October 16, 2020

Subject: **Notification of January 2021 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 in the following provider manual sections are effective January 1, 2021.

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 2021 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

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

T11239 (10/20)

UPDATES TO THE JANUARY 2021
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.

New Pharmacy Claims Processing Vendor

Effective January 1, 2021, Blue Shield of California will have a new pharmacy claim processing vendor. CVSH will be processing pharmacy claims for all Blue Shield plans. Members will receive new ID cards with updated RxBIN and RxPCN pharmacy information. Direct Member Reimbursement (DMR) forms will be updated to include CVSH information. Members who have questions about their pharmacy benefits should be directed to contact the Customer Care telephone number on their member ID cards.

Section 2.4 Blue Shield Added Advantage POS℠ (Point-of-Service) Plan

CLAIMS PAYMENT DETERMINATION

Clarified *claims payment level in boldface type below:*

Professional Services Claims

If there is a record that the member has self-referred or **"opted-out,"** Blue Shield will pay the claim at the **PPO benefit level.**

Institutional Services Claim

If there is a record of an IPA/medical group or Blue Shield authorization, Blue Shield will pay the claim **at the HMO benefit level.**

If there is a record of an Added Advantage POS Plan member self-referral or "opt-out," Blue Shield will pay the claim **at the PPO benefit level.**

Section 2.5 Optional Benefits (Also Known as Rider Benefits)

BENEFIT DESCRIPTIONS

Updated *benefit coverage for Acupuncture Services, Additional Hearing Aid Benefits and Additional Infertility Benefits. Please refer to the member's Benefit Rider for coverage limitations, exclusions, lifetime maximums and copayments, coinsurance, and deductibles.*

Section 2.8 Benefits and Benefits Programs

PHARMACEUTICAL BENEFITS

Drug Formulary (Commercial Plans)

Added *language on ways to submit prior authorizations requests. This language has also been updated in Section 4.4 Claims for Outpatient Prescription Drugs and Section 5.1 Outpatient Prescription Drugs.*

Drug Formulary (Commercial Plans) *(cont'd.)*

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the Authorizations section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the required information is built into the tool.

Drug Formulary (Medicare Plans)

Added *language on ways to submit prior authorizations requests. This language has also been updated in Section 4.4 Claims for Outpatient Prescription Drugs and Section 5.1 Outpatient Prescription Drugs and Section 6.2 Non-Formulary Outpatient Prescription Drugs.*

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the Authorizations section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Pharmaceuticals in the Medical Benefit

Added *the following language regarding adhering to the Blue Shield Medication Policy:*

Blue Shield requires that all delegated IPA/medical groups adhere to Blue Shield Medication Policies, which may include step therapy and site of administration criteria. High cost medications including CAR-T and Gene Therapy are subject to Blue Shield review for coverage according to Blue Shield Medication Policy regardless if utilization management is delegated to the IPA/medical group. Refer to the Section 5.1 Prior Authorization.

Office/Facility-Administered Medications

This section has been ***deleted and replaced*** *with the following language:*

For some IPA/medical group commercial contracts, Blue Shield identifies and maintains a separate financial risk classification for certain (a) office-administered, (b) high-cost, (c) chemotherapy, and (d) chemotherapy and supportive/adjunctive injectable drugs. Medications are added to these various risk allocation classifications on a quarterly basis. Please refer to your Division of Financial Responsibility (DOFR) for the classification (s) of drugs that are currently contractually carved out to Blue Shield. This policy does not apply to the Medicare Advantage product, as all IPA/medical groups are capitated on a percent of premium methodology, which is presumably self-adjusting and for which we follow Medicare guidelines in risk allocation.

Office/Facility-Administered Medications *(cont'd.)*

Unless contracted differently, IPA/medical group reimbursement of these medications requires encounters or claims be submitted by the IPA/medical group, not the individual participating providers, with the appropriate National Drug Code (NDC) and HCPCS code. Please refer to Section 4.5 for encounter and claims processing procedures.

For reimbursement of medications administered at an outpatient facility, select drugs may require site of service medical necessity authorization for coverage in addition to the authorization of the drug.

The criteria for classification of High-Cost injectables includes those FDA-approved in 1998 or later with an estimated treatment cost per patient at or above $10,000 average wholesale price (AWP) per year. A complete list of High-Cost Injectables and corresponding HCPCS Codes that meet the classification criteria is posted quarterly on Provider Connection at blueshieldca.com/provider under *Claims*, then *Policies & guidelines,* then *Richman injectables*. You may also contact your Provider Relations Coordinator for a listing.

Section 4.1 Network Administration

CONTRACTING REQUIREMENTS FOR ADMINISTRATIVE SERVICES AGREEMENTS (APPLIES TO MSOS OR OTHER ENTITIES)

Deleted *the following language since IPA/medical groups are audited on an annual basis and the sub-delegation contracts are reviewed during the audit:*

The IPA/medical group must provide a copy of the sub-delegation agreement on an annual basis or if there are any changes or updates to the agreements. Please forward a copy of the agreement to Del_UM_Oversight@blueshieldca.com.

PROVIDER STATUS CHANGES

This section has been ***deleted and replaced*** *with the following language:*

For inclusion in the HMO network, practitioners that include any person licensed or certified to provide member care must meet Blue Shield's HMO network criteria.

Upon notification of status changes, Blue Shield will update its provider database and directories accordingly.

The IPA/medical group is required to notify Blue Shield of changes to its provider network, as follows:

- **Addition of New Providers**

  The IPA/medical group must notify Blue Shield 30 days prior to the date a new provider is added to the IPA/medical group. The IPA/medical group is required to send a practitioner profile for all new providers participating with a relationship to the IPA/medical group.

  Delegated IPA/medical groups may send new provider profiles directly to the Provider Information & Enrollment team to be added to the network relationship. Non-delegated IPA/medical groups must first submit a credentialing application with new provider profiles and receive credentialing approval prior to provider being added to the network.

  Blue Shield will not add a provider who does not meet Blue Shield Network Criteria including eligibility to participate in any Blue Shield networks the IPA/medical group is contracted for.

  Blue Shield will not add a provider whose geographic location is outside the IPA/medical group's service area, as set forth in the Zip Code Table in the HMO IPA/Medical Group Agreement, unless contractually amended.

PROVIDER STATUS CHANGES *(cont'd)*

- **Demographic/Administrative Changes**

  The IPA/medical group must notify Blue Shield of demographic or administrative changes as soon as possible for timely directory updates. Examples of these types of demographic or administrative changes include office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

  The minimum required data for all new providers and provider demographic adds, updates, or termination submissions is as follows.

  - Complete name
  - Primary office locations
  - Telephone number and fax number, if applicable
  - Office hours
  - Specialty
  - California license number
  - Hospital staff privileges (list hospitals and types of privilege)
  - Languages spoken
  - Wheelchair access
  - IRS number
  - NPI
  - Designation as PCP or specialist or both
  - Panel data including gender, age or patient restriction
  - Identification of the IPA to which the practitioner should be added
  - Where required by law, individuals requiring supervision must also provide the name, NPI and license number of the supervising physician.

PRIMARY CARE PHYSICIAN TERMINATION NOTIFICATION REQUIREMENTS

Added *language in boldface type below to list of circumstances in which IPA/medical group may be unable to provide advance notice of a PCP termination:*

- Revocation of medical license or Medicare sanction and debarment or **any other sanction status that results in the practitioner being immediately ineligible to render care.**

Deleted *requirement that if IPA/medical group does not provider Blue Shield with 90-day advance written notice, and the termination doesn't qualify as one of the "limited circumstances," Blue Shield will send a letter to the IPA/medical group and will require the IPA/medical group to submit a written explanation within two weeks of receipt of the letter detailing the reasons for non-compliance.*

HMO PHYSICIAN AND HOSPITAL DIRECTORY

Added *language to align with provider contract language updates regarding maintaining directory data:*

In order to reduce administrative burden on providers, Blue Shield delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the IPA/medical group must work with the vendor in lieu of Blue Shield to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.

Added *the following language to comply with 42 C.F.R. Part 2 regulations:*

CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

In 1975, Congress enacted 42 U.S.C. 290dd-2 and its supporting regulations at 42 C.F.R. Part 2. The law is formally referred to as the Confidentiality of Substance Use Disorder Patient Records Act, and informally referred to as "Part 2." The purpose of Part 2 is to protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized use and disclosure of SUD patient records except with patient consent and in limited circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that regulates and enforces Part 2.

If, as a provider, you are a Part 2 Program, you must comply with all of the applicable legal requirements of the Part 2 laws and regulations.

To assist you in meeting your legal obligations, you may inform Blue Shield that you have the patient's consent to disclose their SUD patient records to Blue Shield when submitting an electronic claim (837 P or I) for Part 2 services by placing a "1" in the CLM09 field.

When submitting an electronic claim (837 P or I) for Part 2 services, under the NTE02 segment, you may include in the free-form narrative one of the following mandatory Part 2 disclaimer language options. The shorter version is preferable.

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or
- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

To help you determine if you are a Part 2 Program, please refer to:
https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

To learn more about the Part 2 laws and regulations, please refer to:
https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

To learn more about how Part 2 limits the disclosure of SUD patient records, please refer to:
https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

It is recommended that you consult legal counsel if you are uncertain whether or how these provisions apply to you.

Section 4.4 Claims Administration

CLAIMS FOR MEDICAL BENEFIT DRUGS

Noted *that for office administered medications, drug claims must include the HCPCS code, National Drug Code and service units.*

PERFORMANCE – REGULAR AND COMPLETE SUBMISSION OF ENCOUNTER DATA

Complete Submission

Added *language regarding cost sharing:*

If cost share information applies to a record, please submit the information. If cost share information is not available, do not submit the information. Refer to the EDI Companion Guides on Provider Connection at blueshieldca.com/provider for additional details.

Section 4.5 Provider Appeals and Dispute Resolution

PROVIDER APPEALS OF MEDICARE ADVANTAGE CLAIMS

This section has been ***deleted and replaced*** *with the following language:*

Non-Contracted

CMS requires Medicare Advantage Organizations (MAO) to apply the provider dispute resolution process for payment disputes between non-contracted and deemed providers. Non-contracted and deemed providers are defined as follows:

- A non-contracted provider is one that was not aware the patient was a private fee-for-service member at the time of service, e.g., an emergency situation.
- A deemed provider is one who was aware that the patient was a private fee-for-service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment.

  Note: The provider dispute resolution process for payment disputes between non-contracted and deemed providers does not include Part D claim (Prescription Drug Plans).

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO and/or delegated entity) for a covered service is less than the amount that would have been paid under original Medicare. The disputes may also include instances where there is a disagreement between a non-contracted/deemed provider and the organization about the plan and/or delegated entity's decision to pay for a different service than that billed. An example would include downcoding.

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan and/or delegated entity. All Medicare and CMC non-contracted zero payment provider appeals must be submitted with a Waiver of Liability (WOL). If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is submitted after 3 attempts and before the 60th calendar day, the Plan may dismiss the provider appeal.

If the required information to process the dispute has not been submitted, Blue Shield will send a letter to the provider requesting the necessary documentation. If the additional documentation is not received within 60 calendar days from the date of request, Blue Shield will conduct a review based on what is available.

Blue Shield will resolve the dispute within 60 calendar days of the receipt of the dispute. In the event that the additional payment is warranted in favor of the provider and was due to an error by Blue Shield, interest will be included along with the additional payment.

Non-Contracted *(cont'd.)*

After the MAO Plan and/or delegated entity makes its Payment Review Determination (PRD) decision, if a deemed or non-contracted provider or supplier still disagrees with the pricing decision of a MAO Plan and/or delegated entity, non-contracted Medicare/CMC $0 true denials are sent to Maximus. For any case that is dismissed, the provider has a right to go to Maximus within 60 calendar days of the dismissal. For non-contracted Medicare/CMC underpayments, provider can contact 1-800-Medicare. All Medicare non-contracted zero payment denials are auto forwarded to the IRE.

To appeal the provider organization and/or delegated entity's decision upholding initial payment, the provider must submit a written request to:

Blue Shield of California
Medicare Provider Appeals Department
P.O. Box 272640
Chico, CA 95927

Section 5.1 Utilization Management

DELEGATION

Added *the following language:*

In making utilization management decisions, the IPA/medical group will first adhere to all regulatory guidelines, apply Medicare guidelines where applicable, and then utilize Blue Shield Medical / Medication policies, but where none exist, utilize the nationally recognized criteria adopted by Blue Shield.

DELEGATION OF UTILIZATION MANAGEMENT (UM)

Added *the following activities that may be monitored and reviewed for the delegated entity:*

- Assess member/provider satisfaction with the UM process
- UM System Controls review
- Authorization timeframe compliance for medical necessity, pharmacy and behavioral health

UM CRITERIA AND GUIDELINES

This section has been ***deleted and replaced*** *with the following language:*

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. IPA/medical groups may use their designated evidence-based criteria for UM decisions where Blue Shield Medical & Medication Policies do not apply, and these criteria have been reviewed and approved by the IPA/medical group's UM Committee. For Blue Shield Medicare HMO and PPO Members, Blue Shield follows Medicare national and local coverage guidelines. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications. UM decision-making is based only on the appropriateness of care and service and existence of coverage. All delegated groups must follow the Blue Shield policy which does not reward practitioners or other individuals for issuing denials of coverage or care. There must be no use of financial incentives to encourage decisions that result in underutilization. All decisions to deny, delay, or modify health care services must identify the criteria or guideline in the denial notification and explain why the service is denied in relation to these criteria. IPA/medical groups must make specific guidelines available to the member or provider upon request.

UM CRITERIA AND GUIDELINES *(cont'd.)*

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria. (The specific hierarchy can be found on page 24 of the Utilization Management Program Description.) These criteria consist of internal medical policies established by the Blue Shield Medical Policy Committee, nationally recognized evidence-based criteria (currently MCG Care Guidelines) for medical and mental health conditions as well as for substance use disorders, 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). Where applicable criteria established by the Center for Medicare & Medicaid Services (CMS), and DME coverage criteria are utilized. IPA/medical groups are required to ensure that they are using the most current version of the policies and maintain updating their UM review processes. These policies may be found on blueshieldca.com/provider and may be updated quarterly as needed.

DEFINITION OF MEDICAL NECESSITY

*This section has been **deleted and replaced** with the following language:*

Benefits are provided only for services which are medically necessary.

Services that are medically necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:

- consistent with Blue Shield Medical Policy;
- consistent with the symptoms or diagnosis;
- not furnished primarily for the convenience of the patient, the attending physician, or other provider; and
- furnished at the most appropriate level which can be provided safely and effectively to the patient; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.
- Hospital inpatient services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, an outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services which are not medically necessary include hospitalization.
- diagnostic studies that can be provided on an outpatient basis;
- medical observation or evaluation;
- personal comfort;
- Pain management that can be provided on an outpatient basis; and inpatient rehabilitation that can be provided on an Outpatient basis.

Blue Shield reserves the right to review all services to determine whether they are medically necessary, and may use the services of physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

MENTAL HEALTH – PSYCHIATRIC CARE

*This section has been **deleted and replaced** with the following language:*

The diagnosis and medically necessary treatment of mental health disorders listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* are covered benefits for all Blue Shield plans. Blue Shield's mental health service administrator (MHSA) for commercial HMO members is Human Affairs International of California (HAI-CA). For more detailed information about the services covered by the Blue Shield MHSA and the protocols developed to promote the integration of medical and behavioral health treatment, refer to the *Medical Interface Manual* on Provider Connection at blueshieldca.com/provider under *Guidelines & resources* and *Provider manuals.*

Members must utilize the Blue Shield MHSA provider network to access psychiatric covered services. The MHSA participating provider must obtain prior authorization from the MHSA for all non-emergency mental health and substance use disorder inpatient admissions including residential care, and other outpatient mental health and substance use disorder services.

Commercial HMO members should use the Member Self-Referral phone number to contact Blue Shield's MHSA to access behavioral health care.

ORGAN AND BONE MARROW TRANSPLANTS

Added CAR-T Therapy *to list of transplants requiring prior authorization.*

OTHER ALTERNATE CARE PROVIDERS (OXYGEN)

Noted *that Professional services associated with administration of oxygen in the home are covered under the Home Health Care benefit.*

REHABILITATION SERVICES

Added *detailed definitions of rehabilitation and habilitation therapies.*

Section 5.2 Quality Management Programs

QUALITY MANAGEMENT AND IMPROVEMENT

Accreditation

Added Medicaid *to list of product types that Blue Shield takes through NCQA accreditation.*

Provider Responsibilities for Quality Management and Improvement

Added *the following to the quality improvement activities that Blue Shield seeks provider representatives' participation in:* Investigation of member grievances and quality of care concerns.

DELEGATION OF CREDENTIALING

*This section has been **deleted and replaced** with the following language:*

The decision to delegate any function is based upon the IPA/medical group's demonstrated ability to successfully perform specific functions (e.g., Utilization Management, Credentialing, and Recredentialing). Initially, a pre-contractual or pre-delegation audit is conducted to determine if the IPA/medical group has the ability to perform the delegated function to the standards and requirements of Blue Shield and of the various applicable regulatory and/or accreditation agencies. After initial delegation, Blue Shield conducts an annual evaluation and oversight of the IPA/medical group based on the 12-month (no greater than 14-month) requirement set forth by NCQA. Blue Shield's oversight process is conducted through annual evaluation audits for each of the various delegated functions as well as semi-annual reports. The outcome of the evaluation determines if the delegation status will be continued as contracted or if a change in delegation status is indicated, up to, and including, revocation of delegation. Blue Shield may require more frequent or targeted audits or require a Corrective Action Plan in an effort to address any identified issues or deficiencies to avoid revocation of delegation. The delegation of this function will be granted only to those IPAs/medical groups that meet the standards outlined in the Blue Shield Credentialing/ Recredentialing Delegation Standards (see Appendix 5-B in the back of this manual).

Credentialing Oversight

*This section has been **deleted and replaced** with the following language:*

Blue Shield will evaluate the IPA/medical group's credentialing program annually, per contractual line of business, based on the 12-month (no greater than 14-month) evaluation requirement set forth by the NCQA. The IPA/medical groups are expected to maintain their policies, procedures, programs and keep their processes up to date with the most current NCQA, DMHC, CMS, CDI state and federal regulatory standards and Blue Shield requirements. IPA/medical groups that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/ providers and non-physician practitioners/providers in accordance with the Blue Shield policies and procedures, NCQA, DMHC, CDI, CMS guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

Blue Shield retains ultimate responsibility and authority for all credentialing activities. Blue Shield will assess and monitor the IPA/medical group's delegated credentialing activities as follows:

1. The Credentialing Delegation Oversight Auditor will conduct pre-delegation and annual audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the IPA/medical group's policies and procedures, Credentialing Committee minutes, ongoing monitoring, organizational provider credentialing, sub-delegation oversight activities, quarterly reports and the IPA/medical group's credentials files, as applicable. The Industry Collaborative Effort (ICE) standardized audit tool will be used to conduct an audit. The IPA/medical group will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, and board certification name and expiration date, at least two (2) weeks prior to the scheduled audit date.

Credentialing Oversight *(cont'd.)*

2. Blue Shield will use one of the following techniques for the file review:
   a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the IPA/medical group. The Blue Shield auditor will audit the files in the order indicated on the file pull list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files.
   b. The NCQA's 5 percent or 50 file review methodology of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
3. After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review and performance monitoring review (work history and education/training are not applicable at recredentialing).
4. IPA/medical group will be required to sign and abide by the credentialing delegation agreement.
5. Results of the credentialing review of the Group's program will be forwarded to the Delegated Oversight Committee for action and approval in accordance with Health Plan policy.
6. To be delegated and to continue delegation for credentialing, IPA/medical group must meet the minimum standards by scoring at least 95%. If the IPA/medical group scored below 95%, a Corrective Action Plan (CAP) is required. IPA/medical group must submit all deficiencies to Blue Shield Credentialing Delegation Oversight Department within 30 days of receipt of notification. After reviewing the CAP, the IPA/medical group will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.
7. The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements.
8. Failure to fulfill compliance with delegation standards or to meet expected business outcomes may result in full or partial de-delegation by Blue Shield. Corrective action will be required and may involve additional oversight or co-management of certain functions.
9. Delegated credentialing status may be terminated by Blue Shield at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
10. Plan may terminate this Agreement in the event that Medical Group fails to perform Delegated Activities in accordance with Plan's standards as described in this Agreement. Plan will work with Medical Group to correct the deficiencies. However, if the problem cannot be corrected, then Plan may revoke the delegation status.

Credentialing Oversight *(cont'd.)*

Required Submissions/Notifications of Credentialing Program Activity

Added *Credentialing reporting timelines, as follows:*

Reports may be submitted quarterly to align with other regulatory requirements such as DHCS. Reports are due on the following dates:

- 1st Semi-Annual due August 15th (January 1st – June 30th)
- 1st Quarter due May 15th (January 1st – March 30th)
- 2nd Quarter due August 15th (April 1st – June 30th)
- 2nd Semi-Annual due February 15th (July 1st – December 31st)
- 3rd Quarter due November 15th (July 1st – September 30th)
- 4th Quarter due February 15th (October 1st - December 31st)

SERVICE ACCESSIBILITY STANDARDS

Access standards for the following topics have been ***deleted and replaced*** *with the grids below:*

CATEGORY	ACCESS STANDARDS
Routine office visit (including non-physician providers)	Within 10 business days
Urgent Care	Within 48 hours
Care for an Emergent Non-Life-Threatening Situation	Within 6 hours
Follow-Up Routine Care (including a non-physician mental health care provider)	Within 30 Calendar Days Follow-up routine care appointments are visits at later, specified dates to evaluate the patient progress and other changes that have taken place since a previous visit.

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access related member complaints and grievances	HMO/POS PPO	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	14%	Assessed Quarterly against Standard
PCP, Specialist and Hospital Network Change Analysis	IFP ePPO	10% (change)	Assessed Quarterly against Standard

PCP to Member Ratio	IFP ePPO	1:2000	Quarterly
Top HVS Turnover	HMO/PPO/ CDI/ SHOP HMO/PPO	10%	Assessed Quarterly against Standard
Hospital Turnover	HMO/PPO	5%	Ad hoc for Block Transfer Filings and 10% Change Analysis
Open PCP Panel	HMO/POS Directly Contracted HMO	85%	Assessed Quarterly against Standard
Member Satisfaction	HMO/POS PPO	HMO – Patient Assessment Survey at IPA/MG level HMO/PPO – CAHPS at Health Plan level	Annual

Section 6.1 Blue Shield Medicare Advantage Plan Program Overview

BLUE SHIELD MEDICARE ADVANTAGE PLAN SERVICE AREAS

Added *Medicare Advantage Plan Service Areas in boldface and strikethrough type as follows:*

Individual Blue Shield Medicare Advantage Plan Service Area

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

Section 6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

NON-FORMULARY OUTPATIENT PRESCRIPTION DRUGS

Transition Policy

Added *the following language:*

To request a Formulary Exception (a type of Coverage Determination), Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above via a prior authorization request.

Vision Services

Updated *provider who delivers vision services for individual plans to VSP Vision Care.*

NATIONAL MEDICARE DETERMINATIONS

Added *the following language:*

For Blue Shield Medicare Advantage HMO and PPO Members, Blue Shield follows Medicare national and local coverage determination. For Blue Shield Medicare Advantage PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

EXCLUSIONS TO BLUE SHIELD MEDICARE ADVANTAGE PLAN BENEFITS

Updated *the following plan exclusion in boldface type below:*

- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community. ***Note: This determination is to be based on current National (NCD) or Local Coverage Determinations (LCD). National guidelines from a recognized specialty society or governmental body or health plan policy can be applied if the member's individual circumstances are supported by literature referenced in the guidelines or policy. National guidelines from a recognized specialty society or governmental body or health plan policy are appropriately used to support a medically appropriate decision if the member's individual circumstances are consistent with the literature cited in the guidelines or policy***.

- Routine acupuncture, **except for chronic low back pain**, unless specifically indicated as covered by the Blue Shield Medicare Advantage plan in which the member is enrolled.

Prescription Drug Benefit Exclusions

Updated *the following plan exclusion in strike through and boldface type below:*

- ~~Drugs when used to promote fertility~~ **Drugs related to assisted reproductive technology (ART)**
- Drugs that are prescribed for medically-accepted indications **approved by the FDA** other than sexual or erectile dysfunction (such as pulmonary hypertension) are eligible for Part D coverage. **However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, and DRUGDEX® Information System.**

Section 6.5 Blue Shield Medicare Advantage Plan Benefits and Exclusions

MEDICAL CARE SOLUTIONS GUIDELINES

Second Opinions

*This section has been **deleted and replaced** with the following language:*

In keeping with current legislation, second opinion consultations must be provided when requested by a Blue Shield Medicare Advantage plan member or the participating healthcare provider who is treating the member.

According to Blue Shield Medicare Advantage plan policy, a second opinion for surgery or major procedures (see below) requested by a member is to be provided by an appropriately qualified healthcare professional from within the member's assigned IPA/medical group. Second opinions are only for recommendations about the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy). Payment for the second opinion consultation is drawn from the capitation amount paid to the IPA/medical group for that member. If the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered.

IPA/MEDICAL GROUP RESPONSIBILITIES

***Updated** chart detailing reporting requirement timeframes.*

End Stage Renal Disease (ESRD)

***Updated** eligibility requirements, as follows:*

Beginning January 1, 2021, patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, or who have ongoing dialysis, are eligible to join the Blue Shield Medicare Advantage plan.

Appendices

APPENDIX 4-A CLAIMS COMPLIANCE AND MONITORING

*Renamed to Appendix 4-A Claims, Compliance Program, IT System Security and Oversight Monitoring. **Updated** to align with current CMS, DMHC, DOI and Blue Shield policies and procedures for Delegated Entity claims, Compliance Program, IT system security and other regulatory oversight monitoring policies.*

Key Terms and Definitions

***Added** the following definition:*

Delegated Entity

Any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

APPENDIX 4-A CLAIMS COMPLIANCE AND MONITORING *(cont'd.)*

Principal Officer

Updated *instructions on where to send the Principal Officer Form. It should be submitted by email to ClaimsDelegateReport@blueshieldca.com.*

Measuring Timeliness and Accuracy

Fee Schedule Accuracy (Commercial)

This section has been ***deleted and replaced*** *with the following language:*

Contracted providers must be paid accurately at contracted rates. During a claims delegation audit this is demonstrated by the Delegated Entity providing the header page and the signature page of the provider contract with the fee schedule and evidence of the system configuration.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule that requires the Delegated Entity as mandated by Title 28 CCR 1300.71(a)(3):

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below; the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration; (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's *Evidence of Coverage.*

Best Practices and Claims Adjudication

Compliance Program/Fraud, Waste, and Abuse

Added *the following language:*

Blue Shield will perform review of Delegated Entity's Compliance Program including assessment of the compliance material (program, P&Ps, etc.), training of staff, performance of internal control audits, etc. This oversight is performed either via shared audit through ICE or individually on an annual basis.

Offshore Monitoring

Added *the following language:*

If the commercial line of business is offshored, approval is required from Blue Shield prior to offshoring any Blue Shield commercial delegated claims.

APPENDIX 4-A CLAIMS COMPLIANCE AND MONITORING *(cont'd.)*

Claims Reports (Commercial)

*This section has been **deleted and replaced** with the following language:*

The monthly claims timeliness report is due to Blue Shield on or before the 15th calendar day of the month following the month being reported. The quarterly report including the first two months of the quarter is due by the end of the first calendar month following the calendar quarter end. These include claims processed during the calendar quarter being reported regardless of date of service. This report must be signed by a Principal Officer.

The reports are a validation of compliance for the Delegated Entity. The Delegated Entity should retain supporting documentation for each self-report as consistent with records retention time limitations. Copies of the supporting documentation may be requested and retained by Blue Shield for any non-compliant Delegated Entity. A corrective action plan is required for each non-compliant monthly claims timeliness report submitted. Additionally, a completed Emerging Pattern of Deficiency document signed by a Principal Officer is also required to be submitted.

Sub-Delegated Claims Monitoring

*This section has been **deleted and replaced** with the following language:*

When the Delegated Entity engages a third-party administrator (TPA) or contracts with a management company to perform their claims processing, the Delegated Entity's contract with Blue Shield holds them ultimately responsible for claims compliance. Guidelines for sub-capitated and sub-delegated functions are interchangeable within this section.

The Delegated Entity is expected to require the sub-delegated claims organizations to meet all regulatory requirements and criteria discussed in this supplement. The Delegated Entity must perform the same tasks, e.g., delegation oversight of claims processing, that Blue Shield carries out as the health plan, including obtaining timely monthly reporting from them and including their statistics in the Delegated Entities reports to Blue Shield. The Delegated Entity must audit the sub-delegated organization annually/periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-delegated organization fails to achieve compliance, the Delegated Entity needs to take the appropriate actions to achieve compliance. During the on-site audit, if the Delegated Entity sub-delegates claims functions they will need to demonstrate and provide evidence of their oversight of that entity. If the Delegated Entity outsources claims functions, it will also need to be included how that is being monitored.

The Delegated Entity must include claims-related regulatory and contractual provisions in contract agreements with other provider organizations.

***Added** the following new subsections:*

IT System Security

An IT system integrity audit will be conducted to assure system access controls, policy and procedures regarding system changes, security of data, etc. are maintained. The oversight is also performed either via shared audit through ICE or individually on a bi-annual basis with quarterly monitoring.

APPENDIX 4-A CLAIMS COMPLIANCE AND MONITORING *(cont'd.)*

Oversight Monitoring

Delegated Entity 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 ensure that the program is independent of fiscal and administrative management
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements; and
- Group shall ensure that any and all changes made to data contained in entities' databases are logged and audited.

APPENDIX 4-B QUALIFYING MEDICAL BENEFIT DRUG CLAIMS SUBMISSION INSTRUCTIONS

Deleted *sample spreadsheet format.*

APPENDIX 4-C ACTUARIAL COST MODEL

Updated *the model with 2021 data.*

APPENDIX 5-A UTILIZATION MANAGEMENT DELEGATION STANDARDS

Entities' Timely Submission of Corrective Action Plans

This section has been ***deleted and replaced*** *with the following language:*

Blue Shield's approach to delegated entities' correction of deficiencies is based on a commitment to continuous quality improvement (CQI) and is educational and consultative in nature in an effort to promote collaboration and mutual success.

Upon identification of deficiencies, Blue Shield will outline the deficiencies in writing and send a "Audit results letter follow up needed" letter to the IPA/medical group. The entities are required to submit a written and signed Corrective Action Plan (CAP) for approval within **30** calendar days. The submitted CAP will include supporting documentation to demonstrate that measurable actions are taken to remediate identified deficiencies and identify key staff responsible for the implementation and information will be tracked by Blue Shield. In the event a CAP is issued for a file review, the group will need submit evidence of training to all UM staff within **30** days of the initial CAP notification.

Blue Shield will review the implementation of the CAP to ensure correction of the deficiencies within **10** calendar days or an agreed timeframe from the date of receipt of the CAP response. If the CAP is in compliance with the Blue Shield requirements, a letter will be sent to the group confirming receipt and approval. If the CAP is not in compliance with Blue Shield requirements, a follow-up letter will be sent outlining the areas of deficiency and further requirements for compliance. Failure to correct deficiencies within stated timeframes will lead to further action, including additional audits or monitoring and revocation of specific delegated functions. Revocation of specific delegated functions may be required until the entity can demonstrate the ability to perform the function in compliance with Blue Shield standards.

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

UM Decision Timeliness Standards - CMS

Added *the following requests/timeframes to the grid:*

Type of Request	Decision	Notification Timeframes
Standard Part B Drug Requests	Within 72 hours after receipt of request (includes weekends & holidays). No extension	Within 72 hours after receipt of request (includes weekends & holidays). No extension
Expedited Part B Drug Requests	Within 24 hours after receipt of request. No extension	Within 24 hours after receipt of request. No extension

Service Denial Letter Format Components

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

- The specific reasons for the denial, in easily understandable language.
- A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
- An explanation of the appeal process, including members' rights to representation and appeal time frames.
- Right to request an external review from the DMHC. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.

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

Added *the following that entities must provider evidence for:*

- Annually audits UM denials files against NCQA standards

Clinical Data Collection and Analysis Standards

This section has been ***deleted and replaced*** *with the following language:*

The entities must collect data for tracking, trending and educating the providers in the network and submit on their bi-annual report. Evidence to include health plan specific reports (12 months) containing supporting data that includes rate adherence to time frames for each category of request (e.g., urgent concurrent, urgent preservice, nonurgent preservice and post service.) If the organization is delegated for various line of business, then reports should be generated to reflect those differences. Some areas of review include:

- Inpatient Metrics ER Metrics
- Under- and over-utilization
- Referral Metrics
- UM TAT Metrics (Turn-around time decision, notification and percent compliant for UM, BH and Pharmacy)
- Experience with the UM Process (Member and Provider)

The entities must also document actions taken as a result of clinical data analysis, such as evidence of feedback to individual physicians/practitioners and use of data analysis in improvement of performance.

APPENDIX 5-B CREDENTIALING/RECREDENTIALING STANDARDS

Updated *to align with current Blue Shield policies and procedures, delegation agreements, as well as the delegation oversight process.*