investigate any grievance and may request information from the PMG/IPA, the requesting provider, the Primary Care Physician, facility, and/or the member. This information will be forwarded to Blue Shield Promise's Medical Director. An acknowledgement letter will be sent to the provider and PMG/IPA upon resolution.

**Nondiscrimination in HealthCare Delivery**
- Blue Shield Promise will ensure that its practitioners have policies and procedures that demonstrate that they do not discriminate in the delivery of healthcare services and accept for treatment any member in need of the healthcare services they provide.
- The IPA/MG must have procedures to ensure that members are not discriminated against in the delivery of health care services based on, race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims

experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment (Refer to "UM and Credentialing Audit Tools").

**Delegated Oversight Monitoring Activities:**

**Denials Letters**
Denial letters in all lines of business are reviewed for compliance according to each line of business' specific requirements. These letters are audited for clinical areas by the CMO (denial reason appropriateness and level of understanding) and non-clinical areas by the IPA Compliance team member. A monitoring tool is used that addresses the requirements for all LOBs. Refer to Denial Monitoring P&P 80.2.90

**Reporting Requirements**
Quarterly or semi-annual ICE reports are recorded and tracked for timeliness of the delegates' submission by Blue Shield Promise. The result is incorporated in the annual delegation for the succeeding year and appropriate score is awarded.

Blue Shield Promise ensures the delegates submit the required monthly, quarterly, and annual reports for contracted lines of business to regulatory entities.

**Provision of Medically Necessary Enteral Therapeutic Formulas**
Blue Shield Promise will monitor and regulate the approval of medically necessary enteral therapeutic formulas of its delegates who are contracted for therapeutic enteral formulas during their annual assessment.

Delegate's P&Ps will be reviewed to ensure they are adhering with requirements:

- Approval of therapeutic enteral formulas shall be supervised by qualified healthcare professionals,
- Denials are reviewed by a qualified physician; and
- New plan members are receiving a current therapeutic formula regimen not to exceed 120 days until medical necessity is determined.

**Provision of Medically Necessary Injectables**
Blue Shield Promise will ensure that delegates who are contracted are able to provide medically necessary injectables in the physician's office.

Blue Shield Promise IPA Compliance team will review the contracted delegates' P&P during their annual assessment to demonstrate that the delegate enforces the 24 hour/one day turnaround time.

**Provider Dispute Resolutions**

(AB1455 Claims Settlement Practices & Dispute Resolution Mechanism)

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care.

Each delegated entity has a P&P that describes their claims and dispute resolution processes and must notify the providers in their network. Their policy will include the following timefreame requirements:

- The IPA sends notification acknowledging that the IPA is in receipt of provider grievances within 15 working days of receipt of grievance.
- The IPA makes decision for provider grievances within 45 working days of receipt of grievance
- The IPA has mechanism in place for tracking and trending the provider grievance logs

Blue Shield Promise reviews annually the Provider Dispute Resolution (PDRs) submitted to the health plan for timeliness. If the delegated entity does not achieve the performance goal of 95% in both areas of timeliness (timeframe requirements #1 & 2 above), a Corrective Action (CAP) will be required. Results are sent out within 45 days of the file review and if a CAP is required, the CAP must be sent within 30 days of receipt of the file review results.

**SNP Model of Care (MOC)**

The Medicare Modernization Act of 2003 established the Special Needs Plan (SNP) specifically targeting Medicare beneficiaries with special needs, with the goal of improving care primarily through improved coordination and continuity of care. “Special Needs” individuals are categorized as a) institutionalized beneficiaries (I-SNP); b) dual eligibles (D-SNP); and c) individuals with severe or disabling chronic conditions (C-SNP). SNP enrollees for Blue Shield Promise are the dual eligibles or Medi-Medi.

The Centers for Medicare and Medicaid Services (CMS) mandated that SNPs develop and implement an evidence-based care model with specialized providers that afford a structure for care management processes and systems, which would provide a coordinated care for special needs individuals. The MOC structure encompasses several components designed to support the delivery of a coordinated care.

In addition, the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 imposed new requirements for the Special Needs Plan, which include: a) a comprehensive initial health risk assessment and annual re-assessment of the physical, psychosocial, and functional needs of the special needs individual; b) an individualized care plan that addresses goals and objectives, services and benefits, and measurable outcomes; and c) an interdisciplinary care team used in the management and coordination of care for each beneficiary.

The purpose of Blue Shield Promise Health Plan's Medicare Model of Care is designed to provide specialized benefits that are focused on meeting the needs of the beneficiaries enrolled in Blue Shield Promise's Medicaid subset dual-eligible SNP plans. This program description demonstrates how Blue Shield Promise meets the model of care requirements.

**A. Measurable Goals**

Blue Shield Promise's Medicare Model of Care is designed to meet the following goals:

a. Improving access to essential services such as medical, mental health, and social services
b. Improving access to affordable care
c. Improving coordination of care through an identified point of contact (e.g., gatekeeper)
d. Improving seamless transitions of care across healthcare settings, providers, and health services
e. Improving access to preventive health services
f. Assuring appropriate utilization of services
g. Improving beneficiary health outcomes

**B. The Model of Care elements include:**

a. Description of SNP Target Population
b. Measurable Goals and objectives pertinent to the SNP enrollees
c. Staff Structure and Care Management Roles
d. Interdisciplinary Care Team
e. Specialized Provider Network
f. Health Risk Assessment (HRA)
g. Individualized Care Plan
h. Integrated Communication network
i. MOC training for personnel and network providers
j. Care Management for the Most Vulnerable Population
k. Performance measurement and improvement activities

**C. Delegated Entities Responsibilities: (Refer to SNP Delegation Agreement)**

IPA Compliance Oversight for Delegated Responsibilities:

I. Operations
   a. Ensure that a Care Management Plan is written describing the model of care
   b. Ensure the delegated entities' submission of specific reporting requirements
   c. Ensure the delegates utilize the ICP and coordinate with the ICT and Blue Shield Promise in updating the care plans.
   d. Ensure that delegated entities conduct initial and annual MOC training on all their UM staff.

II. Training
   a. Initial training – will be conducted by Blue Shield Promise Health plan

b. Annual MOC training – will be conducted at least annually during the delegation audit; JOC or telephone conference by the IPA Compliance Department for every delegated entity. The training may be in the form of audio visual (CMS Slides Presentation), face to face in education, or hardcopies/electronic.

III. Oversight Responsibility for Monitoring Effectiveness of Communication

a. Blue Shield Promise has ultimate responsibility for assuring that the ICP is received by the delegated entity.
b. A dedicated personnel at Blue Shield Promise's UM Department's Medicare section, in cooperation with the IPA Compliance team, shall notify the Director of Health Services if there is a break in the distribution of ICP.
c. The IPA Compliance shall report to Compliance Delegation Oversight Committee the results of audits regarding the effectiveness of communication among providers of care (interdisciplinary care team), delegated entity, and the member or the caregiver.

**Other Responsibility by the IPA Compliance:**

1. Ensure that SNP delegation agreement is mutually signed by both Blue Shield Promise and the delegate initially and revised when necessary.
2. Ensure that the MOC training is conducted initially and then annually to all its delegates in collaboration with Provider Network Operations (PNO).
3. IPA compliance auditors will look for evidence that MOC training was conducted by the delegate to their UM staff during the annual audit.
4. Look for evidence or documentation that delegate receives the HRA from Blue Shield Promise and updates the individualized care plan when necessary
5. Disseminate the IPA Compliance Bulletin which includes the SNP MOC information to all delegates at least on an annual basis.

D. Corrective Action Plan (CAP)

Blue Shield Promise shall work with the delegated entities to ensure proper training and implementation are instituted. In the event that training does not take place or the delegated responsibilities are not implemented, as determined in the Annual Due Diligence SNP Model of Care audit, Blue Shield Promise shall notify the delegated entity in writing requiring the delegate to submit a CAP that addresses all the deficiencies. IPA Compliance Dept. shall conduct a follow-up audit to ensure the requirements are met.

Non-compliance with the mandated standards may lead to de-delegation of the function by Blue Shield Promise Health Plan.

## REFERENCES/AUTHORITIES:

- CA Health and Safety Code Regulation 1367.01 (b)
- CA Health and Safety Code Regulation 1367.01 (c)

- CA Health and Safety Code Regulation 1376.01 (i)
- CA Health and Safety Code Regulation 1363.5 (b)
- CA Health and Safety Code Regulation 1367.01 (f)
- CA Health and Safety Code Regulation 1363.5 (b)(5)
- CA Health and Safety Code Regulation 1363.5 (c)
- CA Health and Safety Code Regulation 1367.01 (h)(I)(2)(3) and (5)
- CA Health and Safety Code Regulation 1367.01 (e)(d)(h)(4), 1363.5 (b)(4), 1374.30(i) and 1368(a)(4)
- CA Health and Safety Code 1367.01(j)
- CCR 1300.70(b)(G)(5)
- CA Health and Safety Code 1371.4(a)-(d)
- NCQA Standards, 2008
- L.A Care UM Decision Timelines
- Centers for Medicare & Medicaid Services