

October 11, 2019

Subject: **Notification of January 2020 Updates to the *Blue Shield Promise Health Plan Medicare Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medicare Provider 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 the Blue Shield Promise Provider Portal at <https://www.blueshieldca.com/promise/providers/index.asp>, click on *Providers* on the top, then *Provider Manual* in the drop down list.

The *Blue Shield Promise Health Plan Medicare Provider Manual* is referenced in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medicare providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medicare Provider Manual* and the agreement held by the provider and Blue Shield Promise, 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 Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,



Hugo Florez
Vice President, Provider Network Management
Promise Health Plan and PPO Specialty Networks
Blue Shield of California

T10635 (10/19)



Promise
Health
Plan

**UPDATES TO THE JANUARY 2020
BLUE SHIELD PROMISE HEALTH PLAN MEDICARE MANUAL**

Section 1: Provider Services

Updated contact information throughout this section. Notifications for provider network additions, changes, terminations, and directory updates must be sent to Provider Information & Enrollment at the email or address below:

Blue Shield of California
Provider Information & Enrollment
P.O. 629017
El Dorado Hills, CA 95762-9017
Fax: (916) 350-8860
Email: BSCProviderInfo@blueshieldca.com

Updated Provider Service resources to include the following:

- Provider Relations Representative
- Provider In-Service
- Provider Manual
- Provider Bulletins
- Provider Communication
- Joint Operation Committee for Participating Provider Group (PPG) and Hospitals only

1.2: Provider Orientations

Added ancillary providers to list of providers that orientations are conducted for.

1.4: Provider Affiliations

Removed the hospital affiliation requirement from this section as it is stated in Credentialing Section 2:3: Minimum Credentials Criteria.

Section 1: Provider Services (cont'd.)

1.6.7: Reporting Provider Inaccuracies

Removed separate contact information for San Diego providers. All provider inquiries can be directed to the updated contact information for the Provider Information & Enrollment team listed below:

Providers can promptly verify or submit changes to the information listed in the directories through the following:

- a. By telephone (800) 258-3091
- b. Fax (916) 350-8860
- c. Email BSCProviderinfo@blueshieldca.com
- d. Completing an online interface for providers to submit verification with requested changes generating an acknowledgment of receipt

1.11 Provider Directory

Added new contact information for directory updates in boldface type below:

The Blue Shield Promise Health Plan printed and online provider directories are updated every 30 calendar days. The directory is solely used as a Member handbook referencing participation of primary care physicians, hospitals, vision providers, and pharmacies. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted PPG and/or Blue Shield **Provider Information & Enrollment email address at bscproviderinfo@blueshieldca.com**. Providers may also review their information on the Blue Shield Promise Health Plan website at www.blueshieldca.com/promise. Blue Shield Promise Health Plan is committed to ensuring the integrity of the directory to the best of its ability dependent on notification by the group.

Section 2: Credentialing

2.2: Credentials Committee

Added language to the responsibilities of the Credentials Committee, in boldface type below:

- Review and recommend actions for all network practitioners identified with sanction activities from the state licensing agency, OIG, SAM and CMS OPT-Out reports, **Preclusion List**.

Section 2: Credentialing (cont'd.)

2.3: Minimum Credentials Criteria

Added language in boldface type below:

1. All applicants will meet the following minimum credentialing requirements and provide a comprehensive profile sheet to include:
 - k. Hold a current and valid DEA certificate **with California license**, if applicable.

Removed the following training requirements in order for providers to be credentialed to align with an updated Blue Shield Promise Health plan policy:

- a. A specialist provider applying as primary care provider must credentialing in the Medicare line of business and must have completed at least one-year stateside training in primary care medicine (Internal Medicine or Family Practice);
- b. A primary care provider applying as a specialist must completed at least one year of specialized training (not in primary care medicine) in United States and provide two letters of recommendation from other primary care physicians.
- c. An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine. If an OB/GYN has completed at least one year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.

2.9: Sanction Review

Added "Preclusion List" to items that are queried at the time of credentialing, in boldface type below:

Blue Shield Promise Health Plan queries the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), Opt-Out Report, **Preclusion List**, SAM Report and state licensing agencies at the time of initial credentialing and recredentialing to determine if there have been any sanctions placed or lifted against a practitioner/provider. Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner is contracted directly with Blue Shield Promise Health Plan, then the practitioner is notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome. If the practitioner is delegated to a PPG, then the affected PPG is notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the PPG's response, is forwarded to the Credentials Committee for review and action.

Section 2: Credentialing (cont'd.)

2.9: Sanction Review (cont'd.)

Added language in boldface type below:

Blue Shield Promise Health Plan also monitors the practitioner for license, DEA, malpractice insurance **and board certification** expiration dates. Monthly, the Credentialing Department runs a report for the medical/ professional license, DEA, malpractice insurance **and board certification** due to expire within the following month.

License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the National Technical Information Service (NTIS) or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider. **Board certification renewals are verified through ABMS.**

Section 3: Member Services

3.1: Covered Benefits

Added the Blue Shield Promise website address where Evidence of Coverage can be found, in boldface type below:

The benefit designs associated with the Blue Shield of California Promise Health Plan Medicare Advantage plans are described in the *Summary of Benefits* and the *Evidence of Coverage*.

Providers can view these documents online by visiting our Provider Portal at

<https://www.blueshieldca.com/promise/medicare/?secMedicare=EvidenceOfCoverage>. To

request printed copies of the publications, please contact the Provider Customer Services Department at (800) 468-9935.

Section 6: Pharmaceutical Management

6.3: Pharmaceutical Utilization Management

Updated language to note that the Blue Shield of California Pharmacy & Therapeutics Committee reviews and approves the utilization management tools.

Removed the following language below. Therapeutic interchange programs are not reviewed and approved by the Pharmacy & Therapeutic (P&T) Committee. The preferred formulary agents vs. non-preferred/non-formulary agents are approved by the P&T Committee and any substitutions by the pharmacy are based on the P&T-approved formulary.

- Therapeutic interchange: Is the practice of offering clinically appropriate, cost effective formulary alternatives. Blue Shield of California Promise Health Plan will work with the prescribing physicians to get this accomplished.

Removed the following language to align with Blue Shield and Blue Shield Promise policies:

Blue Shield of California Promise Health Plan Members shall have access to all FDA-approved drugs that are medically necessary via the drug formulary or prior authorization procedures.

6.3.1: Prior Authorizations and Exceptions

*This section was **rewritten** for clarification and to align with Blue Shield and Blue Shield Promise policies and procedures.*

Added the following new section outlining the Transition Policy:

Transition Policy

New Blue Shield Promise Health Plan members may be taking drugs not listed in the Blue Shield Promise Health Plan Medicare drug formulary, or the drug(s) may be subject to certain restrictions, such as prior authorization or step therapy. Members are encouraged to talk to their doctors to decide if they should switch to an appropriate drug in the plan formulary or request a Formulary Exception (a type of Coverage Determination) in order to obtain coverage for the drug. While these new members may discuss the appropriate course of action with their doctors, Blue Shield Promise Health Plan may also cover the non-formulary drug or drug with a coverage restriction in certain cases during the first 90 days of new membership.

For each of the drugs not listed in the formulary or that have coverage restrictions or limits, Blue Shield Promise Health will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a Network Pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, Blue Shield Promise Health Plan will not pay for these drugs, even if the new member has been enrolled for less than 90 days.

If a member is a resident of a long-term-care facility (LTC) such as a nursing home, Blue Shield Promise Health Plan will cover supplies of Part D drugs in increments of 14 days or less for a temporary 31-day transition supply (unless the prescription is written for fewer days) during the first 90 days a new member is enrolled in our Plan beginning on the member's effective date of coverage. A transition supply notice will be sent to the member within 3 business days of the first incremental transition fill. If the LTC resident has been enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions, such as step therapy or dosage limits, Blue Shield Promise Health Plan will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from an LTC facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above. To request prior authorization, please contact Blue Shield Promise Health Plan, 601 Potrero Grande Drive, Monterey Park, CA 91755.

Pharmacy Services is available by phone at (800) 468-9935, Monday through Friday, 8:30 a.m. to 5 p.m. PST, excluding holidays. Faxed requests may be sent to (866) 712-2731 at any time or requests may be submitted electronically through the electronic health record, if available. Prescribers who have questions regarding formulary or non-formulary drugs and/or need a copy of the formulary can call the number above or go to blueshieldca.com and navigate to the Provider Connection or Pharmacy page.

Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours for an expedited review and 72 hours for standard requests.

Section 7: Quality Improvement

*This section was **rewritten** for clarification and to align with Blue Shield and Blue Shield Promise policies.*

Section 8: Encounter Data

***Removed** the following language as this is no longer a Blue Shield Promise health plan procedure:*

Blue Shield of California Promise Health Plan will provide a report card to the Medical Group on a regular basis and will use this report card to evaluate the encounter data quality performance.

Section 10: Accounting

10.1: Financial Ratio Analysis (PPG Only)

***Added** language to align with Blue Shield and Blue Shield Promise policies, in boldface type below:*

The Accounting Department is responsible for the accurate financial reporting of capitation and claims expense transactions. The Managed Care Finance Department is responsible for data generation and timely payment of capitation.

PPG must submit year-end financial statements audited by an independent certified public accountant firm within **150** calendar days after the close of the fiscal year **to Promise and the Department of Managed Health Care (DMHC) (regulator)**. On a quarterly basis, financial statements must be submitted to DMHC within 45 calendar days after the quarter ends

PPG shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability).
- A positive tangible net equity as defined in regulation 1300.76(e).
- A cash to claims ratio as defined in regulation 1300.75(f).
- **A claims timeliness requirement as defined in regulation SB260.**

Section 10: Accounting (cont'd.)

10.2: Capitation Payment

Added/removed language to align with Blue Shield and Blue Shield Promise policies, in boldface and strike through type below:

The Capitation Department is responsible for sending the monthly capitation payments to its contracted PPGs. Capitation payments are made **no later than** the 10th of each month **for Medicare and no later than the 15th for Cal MediConnect (CMC)** or within 10 days from receipt of revenue from ~~DHCS, LA Care or CMS~~.

Capitation reports and eligibility reports are posted on a secured site or what is widely known as a Secure File Transfer Protocol ("SFTP") server. These reports are available to the PPGs **no later than** the 10th of each month **for Medicare and no later than the 15th for Cal MediConnect (CMC)**. Each PPG is responsible for coordinating with Blue Shield of California Promise Health Plan on how to access the SFTP server. For security measures, only two individuals per PPG are issued a **username and password** to access this site. Any changes to the PPG's **contact person** will require a new password or PGP key. PPGs must request and fill out a new PGP Key Form and **submit to their assigned Provider Relations Representative**.

Section 12: Culturally and Linguistically Appropriate Services (CLAS)

Added the Blue Shield Promise website address where grievances can be filed, in boldface type below:

VI. CLAS Related Grievances:

Blue Shield of California Promise Health Plan Medicare Members have the right to file a grievance if their cultural and/or linguistics needs are not met. Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office. Please visit our website at

<https://www.blueshieldca.com/promise/members/index.asp?memSec=filing-a-grievance>

Appendices

Appendix 6: Access to Care Standards

Attachment A: Primary Care Practitioners Access to Care Standards (PCPS)

Removed "Initial prenatal visit to OB/GYN," "Well-child visits (for child under 2 years of age)," and "Initial Health Assessments and Behavioral Health screening" standards to align with Medicare standards of care.

Appendices (cont'd.)

Appendix 6: Access to Care Standards (cont'd.)

Attachment C: Behavioral Health Access to Care Standards

Added the following criteria language for specialty providers:

Criteria	Standard
Specialty Provider	Within fifteen (15) Business Days (after appropriate PCP visit). Perform comprehensive evaluation and submit to Plan.

*The following attachments have been **added** to Appendix 6 to align with Blue Shield and Blue Shield Promise policies.*

Attachment D: Ancillary Access to Care Standards

Criteria	Standard
Ancillary Providers	Will be seen within fifteen (15) Business Days , for services where prior authorization that has been obtained.

Attachment E: Long Term Services and Support Access to Care Standards

Criteria	Standard
Skilled Nursing Facility	Skilled Nursing Facility services will be available within 5 business days of request.
Intermediate Care Facility/ Developmentally Disabled (ICF-DD)	ICF-DD services will be available within 5 business days of request (These services are provided by Skilled Nursing Facilities and Nursing Facilities (LTC) where 24-hour nursing services are provided.
Community Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment.

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