Cal MediConnect Provider Manual

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WELCOME

Thank you for being a Blue Shield of California Promise Health Plan (Blue Shield Promise) provider. As a provider you play a very important role in the delivery of health care services to our members.

The *Blue Shield Promise Health Plan Cal MediConnect Provider Manual* is intended to be used as a guideline for the provision of covered services to Blue Shield Promise Cal MediConnect beneficiaries.

This manual contains policies, procedures, and general reference information, including minimum standards of care that are required of Blue Shield Promise providers. This manual also contains a brief history of the company as well as an overview of the Cal MediConnect Program, which is one of our products.

We hope this information will help you better understand our operations. This manual is applicable to the Blue Shield Promise Cal MediConnect line of business only. Should you or your staff have any questions about the information contained in this manual or anything else pertaining to Blue Shield Promise, please contact our Provider Customer Service Department at (800) 468-9935.

We work closely with our contracted Primary Care Physicians (PCPs), Specialists, and other providers to ensure that our members receive medically necessary and clinically appropriate covered services. We are a managed care delivery system in which the PCPs serve as a "gatekeeper" for member care. PCPs are responsible for coordinating and overseeing the delivery of services to members on their patient panel. We look forward to working with you and your staff to provide quality health care services to Blue Shield Promise Health Plan members.

MISSION

Blue Shield Promise Health Plan's mission is to ensure that all Californians have access to high-quality health care at an affordable price.

BLUE SHIELD PROMISE CAL MEDICONNECT OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) have partnered to enroll beneficiaries who are covered by both Medicare and Medi-Cal (dual eligible) into managed care health plans that combine the two sets of benefits into one product. This integrated care delivery program is known as the Cal MediConnect Plan (Medicare-Medicaid Plan).

Blue Shield of California Promise Health Plan is contracted with CMS and DHCS to participate in Cal MediConnect in Los Angeles and San Diego counties.

The goals of Blue Shield Promise's Cal MediConnect Plan are to improve the quality of care dually eligible managed care members receive by providing access to seamless, integrated care, and to increase the availability and access to home- and community-based services and behavioral health so members have better health outcomes and remain in their homes and communities as long as possible.

Blue Shield Promise's Cal MediConnect Plan aims to promote better care and improve alignment and coordination of Medicare and Medi-Cal benefits for dually eligible members.

SECTION 1: PROVIDER SERVICES

The Provider Services Department is dedicated to educating, training, and ensuring all participating providers have a resource to voice any concern they may have.

The Provider Services staff acts as a liaison between Blue Shield Promise departments and the external provider network to promote positive communication, facilitate the exchange of information, and seek efficient resolution of provider issues. Your Provider Relations Representative is your key contact and source of information. Please send all inquiries to your assigned Provider Relations Representative. If you are not sure who your Provider Network Representative is and/or need to contact Blue Shield Promise for any additional reason, please email ProviderRelations@blueshieldca.com or call (800) 468-9935.

The following resources are available to you and your staff:

- Provider Relations Representative
- Provider In-Service
- Provider Manual
- Provider Bulletins
- Provider Communication
- Joint Operation Committee (IPA/Medical Groups and Hospitals only)

We encourage providers to make recommendations and suggestions that will better allow us to serve our Members and to improve the processes within our organization through open discussions and meetings.

1.1: Provider Manual Distribution

Provider Manuals are distributed to all new IPA/medical groups and hospitals during Joint Operation Committee Meetings and to Blue Shield Promise directly contracted providers within ten (10) business days of placing the Provider on active status. Blue Shield Promise will maintain documented receipt of all Provider Manuals distributed. Provider Manuals are updated annually and/or as required. Updates to the provider manual are made available on the Blue Shield Promise provider website at blueshieldca.com/promise/provider under *Provider Manuals* or print upon request.

1.2: Provider Orientations

Orientations are conducted by the Provider Services staff to educate new IPA/medical groups, hospitals, ancillary providers, and Blue Shield Promise directly contracted providers on Plan operations, policies, and procedures within ten (10) business days of placing the Provider on active status.

IPA/Medical Group Responsibilities

Blue Shield Promise's contracted IPA/medical groups are responsible for conducting provider training and orientation for its contracted providers within ten (10) business days of placing the Provider on active status regardless of their effective status with Blue Shield Promise. IPA/medical groups are required to provide evidence of 10-day training as requested by Blue Shield Promise.

1.3: Joint Operation Committee Meetings (IPA/Medical Groups and Hospitals Only)

Joint Operation Committee (JOC) meetings are conducted by the Provider Relations Representative at least annually or as needed to allow monitoring and oversight of delegated responsibilities, ensure effective problem resolution, and maintain ongoing communication between Blue Shield Promise and its contracted IPA/medical groups and hospitals. Blue Shield Promise will maintain documentation of attendees and issues discussed.

1.4: Provider Network Additions (IPA/Medical Groups)

Blue Shield Promise maintains the following per submission and notification by contracted IPA/medical groups:

- Primary Care Physicians
- Specialty Care Physicians
- Hospitals
- Urgent Care Centers

The addition of an IPA/medical group provider requires submission of a provider profile to the Blue Shield Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

See Section 2: Credentialing for credentialing guidelines.

1.5: Provider Network Changes

Provider network changes include terminations, leave of absences/vacation, enrollment status/restrictions, and changes in IPA/medical group affiliation.

All provider changes require a minimum of 90-day advance written notification. **Providers affiliated with Blue Shield Promise through the Plan or an IPA/medical group must send notification to the Plan or IPA/medical group in accordance with their contractual agreement.** Notification of changes should be directed to the Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

1.5.1: PCP Terminations

IPA/medical groups shall send written notification of all provider terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the IPA/medical group is notified and at a minimum of 90 days in advance. Blue Shield Promise cannot guarantee that Members will remain with the same PCP/IPA/medical group due to Member choice.

In all Member notifications, the Members are given an option to select a new different PCP and/or IPA/medical group. Thus, Blue Shield Promise does not guarantee the assignment to remain with their current PCP/IPA/medical group.

Blue Shield Promise retains the right to obligate the PCP/IPA/medical group to provide medical services for existing Members until the effective date of member transfer.

IPA/Medical Groups

1. If the terminating PCP practices in a Federally Qualified Health Center (FQHC), clinic, or staff model, the Members will remain with the FQHC, clinic, or staff model and will remain with the group.
2. If the terminating PCP is a solo practitioner provider and is currently affiliated with more than one IPA/medical group, the Members will be transferred to follow PCP with the IPA/medical group that will cause least disruption to a) a hospital and/or b) a specialist panel.
3. If the PCP is administratively terminated by Blue Shield Promise and/or IPA/medical group for reasons such as, but not limited to suspension of license, malpractice insurance, or Facility Site Review, the Members will remain within the IPA/medical group.
4. If the IPA/medical group wants members reassigned to specific primary care physicians, the IPA/medical group must provide that information to Blue Shield Promise at the time of the notification of PCP termination. Blue Shield Promise will strive to accommodate such requests subject to the member's right to make a final PCP selection.

1.5.2: Specialist/Specialty Group Termination Notification Requirements

Blue Shield Promise recognizes the importance of timely member notification prior to the termination of a regularly seen specialist or specialty group. The IPA/medical groups and/or Blue Shield Promise directly contracted providers shall send written notification for all provider withdrawals and terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the Group is notified and at a minimum of 60 days in advance. In accordance with the Department of Health Care Services (DHCS), Blue Shield Promise members are required to receive at least 30 days' prior notice of an upcoming physician termination, including specialist or specialty group termination. Because Blue Shield Promise does not assign members to specialist physicians/specialty groups, but rather relies on the provider to coordinate the member's specialty care arrangements, the responsibility to notify the member of

upcoming specialist terminations rests with the provider.

The specifics of the requirements are as follows:

1. All Blue Shield Promise contracting providers must notify members seen regularly by a specialist or specialty group whose contract is terminated at least 30 days prior to the effective termination date. The letter to the member must include notification of the specialist or specialty group's termination, the effective date of termination, and the procedures for selecting or assigning another specialist or specialty group.

2. Contracting providers must have policies that define members seen regularly by a specialist or specialty group and which outline the provider's implementation plan for notifying members of the specialist/specialty group termination, as well as the procedures they may follow to select another specialist. Ways to identify affected members may include but are not limited to:

    - Number of visits within a specified time period such as two or more cardiac follow-up visits within one-year.
    - Repeated referrals for the same type of care over a specified time period such as four referrals for the treatment of diabetes over a two-year period.
    - Receipt of periodic preventive care by the same specialist or specialty group such as a woman receiving an annual well woman exam by the same OB-GYN.

3. If the provider does not provide Blue Shield Promise affected members with 30 days' advance written notice, the provider is responsible for ensuring the specialist and/or specialty group continues to provide medical services to affected members until a 30-day advance notice of the termination is given.

1.5.3: Blue Shield Promise Oversight

Blue Shield Promise provides appropriate oversight of each of its contracting providers, including, but not limited to:

- Specialist/Specialty Group Termination Policy and procedures as outlined above;
- Review of member notification letter regarding specialist/specialty group terminations.

As such, Blue Shield Promise's Delegation Oversight Consultant will review each provider's policy and procedure and member notification letters during its annual delegation audit process.

The specialist termination notification policy and procedure will outline how your organization will:

1. Identify "affected members" regularly seen by a specialist or specialty group;
2. Inform affected members of the specialist/specialty group termination; and
3. Assign or direct affected members to select another specialist or specialty group.

In addition, the provider is required to maintain copies of all notification correspondence between the provider and affected members.

1.5.4: Office Relocation

IPA/medical groups shall send written notification 60 days in advance for all office relocations to BSCProviderInfo@blueshieldca.com. The PCP/IPA/medical group is responsible for submitting a coverage plan to Blue Shield Promise, if necessary.

The provider's address will be updated, and Members will be transferred from the existing site to the new site. If the PCP moves outside of the former office's geographic area, Blue Shield Promise will coordinate with the IPA/medical group to reassign the Members to a new PCP within Blue Shield Promise's access standard of five (5) miles and not to exceed ten (10) miles. In transferring Members, the provider's location, specialty, and language are taken into consideration. If the IPA/medical group is unable to meet this requirement, Members will be transferred to a provider in the geographic area of the former office location.

1.5.5: Provider Leave of Absence or Vacation

PCPs/IPA/medical groups must provide adequate coverage for providers on leave of absence or on vacation. PCPs/IPA/medical groups must submit a coverage plan to their appointed Blue Shield Promise Provider Relations Representative for any absences greater than four (4) weeks. Absences over 90 days will require transfer of Members to another Blue Shield Promise PCP.

1.5.6: Change in a Provider's IPA/Medical Group Affiliation

PCPs may change their Blue Shield Promise IPA/medical group affiliation by submitting written notification of their change request in accordance with their contractual agreement and with contract regulators. Blue Shield Promise will process the request in accordance with the member notification policy. Written notification must be submitted to:

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

1.5.7: Change in a Provider's Panel Status

The IPA/medical group shall notify the Plan within five (5) business days of:

- Any Provider who is no longer accepting new patients
- Any Provider who was previously not accepting new patients and is now open to new patients
- A Provider who is now available by referral only
- A Provider who is available only through a hospital or facility

An IPA/medical group Plan Physician who is not accepting new patients and is contacted by Plan Member or potential member seeking to be assigned shall direct the Plan Member or potential member to Plan to find an IPA/medical group Plan Physician who is accepting new patients and to the Department of Managed Health Care (DMHC) to report any inaccuracy with Plan's provider directory.

1.5.8: Reporting Provider Inaccuracies

Providers can review their information on the Blue Shield Promise website and submit changes to the information listed in the directories through the following:

- Submit provider demographic changes on Blue Shield's provider portal, Provider Connection at blueshieldca.com/provider
- Email BSCProviderInfo@blueshieldca.com
- Complete an Online Interface Form

When a report indicating that information listed in the provider directory is inaccurate, Provider Information & Enrollment will verify the reported inaccuracy and, no later than thirty (30) business days following receipt of the report, either verify the accuracy of the information or update the information in the provider directory.

When verifying a provider directory inaccuracy, Blue Shield Promise shall, at a minimum:

1. Contact the affected provider no later than five (5) business days following receipt of the report; and
2. Document the receipt and outcome of each report.

Documentation shall include the provider's name, location, and a description of the

Blue Shield Promise validation, the outcome, and any changes or updates made to the provider directory.

Blue Shield Promise will terminate a provider upon confirming:

1. Provider has retired or otherwise has ceased to practice;
2. A provider or provider group is no longer under contract with the plan for any reason;
3. The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

1.5.9: Online Interface Form

The Online Interface Form is an electronic web form that contains the required provider directory information Blue Shield Promise has on file for the provider. Providers can notify Blue Shield Promise of changes to their demographic data by completing the Online Interface Form and/or providing an affirmative response to Blue Shield Promise's Outreach Program, through the online interface. The Online Interface Form is available to the following provider types:

1. Practitioners (i.e., physicians and other health professionals such as PT, OT, podiatrist
2. IPA/medical groups
3. Hospitals and Ancillary providers

A system generated acknowledgment is automatically sent upon submission of an Online Interface Form.

1.6: Provider Verification Requirements

Blue Shield Promise shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the directories and shall review and update the entire provider directories for line of business. Blue Shield Promise will conduct outreaches to all providers, with a request to validate the accuracy of their demographic data. In order to reduce administrative burden on providers, Blue Shield Promise delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield Promise, the provider must work with the vendor in lieu of Blue Shield Promise 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.

1. Quarterly Network Validation
   Blue Shield Promise validates the IPA/medical groups provider network quarterly through established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels, etc.

2. Bi-annual Network Validation
   Blue Shield Promise direct contract providers validate their data bi-annually.

Providers are asked to validate the information and report any changes to their record(s) such as provider terminations, name changes, address changes, open/closed panel, etc.

3. Annual Validation
   Hospitals and facilities are validated on an annual basis through established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, etc.

Notification

The notification will include:

1. The information Blue Shield Promise has in its provider directories regarding the provider including a list of network and/or lines of business that the provider participates in.
2. Instructions on how the provider can update the information including the option to use an online interface for providers to submit verification or changes electronically and which shall generate an acknowledgement of receipt from Blue Shield Promise.

A statement requiring an affirmative response from the provider acknowledging that the notification was received and requiring the provider to confirm that the information in the provider directories is current and accurate or to provide an update to the information required to be in the provider directories including whether or not the provider is accepting new patients or not accepting new patients for each applicable Blue Shield Promise Health Plan network and/or line of business.

1.7: IPA/Medical Group Specialty Network Oversight

See Section 7.5 Access to Care.

1.8: Changes in Management Service Organizations (IPA/Medical Groups Only)

IPA/medical groups must provide a 90-day advance written notification of a change in management service organization (MSO) along with a copy of the executed contract between the IPA/medical group and the new MSO to Blue Shield Promise's Provider Services Department.

The new MSO must meet Blue Shield Promise's pre-contractual criteria. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the IPA/medical group/MSO to comply will result in panel closure of all providers.

1.9: Provider Grievances

See Section 3.3.3: Provider Appeals under Member Appeals and Grievances.

1.10: Provider Directory

The Blue Shield Promise 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 IPA/medical group and/or Blue Shield Provider Information & Enrollment email address at BSCProviderInfo@blueshieldca.com. Providers may also review their information on the Blue Shield Promise website at www.blueshieldca.com/promise. Blue Shield Promise is committed to ensuring the integrity of the directory to the best of its ability dependent on notification by the group.

1.11: Prohibition of Billing Members

Each provider agrees that in no event including, but not limited to, nonpayment by the Plan, the Plan's insolvency or the Plan's breach of this agreement shall any Plan Member be liable for any sums owed by the Plan.

A provider or its agent, trustee, assignee, or any subcontractor rendering covered medical services to Plan Members may not bill, charge, collect a deposit or other sum; or seek compensation, remuneration or reimbursement from, or maintain any action at law or have any other recourse against, or make any surcharge upon, a Plan Member or other person acting on a Plan Member's behalf to collect sums owed by Plan.

Should Blue Shield Promise receive notice of any surcharge upon a Plan Member, the Plan shall take appropriate action including but not limited to terminating the provider agreement for cause. Blue Shield Promise will require that the provider give the Plan Member an immediate refund of such surcharge.

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SECTION 2: CREDENTIALING

The credentialing program applies to all directly contracted providers/practitioners and those who are affiliated with Blue Shield Promise through their relationship with a contracted IPA/medical group. Blue Shield Promise requires the credentialing of the following providers/practitioners:

- Physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), optometrists (OD), and non-physician medical practitioners (PA, NP CNS, and NMW) employed in these practitioners' offices and who see Blue Shield Promise members.
- Blue Shield Promise and its delegates may also credential other allied health professionals, such as psychologists (PhD, PsyD), autism specialists, audiologists (AU), registered dietitians and nutritionists (RD, RDN) and other practitioners authorized by law to deliver health care services and who are contracted by Blue Shield Promise on an independent basis.

Blue Shield Promise does not credential hospital-based practitioners (i.e., radiologists, anesthesiologists, pathologists, and emergency medicine physicians) who practice exclusively in an inpatient setting and provide care of Blue Shield Promise members because Blue Shield Promise members are directed to the hospital.

Objectives

1. To ensure that all practitioners, including both directly contracted and delegated, who are added to the network meet the minimum Blue Shield Promise requirements.
2. Blue Shield Promise practitioners are evaluated for, but not limited to, education, training, experience, claim history, sanction activity, and performance monitoring.
3. To ensure that network practitioners/providers maintain current and valid credentials.
4. To ensure that network practitioners are compliant with their respective state licensing agency and Medicare programs, Blue Shield Promise has a process to ensure that appropriate action is taken when sanction activity is identified.
5. To establish and maintain standards for credentialing and to identify opportunities for improving the quality of providers in the network.

2.1: Credentialing Policies and Procedures

Policies and procedures are reviewed annually and revised, as needed, to meet the NCQA, DHCS, DMHC, CMC, CMS, state, and federal regulatory agencies' requirements. Policies and procedures are reviewed by the Medical Director and submitted to the Credentials Committee and Compliance Committee for review and approval.

2.2: Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners contracted with Blue Shield Promise Health Plan. The Medical Director serves as chairman of the Credentials Committee, which is comprised of a multi- specialty panel of practitioners in the Blue Shield Promise Health Plan network, the credentialing manager, and a range of additional physicians, as needed, for their professional expertise. However, only physicians may have the right to vote in Credentialing Committee Meeting. A minimum of three voting Members is considered a quorum. The Credentials Committee will meet once a month but not less than quarterly. If there is a need, committee will conduct an ad-hoc meeting.

The responsibilities of the Credentials Committee include, but are not limited to:

- Review, recommend and approve/deny initial credentialing, recredentialing, ongoing monitoring activities and inactivation of directly contracted and delegated practitioners/providers for the Blue Shield Promise Health Plan network;
- Review and approve credentialing policies and procedures and ensure that they are in compliance;
- Review and recommend actions for all network practitioners identified with sanction activities from the state licensing agency, OIG, SAM, Medicare Opt-Out reports, Medi-Cal Suspended and Ineligible List and Preclusion List;
- Ensure appropriate authorities were reported when there is quality deficiency; and
- Ensure Fair Hearings are offered and carried out in accordance with the established policies and procedures.

2.3: Minimum Credentials Criteria

All practitioners will be credentialed and recredentialed in accordance with the approved policies established by Blue Shield Promise.

1. All applicants will meet the following minimum credentialing requirements and provide a comprehensive profile sheet to include:
    a. Name
    b. Professional Title
    c. Office Address
    d. Telephone and Fax Numbers
    e. Office Hours

f. Provider Type (PCP/Specialist)
g. Specialty with Board Certification Status or Complete Internship/Residency Training
h. Languages Spoken by Provider and staff; includes American Sign Language
i. Hold and maintain a current and unrestricted state medical or professional license
j. Hold a current and valid DEA certificate with California license, if applicable
k. Tax Identification Number
l. National Provider Identifier (NPI)
m. Maintain current and valid malpractice insurance in at least a minimum coverage of $1 million per occurrence and $3 million annual aggregate (Optometrists and audiologists are required to have minimum malpractice coverage of $1 million per occurrence and $2 million annual aggregate)
n. Maintain current hospital privileges in the requested specialty at a Blue Shield Promise Health Plan contracted hospital. This requirement may be waived only if the physician arranges for another Blue Shield Promise Health Plan practitioner to provide hospital coverage at a contracted hospital. This arrangement must be documented in writing by the covering physician and submitted to Blue Shield Promise. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, allergy & immunology, psychology, pathology, radiology, radiation oncology, dental surgery, physical therapy, audiology, chiropractic, acupuncture, and optometry)
o. Initial Approved/Recredentialed Date
p. Birth Date
q. Medi-Cal Number & Medicare Number
r. Gender
s. Ethnicity
t. Panel Status:
    1. Accepting new patients
    2. Accepting existing patients
    3. Available by Referral only
    4. Available only through a hospital or facility; or
    5. Not accepting new patients
u. Email address, if permitted by provider via written communication
v. FQHC or Clinic name
w. If applicable, web site URL for each service location
x. Meet minimum training requirements for the requested specialty. The applicant must have no mental or physical conditions that would, with reasonable accommodation, interfere with his/her ability to practice within the scope of the privileges requested.
y. Be eligible to participate in the Cal MediConnect program with no sanctions

z. Have no felony convictions.

aa. For SNP participants, must complete a MOC training attestation form.

bb. Be able to provide coverage to members, either personally or through appropriate physicians, 24 hours per day, seven (7) days per week.

cc. Agree to abide by Blue Shield Promise policies and procedures.

dd. PCPs are required to have a passing score on the facility site review and medical record review.

2. All applicants will meet the following minimum training requirements: Physicians (MD, DO) must be either:
   - Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards.
   - Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board; or
   - A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969, and had been in practice full time since, may be "grandfathered" into Family Practice.

     a. The physician has completed an International Medical Graduate (IMG) training program and has completed a Canadian or British Isles residency program. (The ABMS formally recognizes Canadian and British medical schools and residencies as equivalent to US training but does not recognize Canadian and British Specialty Boards).

     b. Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Foot and Ankle Surgery (ABFAS) [formerly American Board of Podiatric Surgery (ABPS)] or American Board of Podiatric Medicine (ABPM) [formerly American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)].

     c. Optometrists (OD) are required to complete a professional degree in optometry.

     d. Oral Surgeons (DDS, DMD) are required to have completed a professional degree in dentistry.

     e. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), and nurse mid-wives (NMW) must have successfully completed the academic program required for the requested status. For example, a nurse practitioner must have completed a nurse practitioner academic program.

     f. Allied health professionals are required to have successfully completed the professional program required for their requested specialty.

The Credentialing Committee may consider other exceptions as it deems necessary and/or appropriate. The Chief Medical Officer may recommend the acceptance of an applicant even if the practitioner does not satisfy minimum criteria and if there is a determined need and if there is credible evidence that the practitioner can provide the services requested.

2.4: Recredentialing

At least every three (3) years, a practitioner must be recredentialed to maintain his/her membership with Blue Shield Promise Health Plan. Six months prior to the recredentialing due date, the Credentialing Department will mail out a recredentialing application to non-CAQH participant practitioner/provider or will retrieve the recredential application from CAQH for CAQH participant practitioner/provider. The non-CAQH participant practitioner/provider will be instructed to complete the application with current information, complete an attestation questionnaire, sign, date the appropriate pages, and return it with the supporting documentation as required to the Credentialing Department. A cover letter stating that failure to return the recredentialing application by its deadline may be considered a voluntary resignation by the practitioner. Upon receipt of a completed recredentialing application, the Credentialing Department will follow its procedures in processing the application for recredentialing. If the recredentialing application is not received by Blue Shield Promise Credentialing Department by the given timeframe, a follow-up for recredentialing will be mailed to the practitioner/provider. A final follow-up will be sent to any practitioner/provider who has not returned his/her applications after 90 days from the initial mailing. The Credentials Committee and the Contracting Department will be notified of the practitioner who is non- responsive to the recredentialing requests and will follow the procedures for appropriate action, including administrative termination for non-compliance.

2.5: Credentialing Time Limit

The primary source verifications must be completed, and the provider's attestation must be signed and dated within 180 calendar days prior to the Credentialing Committee decision.

2.6: Practitioners' Rights

Practitioners shall have the right to:

- Review all non-protected information obtained from any outside source in support of their credentialing applications, except references or recommendations protected by peer review laws from disclosure.
- Respond to information obtained during the credentialing process that varies substantially from the information provided by the practitioner/provider.
- Correct erroneous information supplied by another source during the credentialing verification process.
- Practitioners will be notified of their rights in the initial and recredentialing application packet.

2.7: Confidentiality of Credentials Information

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in locked file cabinets in the Credentialing Department.

Only authorized personnel will have access to credentials files. Practitioners may access their files in accordance with the established policies. All confidential electronic data will be access-controlled through passwords. Access will be assigned based on job responsibility, and on a need- to-know basis. All Credentials Committee Members, guests, and staff involved in the credentialing process will sign a confidentiality agreement at least annually.

2.8: Sanction Review

Blue Shield Promise 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 directly contracted with Blue Shield Promise, 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 an IPA/medical group, then the affected IPA/medical group 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 IPA/medical group's response, is forwarded to the Credentials Committee for review and action.

Blue Shield Promise 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 U.S. Drug Enforcement Administration 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.

2.9: Medicare Opt-Out Report

The Credentialing Department will check the Medicare Opt-Out Report to verify whether the practitioner has chosen to opt-out of Medicare. The results of the findings will be documented in the credentialing file and applicants identified on the report will not be credentialed for Medicare line of business.

2.9.1: Summary Suspension of a Practitioner's Privileges

1. Immediate action will be taken to suspend a practitioner's privileges in the event of a serious adverse event. A serious adverse event is defined as any event that could substantially impair the health or safety of any Member.
2. Immediate action will also be taken to suspend a practitioner's privileges in the event the practitioner fails to meet the following minimum credentialing criteria:
    a. The practitioner's license to practice has been revoked, suspended, or under any type of restriction or stipulation, including probation, by the state licensing agency.
    b. The practitioner has been suspended from the Medicare program.
    c. The practitioner fails to maintain the minimum malpractice liability coverage.
3. Should a practitioner fail to meet the minimum credentialing criteria as described above, Blue Shield Promise will allow the practitioner a chance to correct the deficiency before inactivating the practitioner. Upon knowing that a practitioner is noncompliant, the Credentialing Department will notify the practitioner immediately in writing of the deficiency. The notification will specify the methods available for correcting the deficiency and the timeframe allowed for the submission, and that failure to correct the deficiency will result in immediate inactivation.
4. Any information regarding an adverse event will be forwarded to the Quality Improvement (QI) Department as a Potential Quality Issue (PQI) and handled in accordance with the established policies and procedures. The Medical Director has the authority to immediately suspend any or all portions of a practitioner/ provider's privileges in the event of a serious adverse event (as defined above). The written notice will include a notice of the practitioner's right to a Fair Hearing. (Please refer to Policy 70.1.3.10 Fair Hearing Plan for detail).
5. A summary suspension of a practitioner's membership or employment is imposed for a period in excess of fourteen (14) days.

6. The notice of suspension shall be given to the legal department for ratification. In the event of suspension, the practitioner/provider's members shall be assigned to another practitioner. The wishes of the patient shall be considered, where feasible, in choosing another practitioner/provider.

Blue Shield Promise will adhere to the California Business and Professional Codes requirements for submitting 805 and 805.01 reports to the Medical Board of California and to the Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner Data Bank. Any summary suspension or restriction of a practitioner's privileges based on a medical disciplinary action for a period of 14 days or more will be reported to the Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California through the 805-reporting process and to the National Practitioner Data Bank in accordance with Blue Shield Promise policy. The California Business and Professions Code Section 805 define medical disciplinary cause or reason as "that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care."

2.10: Health Delivery Organizations

Prior to contracting with, and at least every three (3) years thereafter, Blue Shield Promise will reevaluate health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers to ensure they have appropriate structures and mechanisms in place to render quality care and services.

The evaluation process includes confirmation within 180 calendar days of the following:

- In good standing with the state and federal regulatory bodies.
- Current accreditation by a Blue Shield Promise recognized accrediting bodies.
- If the HDO is not accredited, the Blue Shield Promise facility site review, CMS or DHCS survey is required.

2.11: Credentials Process for IPA/Medical Groups

IPA/medical groups that are delegated credentialing activities are required to credential and recredential medical professionals, mid-level practitioner and non-physician medical practitioners, and allied health professionals in accordance with the above Blue Shield Promise policies and procedures, NCQA, CMS, and DMHC guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

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

- The Credentialing Delegation Oversight Auditor will conduct pre-delegation and annual onsite 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. The Industry Collaborative Effort (ICE) standardized audit tool will be used to conduct an audit. The audit tool can be found on the ICE website under *Approved ICE Documents*. The IPA/medical group will be required to submit a credentialing roster with specialty, credentialing and recredentialing dates, board certification status, and forward all the required documents to the Blue Shield Promise Credentialing Department at least two (2) weeks prior to the scheduled audit date.

- Blue Shield Promise 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 Promise 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 Promise 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 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.
- After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review.
- IPA/medical groups will be required to sign and abide by the credentialing delegation agreement.
- To be delegated and to continue delegation for credentialing, IPA/medical groups 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 Promise Delegation Oversight Department within 30 days of notification is received. After reviewing the CAP, the s will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.
- The Delegation Oversight Department will ensure the CAP meets all regulatory requirements.
- Delegated credentialing status may be terminated by Blue Shield Promise at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.

- Blue Shield Promise retains the right to approve, suspend and terminate practitioner/providers or sites based on issues with quality of care.
- Delegated IPA/medical groups are required to submit a quarterly report for practitioners/ providers credentialing, recredentialing, termination and suspension activities, and quality improvement activities utilizing the Industry Collaborative Effort (ICE) standardized reporting tools found on the ICE website under *Approved ICE Documents*.
- Quarterly reports are due on the following dates:
    - 1st Quarter due May 15th (January 1st – March 30th)
    - 2nd Quarter due August 15th (April 1st – June 30th)
    - 3rd Quarter due November 15th (July 1st – September 30th)
    - 4th Quarter due February 15th (October 1st - December 31st)
- Reports may also include credentialing and recredentialing activity of Organizational Providers if oversight responsibility is delegated.
- Reports are submitted to the designated credentialing mailbox, or the assigned Delegation Oversight Auditor assigned to the group.
- The IPA/medical group must develop and implement policies and procedures for ongoing monitoring of practitioner's sanctions, complaints, and quality issues between recredentialing cycles and taking appropriate action against practitioners when it identifies occurrences of poor quality. At a minimum, the IPA/medical group must collect and review the following:
    - Medicare and Medicaid sanctions;
    - Sanctions or limitations on licensure;
    - Medi-Cal Suspended and Ineligible Provider List at Initial and Recredentialing, as well as monthly;
    - Medicare Opt-Out;
    - Member complaints; and
    - Identified adverse events.
- The IPA/medical group is required to review all Blue Shield Promise practitioners/ providers sanction activities within the 30 days of the report issued date and report the finding to Blue Shield Promise as practitioners/providers are identified.
- The IPA/medical group is responsible to provide and assist any credentials document needed for investigation and audit which include but not limited to specific information related to a provider's training, action related to any sanctions, etc.
- The IPA/medical group is required to submit copies of originals files for selected practitioners at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audit.

SECTION 3: MEMBER SERVICES

3.1: Covered Benefits

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 the Blue Shield Promise website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/Medicare-members/plan-documents/eoc-medical. To request printed copies of the publications, please contact the Provider Customer Services Department at (800) 468-9935.

3.2: Member Rights and Responsibilities

Blue Shield Promise is committed to providing quality health care and to communicate the Member's Rights and Responsibilities to its Members, providers, and staff.

Blue Shield Promise requires its providers to understand and abide by these Member Rights and Responsibilities when providing services to our Members. Providers are informed of Member rights through the Provider Manual and Provider Newsletters.

Blue Shield Promise informs each Member of these Rights and Responsibilities in the Member's *Evidence of Coverage*, which is distributed upon enrollment and annually thereafter.

MEMBER RIGHTS AND RESPONSIBILITIES

What are your health care rights?

You have the right to know.

- Know and receive information about Blue Shield Promise
- Know and receive your rights and responsibilities
- Know about our services, doctors, and specialists and be informed when your doctor is no longer contracted with Blue Shield Promise
- Know about all our other caregivers
- Be able to see your medical records. You must follow the State and Federal laws that apply

You have the right to be treated well.

- Always be treated with respect and recognition of your dignity
- Have your privacy kept safe by everyone in our health plan
- Know that we keep all your information private

You have the right to be in charge of your health care.

- Choose your primary care doctor
- Say no to care from your primary care doctor or other caregivers
- Be able to make choices and to participate with your provider about your health care
- Make a living will (also called an Advance Directive)
- Have an honest talk with your doctor about all treatment options for your condition, regardless of cost or benefit coverage
- Voice complaints or appeals about Blue Shield Promise or the care it provides including the right to file a grievance if you do not receive services in the language you request

You have the right to get a range of services.

- Get family planning services
- Get preventative health care services
- Get minor consent services
- Be treated for sexually transmitted diseases (STDs)
- Get emergency care outside of our network
- Get health care from a Federally Qualified Health Center (FQHC)
- Get health care at an Indian Health Center
- Get a second opinion
- Get interpreter services at no cost. This includes services for the hearing-impaired
- Get informing information materials in alternative formats and large size print upon request

You have the right to suggest changes to our health plan.

- Tell us what you don't like about our health plan
- Tell us what you don't like about the health care you get
- Question our decisions about your health care
- Tell us what you don't like about our right and responsibilities policy
- Ask the Centers for Medicare & Medicaid Services (CMS)

What are your responsibilities as a health care Member?

We hope you will work with your doctors as partners in your health care.

- Make an appointment with your doctor within 120 days of becoming a new Member for an initial health assessment
- Tell your doctors what they need to know to treat you
- Learn as much as you can about your health
- Follow the treatment plans you and your doctors agree to
- Follow what the doctor tells you to do to take good care of yourself
- Do the things that keep you from getting sick
- Bring your ID card with you when you visit your doctor
- Treat your doctors and other caregivers with respect
- Use the emergency room for emergencies only. Your doctor will provide most of the medical care that you need
- Understand your health problems and participate in developing a mutually agreed- upon treatment goal(s), to the degree possible
- Report health care fraud

We want you to understand your health plan.

- Know and follow the rules of your health plan
- Know that laws guide our health plan and the services you get
- Know that we can't treat you different because of, age, sex, race, national origin, culture, language needs, sexual orientation and/or health

3.3: Member Appeals and Grievances

3.3.1: Member Appeals

Different CMS terminologies are used in the appeals process:

Definitions:

Organization Determination - Any initial decision made by the managed care organization regarding a service or benefit, including payment or refusal to pay for medical care or services.

Coverage Determination - Initial decisions regarding Part D drugs.

Reconsideration - First step in the appeal process after an adverse organization determination of Medical Care or Services (Part C).

Redetermination - Appeal of an adverse coverage determination under Prescriptions Drug (Part D).

All redetermination and reconsideration decisions made by Blue Shield Promise may be appealed to MAXIMUS Center for Health Dispute Resolution (CHDR), an independent review entity (IRE).

Level 1 – Health Plan Appeal

A Cal MediConnect or Medicare Member or representative may file a standard appeal. To ask for a standard appeal, the written or verbal appeal request must be sent to Blue Shield Promise Appeals and Grievances Dept. A fast appeal may be requested by calling, faxing, or writing to Blue Shield Promise Health Plan. If the physician provides a written or oral supporting statement explaining that the Member needs a fast appeal, then it is automatically granted to the member. If the Member or representative asks for a fast appeal without support from the physician, Blue Shield Promise will decide if Member's health requires a fast decision. If a request for fast appeal is denied, the standard appeal will apply.

For Cal MediConnect appeals, contracted providers do not have standard appeal rights, but may request an expedited reconsideration for the member. Thus, without being a member's appointed representative, a physician is prohibited from requesting a standard reconsideration (appeal) but may expedite a member's appeal.

For Part D appeals, a prescribing physician or other prescriber acting on behalf of the member or staff of a physician's office action on a physician's behalf may request an expedited redetermination without being the member's appointed representative.

Level 2 – Independent Review Entity (IRE)

Unfavorable appeal decisions, in part or in whole, made by Blue Shield Promise regarding a Medicare Managed Care service that is not related to Part D are auto forwarded to the IRE for "reconsideration." A request by the appealing person is not necessary for managed care.

Part D unfavorable Member decisions made by Blue Shield Promise are not auto forwarded to the IRE. An appeal request from Blue Shield Promise to the IRE is necessary for Part D. Blue Shield Promise will comply with CMS's Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. The timeframes for filings and resolutions will be adhered to. Appeals should be filed within sixty (60) calendar days from the date of the initial determination, unless the IRE extends the timeframe for good cause. Appeals on behalf of the member must be in writing or verbal and state with specificity the action being appealed and what resolution is being requested. The provider should provide documentation supporting the Member's position. Providers are encouraged to exhaust all other available means of resolving an issue before filing a dispute.

Decisions will be issued in writing within the time frame allowed for the kind of appeal requested and approved by the health plan. Standard decision for a Part D drug that has been paid for and received is within 7 calendar days of receiving the appeal request; expedited decision for Part D that has been received is rendered within 72 hours after the appeal request is received, or sooner if health condition requires. Any decisions not given within these required timeframes automatically go to Level 2.

For Part C medical care or services, requests for payment of services already received are made within 60 days. For a standard decision for Part C that has not been received, the decision is given within 30 days, plus additional 14 days if an extension is requested. For expedited appeals for Part C for services not yet received, a decision is rendered within 72 hours or sooner if the health condition requires. If an extension is requested, an additional 14 days is given to make the decision. If no decision is rendered during the required timeframe or at the end of extended time period, the appeal automatically goes to Level 2.

If a provider disagrees with the resolution of a matter, CMS guidelines for appeals of health plan redeterminations and reconsiderations will be adhered to. Appeal rights will be provided as appropriate with health plan decisions.

Medi-Cal Level 2 Appeals - Independent Medical Review (IMR)

Members can request an Independent Medical Review within 6 months after a decision has been made by Blue Shield Promise Health. IMR requests are made to the Department of Managed Health Care. IMRs are free to the member.

State Hearing

The State Hearing request is for Medi-Cal covered services. A member can request a State Hearing within 120 days after the member receives the "Your Rights" notice during the Public Health Emergency created by COVID-19. After the public health emergency ends, a member can request a State Hearing within 90 days after the member receives the "Your Rights" notice.

3.3.2: Member Grievances

Purpose

Blue Shield Promise has established a system for Members to communicate problems and concerns regarding their health care and to receive an immediate response through the Plan's grievance system. This is outlined in the Member Grievance policies and procedures, which may be obtained from Blue Shield Promise. There are 2 categories of Grievances:

- Quality of Care – Allegations of substandard care that could impact clinical outcomes
- Quality of Service – Allegations that service did not meet standards

Procedure

Members are encouraged to speak with their IPA/medical group or PCP regarding any questions or concerns they may have. Members may also communicate their concerns directly to Blue Shield Promise Member Services by telephone at (855) 905-3825 (TTY 711), in writing, by email, or in person.

Grievances can be filed by telephone, in person, in writing, or online at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/cmc-members/cmc-members under *Get to Know Blue Shield Promise Cal MediConnect*, then *Submit a grievance form online,* no later than 60 calendar day after the event. Blue Shield Promise will acknowledge receipt of all written formal grievances within five (5) business days. Blue Shield Promise will resolve grievances within 30 days and/or as expeditiously as the enrollee's health status requires but no later than 30 calendar days from the date the oral or written request is received unless as extension is made and documented in the best interest of the enrollee and provides prompt notification to the enrollee when a 14-day calendar extension is taken.

Blue Shield Promise will provide a resolution letter in writing to the Member. Providers and IPA/medical groups are required to provide medical records, authorizations, or responses within 7 calendar days of the request to resolve the grievance within the regulatory timelines.

Grievances concerning quality of care issues are reported immediately to the Quality Management (QM) Department. The QM Department logs the grievance, gathers medical records/information concerning the grievance, and reviews the case for quality of care. All quality related grievances are reviewed by the Medical Director. All grievances are tracked by type/category and by provider and are reviewed regularly by the QM Committee for potential quality of care issues.

Blue Shield Promise is responsible for establishing and administering grievance procedures. The IPA/medical group and/or the PCP must participate with Blue Shield Promise by providing assistance and information. Grievance forms shall be made available to Members at each PCP site. Additionally, providers are given the opportunity to review all member concerns and respond to the issues identified.

Expedited Grievance: The member may request an expedited grievance when the member disagrees with the decision not to expedite an appeal. In this situation, they can file a "fast complaint" with the health plan's refusal to expedite an appeal as the member feels that the appeal meets criteria to be expedited.

Blue Shield Promise responds to an enrollee's expedited grievance request within 24 hours when Blue Shield Promise invokes an extension relating to an organization determination or reconsideration or the complaint involves a refusal by Blue Shield Promise to grant an expedited organization determination or reconsideration.

The complaint involves an MA organization's decision to invoke an extension relating to an organization determination or reconsideration. The complaint involves an MA organization's refusal to grant an enrollee's request for an expedited organization determination under the CMS *Managed Care Manual* Chapter 13, Sections; §422.570 or reconsideration under§422.584.

3.3.3: Provider Appeals

Purpose

To establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with 42 CFR §405.1200 et.seq.

3.3.3.1: Provider Questions, Concerns, and Appeals

Providers can communicate questions and issues to the Blue Shield Promise Provider Services Department or Provider Dispute Department by telephone, in writing, or in person. Many of these issues can be addressed very quickly following a brief investigation. Issues that cannot be resolved within one day or involve quality of care issues will be logged as a dispute. Examples of disputes are issues relating to noncompliant Members and non-payment or underpayment of claims by IPA/medical groups. All disputes entered in the provider dispute database will be investigated and a response will be provided in writing.

3.3.3.2: Reconsiderations

A provider will have the ability to furnish the Blue Shield Promise Provider Dispute Department with any additional information or documentation that may have a bearing on the initial determination of a request for authorization that has been previously denied, deferred, and/or modified.

Procedure for Reconsideration

1. A provider requesting reconsideration may call, fax, or submit in writing any additional information to the Blue Shield Promise UM Department to support the original authorization request. The fax number to the UM Department is (323) 889-6219**.**
2. A reconsideration request will occur within one (1) business day upon receipt of the provider telephone call, written or faxed request.
3. The additional information will be reviewed by the Chief Medical Officer (CMO) of Blue Shield Promise or his/her designated physician reviewer.
4. If the CMO or designated physician reviewer reverses the original determination based on additional information provided by the provider, an approval letter will be sent to the provider and the Member.
5. If reconsideration does not resolve a difference of opinion, the provider may then submit an appeal and/or grievance in writing to the Provider Dispute Department.

3.3.3.3: Provider Disputes Policy and Procedure

Non-Contracted Providers

Non-contracted providers must include a signed Waiver of Liability (WOL) form holding the enrollee harmless regardless of the outcome of the appeal. If a signed WOL form is not submitted along with appeal letter, Blue Shield Promise will make reasonable attempts to fax or call provider to request for a signed WOL form. If a signed WOL form is not received by the 60th calendar day of receipt of the appeal, a dismissal letter will be sent to provider. The Waiver of Liability form can be obtained through the following link https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html under *Downloads*.

Contracted and Non-Contracted Providers

Providers may submit a written appeal to the Blue Shield Promise Provider Dispute Department. Appeals may pertain to such issues such as post service authorization or denial of a service, nonpayment or underpayment of a claim, or disputes with our delegated entities.

All written, formal appeals will be responded to in writing. Upon receipt of the written appeal specifying the issue of concern, the appeal will be entered into the provider dispute database.

All provider appeals must be submitted in writing. If a provider attempts to file a provider appeal via telephone, Blue Shield Promise staff will instruct the provider to submit the provider dispute to Blue Shield Promise in writing. Information about how to file an appeal can be found on the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/disputes-medi-cal.

A provider can submit a provider appeal in writing to Blue Shield Promise by mail. All provider appeals are forwarded to the appropriate department for processing.

3.3.3.4: First Level Appeal

A provider may appeal a denial decision made by Blue Shield Promise or one of its IPA/medical groups.

When the appeal is referred for clinical review, the clinical reviewer shall evaluate the medical records and submit his/her findings and recommendations to the Physician Reviewers for approval:

Provider Dispute Department will acknowledge and review all written requests. An acknowledgement letter will be submitted to provider within 15 working days of receipt of the appeal. A written letter of resolution outlining its conclusions with background information will be sent to provider within 60 calendar days of receipt of the appeal for contracted provider, within 60 calendar days of receipt of the appeal for non-contracted provider disputes and within 60 calendar days of receipt of the appeal for non-contracted provider appeals. Language in the letter will include the next appeal steps the provider can take to purse the dispute. Blue Shield Promise shall retain all documentation related to the clinical review for a minimum of (5) five years.

Please submit written provider disputes resolution requests to:

Blue Shield of California Promise Health Plan
Attn: Medicare Provider Dispute Resolution Dept.
P.O. Box 3829
Montebello, CA 90640

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SECTION 4: ELIGIBILITY AND ENROLLMENT

To be eligible for enrollment at Blue Shield Promise Health Plan, the applicant must be entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date. In addition, enrollees in the Blue Shield Promise Health Plan Dual Special Needs Plan or the Cal MediConnect plan must be eligible for Medicare Parts A, B & D and Medicaid. Blue Shield Promise does not discriminate against enrollees based on their health status. Each application received will be reviewed and processed according to Center for Medicare & Medicaid Services (CMS) regulations and guidelines.

Enrollees must reside within the CMS approved service area (defined by zip code) for Blue Shield Promise. Enrollees who reside outside the approved service area will be denied enrollment. While a P.O. Box may be used for a mailing address, the enrollees must reside within the Blue Shield Promise Health Plan service area. In the case of homeless individuals, a P.O. Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

Enrollees with End-Stage Renal Disease (ESRD) would not be eligible unless they have received a transplant that restored kidney function and they no longer require a regular course of dialysis to maintain life (they would not be considered to have ESRD for purposes of Medicare Advantage (MA) eligibility). Such an individual may elect coverage in an MA plan if the individual makes an election during an election period and submits proper documentation from their physician that the individual has received a kidney transplant and no longer requires a regular course of dialysis to maintain life.

4.1: Provider Selection

The Enrollment Specialist will verify the provider and IPA/medical group chosen on the application. In general, if the primary care physician (PCP) is confirmed as active in the system and accepting new members, then the chosen provider will be honored. The patient provider relationship is very important so in any circumstance where the chosen PCP and/or IPA/medical group cannot be met, then the enrollee will be contacted by Blue Shield Promise's Member Services Department to review further options.

If for example, the PCP is not active or not accepting new Members, the enrollee is contacted to inform him/her that the PCP chosen is inactive and with the PCP, then asked to make another choice. If the application does not list a PCP, the enrollee is contacted to choose a PCP.

4.2: Change of Primary Care Physician

4.2.1: Member Initiated Change

Members may request a PCP change during any given month. A Member may request a PCP transfer by calling Member Services. Each eligible Member in a family may select a different PCP.

All transfer requests received by Member Services by the 15th of the month will be effective on the first of that same month if the Member has not utilized any medical services. If services were rendered the transfer will not take place until the first of the following month. PCP transfers requested or received after the 15th of the month will be effective on the first of the following month that the request was made.

> *Note:* All exceptions to this policy must be pre-authorized by the Member Services Supervisor/Lead or Director prior to approving/processing the transfer request. Each retroactive transfer request is reviewed and approved on an individual per case basis pending circumstances involved, access, and urgency of care. Prior to any change, inquiries will be made to assure there was no prior utilization of services during the month.

When the PCP change is processed and completed, a new ID card will be generated and sent to the Member. All PCP changes are processed by the Enrollment Unit and are noted in the Blue Shield Promise Customer Service and Inquiry Module database by Member Services for future reference.

4.2.2: PCP Initiated Change

Occasionally, circumstances may arise in which a PCP wishes to transfer an assigned member to another PCP. In such cases, the PCP must submit a written transfer request to Blue Shield Promise for approval to send a member notification letter. The PCP must note the reason for the transfer request and provide written documentation to support the removal of a member from their panel.

Upon receipt of a transfer request form, a Blue Shield Promise Medical Director will evaluate the information presented and make a determination. The following are not acceptable grounds for a provider to seek the transfer of a member:

- The medical condition of a member
- Amount, variety, or cost of covered services required by a member
- Demographic and cultural characteristics of a member

Blue Shield Promise will ensure that there is no Member discrimination for the above or any other reasons.

If the transfer request is approved, the provider will be asked to send an approved notification letter to the member giving the member 30 days to change their PCP. Blue Shield Promise will contact and reassign the member according to their choice considering geographic location, linguistic congruity, and other variables.

4.3: Eligibility List

Each Blue Shield Promise IPA/medical group and directly contracted primary care physician is provided an eligibility file monthly of all its assigned members via the national HIPAA compliant standard 834 5010 file format. The eligibility file is distributed by the 10th of each month via our secure file transfer protocol (SFTP) The eligibility files contains at the minimum but not limited to the following information listed below. *Note:* Providers participating with Blue Shield Promise Health Plan through a delegated IPA/medical group will receive eligibility within the format and timeframe established by the IPA/medical group.

1. Month of Eligibility
2. Provider Name, Address, and Provider Number
3. Member's Subscriber Number
4. Member's Last Name
5. Member's First Name
6. Date of Birth
7. Age
8. Social Security Number (new Members only)
9. Member's Address (new Members only)
10. Member's Telephone number (new Members only)
11. IPA/Medical Group Effective Date
12. Sex
13. Special Remarks

4.4: Identification Cards

Blue Shield Promise will furnish each new Member an identification card within the first seven (7) days of enrollment.

The member identification card is for identification purposes only and does not guarantee eligibility for Blue Shield Promise providers. Refer to the Eligibility List for current eligibility information by logging into the Blue Shield provider website at blueshieldca.com/provider and click on *Eligibility & benefits.* If necessary, contact the Provider Network Administrator or call Blue Shield Promise Member Services for eligibility verification.

4.5: Disenrollment

Disenrollment refers to the termination of a Member's enrollment with Blue Shield Promise. It does not refer to a Member transferring from one primary care physician to another.

For individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program and are enrolled in a Cal MediConnect plan, CMS allows individuals to enroll in, or disenroll from, a Cal MediConnect plan or an MA plan, on a continuous basis. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid.

Under certain circumstances it may be mandatory to disenroll a Member from Blue Shield Promise. Some circumstances include but are not limited to:

- The member loses entitlement to either Medicare Part A or Part B.
- The Special Needs Plan (SNP) enrollee loses special needs status and does not reestablish SNP eligibility within the CMS allowable timeframe.
- Relocation of the Member outside of Blue Shield Promise Health Plan's service areas.

SECTION 5: UTILIZATION MANAGEMENT

5.1: Utilization Management Program

The role of the Utilization Management (UM) Department is to ensure consistent delivery of high-quality health care services to our Members through Blue Shield of California Promise Health Plan affiliated providers. Health care services are provided through full and shared risk networks structured to provide a continuum of care. The UM Department functions include authorization of the facility component for inpatient and outpatient procedures, home health, inpatient concurrent reviews, discharge planning, and retrospective reviews. Referrals for specialty care, diagnostic testing and other ancillary providers are reviewed by the IPA/medical group. For questions regarding to whom you should submit a referral request, please contact the IPA/medical group.

Blue Shield Promise makes Utilization Management (UM) decisions only on appropriateness of care and service, based on the current *Evidence of Coverage* and the community standard of care. Blue Shield Promise does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives that would encourage UM decision makers to make decisions that would result in underutilization of services.

Blue Shield Promise Health Plan contracted IPA/medical groups may only utilize Blue Shield Promise approved criteria as listed below. IPA/medical groups must first use either CMS Local Coverage Determinations (LCD) or CMS National Coverage Determination (NCD) for medical necessity determination. If an NCD or LCD is not available for the service being requested, the IPA/medical group may use one of the other guidelines listed below to establish whether a service is **reasonable and necessary**. The following is a complete list of the Blue Shield Promise approved guidelines or sources that may be utilized for issuing approvals, denials, or modifications. IPA/medical group/MSO Internal Policy or guidelines should not be used for any medical necessity determination of services fora Blue Shield Promise member. All benefit denials should either reference a CMS source or the Blue Shield Promise Health Plan *Explanation of Coverage (EOC)*.

Blue Shield Promise Health Plan Approved Guidelines
CMS Local Coverage Determinations (LCD)
CMS National Coverage Determinations (NCD)
MCG 23rd Edition
Up to Date
National Guideline Clearinghouse
Hayes
NCCN

These criteria alone cannot ensure consistent UM decision making across the organization. Blue Shield Promise recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan's review process. The UM review criteria are available for disclosure to providers, Members, and the public upon request either in writing or by contacting the Blue Shield Promise UM Department at (800) 468-9935.

Blue Shield Promise Health Plan uses nationally recognized clinical criteria to make UM decisions. These criteria are available to you upon request, by contacting (800) 468-9935.

5.2: Authorization and Review Process

5.2.1: Authorization Timeframes

Inpatient and outpatient referral requests received from primary care and specialty care physicians shall be processed by the IPA/medical group according to the following designated time frames:

Standard – Decision within 14 calendar days from the date of request; notification within 14 calendar days after the receipt of request.

Expedited (no extension) – Decision within 72 hours from the date of the request (including weekends and holidays); notification within 72 hours after receipt of request.

Termination from Home Health Agency (HHA), Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF) – Decision and Notice of Medicare Non-Coverage delivery no later than 2 calendar days or 2 visits before coverage ends.

Note: Clean referrals are those referrals that contain adequate documentation and/or information to medically support the request, such as patient history to date, current symptoms, proposed treatments etc. If the information submitted is not adequate, the determination will be based upon the available information and/or lack of medical information. To expedite the process and to ensure appropriateness of the decision, it is very important that relevant clinical information be submitted with the request.

Request for Extensions

Blue Shield Promise may extend the decision time frame up to 14 calendar days. This extension is allowed if the enrollee requests the extension or if the provider or organization can justify a need for additional information and documents how the delay is in the best interest of the enrollee. For example, the receipt of additional medical evidence from non-contracted providers may change Blue Shield Promise's decision to deny. There are no extensions for collecting existing information from contracted providers.

Expedited Initial Organization Determination (EIOD)

When processing EIODs, it is necessary to determine if the expedited request is deemed to be expedited:

1. If expedited criteria are not met, the standard determination timeframe applies. Members must receive oral notice of the denial of expedited status and an explanation that the request will be processed using the 14-day timeframe. The oral notification must be followed with written notice within 3 calendar days of the oral notice. The UM Department staff notifies the Member orally, then sends the standard denial letter informing the Member that the request did not qualify for expedited request and, will be processed using 14-day timeframe.
2. If no extension – decision within 72 hours of receipt after receipt of request (includes weekends and holidays); notification within 72 hours after receipt of request.
3. If extension requested – decision may extend up to 14 calendar days; written notification within 72 hours of receipt of request.

The physician reviewer rendering the determination will be available to discuss the decision with the requesting providers. The reviewer is available by calling (800) 468-9935.

Blue Shield Promise provides written notification to Members and practitioners a reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. Blue Shield Promise notifies Members of the reason for the denial in clear and understandable language. The reason(s) for denial must be translated into the Member's preferred language.

5.2.1.1: Appeal Rights

When health care service is denied, the practitioners are notified of the appeal process. It includes the following:

1. Description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal;
2. Explanation of the appeal process, including the right to Member representation and time frames for deciding appeals; and
3. Description of the expedited appeal process for urgent preservice or urgent concurrent denials.

Please see Section 3.3: Member Appeals and Grievances and Appendix 1 for the Utilization Management Timeliness Standards.

5.2.2: Authorization Validity

Authorizations are generally approved for 90 days with a disclaimer stating that authorizations are valid only if the Member is eligible on the actual date of service. Blue Shield Promise providers must verify Member eligibility prior to delivery of non-emergency services. Eligibility can be verified for most Members 24 hours a day, seven (7) days a week by calling Member Services at (800) 544-0088.

Providers are responsible for re-verifying eligibility and obtaining an updated authorization once the authorization has expired.

5.2.3: Specialty Referrals

PCPs are responsible for providing all routine health care services, including preventive care, to their enrolled Members. However, Blue Shield Promise recognizes that in many circumstances Members may require care that must be rendered by qualified specialists.

When, in the opinion of the PCP a Member referral to a specialist is indicated, a request shall be submitted to the Member's assigned IPA/medical group's UM Department for review and authorization except for services established as no prior authorization required under the direct referral process.

The PCP's office shall maintain a log indicating the Member information, date of request, type of specialist, clinical reason for referral and the authorization number. This log must be completed by indicating the date when the consultation report was received, and whether the Member made it to the appointment or not. The office must have a process for recalling patients if the Member missed the appointment.

The specialist is required to send a completed consultation report to the PCP.

After review of the consultation results and recommendations, the PCP may request additional treatment authorization if clinically indicated.

5.2.4: Ancillary Referrals

PCPs are responsible for providing total coordination of all routine healthcare services, including use of ancillary services, for their enrolled Members. Therefore, all requests for Member referrals for ancillary services are submitted to the Member's assigned IPA/medical group's UM Department for review and authorization. Ancillary services are defined as those medical services provided by non-physician or mid-level professionals (i.e., PA's, NP's, etc.). This includes, but is not limited to, home care; physical, occupational, and speech therapies; diagnostic laboratory; x-ray; infusion services; and services provided by hospital-based outpatient departments, excluding ambulatory surgery, emergency room, and/or urgent care.

5.2.5: Outpatient Services

Ambulatory services and outpatient surgery procedures require authorization by the Member's assigned IPA/medical group's UM Department.

5.2.6: Elective Admission Requests

All elective inpatient admissions require an authorization by the Blue Shield Promise UM Department. Requests for elective inpatient admissions should be submitted to the Member's assigned IPA/medical group's UM Department. These requests will then be forwarded to the Blue Shield Promise UM Department for final authorization.

Plan Notification

All contracted per diem hospitals are responsible for notifying the Blue Shield Promise UM Department of the inpatient admission by faxing the appropriate hospital admission sheets to the Blue Shield Promise UM Department within 24 hours of admission, except for weekends and holidays.

5.3: Emergency Services and Admissions Review

An "emergency medical condition" is defined as a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain, such that a reasonable person would expect that the absence of immediate medical attention could result in (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

5.3.1: Emergency Care

Blue Shield Promise Members are entitled to access emergency care without prior authorization. However, Blue Shield Promise requires that when an enrollee is stabilized, but requires additional medically necessary health care services, providers must notify Blue Shield Promise prior to, or at least during, the time of rendering these services. Blue Shield Promise wishes to assess the appropriateness of care and assure that this care is rendered in the proper venue.

5.3.2: Life Threatening or Disabling Emergency

Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be delegated to a non-direct care giver at the emergency department (ED) to be done either concurrently with the provision of post-stabilization care or as soon after as possible.

5.3.3: Business Hours

Blue Shield Promise UM Department is available via telephone from 8:00 a.m. to 5:00 p.m., Monday through Friday. In a 911 situation, if a Member is transported to an ED, the ED physician shall contact the Member's PCP (printed on the Member's enrollment card) as soon as possible (post stabilization) to give him/her the opportunity to direct or participate in the management of care.

5.3.4: Medical Screening Exam

Hospital emergency departments under federal and state Laws are mandated to perform a medical screening exam (MSE) on all Members presented to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Blue Shield Promise will cover emergency services necessary to screen and stabilize Members without prior authorization in cases where a member had a reasonable belief that an emergency medical condition existed.

5.3.5: After Business Hours

After regular Blue Shield Promise business hours, Member eligibility is obtained, and notification is made by calling the 800 number on the Member ID card. The 800 number connects to a 24-hour multilingual information service, which is available to Members as well as to providers. For information other than eligibility requests, the call service will cross connect the caller to a Blue Shield Promise Case Manager.

The following are some of the key services that the on-call Case Managers will provide:

- Issue urgent/emergent treatment authorization numbers to providers.
- Act as a liaison to PCPs, specialists, and other providers to ensure timely access and the coordination of follow-up care for Member's post emergency care.
- Facilitate Member transfers from emergency departments to contracted hospitals.
- Arrange facility transfer ambulance transport services.
- Assist Members with non-emergent transportation services for weekend appointments when needed.
- Provide network resource information to Members and providers.
- Assist in pharmacy issues.
- Link Blue Shield Promise contracted physicians to ED physicians when necessary.

For additional support, the case manager has access to the Chief Medical Officer (CMO), or an alternate covering physician, to assist in physician related issues.

Upon receipt for a request for authorization from an emergency provider, a decision will be rendered by Blue Shield Promise within 30 minutes, or the request will be deemed as approved. If assistance is necessary for directing or obtaining authorization for care after the immediate emergency is stabilized, the on-call nurse will assist as the liaison to PCPs, specialists, and all other providers to ensure timely access and the effective coordination of all medically necessary care for the Member.

Nurse Advice Line

Blue Shield Promise Cal MediConnect Members can access the Nurse Advice Line to receive fast and free medical advice over the phone. Registered nurses are available 24 hours a day – 7 days a week, including weekends and holidays. Members can call the Nurse Advice Line at (800) 609-4166.

5.3.6: Urgent / Emergent Admissions

Prior authorization is not required for emergency admissions (see Emergency Services for definition of "Emergency Medical Condition"). However, authorization should be attempted for urgent admissions. If the admitting physician is not the Member's PCP, the PCP should be contacted prior to admission when possible.

Plan Notification

All contracted per diem hospitals must notify the Blue Shield Promise UM Department of inpatient admissions to the Blue Shield Promise UM Department by faxing the hospital admission (face) sheets within 24 hours of admission, except for weekends and holidays. Upon receipt of the hospital admission sheet, the UM Department will record a tracking number on the hospital admission sheet and fax it back to the hospital. The hospital admission sheet comes from the hospital.

If no admission notification is received from the hospital by the next business day (with exception of weekends and holidays), the authorization for admission and continued stay will then be based on concurrent and/or retrospective review procedures.

5.3.7: Concurrent Review

Blue Shield Promise provides for continual reassessment of all acute inpatient care. Other levels of care, such as partial day hospitalization or skilled nursing care, may also require concurrent review at the discretion of Blue Shield Promise.

Review may be performed on site or may be done telephonically. Authorization for payment of inpatient services is generally on a per diem basis. The authorization is given for the admission day and, on a day-to-day basis thereafter, contingent on the condition that the inpatient care day has been determined to satisfy criteria for that level of care for that day. Any exceptions to this (i.e., procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment.

The date of the first concurrent review will generally occur on the second hospital day. The benefit of this process is to identify further discharge planning needs the Member may have due to unforeseen complications and or circumstances.

Clinical information may be obtained from the admitting physician, the hospital chart, or the hospital Utilization Review (UR) Nurse. The UM Clinician will compare the clinical presentation to pre-established criteria (MCG Guidelines). If the criteria are satisfied, an appropriate number of days will be authorized for that stay. If the Member remains inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized for elective admissions are variable and are based on the medical necessity for each day of the Member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the CMO.

5.3.8: Discharge Planning

The purpose of discharge planning is to identify, evaluate and coordinate the discharge planning needs of Blue Shield Promise Members when hospitalized. Discharge planning will begin on the day of admission for unscheduled inpatient stays. The review process will include chart review, data collection, and review of the care plan by the attending physician and other Members of the healthcare team. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process.

The goal of the discharge planning process is to follow Members through the continuum of levels of care until the Member is returned to his/her previous living condition prior to hospitalization, when possible. This approach is performed to ensure continuity of care and optimum outcomes for Blue Shield Promise Members.

Multiple factors are taken into consideration to effectively evaluate the Member's clinical and psychosocial status for discharge needs. This includes the active problem, clinical findings, Member's past medical history and social circumstances, and the treatment plan.

If the PCP was not the Attending Physician of the Member while hospitalized, all efforts will be made to notify him/her of any arrangements made for the Member. This may be done by one of the following mechanisms:

- Dictated hospital summary note from the Attending Physician
- Phone call from the Attending Physician
- Phone call from the Blue Shield Promise UM Clinician
- Inpatient Hospital Notification Form faxed by the UM Clinician

5.3.9: Retrospective Review

Blue Shield Promise reserves the right to perform a retrospective review of care provided to a Member for any reason. There may also be times during the process of concurrent review (especially telephonic) that the UM Clinician does not receive sufficient information to meet the criteria (MCG Guidelines). When this occurs, the case will be pended for a full medical record review to the CMO or designated physician reviewer.

All retrospective review referrals are to be turned around within 30 business days after obtaining all necessary information. Notification of retrospective review denials will be in

writing to the Member and the provider.

When a retrospective UM review indicates that there has been an inappropriate provision of care, the case will be referred to the Quality Management Department for further investigative review and follow-up.

5.4: Direct Access to Women's Health Services

Blue Shield Promise provides for direct access to women's health services for routine and preventive health care services such as annual well woman exams. These services must be provided by a Gynecologist within the IPA/medical group network. These services do not require prior authorization. Any treatments, procedures or surgeries that are recommended as a result of this evaluation will require prior authorization from the IPA/medical group.

As of July 2019, California law (AB 2193) requires that licensed health care practitioners providing prenatal or postpartum care for a patient must ensure the patient is offered a screening, or is appropriately screened, for any type of mental health conditions that may be occurring. In accordance with the law, Blue Shield Promise requires all participating network practitioners, as well as delegated entities that contract with individual practitioners, to comply with the requirement included in Article 6, Section 123640 (September 2018) of California's Health and Safety Code, following approval of the Assembly Bill 2193 (AB 2193) approved in September 2018.

Blue Shield Promise has developed a Maternal Mental Health Program to assist participating practitioners and delegated entities in implementing the requirement. Providers may visit the Blue Shield Promise provider website Maternal Mental Health Services Program link at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/maternal-mental-heath-program to view information on required frequency of maternal mental health screenings, approved screening tools, and the appropriate codes to submit with encounters data once the screening has occurred.

5.5: Advance Directive

Blue Shield Promise implements policies and procedures on advance directives for its Members and allows a Member's representative to facilitate care or treatment decisions for a Member who is unable to do so. Blue Shield Promise allows a Member or Member's representative to be involved in decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.

5.6: Care Coordination and Integration

Blue Shield Promise facilitates access to care for Members with specific care needs which includes arrangements with community and social services programs. This includes transition to and coordination of care by contracted and non-contracted providers. Blue Shield Promise Case Managers implements procedures to ensure that services are appropriately coordinated. Blue Shield Promise educates providers about coordinated Cal MediConnect benefits for which Members are eligible and about Members' special needs.

5.7: Non-discrimination in Healthcare Delivery

Blue Shield Promise ensures 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.

5.8: Clinical Practice Guidelines

Blue Shield Promise, in collaboration with the Blue Shield Promise Medical Services Committee, approves clinical practice guidelines that are available for physician reference. Please contact the Blue Shield Promise Quality Management Department if you would like to receive these guidelines.

The current set of clinical practice guidelines include:

- Cardiac Care Guideline
- COPD Care Guideline
- Asthma Management Guideline
- Diabetes Management Guideline
- Attention Deficit Hyperactivity Disorder (ADHD) Guideline
- Major Depressive Disorder Guideline
- Major Depressive Disorders Unique to Women Guideline
- Schizophrenia Guideline

Clinical Practice Guidelines

Clinical Practice guidelines provide evidence-based recommendations for the assessment and treatment of various disorders. Additionally, the Clinical Practice Guidelines are reviewed and approved every two (2) years through our Medical Services Committee.

All guidelines used for the Blue Shield Promise CARES Disease Management Program are nationally recognized and represent appropriate standard of care for each condition.

Disease Management Program

Blue Shield Promise provides a Disease Management Program that oversees and manages a defined Member population with chronic conditions by the consistent application of approved guidelines and criteria to achieve optimum Member outcomes with a focus on Member self-care efforts.

The intent of the Disease Management is to enhance quality of life and activities of daily living, improve the disease pathway, to reduce health care service usage and costs associated with avoidable complications, such as emergency room visits and hospitalizations.

A focus of the program is to ensure a standardized approach in providing an educational pathway to assist Members with management of their chronic condition(s).

Blue Shield Promise Disease Management establishes ongoing dialog and one-to-one communication with Members to assist in setting goals, developing actionable care plans, motivating the Member to succeed by achieving benchmarks in their care and encouraging Members to make the right choices regarding lifestyle changes. This Program is designed to inspire Members to participate actively in the management of their chronic conditions and focuses on improving the Member's health and quality of life. Optimal care implementation can lead to measurable reduction in costs and improved outcomes.

Blue Shield Promise Disease Management is considered a multidisciplinary, continuum-based approach to the delivery of health care, proactively identifying distinct populations with a chronic condition considered high-risk. Chronic conditions included in the program are Chronic Lung Disease, Congestive Heart Failure, Diabetes, and Coronary Artery Disease. It reinforces the Member-practitioner relationship, prescribed plan of care with a focus on Member self-management, prevention of condition exacerbation, understanding signs and symptoms, various lifestyle choices, medication management, and minimizing complications through the application of evidence-based practice guidelines within a structured program. The Blue Shield Promise Disease Management Program continuously assesses the Member's clinical condition and reinforces a Member empowerment approach to improve overall health status through shared decision-making.

The Blue Shield Promise Disease Management Program content addresses the following for each disease condition:

- Condition monitoring:
  - Includes Member reminders for self-monitoring tests or practitioner office testing
  - Initial and ongoing assessments by the Case Manager to assess how well the high-risk Member is managing their care
  - Quality of life/functional status questions included in assessment
  - Symptom monitoring

- Adherence to treatment plans:
  - Includes adherence to self-monitoring activities, medication adherence and scheduled practitioner visits
  - Telephonic calls to Member by the Case Manager to assess:
    - Adherence to medications
    - Preventive care
    - Disease specific education
      - Action plan
      - Daily treatment plan
      - Recognize signs and symptoms of worsening condition
      - Keeping appointments with providers
      - Community education classes
      - Educational mailings
      - Enhance communication between Member and Providers
- Consideration of other health conditions:
  - Assessing co-morbidities, cognitive/functional status
- Lifestyle issues
  - Addresses factors effecting chronic condition(s)
  - Targeted mailings and telephonic interventions including:
    - Smoking cessation
    - Nutrition
    - Triggers
    - Medication compliance
    - Obesity
    - Lack of exercise
    - Alcohol/drug abuse

Blue Shield Promise Disease Management Program interaction with Members is conducted either telephonically and/or via written correspondence.

Medicare: CHF & COPD Medi-Cal: Asthma & CHF

Please feel free to contact the Utilization Management Department if you have additional questions at (800) 468-9935.

Blue Shield Promise Transitional Care Management Program

It is clearly established that hospital readmissions contribute significantly to the health care costs for the Medicare program. The most vulnerable Members affected by this problem are our Special Needs Plan (SNP) Members. CMS requires that all SNP Plans have a Care Transition Program in place.

Blue Shield Promise's Transitional Care Management (TCM) Program has been developed to meet all CMS requirements and deliver high quality care to our SNP Members during transition of care episodes. A care transition is defined as any time a Member moves from one care setting to another. Anytime a Member is admitted from home to the hospital or discharged from the hospital to the Skilled Nursing Facility and eventually back home they are experiencing a care transition.

Blue Shield Promise's care transition team is comprised of Case Managers, Social Workers, Pharmacists, Physicians and Care Coordinators. This team will work closely with the Member and/or caregivers to assist them through each care transition concurrently. Every time a care transition occurs, the PCP will be notified in writing. Once the Member transitions to their home, the Care Manager will call the Member and perform a comprehensive hospital discharge assessment and medication reconciliation.

The Care Manager will also assist the Member with making an appointment to see the PCP and or any specialists needed. Copies of both the Hospital Discharge Assessment and a Medication Reconciliation Form will be mailed to the PCP.

We are confident that this program will be successful in lowering our readmission rates and improving the quality of care our SNP Members receive.

Please visit the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/transitional-care-management for program information.

Model of Care – Special Needs Plan

The Centers for Medicare & Medicaid Services issued final regulations on the Medicare Improvements for Patients and Providers Act of 2008, also known as MIPPA. As part of this regulation, the Special Needs Plan Model of Care was implemented as of January 1, 2010.

The SNP Model of Care requires that all SNP Members receive an initial Health Risk Assessment (HRA) within 90 days of enrollment, and that an Individualized Care Plan (ICP) be created for each Member. The ICP will be developed and shared with the Member, the PCP and any other parties involved in managing the Member's care such as IPA/medical group case managers or social workers. The purpose is to encourage the early identification of the Member's health status and allow coordinated care to improve their overall health.

Health Risk Assessment (HRA) Process

Blue Shield Promise has created a standardized HRA that evaluates the physical, psychosocial, cognitive, and functional needs of the SNP Member. Blue Shield Promise has contracted with a vendor to perform the telephonic HRA. The process is as follows:

- All HRAs will be conducted telephonically from vendor's centralized call center.
- All successful and unsuccessful attempts will be documented and reported to Blue Shield Promise on a weekly basis.

Care Plan Process

Depending on the answers to specific HRA questions, an Individualized Care Plan is generated. The Care Plan is comprised of problems, interventions, and goals. The problem is specific to the identified issue based on the Member's answer to the particular question. The intervention is targeted to address the associated problem and either a short term or long-term goal is triggered.

The Member and Member's PCP receive a cover letter explaining the HRA process and the Individual Care Plan. The PCP also receives a summary of the Member's responses to the HRA. The Blue Shield Promise HRA is available on the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/snp-model-of-care.

SECTION 6: PHARMACEUTICAL MANAGEMENT

6.1: Medication Therapy Management Program

Blue Shield Promise Health Plan provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The MTMP is for members meeting all of the following criteria:

- Have two of the following conditions:
    - Chronic Heart Failure (CHF)
    - Diabetes
    - Hypertension
    - Osteoporosis
    - Respiratory Disease
- Receive seven or more different covered Part D maintenance medications monthly
- Likely to incur an annual cost threshold established by the Centers for Medicare & Medicaid Services (CMS) each calendar year for Medicare covered prescriptions

Members meeting these criteria will be automatically enrolled in the MTMP at no additional cost relating to the program and they may opt-out if they desire.

Members have the option to speak with a designated pharmacist to discuss their medication therapy issues. The pharmacist consultations are designed to improve member health while controlling out-of-pocket costs and may include topics such as:

- Drug adverse reactions
- Drug side-effects
- Drug-drug interactions
- Drug-disease interactions
- Medication non-compliance and non-adherence
- Duplicate therapy
- Dosing that can be consolidated
- Non-prescription drug use

A written summary of the consultation with relevant assessments and recommendations will be provided to the member. The member's prescribing physician or primary care physician may be contacted by the pharmacist to coordinate care or recommend therapy changes when necessary.

6.2: Pharmaceutical Quality Assurance

Blue Shield Promise established measures and systems to conduct drug utilization reviews for all our Members to make sure that they are getting safe and appropriate care. The programs include real-time and historic review of prescriptions claims to reduce medication errors and adverse drug interactions. These reviews are especially important for Members who have more than one doctor who prescribe their medications, use more than one drug, or have more than one pharmacy.

Blue Shield Promise conducts drug utilization reviews when the pharmacy fills a prescription at the point-of-sale. The claim may be electronically reviewed for the following:

- Screen for duplicate drugs that are unnecessary because the Member is taking another drug to treat the same medical condition.
- Age-related contraindications
- Gender-related contraindications
- Drug-Drug interactions
- Incorrect drug dosage
- Drug-Disease contraindications
- Drug-Pregnancy precautions
- Clinical abuse or misuse

In addition, retrospective drug utilization reviews identify inappropriate or medically unnecessary care. We perform ongoing, periodic review of claims data to evaluate prescribing patterns and drug utilization that may suggest potentially inappropriate use.

6.3: Pharmaceutical Utilization Management

This program incorporates utilization management tools to encourage appropriate and cost-effective use of Part D medications. The Blue Shield of California Pharmacy & Therapeutics Committee reviews and approves these requirements to provide quality coverage to our Members. These tools include, but are not limited to prior authorization, clinical edits, quantity limits and step therapy.

- Age Limits: Some drugs may require a prior authorization if the patient's age does not meet the manufacturer, FDA, and clinical practice guidelines.
- Quantity Limits: For certain drugs, we limit the amount of the drug we will cover per prescription or for a defined period. Similar to the age limit, the quantity limit threshold is based on manufacturer, FDA, and clinical practice guidelines.
- Prior Authorization: Prior authorization is required for certain drugs. Typically, a prior authorization is established to ensure appropriate use.
- Step Therapy: In some cases, Blue Shield Promise will require that the patient has a trial of a first-line medication, prior to approving a second-line medication.
- Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates "brand only". If an FDA-approved generic alternative is available on the Blue Shield Promise Health Plan Formulary, the prescribing physician will need to submit medical justification for the use of the brand product.

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

The Blue Shield Promise Health Plan Formulary is available on the Blue Shield Promise website at www.blueshieldca.com/promise. To ensure Members receive high quality, cost-effective and appropriate drug therapy, Blue Shield Promise will maintain drug formularies consistent with the required pharmacy benefit design. The formularies will be maintained by the Blue Shield of California Pharmacy & Therapeutics (P&T) Committee.

6.3.1: Prior Authorizations and Exceptions

Many medications on the formulary are covered without prior authorization. However, some medications require the patient's prescription and medical history to establish medical necessity and to evaluate use of preferred, formulary alternatives prior to coverage.

Medications not covered on the formulary or that are prescribed outside of coverage rules require an exception for coverage based on medical necessity. Types of exceptions include:

- Formulary exceptions. Coverage of a non-formulary (non-listed) drug when formulary alternatives are not appropriate for the individual patient.
- Waiver of coverage restrictions or limits, such as prescription quantity limits or step therapy protocols for prior use of preferred drugs.

If a drug is not listed in the Blue Shield Promise Health Plan Formulary or requires a prior authorization, the prescriber or member may contact Blue Shield Promise Member Services to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Promise Health Plan Formulary and not covered, the member has two options:

- The member can ask the prescriber to prescribe a different drug, one that is part of the Blue Shield Promise Health Plan Formulary.
- The member can request that Blue Shield Promise make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

If a member recently joined Blue Shield Promise and is taking a drug not listed in the Blue Shield Promise Health Plan Formulary at the time the member joined, the member may be eligible to obtain a temporary supply. For more information, please refer to the next section, which reviews the rules that govern dispensing temporary supplies of a non-formulary drug.

To request prior authorization or an exception to cover a drug by Blue Shield Promise Heath Plan, please contact Provider Customer Service Department at (800) 468-9935, Monday through Friday, 8:30 a.m. to 5 p.m. PST, excluding holidays. Prior authorization requests can be submitted electronically by utilizing an electronic prior authorization vendor such as Surescripts or Cover My Meds. Prior authorization requests can also be

faxed to (888) 697-8122. 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 www.blueshieldca.com/promise.

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. The determination will be communicated to the provider in writing and by phone/fax once the final determination has been made.

Transition Policy

New Blue Shield Promise 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 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 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 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 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 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 (888) 697-8122 at any time or requests may be submitted electronically through the electronic health record, if available. Prior authorization requests can be submitted electronically by utilizing an electronic prior authorization vendor such as Surescripts or Cover My Meds. 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 www.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.

6.4: Reporting

Blue Shield Promise provides IPA/medical groups access to pharmacy claim files. These files are available by the 10th of each month and can be accessed via a secure web portal. To obtain access, IPA/medical groups are required to complete an access request form. To request an access request form, an email can be sent to BSCCalinxRx@blueshieldca.com. Once the access request form has been submitted and approved, access instructions and additional information will be sent to the requestor.

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SECTION 7: QUALITY IMPROVEMENT

7.1: Quality Improvement Program

Mission Statement

Blue Shield Promise Health Plan's mission is to ensure all Californians have access to high-quality health care at an affordable price. Blue Shield Promise's Quality Program is comprehensive and designed to objectively, systematically, and continuously monitor, evaluate, and improve the quality of care and/or services delivered to all Blue Shield Promise members and providers. Quality improvement activities are conducted in all areas and dimensions of clinical and non-clinical member care and service. Performance improvement projects and activities are selected and conducted using methodologies and practices that conform to respected health services research entities as well as standards and best practices established by regulatory and accrediting bodies.

Goals

- Improve the quality and efficiency of health care.
- Improve members' experiences with services, care, and their own health outcomes.
- Deliver an exceptional quality program across the organization.

Objectives

- Ensure that timely, quality, medically necessary, and appropriate care and services that meet professionally recognized standards of practice are available to members.
- Deliver quality care that enables enrollees to stay healthy, get better, manage chronic illness and/or disabilities and improve and maintain quality of life.
- Ensure our members are afforded accessible health care by continually assessing the access to care and availability of our network of primary care and specialty providers.
- Implement or improve programs and services that support the elimination of health care disparities in our membership.
- Adhere to National Culturally and Linguistic Appropriate Services (CLAS) standards.
- Ensure the provider network is sufficient to meet the language needs and preferences of the membership.
- Ensure any language spoken by at least 5% of our membership is addressed by languages spoken by our provider network.

- Provide a confidential mechanism of documentation, communication, and reporting of Quality Improvement issues and activities to the Quality Management Committee (QMC), Quality Oversight Committee, Board Quality Improvement Committee (BQIC), Compliance Department, and other appropriate involved parties.
- Assess the effectiveness of the Quality Improvement Program across all lines of business and act on opportunities for improvement.
- Ensure that Blue Shield Promise is meeting member cultural and linguistic needs at all points of contact.
- Ensure members have access to all medically necessary covered services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Ensure mechanisms are in place to identify and address patient safety issues.
- Maintain an adequate, qualified provider network based on a thorough credentialing process.
- Assure compliance with the quality requirements, standards, and guidelines of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA, and escalate issues to the appropriate department.
- Identify potential risk management issues.
- Conduct oversight of all delegated activities, identify opportunities for improvement and ensure action is taken.
- Ensure that mechanisms are in place to support, facilitate and improve continuity and coordination of care.
- Ensure adequate clinical resources are in place to administer the quality program, including a full-time medical director whose responsibility is direct involvement in the implementation of the QI activities, in accordance with Title 22 CCR Section 53857.
- Ensure accountability through involvement of the governing body, designation of the Quality Oversight Committee and Quality Management Committee (QMC) with oversight and performance responsibility, delegation of the Medical Director with supervision of QI activities, and inclusion of contracting practitioners and providers in the QI process and performance review.
- Effectively interface with all interdisciplinary departments and practices for the coordination of quality improvement activities.

Scope

The scope of the Quality Improvement Program is to monitor care and service and identify opportunities for improvement of care and services to both our members and providers/practitioners. This is accomplished by evaluating data, and leading or supporting the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program include but are not limited to:

- Adverse outcomes/sentinel events
- Medicare Chronic Care Improvement Program (CCIP)
- Credentialing and Re-credentialing
- Clinical measurement and improvement monitoring
- Compliance with regulatory requirements and reporting
- Culturally and Linguistically Appropriate Services Delegation Oversight (Claims, Credentialing, and Utilization Management)
- Evidence-based practice guidelines
- High risk and high-volume services
- Facility site reviews
- Initial Health Assessments
- Independent Physician Associations (IPA)/Medical Group Oversight
- Medication Therapy and Management
- Medical record keeping practices
- Member safety
- Member satisfaction/grievances
- Dual Special Needs Plan (DSNP) Model of Care
- Potential Quality Issues
- Peer Review
- Practitioner accessibility and availability
- Practitioner satisfaction/grievances
- Provider Incentives
- Performance Improvement Projects (PIPs)
- Plan-Do-Study-Act (PDSA)

Confidentiality and Conflict of Interest

All information related to the quality improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and reviews, are housed in a designated, secured area in the Quality Improvement Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All quality improvement activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPPA) for patient's confidentiality. All persons attending the Quality Management Committee (QMC), or its related committee meetings will sign a confidentiality statement, and all Blue Shield Promise personnel are required to sign a confidentiality agreement upon employment. Only designated employees by the nature of their position will have access to member health information as outlines in the policies and procedures.

No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical/financial decision making and all committee members. Committee chairs and the Chief Medical Officer sign a statement of this understanding.

7.1.1: Program Structure Governing Body

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

Committees

Quality Management Committee

The Quality Management Committee (QMC) is charged with the development, oversight, guidance, and coordination of Blue Shield Promise quality activities. Comprised of a voting membership of network providers, the QMC also assures compliance with accrediting and regulatory quality activities from entities such as DHCS, DMHC, CMS, NCQA, and L.A. Care. The QMC monitors provisions of care, identifies problems, and recommends corrective action, and informs educational opportunities for practitioners to improve health outcomes. Chaired by the Chief Medical Officer or physician designee, the Quality Management Committee reports to the Quality Oversight Committee and meets at least four times per year. The following sub-committees report up to the Quality Management Committee:

- Access and Availability
- Behavioral Health
- Medical Services

Scope *(includes but not limited to):*

- Directing all Quality Improvement activities.
- Monitoring, evaluating, and directing the overall compliance with the Quality Improvement Program.
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols. Recommending policy decisions.
- Reviewing, analyzing, and evaluating Quality Improvement activities.
- Ensuring practitioner participation in the QI program through planning, design, implementation, and review.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA, and L.A. Care.
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Behavioral Health, Medical Services, Model of Care, and Timely Access & Availability).
- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions, and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.

- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
- Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies.
- Responsibility for evaluating and giving recommendations from monitoring and tracking reports, including appeals and grievances, potential quality investigations, member service metrics, Initial Health Assessments, and Facility Site Review.
- Ensuring follow-up, as appropriate.

Delegation

Blue Shield Promise may delegate any or all utilization management (UM), credentialing, and/or claims functions to Independent Practice Associations (IPAs), hospitals, medical groups, or vendors. A pre-delegation assessment is conducted within 12 months of implementing a delegated relationship, to assess the entity's ability to perform the proposed delegated functions.

Blue Shield Promise is ultimately responsible for all care and services provided to its members directly or through a delegated arrangement. Blue Shield Promise's ongoing delegation oversight activities are directed by the Delegation Oversight Committee (DOC).

Blue Shield Promise ensures all functions delegated by Blue Shield Promise to providers, vendors, or other organizations, either first tier, downstream or related entities (FDRs), are performed according to accreditation, regulatory, and Blue Shield Promise requirements. At least annually, Blue Shield Promise reviews the delegate's programs, policies and procedures, and data systems and files, if applicable to the delegated relationship. At least quarterly, delegates are required to submit performance reports, which are reviewed for compliance. Any identified deficiencies require a corrective action plan, which will be monitored until activities are compliant. If needed, additional actions, up to and including de-delegation, are taken for groups that do not correct deficiencies.

7.1.2: Standards of Practice

The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the Quality Improvement process are based on professionally recognized standards. These standards are used to evaluate quality of care of practitioners/providers and are incorporated into policies and procedures. Sources for standards include but not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Review of applicable medical literature
- Available medical knowledge
- State and federal requirements

Thresholds and targets derived from these standards and norms are:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines
- Valuable to the assessment and improvement of quality for members

Standards are communicated to practitioners through the Plan in a systematic manner that may include but not limited to:

- Blue Shield Promise Health Plan Provider Manual
- Newsletters
- Bulletins
- Provider mailings

7.1.3: Quality Improvement Process

Blue Shield Promise utilizes a Quality Improvement Process to identify opportunities to improve both the quality of care and quality of service for all Plan members. Blue Shield Promise adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured.

Blue Shield Promise uses a continuous quality improvement (CQI) process to measure performance, conduct quantitative and qualitative analysis, and assess and identify barriers and opportunities for improvement. Interventions are implemented to improve performance and are remeasured to determine effectiveness of the interventions.

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

- Quality Screens
- Chronic Care Improvement Plans
- HEDIS
- QIA Studies
- Monitors
- Indicators
- Medical Record Audits
- Facility Site Reviews
- Outcome Measures
- Focused Review Studies
- Member Satisfaction Surveys
- Practitioner/Provider Satisfaction Surveys
- Access to Care Audits

Contracted providers, including IPA/medical groups, are required to abide by and comply with the provisions of, and participate in, Plan's Quality Improvement Program (including the applicable Dual Special Needs Plan Model of Care) as described in this Provider Manual.

Contracted providers, including IPA/medical groups, shall comply with all Blue Shield Promise administrative policies and procedures as described in this Provider Manual, as well as with all applicable state and federal laws and regulations relating to the delivery of Covered Medical Services. Providers/medical groups may appeal adverse determinations in accordance with the procedures established by Blue Shield Promise.

Failure to comply with the requirements of the Quality Improvement Program or to abide by Blue Shield Promise's policies and procedures may be deemed by Blue Shield Promise as a material breach of this Agreement, and may, at Plan's option, be grounds for termination of contract.

Quality of Care Reviews

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

During the review process, requests for additional information may be made to the IPA/Medical Group or directly to the involved provider. Upon review completion and dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a corrective action request or an educational letter outlining opportunities for improvement. Provider monitoring related to quality of care occurs on an ongoing basis as new potential quality issues are received and on an aggregate basis along with service complaints at least every six (6) months. Patient safety concerns or patterns of poor care can be considered during Blue Shield Promise re-credentialing activities or reviewed in more detail by the Credentialing Committee and may result in termination from the Blue Shield Promise network.

Contracted providers are obligated to participate in quality of care reviews and provide requested documents. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157.

Quality Studies (HEDIS/QISMC/QIA/Focused Review Studies)

QI Department staff will perform quality studies, as indicated, based on findings from reviews of QCIs, utilization data, pharmacy data, complaints and grievances, satisfaction survey results, medical record audit results, facility site review results and other clinical indicators. In addition, Blue Shield Promise will participate with collaborative plans and regulatory agencies in state required HEDIS/QISMC/QIA studies. Studies conducted jointly with regulatory agencies will be in accordance with regulatory agency and state requirements. Quality studies conducted independent of regulatory bodies will be in accordance with Blue Shield Promise policies and procedures.

Credentialing

Blue Shield Promise conducts a credentialing process that follows all regulatory and oversight requirements.

7.1.4: Communication of Information

All Quality Improvement activities are presented and reviewed by the Quality Management Committee. Communication to the Quality Management Committee may include but not limited to:

- Access to Care (Appointment Availability, After-Hours, Ancillary)
- Delegation audit results
- Disability and Equality Program
- HEDIS and Quality Outreach summary
- Initial Health Assessment
- Facility Site Review and Patient Safety
- Member Call Timeliness and Abandonment Rate summary
- Member grievance statistics and trends
- Medical Record and Facility review audit reports and trends
- Study outcomes (Geo Access – Distance and Language Accessibility to providers)
- Policies and Procedures
- Provider and Member (CAHPS) Satisfaction survey results
- Quality Compliance
- Quality Improvement activities
- Quality Improvement Program, Work Plan, Annual Evaluation, and Quarterly Reports
- Regulatory and legislative information

Results of Quality Improvement activities are communicated to Practitioners in the most appropriate manner including, but not limited to:

- Correspondence with the Practitioners showing individual results and a comparison to the group
- Correspondence with the IPA/PMGs showing results and comparisons to the network
- Newsletter articles
- Fax updates
- Provider Manual updates

The Quality Improvement Program description is made available to all practitioners and members. Members and practitioners are notified of the availability of the Quality Improvement Program through the Member Handbook, Provider Manual, and website, respectively.

Quality Improvement Program and Policies and Procedures

The Quality Improvement Program and its policies and procedures are reviewed at least annually and revised, as needed, to meet the needs of the Plan, its members, and practitioners/providers; the changing demands of the healthcare industry, and regulatory requirements. The program description, work plan, and annual evaluation are reviewed and approved by the Quality Management Committee and Board Quality Improvement Committee (BQIC). Quality Improvement policies and procedures are reviewed and approved by the Quality Management Committee.

Annual Work Plan

The Quality Work Plan outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the Quality Management Committee, Quality Oversight Committee, and BQIC.

The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement.

Annual Program Evaluation

An annual evaluation is conducted each year to assess the quality activities that took place the prior year. The Clinical Quality department coordinates with the business areas responsible for the respective work plan activities to ensure the data collection, assessment of whether goals were met, quantitative and qualitative analysis, and identification of opportunities for improvement and/or corrective action if goals were not met. Any opportunities for improvement and corrective actions inform the subsequent year's Quality Improvement Program and work plan.

The Annual Evaluations are reviewed by the Chief Medical Officer and submitted to the Quality Management Committee, Quality Oversight Committee, and Board Quality Improvement Committee (BQIC) for review and approval.

7.2: Quality of Care Focused Studies

Policy

The Blue Shield Promise Quality Improvement Department develops quality improvement studies based on data collected through various methods including, but not limited to, encounter data, claims data, complaints and grievances, potential quality of care issues (PQI), access and availability surveys, and satisfaction surveys. Blue Shield Promise participates with regulatory agencies in the state-mandated Quality Improvement System for Managed Care (QISMC), Health Plan Employer Data and Information Set (HEDIS), and Quality Improvement Activities or Projects (QIAs or QIPs). Studies conducted in collaboration with other health plans and statewide collaborative Quality Improvement Projects will be conducted in accordance with regulatory agency requirements. Focused review studies conducted independent of a regulatory agency will be in accordance with the procedures as described herein.

Procedure

1. Focused review studies will include the following design elements:
   - Objective and reason for topic selection
   - Sampling framework and sampling methodology
   - Data collection criteria and analysis methodology
   - Report of data and/or findings
   - Quantitative/Qualitative analysis Barrier analysis
   - Action plans, as appropriate
   - Reassessment, as appropriate

2. The study will be designed to produce accurate, reliable, and meaningful data in accordance with standards of statistical analysis. The study questions will be framed using information from scientific literature, professional organizations, practitioner/provider representatives, regulatory requirements, and outcome-related data. The practice guidelines/quality indicators used in the study will be specified, whenever possible. The variables to be collected and analyzed will be defined and derived from the practice guideline/quality indicators.

   Data may be collected through a variety of methods including, but not limited to member surveys, practitioner/provider surveys, medical record audits, on-site practitioner/provider facility inspections, analysis of encounter/claims data, analysis of prior authorization data, and analysis of Member complaints and grievances.

   a. Data may be collected through sampling or may include the entire population that meets the study criteria. The following criteria should be considered in making this decision:
      - The size of the member population eligible for study.
      - The method of data collection (e.g., administrative data, medical record

review or hybrid of both).
- The nature of data to be collected.
- The degree of confidence required for the data.

b. The following questions will be used to determine the method for validating the results:
   - How will the raw data collected be verified?
   - What statistical analytical tests will be performed on the data?
   - What adjustments for age, severity of illness, or other variables, which may affect the findings, will be made?
   - What is an acceptable level of performance?

3. The Quality Improvement Department, in conjunction with the Chief Medical Officer will analyze and interpret study results and develop a corrective action plan to address the findings. Results will be compared to recognized, relevant benchmarks, when available. Action plans will include:
   a. Expected outcomes that must be expressed in measurable terms
   b. Specific interventions/actions to be taken to positively impact the problem.
   c. Improvement actions/interventions may include but are not limited to the following:
      - Assign members to case manager for specialized attention
      - Re-engineer organizational processes and structures
      - Provide members with educational materials or programs
      - Develop member incentive programs
      - Introduce new technology to streamline operations
      - Develop employee training programs to improve understanding of health practices of various cultural groups
      - Disseminate practitioner/provider performance data to allow peer measurement
      - Provide educational materials that may be relevant to understanding and treating the population to practitioners/providers
      - Develop clinical practice guidelines through collaboration with plan partners and other collaborative plans
      - Address any practitioner/provider-specific concerns through the peer review process
   d. Implementation schedule
   e. Monitoring plan

4. The results, interpretation and action plan will be presented to the Quality Management Committee for review and approval and then forwarded to the Board Quality Improvement Committee.

5. Reports will be made to the Quality Management Committee as required by the action plan.

6. Results will be made available to members and practitioners through newsletters, bulletins, faxes, special mailings, etc., as appropriate.
7. Sources for standards, norms and guidelines pertaining to the measurement of quality of care include, but are not limited to, the following:
    - National Committee of Quality Assurance standards for quality and utilization management.
    - Other independent credentialing, certification, and accreditation organizations, including Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), JCAHO, CMRI, The Quality Commission, AAAHC and URAC.
    - HEDIS Medicare performance standards. Medicare performance standards.
    - Federal Agency guidelines including the Centers for Medicare & Medicaid Services (CMS), Office of Technology Assessment (OTA), Agency for Healthcare Policy and Research (AHCPR), National Institute of Health (NIH), Department of Health and Human Services (DHHS), Center for Disease Control (CDC), and the United States Public Health Services (USPHS).
    - United States Preventive Services Task Force (USPSTF) guidelines.
    - National consensus organization guidelines for clinical practice.
    - Child Health and Disability Prevention (CHDP) program guidelines.
    - Professional specialty service guidelines, including American Academy of Family Practice, American College of Physicians, American Academy of Pediatrics, American College of Obstetrics and Gynecology, and the American Medical Association.
    - English language peer reviewed medical literature.
    - Milliman Care Guidelines.
    - Pharmacology guidelines extracted from the practice standards of the American Society of Hospital Pharmacists (ASHP) and the PDR.
    - Expert opinion.
    - HMO standards for access to ambulatory care.
    - InterQual Severity of Illness/Intensity of Service (ISSI).
    - Commission for Professional Activity Studies (PAS) length of stay norms.

7.3: Clinician and Member Satisfaction Surveys

Clinician Satisfaction Survey

Blue Shield Promise established and implemented one annual uniform satisfaction survey for clinician practices. The Clinician Satisfaction Survey gauges satisfaction rates to guide Blue Shield Promise's process enhancements geared toward improved access, care delivery and quality that demonstrate year-over-year improvement in the majority of measured categories. Blue Shield Promise conducts the annual Clinician Satisfaction Survey with participating primary and specialty care clinicians using an NCQA-certified/ CMS-approved consultant. Results of the Clinician Satisfaction Survey are summarized and reported to the appropriate departments and committees for follow- up and action.

Member Satisfaction Survey

Blue Shield Promise will conduct a Member Satisfaction Survey at least annually using a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. Results will be summarized and reported to the appropriate departments and committees.

7.4: Clinical Practice Guidelines

Policy

Blue Shield adopts nationally recognized clinical practice guidelines which are reviewed and approved annually through our committees and is overseen by our Utilization Management department.

7.5: Access to Care

7.5.1: Access to Care Standards

Policy

Blue Shield Promise will ensure that all contracted Primary Care Practitioners (PCP) are in compliance with approved access to care standards, as listed in Attachment A. Blue Shield Promise will ensure all contracted Specialty Care Practitioners (SCP) are in compliance with approved standards, as listed in Attachment B; Managed Behavioral Healthcare Organizations (MBHOs are in compliance with approved access to care standards, as listed in Attachment C; Ancillary Providers are in compliance with approved access to care standards, as listed in Attachment D; Long Term Services and Support providers are in compliance with approved access to care standards, as listed in Attachment E. In addition, Blue Shield Promise will provide or arrange for the provision of access to health care services in a timely manner and establish metrics for measuring and monitoring the adequacy. Compliance with these standards is monitored through member complaints and grievances, PQIs, member satisfaction surveys, medical record reviews, disenrollments, PCP transfers, and annual Access Surveys and Studies. Blue Shield Promise will ensure that provider contact lists are generated for all provider groups required to be surveyed for the current measurement year.

Blue Shield Promise shall ensure that its provider network is sufficient to provide accessibility, availability, and continuity of covered health care services established by Section 1300.70 of Title 28.

Procedure

Blue Shield Promise provides and arranges for the provision of covered health care services in a timely manner appropriate for the nature of each member's condition consistent with good professional practice. Blue Shield establishes and maintains provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standards.

1. Primary and specialty care physicians are required to be available to render emergency care to Members 24 hours a day, 7 days a week, either directly or through arrangements for after-hours coverage with an appropriately qualified practitioner/provider. Physicians may provide care in their offices or based on the medical necessity of the case, refer the Member to an urgent or emergency care facility. Blue Shield Promise has a nurse on call to arrange for care if a practitioner/provider is unavailable. If a Member contacts the Plan about an emergency situation, the Plan will direct the Member to an appropriate urgent or emergency care center for immediate assessment and treatment. After-hours access issues will be referred to QI as a potential quality issue (PQI) and handled in accordance with approved procedures.
2. The Plan's Access to Care standards provide that no Member be required to travel any unreasonable distance or for any unreasonable period of time in order to receive covered services. For the purposes of these standards, "reasonable" is determined by analysis of the following factors:
   a. The population density of the geographic area traveled.
   b. Typical patterns of traffic congestion throughout the day.
   c. Established travel patterns in the community.
   d. Established patterns of medical practice in the community.
   e. Natural boundaries and geographic barriers to travel.
   f. Any other relevant factors.

   For Medicare, the minimum number of provider/facilities, network time and distance criteria vary by county type, specialty type, and by year. Please refer to the attachments of CMS standards for network adequacy in Policy # 70.1.1.29.
3. The provider contract allows the Plan to monitor accessibility and requires contracted providers to abide by standards established for accessibility. The provider contract also specifically provides that Members will not be discriminated against with respect to physical accessibility to care. The provider will also ensure reasonable accessibility to emergency services, after hour's coverage and minimal weekly availability for the provision of health care services.
4. The practitioner/provider contract also mandates participation in the Plan's quality of care review program. Participation in the quality of care review program requires practitioner/ provider cooperation with the assessment of quality of care, accessibility, and utilization patterns. The contracted practitioner/provider agrees to take any appropriate remedial action deemed necessary by the Plan.
5. Access & Availability surveys are conducted at least annually using the Access to Care standards as a benchmark. Performance is measured for compliance with the guidelines. Standardized methodology appropriate for this type of survey will be used. Provider types as determined by established methodology are audited annually by the Plan.

6. Access & Availability survey results are reviewed by the Quality Improvement Department and the Quality Management Committee, where opportunities for improvement are identified and discussed. Results and quality activities are reported to the BQIC. Results are communicated to individual providers and to delegated IPA/medical groups through performance notifications, JOCs, newsletters, etc.
7. Selected interventions are implemented to improve performance. These may include written counseling and/or written corrective action plans for physicians not complying with the Access to Care standards. Continued noncompliance may result in referral to the Peer Review Committee for action up to and including termination. Interventions may also include global education for providers and IPA/medical groups regarding the standards.
8. The effectiveness of the interventions is evaluated or re-measured. Additional telephone or mail surveys may be conducted to further evaluate a particular finding.
9. Access to care is also monitored and tracked through Member satisfaction surveys, Member complaints and grievances, potential quality of care issues, Member requested disenrollments and transfers, emergency room utilization and facility site reviews.
10. IPA/medical groups are expected to ensure that each practitioner/provider in their network receives and complies with Appendix 4: Access to Care Standards.

Plan-to-Plan Arrangements

In addition to measuring compliance with clinical appropriateness standards for each member's condition relative to good professional practice, Blue Shield Promise also ensures compliance with the network components offered under plan-to-plan arrangements. Plan-to-Plan arrangements include all or some behavioral health, dental, vision, chiropractic, and acupuncture provider services. Blue Shield Promise ensures that services covered under a plan-to-plan arrangement provide an adequate network for existing and potential member capacity as well as adequate availability of providers offering members appointments for covered services in accordance with the requirements.

7.5.2: Monitoring Process

The effectiveness of this policy will be monitored through oversight by regulatory agencies including DMHC, DHCS, CMS and accrediting entities. Effectiveness will also be measured annually through the annual access to care studies and annual quality improvement program evaluation.

7.6: Broken/Failed Appointments

7.6.1: Broken/Failed Appointment Follow-up

Policy

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients, within 48 hours, who fail to keep scheduled appointments. Outreach to patients is documented within the medical records.

Procedure

The following is a sample "Broken/Failed Appointment" protocol which may be implemented by practitioner/provider offices if no other protocol is currently in place. Blue Shield Promise will monitor its provider network for compliance via oversight activities that may include medical record review, provider surveys and/or review of provider policies.

1. To assure timely and efficient recall of patients who fail to keep scheduled appointments. The primary care, and/or specialty care practitioner/provider is responsible to:
   a. Determine daily whether and what type of follow-up is necessary
   b. Document this decision in the patient chart, using a "Broken/Failed Appointment" rubber stamp. An example is provided here:

Broken/Failed Appointments

BROKEN APPT. DATE:	
REVIEW DATE:	
FOLLOW-UP REQ:	
FOLLOW-UP ASAP:	
NEW APPT. DATE:	
PRACTITIONER / PROVIDER SIGNATURE:	
COMPLETED BY:	

2. At the end of each day the receptionist will determine which patients failed to keep their appointment by:
   a. Checking the appointment schedule and making a list of all failed appointments.
   b. Gathering the pulled charts which were ready for appointments. (Charts are pulled the day before scheduled appointments).
3. Use a progress sheet with the latest date or a new progress sheet and stamp the sheet with the "Broken/Failed Appointment" rubber stamp.

4. Attach the progress sheet to the medical record and forward to the primary care practitioner/provider.
5. The medical assistant (M.A.) or designated individual will review all charts of those patients who missed an appointment and wait for further orders from the practitioner/provider.
6. The practitioner/provider will review the chart to determine the need for patient recall.
7. The practitioner/provider will complete items 2, 3, 4 and 6 as needed, on the Broken/Failed Appointment" rubber stamp, using the following guidelines:
    - Item 2 – Write in review data.
    - Item 3 – Enter a checkmark if follow-up action is ordered.
    - Item 4 – Enter a checkmark if the patient is to return to the clinic as soon as possible.
    - Item 6 – Enter signature and title.
8. If the patient needs follow-up, the M.A. or designated individual shall try to contact the patient one time by phone. If no results, a recall postcard or letter will be mailed out to the patient's current address of record. A copy will be filed in the chart.
9. Every attempt to contact the patient, with date and time of each attempt, must be documented in the progress notes. Only the following staff may document patient recall activities in the medical record: M.D., P.A., N.P., R.N., L.V.N., or M.A.
10. The M.A. completes items 1, 5 and 7 as needed on the broken/failed appointment stamp using the following guidelines:
    - Item 1 – Enter the date of the broken/failed appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 7 – Enter date, signature and title of person doing recall activity.
11. The broken/failed appointment will also be documented in the appointment schedule for tracking purposes.
12. The practitioner/provider is responsible for final decisions concerning a broken/failed appointment follow-up. Patients being followed for reportable conditions shall also be reported to the local health authority.
13. The administrator or office manager is responsible for:
    a. Assuring that all clinic personnel are aware of their responsibilities under this procedure.
    b. Designating, in conjunction with the Medical Director, the persons responsible for implementing this policy.
    c. Periodically monitoring the performance of staff in carrying out their duties.

7.7: Advance Directives

A primary care practitioner/provider is required to offer and/or educate each Member 18 years or older about advance directives. This must be documented in the medical record. The Member does not need to sign any advance directive but must be informed and educated about what an advance directive entails.

7.8: Clinical Telephone Advice

Policy

1. All telephone calls from patients with problems or medical questions must be documented (by date and time of call and return phone number) and promptly brought to the attention of the doctor.
2. At no time shall office personnel give medical advice without the direct involvement of the practitioner/provider or physician assistant.
3. The doctor must renew all prescriptions.
4. In the event a patient calls with a medical emergency, the patient will be instructed to call 911 immediately.
5. Medical groups that offer or contract with a company to offer telephone medical advice services must ensure that the service meets the requirements of Chapter 15 of Division 2 of the Business and Professionals Code, which include registration and monitoring.

Services which only direct patients to the appropriate setting for care (e.g., hospital or urgent care clinic) or prioritize physician appointments are not considered telephone medical advice services.

Blue Shield Promise contracts with a certified vendor for after-hours Nurse Advice line.

7.9: HEDIS Measurements

Use of Practitioners/Providers Performance Data

Practitioners and Providers will allow Blue Shield Promise to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). Blue Shield Promise will also share member experience and clinical performance data with practitioners and providers when requested. Requests should be submitted via email to your delegation coordinator.

Measure	Criteria	Description
1. Controlling High Blood Pressure (CBP)	Blue Shield Promise will audit Members that are age 18 - 85 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	Members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
2. Comprehensive Diabetes Care (CDC)	Blue Shield Promise will audit Diabetic Members that are age 18-75 years of age during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.	Diabetic Members must have the following done during the past year: • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) • Retinal eye exam performed. • Medical attention for nephropathy • BP control (<140/90 mm Hg)
3. Care for Older Adults (COA)	Blue Shield Promise will audit Members that are age 66 and older during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.	The Member must have each of the following during the measurement year: • Advanced Care Planning • Medication Review • Functional Status Assessment • Pain Screening

Measure	Criteria	Description
4. Colorectal Cancer Screening (COL)	Blue Shield Promise will audit Members that are age 50 – 75 who had appropriate screening for colorectal cancer.	Members should have one or more following screenings for colorectal cancer: • Fecal occult blood test (FOBT/iFOBT) during measurement year • Flexible sigmoidoscopy during the measurement year or the four (4)years prior to the measurement year • Colonoscopy during the measurement year or the nine (9) years prior to the measurement year • CT colonography during the measurement year or the four (4) years to the measurement year • FIT-DNA test during the measurement year or the two (2) years prior to the measurement year
5. Osteoporosis Management in Women who had a Fracture (OMW)	Blue Shield Promise will audit female Members that are age 67-85 during the measurement year and suffered a fracture. There must not be more than a one-month gap in enrollment during the measurement year.	Female Members who suffered a fracture must have had either a bone mineral density (BMD) test or prescribed a drug to treat or prevent osteoporosis within six (6) months after the fracture.
6. Plan All-Cause Readmissions (PCR)	Blue Shield Promise will audit Members 18 years of age and older that have acute inpatient stays that were followed by an unplanned acute readmission	Members that have had an acute inpatient stay that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Measure	Criteria	Description
7. Transitions of Care (TRC)	Blue Shield Promise will audit Members that are 18 years of age and older who have had a notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, medication reconciliation post-discharge.	The Member must have each of the following during the measurement year: • Notification of inpatient admission o Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days) • Receipt of discharge information • Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) • Patient engagement after inpatient discharge o Documentation of patient engagement provided within 30 days after discharge • Medication reconciliation post-discharge o Documentation of medication reconciliation on the date of discharge through 30 days after discharge
8. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	Blue Shield Promise will audit the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	At least one claim/encounter for spirometry (Spirometry Value Set) during the 730 days (2 years) prior to the IESD (Index Episode Start Date) through 180 days (6 months) after the IESD.

Measure	Criteria	Description
9. Pharmacotherapy Management of COPD Exacerbation (PCE)	Blue Shield Promise will audit the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.	Dispensed prescription for systemic corticosteroid (Systemic Corticosteroid Medications List) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.
10. Breast Cancer Screening (BCS)	Blue Shield Promise will audit Members that are age 50–74 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	The Member must have at least one (1) bilateral mammogram screen for breast cancer within the past two years.
11. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Blue Shield Promise will audit the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	At least 135 days of treatment with beta-blockers (Beta-Blocker Medications List) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval. Assess for active prescriptions and include days' supply that fall within the 180-day measurement interval. For members who were on beta-blockers prior to admission and those who were dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval.
12. Statin Therapy for Patients with Cardiovascular Disease (SPC)	Blue Shield Promise will audit the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. Received Statin Therapy.	The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.

Measure	Criteria	Description
	Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.	
13. Cardiac Rehabilitation (CRE)	Blue Shield Promise will audit the percentage of members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported: • Initiation. The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event. • Engagement 1. The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event. • Engagement 2. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. • Achievement. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.	At least 2 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 30 days after the Episode Date (31 total days) (on the same or different dates of service). At least 12 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 90 days after the Episode Date (91 total days) (on the same or different dates of service). At least 24 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service). At least 36 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service).
14. Kidney Health Evaluation for Patients with Diabetes (KED)	Blue Shield Promise will audit The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	Members who received both of the following during the measurement year on the same or different dates of service: • At least one eGFR (Estimated Glomerular Filtration Rate Lab

Measure	Criteria	Description
		Test Value Set). • At least one uACR identified by both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
15. 15. Statin Therapy for Patients with Diabetes (SPD)	Blue Shield Promise will audit the percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. 2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	The number of members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.
16. Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Blue Shield Promise will audit the percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).	Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. There are two ways to identify members who received a DMARD: by claim/encounter data and by pharmacy data. The organization may use both methods to identify the numerator, but a member need only be identified by one method to be included in

Measure	Criteria	Description
		the numerator. Claim/encounter data. A DMARD prescription (DMARD Value Set) during the measurement year. Pharmacy data. Members who were dispensed a DMARD during the measurement year on an ambulatory basis (DMARD Medications List).
17. Osteoporosis Management in Women Who Had a Fracture (OSW)	Blue Shield Promise will audit the percentage of women 65–75 years of age who received osteoporosis screening.	One or more osteoporosis screening tests (Osteoporosis Screening Tests Value Set) on or between the member's 65th birthday and December 31 of the measurement year.
18. Antidepressant Medication Management (AMM)	Blue Shield Promise will audit the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Measure	Criteria	Description
19. Follow-Up After Hospitalization for Mental Illness (FUH)	Blue Shield Promise will audit the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.	A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge. A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.
20. Follow-Up After Emergency Department Visits for Mental Illness (FUM)	Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
21. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Blue Shield Promise will audit the percentage of acute inpatient hospitalizations, residential treatment. or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported: 1. The percentage of visits or	A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode. A follow-up visit or event with

Measure	Criteria	Description
	discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.	any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode.
22. Follow-Up After Emergency Department Visits for Alcohol and Other Drug Abuse or Dependence (FUA)	Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
23. Pharmacotherapy for Opioid Use Disorder (POD)	Blue Shield Promise will audit the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members aged 16 and older with a diagnosis of OUD.	New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days.
24. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Blue Shield Promise will audit the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period	The number of members who achieved a PDC of at least 80% for their antipsychotic medications during the measurement year.
25. Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions (FMC)	Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

Measure	Criteria	Description
26. Non-Recommended PSA-Based Screening in Older Men (PSA)	Blue Shield Promise will audit Blue Shield Promise will audit the percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.	A PSA-based screening test (PSA Lab Test Value Set; PSA Test Result or Finding Value Set) performed during the measurement year.
27. Appropriate Treatment for Upper Respiratory Infection (URI)	Blue Shield Promise will audit the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.	Dispensed prescription for an antibiotic medication from the CWP Antibiotic Medications List on or 3 days after the Episode Date.
28. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Blue Shield Promise will audit the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.	Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date.
29. Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)	Blue Shield Promise will audit the percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition, or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis.	Dispensed an ambulatory prescription for an antiepileptic, SSRI, or SNRI (Potentially Harmful Drugs—History of Falls Medications List) or antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Potentially Harmful Drugs—History of Falls and Dementia Medications List) on or between the IESD and December 31 of the measurement year.
30. Use of High-Risk Medications in Older Adults (DAE)	Blue Shield Promise will audit the percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication.	Members who received at least two dispensing events for high-risk medications from the same drug class during the measurement year. Members with two or more dispensing events (any day's supply) for high-risk medications from the same drug class on different dates of service during the measurement year are numerator compliant.

Measure	Criteria	Description
31. Use of Opioids at High Dosage (HDO)	Blue Shield Promise will audit the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.	The number of members whose average MME was ≥90 during the treatment period.
32. Use of Opioids from Multiple Providers (UOP)	Blue Shield Promise will audit the proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers.	Identify all opioid medication dispensing events during the measurement year. Include members who received opioids from four or more different prescribers during the measurement year. Use the NPI to determine if the prescriber for medication dispensing events was the same or different. Identify all opioid medication dispensing events during the measurement year. Include members who received opioids from four or more different pharmacies during the measurement year. Use the NPI to determine if the pharmacy for medication dispensing events was the same or different. Identify all opioid medication dispensing events during the measurement year. Include members who received opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).
33. Risk of Continued Opioid Use (COU)	Blue Shield Promise will audit the percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use.	Use all the medication lists below to identify opioid medication dispensing events for the numerator. Calculate covered days using the instructions in the measure definition.

Measure	Criteria	Description
34. Adults' Access to Preventive/Ambulatory Health Services (AAP)	Blue Shield Promise will audit the percentage of members 20 years and older who had an ambulatory or preventive care visit.	Medicaid and Medicare: One or more ambulatory or preventive care visits during the measurement year. Commercial: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.
35. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Blue Shield Promise will audit the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.	Initiation of AOD treatment within 14 days of the IESD.
36. Frequency of Selected Procedures (FSP)	Blue Shield Promise will audit This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.	Report counts for the procedures as specified regardless of the site of care (e.g., inpatient or ambulatory setting). Report the number of procedures rather than the number of members who had the procedures. Do not double-count the same procedure.
37. Plan All-Cause Readmission (PCR)	Blue Shield Promise will audit for members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability	Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under

Measure	Criteria	Description
	of an acute readmission.	Count of Observed 30-Day Readmissions.
38. Hospitalization Following Discharge From a Skilled Nursing Facility (HFS)	Blue Shield Promise will audit for members 65 years of age and older, the percentage of skilled nursing facility discharges to the community that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days.	The number of observed acute inpatient admission or observation stay hospitalizations for each age and total, for each category (30-day hospitalization, 60-day hospitalization).
39. Acute Hospital Utilization (AHU)	Blue Shield Promise will audit for members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year reported by Surgery, Medicine and Total.	Identify all acute inpatient and observation discharges during the measurement year. To identify acute inpatient and observation discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.
40. Emergency Department Utilization (EDU)	Blue Shield Promise will audit for members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.	Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement year using either of the following: • An ED Visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). • Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set) or an observation stay

Measure	Criteria	Description
		(Observation Stay Value Set).
41. Hospitalization for Potentially Preventable Complications (HPC)	Blue Shield Promise will audit members 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.	
42. Enrollment by Product Line (ENP)	Blue Shield Promise will audit the total number of members enrolled in the product line, stratified by age and gender.	
43. Enrollment by State (EBS)	Blue Shield Promise will audit the number of members enrolled as of December 31 of the measurement year, by state.	
44. Language Diversity of Membership (LDM)	Blue Shield Promise will audit an unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.	
45. Race/Ethnicity Diversity of Membership (RDM)	Blue Shield Promise will audit an unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.	
46. Total Membership (TLM)	Blue Shield Promise will audit the number of members enrolled as of December 31 of the measurement year.	

SECTION 8: ENCOUNTER DATA

8.1: Encounter Data – Cal MediConnect

Policy and Procedures

Encounter Data Submission

Capitated IPAs and medical groups are required to submit all encounter data to Blue Shield Promise, including encounters for primary care, specialty care, and ancillary services.

For Cal MediConnect encounter data, submissions may be made directly to Blue Shield Promise or via a vendor. Regardless of the route of submission, providers may request the professional and facility encounter data specifications and procedures from Blue Shield Promise using the contact information below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

Cal MediConnect Encounter Data

Contact EDI Operations at (800) 480-1221 with EDI questions only.

For encounter processing questions call the Customer Service number on back of the member's card.

Vendors

A list of approved vendors can be found on Blue Shield's Provider Connection website at blueshieldca.com/provider. Click on *Claims*, *Manage Electronic Transactions*, then *Enroll in Electronic Data Interchange*. You may also contact the EDI Helpdesk at (800) 480-1221.

Performance - Regular and Complete Submission of Encounter Data

COMPLIANCE GUIDELINES

Monthly Submission

It is a Blue Shield Promise requirement that encounter data be submitted at least once each month and each submission must be in the correct HIPAA-compliant electronic format with usable data. Files with significant data quality problems may be rejected and may require correction of problems.

Complete Submission

Blue Shield Promise will measure encounter submissions based on a rolling year of utilization data. Beginning April 1, 2014 the Centers for Medicare & Medicaid Services (CMS) requires EOBs for Cal MediConnect members with Medicare Part C. IPAs are required to submit encounter submissions with Maximum Out-of- Pocket "MOOP" for Cal MediConnect members.

For Cal MediConnect encounter data submissions to CMS, there is a compliance measurement reflecting the data collection period. Benchmarks using Evaluation and Management (E&M) CPT codes are used. The benchmarks are:

Cal MediConnect Membership: 8.0 E&M Visits PMPY

Certain types of denied services are included in calculating each IPA/medical group's annual E&M visit rates.

A provider network contract may include an incentive program or capitation withhold provision that would apply for performance, relative to the above benchmarks. The current performance target is at least 90% of the benchmark.

In addition, Blue Shield Promise will analyze the completeness of encounter data submissions for specialty and ancillary services.

Blue Shield Promise requires that, on a periodic basis, an officer of the IPA/medical group attest to the completeness and truthfulness of encounter data submission.

Cal MediConnect Denials

All denied Cal MediConnect encounters should be submitted to Blue Shield Promise, except for duplicate encounters and eligibility denials.

SECTION 9: CLAIMS

9.1: Claim Submission

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

A. Providers are required to submit claims electronically that do not have a medical record attached unless the provider contract specifically states otherwise. Claims are submitted in the ASC X12 837 5010 format. To enroll in electronic claim submission, providers can use any clearinghouse with established Blue Shield of California connectivity. Blue Shield Promise claims must be submitted via Office Ally or Change Healthcare. Primary clearing houses are listed on Blue Shield's Provider Connection website at blueshieldca.com/provider in the *Claims* section under *How to submit claims* or by contacting the EDI Department at (800) 480-1221.

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

   Blue Shield of California Promise Health Plan
   Exela - BSCPHP
   P.O. Box 272660
   Chico, CA 95926

B. Providers must ensure all claims submitted to Blue Shield Promise Health Plan are clean and accurate. Clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

   When submitting paper claims, all required/mandatory fields in the current CMS-1450 or UB format adopted by the National Uniform Billing Committee and CMS-1500 adopted by the National Uniform Claim Committee (NUCC).

   When submitting claims electronically, claims must be HIPAA compliant and meet all requirements for EDI transactions. If you have electronic claim submission questions or if you would like to know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com.

   Claim Data submissions must meet all requirements outlined in the Companion Guides and are exchanged through the established secure server.

C. Claim Filing Limits

Contracted providers must submit clean claims to Blue Shield Promise Health Plan within the timeframe specified in your contract with Blue Shield Promise. Providers who are not contracted with Blue Shield Promise must submit Medi-Cal claims no later than 12 months from the date of service (42 CFR 447.45). Providers who are not contracted with Blue Shield Promise must submit Medicare claims no later than one calendar year from the date of service (42 CFR 424.44).

9.2: Claims Processing Overview

A. Blue Shield Promise makes every effort to ensure c lean claims that are Blue Shield Promise Health Plan financial responsibility are processed (paid or denied) within 30 calendar days of receipt from non-contracted providers. All other claims are processed (paid or denied) within 60 calendar days of receipt.

B. Misdirected Claims
   a. Claims that are financial responsibility of the IPA/medical group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.
   b. Billing Providers receive notices from Blue Shield Promise identifying the responsible payers.

C. Reimbursement Rates
   a. To be eligible for payment, the claim must be clean and accurate.
   b. Contracted providers are paid at contracted rate;
   c. Non-contracted providers are paid at Medicare established rates

D. Interest payments are applied to clean claims from non-contracted providers that are not paid within 30 calendar days. Interest is paid for the period of the time that the payment is late. Interest rate is based on rate published by the Treasury Department.

E. Balance Billing

Beneficiaries are only responsible for plan allowed cost-sharing (copay/ coinsurance). Members shall not be balance billed for any covered/authorized or approved services.

F. Overpayment Recovery

Blue Shield Promise will notify provider of service, in writing, within 365 calendar days from the date of last payment to initiate an overpayment request. The provider of service must respond within 30 working days to contest and/or refund the overpayment. Blue Shield Promise will offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission if (1) the provider fails to reimburse within the 30-working day timeframe and (2) the provider has entered into a written contract specifically authorizing Blue Shield Promise to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions.

G. Emergency Claims

Emergency claims are paid without prior authorization. Legible emergency department reports must be submitted when billing with ER level 5. ER level 5 are forwarded and reviewed by a physician. Physician Reviewer determines whether or not service meets the requirements of emergency level 5.

H. Inpatient hospital claims – Emergency admission

In the event emergency admission is not authorized prior to member's discharge, medical records must be submitted with the claims in order to determine medical necessity and avoid delay on payments. Claims with medical records are forwarded by Claims Department to Utilization Management ("UM") to determine appropriate level of care and medical necessity. Upon completion of UM's review, claims are processed and paid according to approved and authorized service.

I. Inpatient hospital claims – Elective admission

All elective inpatient admissions require prior authorization. Prior authorization, bed type and days billed versus pre-certification are verified for inpatient claims. Claims are paid according to authorized level of care. Claims for these services without prior authorization will result in payment denials.

J. Outpatient and other claims

Ambulatory services, outpatient surgeries, ancillary and specialty services require prior authorization. Claims for these services without prior authorization will result in payment denials with the exception of services established as no prior authorization required under the direct referral process.

K. Hospital-Acquired Conditions / Never Events

Plan will not pay or otherwise reimburse participating hospitals for inpatient services related to those HACs and Never Events listed on Blue Shield's Provider Connection website at https://www.blueshieldca.com/bsca/bsc/wcm/myconnect/provider/provider_content_en/claims/policies_guidelines/payment_policies. (A provider login and password are needed to view this page.)

A copy of the medical record and an itemization of charges must be submitted with acute care hospital claims for inpatient admissions during which there was a Hospital-Acquired Condition (HAC) or Never Event.

L. Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services. Incidental procedure services and supplies are considered included in a global procedure charge(s).

M. Facility Compliance Review (FCR)

In order to comply with our employer group and provider contract agreements

and to ensure that appropriate billing practices are followed, the Plan has developed a comprehensive Facility Compliance Review (FCR) program that involves a comprehensive line-by-line bill audit. The program reviews inpatient and outpatient claims to validate their conformance with provisions of the facility's agreement.

The Plan audits claims for billing accuracy, allowable charges, medical necessity, Hospital Acquired Conditions and Never Events to ensure consistency with currently accepted standards in the industry. These standards include but are not limited to those defined by Optum reference manuals and followed by other commercial payors, as well as the UB 04 Billing Manual guidelines and the National Uniform Billing Committee guidelines. The program encompasses Plan claims for all lines of business and all facilities.

Categories of charges that are subject to review and payment denial include but are not limited to those charges that are mutually agreed to in Plan's contracts (e.g., Disallowed Charges); those charges that are determined to be not medically necessary; those for which there is no substantiating documentation; and those considered to be unbundling of another global charge, such as room and board charges or other facility room charges. Precedence for denial of such charges has been established by Optum resource manuals, and other commercial payors, as well as the Uniform Bill (UB04) Billing Manual guidelines and definitions.

To complete an audit as expeditiously as possible, the Plan may ask a hospital to submit medical records such as Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report, and Implant Log. The Plan may request a copy of the UB 04 (or successor) and a detailed itemization if the claim has been electronically submitted. Timely submission of requests will expedite claims processing.

For questions regarding this program, please contact Provider Information & Enrollment at (800) 258-3091.

Appeals to the Facility Compliance Review results must be submitted in writing and include specific detailed supporting documentation to the following address:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

9.3: Claims Status Inquiry

Providers may verify a claims status within 15 days of submission to Blue Shield Promise by calling (800)468-9935 ext. 3 or by checking the Blue Shield Promise website at www.blueshieldca.com/promise.

9.4 Claims Compliance and Monitoring

Please see Appendix 5: Claims Compliance and Monitoring for Blue Shield Promise claims requirements for Delegated Entities.

9.5: Third Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan and the provider will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from the third-party, third-party insurer or from uninsured or underinsured motorist coverage, Plan and the hospital or facility have the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

1. Notify the Plan and the provider in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party;
2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;
3. Agree, in writing, to reimburse the Plan for benefits paid from any recovery received from the third party;
4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Respond to information requests regarding the claim against the third party and notify the Plan and the provider in writing within ten (10) days of any recovery obtained.

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SECTION 10: ACCOUNTING

10.1: Financial Ratio Analysis (IPA/Medical Groups Only)

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.

IPA/medical groups 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 Blue Shield Promise Health Plan 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.

IPA/medical groups must estimate and document, on a quarterly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate or other actuarial firm certified methodology and calculation.

IPA/medical groups 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 SB 260.

10.2: Capitation Payment

The Managed Care Finance Department is responsible for sending the monthly capitation payments to its contracted IPA/medical groups. Capitation payments are made no later than the 10th of each month for Medicare and no later than the 15th for Cal MediConnect or within 10 days from receipt of revenue from 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 IPA/medical groups no later than the 10th of each month for Medicare and no later than the 15th for Cal MediConnect. Each IPA/medical group is responsible for coordinating with Blue Shield Promise Health Plan on how to access the SFTP server. For security measures, only two individuals per IPA/medical group are issued a username and password to access this site. Any changes to the IPA/medical group's contact person will require a new password or PGP key. IPA/medical groups must request and fill out a new PGP Key Form and submit to their assigned Provider Relations Representative.

10.3: Shared Savings Program and Reports

For certain services not covered under capitation, the Plan and the IPA/medical group share financial risk, as defined by the IPA/medical group's contract with the Plan.

In most arrangements, the IPA/medical group is allocated a certain percentage of the CMS revenue and a certain percentage of the Employer Group revenue as shared savings budget. The Plan administers shared savings claims and the expenses for the IPA/medical group's assigned members are debited from the shared savings budget. Any annual surplus or deficit for the shared savings budget is shared between the IPA/medical group and the Plan according to the terms in the IPA/medical group's Plan contract.

Any Medicare services rendered during a particular agreement year, but not reported to the Medicare Advantage Plan within the predetermined amount of days as stated in the contract after the end of the same agreement year, shall be included in the shared-risk computation for the subsequent agreement year.

If an IPA/medical group has questions regarding a Shared Savings claim, the IPA/medical group can submit the detailed claim records in question to the Managed Care Finance Department of the Plan. The submitted file should have the same layout format as the claim files that were previously sent to them. A column needs to be added to the end of the file for all comments explaining why the claims are being questioned. In addition, the submitted file should only include the claims that are in question. Please note that this process does not replace or change the DMHC Provider Dispute Process.

Quarterly Financial Performance File

The Quarterly Financial Performance File is based on a 90-day fund pool performance (for physician organizations participating in a shared savings program). This report itemizes information on member months, capitation paid, institutional fund allocations, depletions and balances by year-to-date. This report is supported by claim detail for both current and prior year for all applicable fund pools.

Shared-Risk Claims

The Plan will process all claims for which the IPA/medical group and the Plan share financial responsibility. Whenever the Plan receives shared-risk claims that contain capitated components, the Plan will process its portion of the claim and will forward the capitated service portion to the appropriate IPA/medical group for processing.

> *Example: The Plan receives an in-area emergency room (ER) services claim. The Plan will process the claim and identify the ER Professional Services as a capitated service on the EOB. The capitated services will be forwarded to the appropriate IPA/medical group for processing.*

The Plan will also process all claims for services for which the Plan has sole responsibility.

Institutional Services Budget

In an arrangement where hospitals are not capitated for institutional services, the Plan maintains an Institutional Services Budget (for physician organizations participating in a shared savings program). The Institutional Services Budget is a shared savings fund in which the Plan and IPA/medical groups share any surplus based on a negotiated settlement formula.

In general, the Plan provides a quarterly and annual accounting of the shared savings fund and the services paid by the Plan from these funds. Each IPA/medical group receives from the Plan a quarterly and annual Shared Savings report that contains the Shared Savings statement and the claims detail files.

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SECTION 11: HEALTH EDUCATION

11.1: Health Education Program

Purpose

The Health Education (HE) Program is committed to improving and maintaining the health and wellness of Blue Shield Promise Health Plan Members through health education, health promotion, skill training, interventions and disease management provided in a culturally sensitive and linguistically appropriate manner.

Goals

- Promote appropriate use of health services.
- Promote health education services.
- Encourage Member involvement with their Primary Care Physician in the management of his or her personal health.
- Increase member knowledge on preventive health care services and screenings.
- Encourage risk reduction and lifestyle changes to improve health.
- Increase use of preventive services for early detection of disease according to current guidelines for age and gender
- Increase member's knowledge and skills to enable him or her to cope with chronic disease.
- Increase member's feelings of self-efficacy in managing chronic diseases.

11.2: Scope of Health Education Program

The Blue Shield Promise Health Education Program is committed to ensuring its member population receives quality health education services that are appropriate to their cultural and linguistic needs. The Health Education Program promotes knowledge, skills, and behavior change to increase feelings of self-efficacy so that members can manage chronic diseases as well as maintain optimum health. Members and providers may obtain more information about these programs and services by calling the Health Education Department.

11.2.1: Health Education Classes

Blue Shield Promise provides health education classes at various locations in Los Angeles and San Diego Counties. Frequency of these classes varies depending on requests from providers and members. These classes are for all Blue Shield Promise Health Plan members. These classes are implemented in English and Spanish. Additionally, Blue Shield Promise provides individual counseling in English, Spanish, Cantonese, and Mandarin. Counseling topics include Hypertension, Hyperlipidemia, Diabetes and Weight Management. Blue Shield Promise also implements the Stanford Healthier Living Program in English, Spanish, Cantonese, and Mandarin.

11.2.2: Community Outreach

The Health Education Department works with the Outreach Department to coordinate activities for Blue Shield Promise involvement in community outreach efforts and health fairs.

11.2.3: Health Education Materials

A variety of brochures and handouts are available on the Blue Shield Promise website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education. All materials are culturally sensitive and linguistically appropriate, and do not exceed the 6th grade reading level.

Blue Shield Promise is highly committed to the delivery of quality health promotion and education activities. Before materials are purchased or created for the Member population, they are carefully reviewed to meet certain standards. The standards evaluate the content/style, layout/appearance, visuals/graphics, medical accuracy, cultural competency, and readability of all materials.

For Providers Contracted with an IPA/Medical Group

Please contact the health education coordinator at your affiliated IPA/medical group to order health education materials.

11.2.4: Member Resources

The HE Department informs Members of available health education services through provider referrals, the Customer Service phone line, targeted mailings, and community outreach events. Members may call the HE Department to request HE brochures or information on health education classes, and/or other interventions. Access to an over-the-phone interpreter service is also available for Members requiring interpretation. Members can call the Customer Service Department and request to speak to the Health Education Department for information on cholesterol, weight management, exercise, general nutrition guidelines, and diabetes.

Blue Shield Promise develops Preventive Health Guidelines for Members. These guidelines represent a compilation of recommendations from the Centers for Medicare & Medicaid Services, U.S. Preventive Services Task Force and Centers for Control and Disease Prevention. Preventive Health Guidelines are available at blueshieldca.com.

11.2.5: Provider Education

The HE Department Health Educators are available to talk to providers and their staff on health education services if the provider office requests this service.

Blue Shield Promise providers may contact the Health Education Department to request an in-service or more information on health education services.

11.3: Program Resources

11.3.1: Health Education Staff

Health Education and Cultural and Linguistic Senior Manager

The Health Education and Cultural and Linguistic Senior Manager (Senior Manager) works in conjunction with the Chief Medical Officer and other departments to implement health education programs appropriate to identified needs of members and providers. This position reports to the Senior Director of Lifestyle Medicine.

The Senior Manager is responsible for developing, implementing, managing, and evaluating member education programs and provider education programs related to Health Education. The Senior Manager ensures that materials and programs are culturally sensitive and linguistically appropriate to the member population under standards created by CMS. The Senior Manager ensures compliance with NCQA, Multicultural Distinction standards and National CLAS standards.

Responsibilities of the Senior Manager include but are not limited to:

- Development, implementation, and evaluation of annual Health Education Work-plan and Program.
- Development, implementation and evaluation of Policies and Procedure.
- Oversight of development, implementation, and evaluation of health education provider, member, and condition specific programs.
- Oversight of evaluation and distribution of culturally and linguistically appropriate member education materials.
- Meeting the requirements of the CMS, DMHC and other regulatory agencies as appropriate.

The Health Education Manager

The Health Education Manager reports to the Health Education and Cultural and Linguistic Senior Manager. The Health Education Manager leads and manages health education initiatives and ensures compliance with NCQA and CMS requirements.

This position collaborates with a number of external clients such as vendors, consultants, regulators, and internal teams such as case managers, customer services staff, and QI staff.

Health Educator

The Health Educator reports to the Health Education and Cultural and Linguistic Senior Manager and the Health Education Manager and works in conjunction with them to ensure that health education services and materials are appropriate to identified needs of providers and members.

The Health Educator assists in all aspects of program development and implementation as designated by the Health Education and Cultural and Linguistic Senior Manager and the Health Education Manager. The Health Educator also assists in the development and review of member health education materials.

11.3.2: Health and Wellness Portal

The health and wellness portal is an online resource available to members. The goal of the portal is to increase members' ability to manage their health by helping them identify their risks via a wellness assessment and connecting them to self-management tools and resources that can help mitigate their risks. Members can also track their health over time on the portal. Some of the tools available on the portal include a health library on various topics including physical activity, blood pressure, cholesterol, blood glucose, and nutrition. To access the portal, members can log on to the Blue Shield Promise website at www.blueshieldca.com/promise/hra and create an account.

11.3.3: *Wellvolution*

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital and in-person whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. There are over 60 programs to choose from, ranging from general well-being, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow.

Members simply log on to www.wellvolution.com/medicare, create a new account and set their health goals. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results, at no extra cost.

The following programs are offered through Wellvolution:

- **Well-Being Programs** – A hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better or quitting smoking.
- **Weight Loss Programs** – Programs specifically designed to help members make changes that fit their lifestyle and promote a healthy weight. Members can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 pounds per week and improvement in their quality of life across the board.
- **Disease Prevention Programs** – Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide members with a health coach and an individualized plan that meet the unique needs and address several areas of the member's life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.
- **Chronic Condition Reversal Programs** – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence in a matter of weeks.

All Wellvolution programs are 100% covered by Blue Shield Promise.

11.3.4: Departments in Collaboration with Health Education

Cultural and Linguistic Department

The HE Department collaborates with the Cultural and Linguistics Department to develop and implement training sessions for staff, providers, and IPA/medical groups. These units also work together to ensure proper translation of the materials into threshold languages and in alternative formats.

Quality Improvement

The Health Education Department works in conjunction with Quality Improvement to coordinate the exchange of data summarizing member needs and utilization for ongoing program planning. In addition, QI and HE work together in the implementation of various health education programs.

Customer Service Department

The Customer Service Department refers all health education related phone calls to the Health Education Department. The Customer Service Department provides 24-hour interpretation services to Blue Shield Promise members, who speak a language other than English, through an interpreter services vendor.

Provider Relations Department

The Provider Relations Department works with the Health Education Department in identifying provider needs for materials and services. The Provider Relations Department also assists in the delivery of materials and information as well as in the coordination of provider education seminars.

Utilization Management Department

The Health Education Department works with Utilization Management to direct appropriate health education interventions for patients identified through the UM/HE referral process.

Additionally, the Health Education Department assists the UM Department in educational efforts by identifying and supplying appropriate materials for UM to send to members.

SECTION 12: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Purpose

To ensure that members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices, and preferred language, at every medical and non-medical encounter.

Procedure

Blue Shield Promise Health Plan has adopted policies and procedures that are consistent with the National Standards (i.e., CMS) for CLAS. Contracts between Blue Shield Promise and providers, hospitals and ancillary providers include a provision requiring them to participate in and comply with the performance standards, policies, procedures, and programs established from time to time by the local initiative, and Plan with respect to cultural and linguistic services including without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to the local initiative, and Plan.

All providers must ensure that services are provided in a culturally competent manner to all members. This means you should provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical and mental disabilities.

12.1: Provider Responsibility in the Provision of CLAS

I. Identification of Limited English Proficient (LEP) Members

Cultural competency and linguistic capability in managed care is critically important to allow Blue Shield Promise Health Plan to meet the needs of our culturally and linguistically diverse population. Language is a medium used in every step of the health care system, from making appointments to understanding instructions and asking questions.

Blue Shield Promise will ensure members are routinely given opportunities to declare their need for culturally and linguistically appropriate services (e.g. when making an appointment, during Initial Health Assessment, on arrival, and in the exam room, etc.). Providers and clinic staff should record each member's primary language in their medical chart.

Definition:

"***Limited English proficient (LEP) Members"*** are those Members that cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

II. Access to 24 Hours & 7 Days Interpretation Services

It is Blue Shield Promise's responsibility to provide 24 hours & 7 days language assistance necessary to afford Limited English Proficient (LEP) members meaningful access to health care services, free of charge.

Blue Shield Promise and its providers must not require or suggest that LEP, hard-of-hearing, or deaf members provide their own interpreters or use family members or friends as interpreters. The use of such persons may compromise the reliability of medical information and could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. **Minors should not interpret for adults.**

If, after being notified of the availability of interpreters, the member elects to have a family member or friend serve as an interpreter, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality.

III. Posting of Signs at Key Medical and Non-medical Points of Contact

Signs informing members of their right to request free interpreting services should be clearly posted at each provider office (i.e., reception area, waiting room, exam room). Blue Shield Promise Health Plan is responsible for on-going distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural & Linguistic Department.

IV. Cultural Competency Training

Blue Shield Promise values diversity as an integral component of our organization and will promote the achievement of a culturally competent organization. Blue Shield Promise views cultural competency as a responsibility at both the organizational and individual level. Blue Shield Promise will foster an environment of respect and dignity in the treatment of each other and our members actively address the issue of barriers and disparities in health, using multiple strategies to reach providers, members, and staff.

Cultural competency training is designed to assist in the development and enhancement of interpersonal and intra-cultural skills to improve communication, access, and services, and to more effectively serve our diverse membership including Seniors and People with disabilities (SPD).

V. Translation of Member-Informing and Health Education Materials

Blue Shield Promise makes specific materials available in any language that is the primary language of more than ten percent of its geographic service area. Such materials may include but are not limited to:

- Summary of Benefits
- Annual Notice of Change
- Evidence of Coverage
- Appeals and Grievance letters
- Notice of Action (NOA), including clinical rationale
- Notice of Appeal Resolution (NAR), including clinical rationale

VI. CLAS Related Grievances

Blue Shield Promise Health Plan Cal MediConnect 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 the Blue Shield Promise website at www.blueshieldca.com/promise/members/index.asp?memSec=filing-a-grievance.

The Blue Shield Promise CLAS Department is available to provide further explanation on CLAS requirements as well as offer provider and staff education.

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SECTION 13: PROVIDER MEDICARE MARKETING GUIDELINES

13.1: Compliance with Laws and Regulations CMS-4131-F

Practitioners and providers and subcontractors must agree to comply with rules and regulations that are applicable to federal contracts. These laws and regulations include Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the American Disabilities Act, and all other laws applicable to recipients of federal funds. This also includes the general rules that might apply and the policies, procedures, and manual provisions, as well as other program requirements, issued by the Centers for Medicare & Medicaid Services (CMS). These also include Blue Shield of California Promise Health Plan's policies and procedures, including this Provider Manual.

13.2: Specific Guidance about Provider Promotional Activities

CMS is concerned with provider activities for the following reason:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as agent of the Plan versus acting as the beneficiary's provider.

13.3: Adherence to CMS Marketing Provisions

13.3.1: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Marketing Reforms

The MIPPA became a law on July 15, 2008. Effective January 1, 2009, MIPPA included several prohibitions and limitations on sales and marketing activities by Medicare Advantage (MA) and Prescription Drug (PDP) Plan Sponsors and their agents, brokers or other third parties that represent them. Beginning September 18th, 2008, the prohibition on door to door solicitation has been extended to other instances of unsolicited contact that may occur outside of sales and education events.

Providers cannot direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

Providers can refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, www.medicare.gov or 1-800-MEDICARE.

Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates. Providers may also answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information. These discussions may occur in areas where care is delivered. They may also provide information and assistance in applying for the Low-Income Subsidy (LIS).

13.3.2: Plan Activities and Materials in the Health Care Setting

While providers are prohibited from accepting enrollment applications in the health care setting, plans or plan agents may conduct sales presentations and distribute and accept enrollment applications in health care setting as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.

Prohibited Areas

Providers are prohibited from conducting sales presentations, distributing, and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical team and receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

Provider Affiliation Information

Providers may announce new affiliations and repeat affiliation. Communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Provider affiliation banners, displays, brochures, and/or posters located on the premises of the provider must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has as affiliation with certain plans and only lists plan names and/or contact information do not require CMS approval.

Comparative and Descriptive Plan Information

Providers may display benefit information for all contracted plans. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution.

CMS continues to hold the plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers may not conduct health screening or other like activities that could give the impression of "cherry picking" when distributing information to their patients, as health screening is a prohibited marketing activity.

Providers/Provider Group Websites

Providers may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

Providers' Do's and Don'ts

Providers should remain neutral parties in assisting plans with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accept or collect scope of appointment forms.
- Accepting enrollment applications for Medicare Advantage (MA)
- MA-Prescription Drug plans or PDPs.
- Directing, urging, offer inducement, or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mailing marketing materials on behalf of plans.
- Offering anything of value to induce plan enrollees to select them as their provider. Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screenings and distributing information to patients as a marketing activity.
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.

Providers contracted with plans (and their contractors) **are permitted** to do the following:

- Provide the names of plans with which they contract and/or participate.
- Provide information and assistance in applying for the Low-Income Subsidy.
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contract all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plans with which it participates. To that end, providers are permitted to:

        - Provide objective information on plans' specific plan formularies, based on a particular patient's medications and health care needs. Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.
        - Make available and/or distribute plan marketing materials including PDP enrollment applications, but not MA or MA-PD enrollment applications for all plans with which the provider participates.
    - To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
    - Refer their patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at www.medicare.gov, or1-800-MEDICARE.
    - Print out and share information with patients from CMS' website.

Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and /or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plans with which it participates.

The "Medicare and You" Handbook or "Medicare Options Compare" (from www.medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries.

Note: Plans may not use providers to distribute printed information comparing the benefits of different plans unless providers accept and display materials from all plans in the service area and contract with the provider.

Important: CMS conducts its regular marketing oversight and surveillance activities throughout the year. These oversight activities increase significantly during Annual Election and Disenrollment Periods. Blue Shield Promise Health Plan is confident that the release of this information will help you implement CMS policies and procedures and comply with critical program requirements.

To contact the Blue Shield Promise Medicare Marketing Department, please call (800) 847-1222.

SECTION 14: REGULATORY, COMPLIANCE, AND ANTI-FRAUD

14.1: Overview

All providers who render services to Blue Shield Promise Health Plan Members must be informed of their responsibilities through their provider contract or through a provider manual or other provider communication. As a Cal MediConnect provider, you must comply with certain requirements as described in this section.

Blue Shield Promise is responsible for maintaining written agreements with practitioners and providers to provide adequate access to covered services.

Blue Shield Promise is also required to comply with National Coverage Determinations (NCDs) issued by the Centers for Medicare & Medicaid Services (CMS). An NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a specific medical item or service. If the new NCDs or legislative change in benefits meets the "significant costs" threshold, Blue Shield Promise is not required to assume the risk for the costs of the service until CMS has included the cost of the NCDs in Blue Shield Promise capitation payment. Coverage of the services will be provided under the Medicare Fee-for-Service program. Medicare fiscal intermediaries and carriers will make payments on behalf of Medicare Advantage organization directly to providers and practitioners for costs associated with an NCDs. Medicare Advantage enrollees may be liable for any applicable coinsurance amounts under Original Medicare. For more information on NCDs, visit the CMS website at www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html.

14.2: Medicare Part D

Beginning January 1, 2006, the new Medicare Prescription Drug Plan was available to all people with Medicare. Medicare Advantage Members were automatically enrolled in the Medicare Part D. These Members receive their medical care and prescription drug coverage from the Blue Shield Promise Health Plan contracted Pharmacy network.

An important requirement of the Medicare Prescription Drug Improvement and Modernization Act (MMA) is the responsibility of the MA-PD to ensure the integrity of the prescription drug program.

Blue Shield Promise works closely with CMS and CMS' contractors to prevent fraud, waste, and abuse of the prescription drug program. To report suspected or potential fraud, waste, and abuse problems, or for general questions please call the Fraud Hotline at (800) 221-2367 or email to stopfraud@blueshieldca.com.

For questions about Blue Shield Promise's coverage of Medicare Part D, please call the Customer Care Department at (855) 905-3825 .

14.3: Compliance with Laws and Regulations

Providers and their subcontractors must agree to comply with all the rules and regulations that are applicable to federal contracts. These include all laws and regulations applicable to federal contracts including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of federal funds. This also includes general rules that might apply, and the policies, procedures, and manual provisions, as well as other program requirements, issued by CMS. These also include Blue Shield Promise Health Plan's policies and procedures.

14.4: Compliance with Policies and Program

All practitioners and providers must comply with the medical policy and management program and quality assurance/quality improvement program. This includes reviewing and participating in the programs as required.

14.5: Prohibition Against Contracting with Excluded Individuals and Entities and Opt-Out-Providers

Blue Shield Promise is prohibited from employing or contracting with practitioners and providers excluded from participation in federal health care programs or who have opted out of Medicare. Affiliated practitioners are also prohibited from employing or contracting with such providers. Contracts are terminable for these reasons. Affiliated practitioners and providers must certify to Blue Shield Promise that its contractors are eligible to participate in Medicare and/or provisions would be included in the written agreements. Monthly screening of employees, providers, and contracted entities against the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), and the General Service Administration (GSA) System for Award Management (SAM) and Excluded Parties List Systems (EPLS) is essential to prevent inappropriate payment to providers and other individuals or contractors that may have been added to exclusion lists. The link for OIG/LEIE can be found at http://exclusions.oig.hhs.gov and the GSA/SAM/EPLS at https://www.sam.gov/.

14.6: Prompt Payment

The amount of payment and the period in which payment should be made must be set forth in the contract. Any subcontracts that providers have with practitioners or providers to render services to Blue Shield Promise Health Plan Cal MediConnect Members must likewise contain a prompt provision.

14.7: Disclosure of Information to CMS/DHCS

Providers must provide Blue Shield Promise, CMS, or the Department of Health Care Services (DHCS) with all information that is necessary for CMS and DHCS to administer and evaluate the Cal MediConnect program. Simultaneously, practitioners and providers must cooperate with Blue Shield Promise Health Plan in providing CMS/DHCS with the information CMS/DHCS needs to establish and facilitate a process to enable current and potential beneficiaries to get the information they need to make informed decisions with respect to available choices for the Medicare coverage.

14.8: Maintenance and Audit of Record

The purpose of this requirement is to allow CMS and DHCS to evaluate the quality, appropriateness and timeliness of services, the facilities used to deliver the services and other functions and transactions related to CMS requirements. It applies to all parties in relation to service performed, reconciliation of benefit liabilities and determination of amounts payable. All parties are required to have their records available for a 10-year period after Blue Shield Promise Health Plan terminates the Cal MediConnect Three-Party Agreement with CMS and DHCS or the completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS). Providers must have books and records (including, but not limited to, financial, accounting, administrative, patient medical records, and prescription drug files) available to support any activity with Blue Shield Promise.

14.9: Confidentiality

All providers must ensure the confidentiality and accuracy of the medical records or other health and enrollment information of Members and must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records or other health or Membership information. The provider shall not sell, release, or otherwise disclose the name or address of any Member to any third party for any purpose, including scientific study.

Practitioners and providers must maintain records in accurate and timely manner and ensure timely access to Members who wish to examine their records. Confidential patient information that is protected against disclosure by federal or state laws and regulations may only be released to authorized individuals.

14.10: Fraud, Waste and Abuse Training Requirements

Employees and contractors who are involved in the administration or delivery of the Medicare benefits must, at a minimum, receive Fraud, Waste and Abuse (FWA) training within 90 days of initial hiring (or contracting for contractors) and annually thereafter. Blue Shield Promise Health Plan will provide training materials to assist in fulfilling this requirement.

Important Note: Providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the FWA training and education requirements. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or contractor is deemed.

14.11: False Claims Act

The False Claims Act (FCA) (31 U.S.C. Sections 3729-3733) imposes liability on any person or organization that submits a claim to the federal government that is known (or should be known) to be false and allows citizens with evidence of fraud against government contracts and programs to sue on behalf of the government in order to recover stolen funds.

The FCA provides a way for the government to recover money when someone submits or causes to be submitted false or fraudulent claims for payment to the government, including the Medicare and Medi-Cal programs.

Examples of health care claims that may be false include claims where the service is not actually rendered to the patient, is provided but is already provided under another claim, is up-coded, or is not supported by the patient's medical record.

Claims also may be false if they result from referrals made in violation of the Federal Anti-kickback statute or the Stark law.

When the government pursues violations of the False Claims Act, it does not target innocent billing mistakes. False claims are claims that the provider knew or should have known were false or fraudulent. "Should have known" means deliberate ignorance or reckless disregard of the truth. This means providers cannot avoid liability by ignoring inaccuracies in their claims. Health care providers need to understand the program rules and take proactive measures, such as conducting internal audits within their organizations, to ensure compliance.

If a provider makes an innocent billing mistake, that provider still has a duty to repay the money to the government.

For False Claims Act violations, a provider can be penalized up to three times the program's loss, also known as treble damages. The False Claims Act provides a strong financial incentive to whistleblowers to report fraud. Whistleblowers can receive up to 30 percent of any False Claims Act recovery.

Providers must ensure that the claims they submit to Medicare and Medi-Cal are true and accurate. One of the most important steps a provider can take is to have a robust internal audit program that monitors and reviews claims. If a provider identifies billing mistakes in the course of those audits, the provider must repay overpayments to Medicare and Medi-Cal within 60 days to avoid False Claims Act liability.

It is the provider's responsibility to consistently submit accurate claims.

14.12: 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 Promise that you have the patient's consent to disclose their SUD patient records to Blue Shield Promise when submitting an electronic claim (837 P or I) for Part 2 services by placing an "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.

APPENDICES

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Utilization Management Timeliness Standards

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and /or Electronic)**	**Written/ Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request.	Within 5 working days of receipt of all information reasonably necessary to render a decision.	Practitioner: Within 24 hours of the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed (AKA: Deferral).	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request. • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan / Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. • Notify Member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and /or Electronic)**	**Written/ Electronic Notification of Denial and Modification to Practitioner and Member**
	the additional information needed to render the decision, the type of expert reviewed, and/ or the additional examinations or tests required and the anticipated date on which a decision will be rendered.		
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service. **Additional information incomplete or not received** • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the Member notice of denial.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.	Within 72 hours of receipt of the request.	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and /or Electronic)**	**Written/ Electronic Notification of Denial and Modification to Practitioner and Member**
• All necessary information received at time of initial request.			
Expedited Authorization (Pre-Service) Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • Additional clinical information required.	**Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and Member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/ or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. ***Note:*** The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. **Additional information received** • If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and /or Electronic)**	**Written/ Electronic Notification of Denial and Modification to Practitioner and Member**
Concurrent review of treatment regimen already in place (i.e., inpatient, ongoing/ ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition. ***Note:*** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. **CA H&SC 1367.01 (h)(2).**	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and /or Electronic)**	**Written/ Electronic Notification of Denial and Modification to Practitioner and Member**
Concurrent review of treatment regimen already in place (i.e., inpatient, ongoing/ ambulatory services). **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Member & Practitioner: Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, then written/ electronic notification must be given no later than 3 calendar days after the oral notification.
Post-Service / Retrospective Review All necessary information received at time of request (decision and notification are required within 30 calendar days from request).	Within 30 calendar days from receipt or request.	Member & Practitioner: None specified.	Member & Practitioner: Within 30 calendar days of receipt of the request.
Post-Service - Extension Needed • Additional clinical information required.	**Additional clinical information required (AKA: deferral).** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request. **Additional information received** • If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information.	Member & Practitioner: None specified. Member & Practitioner: None required.	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination. Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and /or Electronic)**	**Written/ Electronic Notification of Denial and Modification to Practitioner and Member**
	Additional information incomplete or not received • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information.		
Hospice - Inpatient Care	**Within 24 hours of receipt of request.**	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

blue california | Promise Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: Blue Shield of California Promise Health Plan
Plan/Medical Group Fax#: (323) 889-6254 or (866) 712-2731
Plan/Medical Group Phone#: (877) 792-2731

Urgent or Non-Urgent: _____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request.
Information contained in this form is Protected Health Information under HIPAA.

Patient Information					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		State:	Zip Code:	
Date of Birth:	☐Male ☐Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____		Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			
Insurance Information					
Primary Insurance Name:		Patient ID Number:			
Secondary Insurance Name:		Patient ID Number:			
Prescriber Information					
First Name:	Last Name:		Specialty:		
Address:	City:		State:	Zip Code:	
Requestor (if different than prescriber):		Office Contact Person:			
NPI Number (individual):		Phone Number:			
DEA Number (if required):		Fax Number (in HIPAA compliant area):			
Email Address:					
Medication / Medical and Dispensing Information					
Medication Name:					
☐ New Therapy ☐Renewal ☐ Step Therapy Exception Request If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):					
How did the patient receive the medication? ☐ Paid under Insurance _____ Prior Auth Number (if known): _____ ☐Name: Other (explain):					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:		
Administration: ☐Oral/SL ☐Topical ☐Injection ☐IV ☐Other:					
Administration Location: ☐ Patient's Home ☐ Long Term Care ☐ Physician's Office ☐ Home Care Agency ☐Other (explain): _____ ☐Ambulatory Infusion Center ☐Outpatient Hospital Care _____					

blue california | Promise Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐**YES (if yes, complete below)** ☐**NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date**: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number: ( ) _____

☐Approved ☐Denied Comments/Information Requested: _____

Provider Request to Terminate Patient/Provider Relationship

PROVIDER INFORMATION

Name (First and Last): _____

Address: _____

Phone: _____ **License #:** _____

IPA/Medical Group: _____

PATIENT INFORMATION

Name (First and Last): _____

DOB: _____ **SSN:** _____

Member ID: _____

Reasons for terminating patient/provider relationship:

_____

_____

_____

_____

Please give specific dates and instances of the issues you have had with this member:

_____

_____

_____

What actions have you taken to resolve the issues between the member and you?

_____

_____

_____

Currently identified medical conditions requiring immediate or ongoing treatment:

_____

_____

_____

_____

It is very important to document any non-compliant behavior by the member in the member's medical records. Please provide Blue Shield Promise Health Plan with all the documentation from the member's medical records which supports your claims. You must document your actions taken to attempt to resolve these issues with the member.

Please provide the completed form and supporting documentation to the Clinical Quality Review Department using one of the following options:

- Email: promisehealthplanqualityreview@blueshieldca.com
- Fax: (323) 323-765-2702
  (Note: Email or fax preferred)
- Mail:
  Blue Shield Promise Health Plan
  Clinical Quality Review Department
  601 Potrero Grande Drive, 3rd Floor Saturn Building
  Monterey Park, CA 91755

I hereby attest that the above information is true and accurate to the best of my knowledge at this time. I also hereby attest that this request is based solely on my concern that I cannot effectively and appropriately treat the medical needs of this patient because of the above given reasons and that this request is not based on any financial motives.

Signed: _____

Date: _____

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Primary Care Practitioners Access to Care Standards (PCPS)

ATTACHMENT A

Criteria	Standard
PCPs Defined as:	All practitioners providing primary care to our members which includes: General Practice, Internal Medicine, Family Practice, Pediatrics, NPs, PAs, select OB/GYNs and other specialists assigned member for primary care services.
Emergency exam	**Immediately** When a member calls the Practitioners office with an emergency medical condition, they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911). If the condition is a non-life-threatening emergency, it is still preferable for the member to be given access to care immediately but no later than six (6) hours.
Urgent PCP exam	**Within 48 hours if no authorization is required** **Within 96 hours if an authorization is required** When a member contacts the Practitioners office with an urgent medical condition, we require the member to be seen within above mentioned timeframes. We strongly encourage the Practitioner to work the member in on a walk-in basis the same day. If a situation arises where a Practitioner is not available (i.e., the Practitioner is attending to an emergency or member calls late on a Friday), the member can be seen by a covering Practitioner or directed to an urgent care, covering office or emergency room.

Criteria	Standard
Sensitive Services	Sensitive services must be made available to members preferably **within 24 hours but not to exceed 48 hours** of appointment request. Sensitive services are services related to: • Sexual Assault • Drug or alcohol abuse for children 12 years of age or older • Pregnancy • Family Planning • Sexually Transmitted Diseases, for children 12 years of age or older • Outpatient mental health treatment and counseling, for children 12 years of age or older who are mature enough to participate intelligently and where either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims, of incest or child abuse. *Minors under 21 years of age may receive these services without parental consent. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.*
Routine PCP, Non-urgent exam	**Within ten (10) Business Days** When a member requests an appointment for a routine, non-urgent condition (i.e., routine follow-up of blood pressure, diabetes, or other condition), they must be given an appointment within 10 business days.
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week coverage** to members. The same standards of access and availability are required by physicians "on-call". Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.

Criteria	Standard
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. Urgent and emergent calls must be handled by the physician or his/her "on-call" coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by hanging up and calling 911 or going to the nearest emergency room.
Speed of Telephone Answer (Practitioner's Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Waiting Time in office	**Thirty (30) minutes maximum** after time of appointment
Access for Disabled Members	Blue Shield Promise audits facilities as part of the Facility Site Review Process to ensure compliance with Title III of the Americans with Disabilities Act of 1990.
Seldom Used Specialty Services	Blue Shield Promise will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary.
Missed/ Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/ Broken appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments could result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Specialist Access to Care Standards

ATTACHMENT B

Criteria	Standard
SCPs Defined as:	Practitioners providing specialty care to our members, comprised of all specialty types listed in Blue Shield Promise Health Plan network including dental, chiropractic, acupuncture, and vision providers, according to the services offered per contracted line of business.
Emergency Care	**Immediately** When a member calls the Practitioner's office with an emergency medical condition, they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911). If the condition is a non-life-threatening emergency it is still preferable for the member to be given access to care immediately, but no later than six (6) hours.
Urgent Specialist Exam (no authorization required)	**Within 48 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is not required, the member must be seen within 48 hours or sooner as appropriate from the time the member was referred.
Urgent Specialist Exam (authorization required)	**Within 96 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is required, the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized.
Routine specialist visit, Non-urgent exam	**Within fifteen (15) Business Days**
Urgent Vision Services	Vision services offered **within 72 hours** of request when it is consistent with the patient's individual needs and as required by professionally recognized standards of vision practice.
Non-Urgent Vision Services	Vision Services are offered **within 36 business days** of request for an appointment.
Preventative Care Vision Services	Vision services are offered **within 40 business days** of request for an appointment.

Criteria	Standard
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week** coverage to members. Physicians "on-call" require the same standards of access and availability. Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. The physician or his/her "on-call" coverage must handle urgent and emergent calls within thirty (30) minutes. Appropriately qualified staff can only provide clinical advice (e.g., physician, physician assistant, nurse practitioner or registered nurse). Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Our Member Services Department will keep an abandonment rate less than 5%. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer (Practitioner's Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Waiting Time in office	**Thirty (30) minutes maximum after time of appointment**

Criteria	Standard
Missed/Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/Broken appointments must be documented in the medical record and the member's primary care Practitioner must be notified within 24 hours of the missed appointment. The member must be contacted by mail or phone to reschedule. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments can result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Behavioral Health Access to Care Standards

ATTACHMENT C

Criteria	Standard
Life threatening/Emergency needs	**Will be seen immediately** (preferably directing the members to the Emergency Room or calling 911)
Non-Life-threatening emergency needs	**Will be seen within six (6) hours**
Urgent Visit	**Within 48 hours**
Initial Visit for Routine Care office visit & Non-urgent exams (all practitioner types)	**Within ten (10) Business Days**
Follow-Up Routine Care	**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
After-hours care	Behavioral Health services for Medi-Cal "Specialty Mental Health Services" and "Alcohol and Other Drug Programs" (AOD) are the responsibility of the appropriate County Mental Health Plan (MHP). Behavioral Health Services for Medi-Cal members with mild and moderate dysfunction outpatient services, and for all other lines of business are carved out to contracted MBHOs The MBHOs each have 24 hour a day, 7 day a week coverage. Blue Shield Promise also has RN's on-call 24 hours a day, 7 days a week to coordinate and arrange behavioral health coverage to members.
Telephone Access	Access by telephone for screening and triage is available 24 hours a day 7 days a week, through our contracted MBHOs and the County MHPs, as appropriate. Blue Shield Promise and its contracted MBHOs require access to a non-recorded voice within thirty (30) seconds and abandonment rate is not to exceed 5%. Blue Shield Promise has RN's on-call at all times to arrange behavioral health coverage to members. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.

Criteria	Standard
Speed of Telephone Answer (Practitioner's Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Standard for reaching a behavioral health professional	Blue Shield Promise, through our contracted MBHOs, is available to arrange immediate access to a behavioral health professional. The County MHPs also have 24/7 access lines.
Hours of Operation Parity (Medicaid LOB only)	The organization requires the hours of operation that practitioners offer to Medicaid members to be no less than offered to commercial members. For more information, see Section 9 of the *Blue Shield Promise Medi-Cal Provider Manual*.
Specialty Provider	**Within fifteen (15) Business Days** (after appropriate PCP visit) Perform comprehensive evaluation and submit to Plan.
Qualified Autism Service (QAS) Provider	**Within fifteen (15) Business Days** after evaluation is approved by the Plan. Perform functional assessment and submit treatment plan to Plan.
QAS Provider (professional or paraprofessional)	**Within fifteen (15) Business Days** after treatment plan approved by Plan. Begin treatment/services.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Ancillary Access to Care Standards

ATTACHMENT D

Criteria	Standard
Ancillary Providers	**Within fifteen (15) Business Days** for services where prior authorization that has been obtained.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Long Term Services and Support Access to Care Standards

ATTACHMENT E

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.

Claims Compliance and Monitoring

A Supplement to the *Blue Shield Promise Cal MediConnect Provider Manual*

January 2022

Claims Compliance and Monitoring

Definitions:

"*Delegated Entity*" describes 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.

Blue Shield Promise monitors Delegated Entities' monthly and quarterly claims processing timeliness via the Delegated Entity's submission of the monthly/quarterly timeliness report. Additionally, Blue Shield Promise monitors the Delegated Entity's provider dispute resolution (PDR) process via submission of the quarterly Cal MediConnect Report. Specific to the Department of Managed Health Care (DMHC) requirements, Blue Shield Promise is required to combine Medi-Cal and Cal MediConnect claims and PDR timeliness results via the DMHC portal submission. Both report templates are available from Delegation Oversight Claims Team or located on the Industry Collaborative Effort (ICE) website under *Approved ICE Documents.*

Blue Shield Promise performs, at a minimum, annual claims and PDR audits. Follow-up/focused audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or audits will be performed. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators.

Blue Shield Promise audits include review of Delegated Entity's claims and PDR processing according to regulatory and contractual requirements, including but not limited to Section 42 CFR 447.45 as noted in the Cal MediConnect Program three-way Contract (Medicare, Medi-Cal Program). The three-way 2019 Cal MediConnect Contract between the Health Plan, Department of Health Care Services (DHCS), and Centers for Medicare & Medicaid Services (CMS) is located on the CMS website. See Sections 5.1.9 - 5.1.9.2 and 5.1.10.1. These requirements include but are not limited to timeliness of payment/denial of non-contracted provider claims, member denials, re-openings, adjustments, misdirected/forwarded claims, provider disputes, etc.

Claims Compliance Audit Review Process

Paid and Denied Claims

Contractor must ensure that 90% of claims from Network Providers who are in individual or group practice, which can be processed without obtaining additional information from the physician or third party, will be paid within 30 days of the date of receipt of the claim. In addition, 99% of all clean claims from Network Providers will be paid within 90 days of the date of receipt of the claim as stipulated the Code of Federal Regulations (42 CFR 447.45) along with Section 5.1.9.2 of the three-way 2019 Cal MediConnect Contract between DHCS, CMS, and Blue Shield Promise.

The Contractor shall pay ninety-five percent (95%) of clean claims from non-contracted providers within thirty (30) days of request. All other claims shall be paid or denied within sixty (60) days of request. (Section 5.1.10: Provider Payments of three-way 2019 Cal MediConnect Contract.)

The Contractor shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits, per WIC Section 14182.16 and in accordance with applicable DPL(s) and 5.1.10.1.

Medi-Cal Alignment: The Contractor shall pay providers, including institutional providers, in accordance with the prompt payment provisions in compliance with 42 C.F.R. § 447.45, ARRA 5006(d) and as contained in each Contractor's Medi-Cal Managed Care Contract with DHCS, including the ability to accept and pay electronic claims.

Interest & Penalty

Medi-Cal interest: Applies to paid claims, adjustments, and Provider Disputes (CCR Title 28 Section1300.71(i)).

Interest is applicable for contracted and non-contracted providers claims paid later than the statutory deadline. Interest must be paid beginning with the first day after deadline through the day the payment/ check is mailed.

Interest is due on adjustments found in favor of the provider (in whole or in part) when the Delegated Entity was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15 percent annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below.

To avoid a mandated $10.00 per claim penalty, the interest must be paid "automatically." Automatically means that the full amount of interest warranted must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due. (CCR Title 28 Section 1300.71(i)).

If the interest amount is less than $2.00 the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included. (CCR Title 28 Section 1300.71 (a)(b)).For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Medicare Interest: Clean claims from unaffiliated/non-contracted providers, including adjustments, in which the payor was at fault on the initial determination that are paid later than the statutory deadline requires interest to be paid. Interest is to be calculated beginning on the thirty-first calendar day through the day the check is mailed.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. The current interest rate can be found at https://www.fiscal.treasury.gov/prompt-payment/rates.html. Interest is to be calculated based on (1) the number of calendar days over thirty (30), (2) the current Medicare interest rate and (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment.

Reopenings

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process.

Reopenings are different from adjustment claims in that adjustment claims are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

Reference Materials for Reopenings

- 42 CFR 405.980
- MLN Matters Number SE 1426
- Medicare Manual Chapter 34
- Medicare Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
- https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin

Note: All other categories audited follows either Medi-Cal or Medicare regulatory and contractual requirements.

New Network Provider Training Oversight and Monitoring

To ensure Delegated Entity's newly contracted providers receive a new provider orientation within thirty (30) business days of becoming a participating Cal MediConnect provider with your organization, evidence of training is required to be submitted to the Blue Shield Promise Delegation Oversight Compliance Team for audit/review. Your organization is required to submit annual training materials for new contracted providers, updates to training material to existing providers, and information shared for out-of-network providers.

For profile submission of newly contracted providers, you are required to submit the date the newly contracted provider completed training, a signed attestation from your organization provider training team, as well as a signed attestation from the newly contracted provider that list the material that was trained to and the date the provider completed the training.

Providers receive training regarding the Cal MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract. Delegated Entity shall ensure that Network Provider training relates to Cal MediConnect services, including but not limited to the care coordination benefit, policies, procedures, and any modifications to existing services, policies, or procedures. Training shall include methods for sharing information between Network Provider, member and/or other healthcare professionals. Delegated Entity shall ensure that Network Provider training includes information on all member rights including the right to full disclosure of health care information and the right to actively participate in health care decisions. The Delegated Entity will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its Network Providers concerning its policies and procedures on Advance Directives. Delegated Entity shall ensure that ongoing training is conducted when deemed necessary by either Blue Shield Promise, CMS, or DHCS.

Compliance Program Oversight and Monitoring

Delegation Oversight will perform a review of Delegated Entity's Compliance Program including assessment of the compliance material (program, P&Ps, etc.), training of staff, monitoring of regulatory compliance, auditing for internal controls and conflicts of interest. This oversight is performed either via shared audit through ICE or individually on an annual basis.

IT System Integrity Oversight and Monitoring

Delegation Oversight will perform an IT system security and integrity audit 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.

Claims Delegate Reporting Instructions

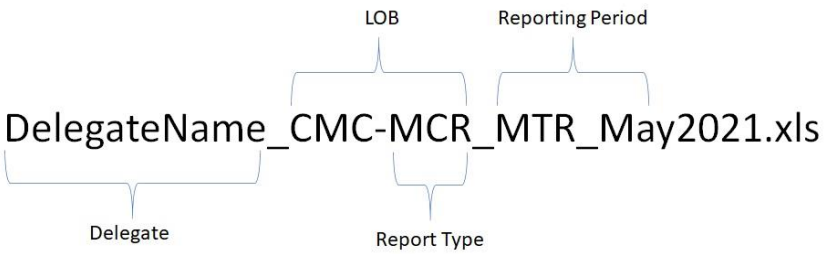
Please email reports to the following contacts:

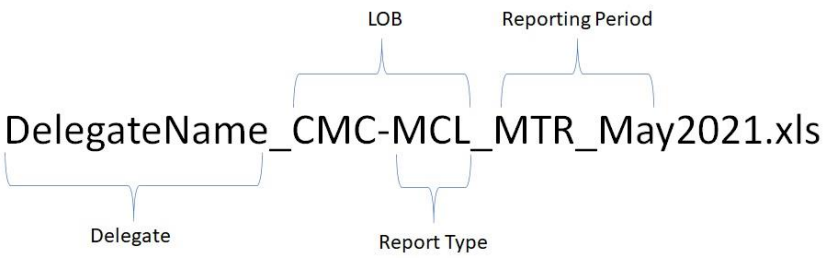
Report Type	Contact
Disclosure of Emerging Claim Deficiencies	ClaimsDelegateReport@blueshieldca.com
Report Type	**Contact**
MTR	ClaimsDelegateReport@blueshieldca.com
PDR	ClaimsDelegateReport@blueshieldca.com
Principal Officer Form	ClaimsDelegateReport@blueshieldca.com
SARAG	ClaimsDelegateReport@blueshieldca.com

Report files should be named to identify the Group, LOB, Report Type, and Reporting Period. Following this naming convention will uniquely identify the report and help streamline the reporting process.

File Naming Convention	Description
Delegate	The delegated entity's name or an acronym which represents the group.
LOB	Cal MediConnect (CMC)
Report Type	MTR (MTR) PDR (PDR) Principal Officer Form (POF) SARAG (SARAG)
Reporting Period	Identify the period being reported on, i.e., Jan2021, 2021Q1, etc.

Below are examples of the file names for Medicare and Medi-Cal MTR reports specific to Cal MediConnect for group "DelegateA", covering the month of May 2021.





Reports

Please review all the Monthly/Quarterly report requirements. Please submit the Excel/Word report in addition to the signed document. Reports that do not meet reporting standards or have issues will be returned with a request to correct the inconsistencies. Prompt submission is expected to ensure timely reporting.

1. ***Disclosure of Emerging Claim Deficiencies***

In accordance with the California Code Regulation (Title 28, Section 1300.71- Claims Settlement Practices), delegated entities that report claims deficiencies, must complete a Disclosures of Emerging Claims Payment Deficiencies form. The delegated entity will identify the reason for such reported deficiencies by selecting series of check mark boxes, which explain the lack or thereof compliance during the reporting period.

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Cal MediConnect	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • October report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	 ICE_CMS_MA_MTR_revised_09_2020.xlsx

2. *PDR (Cal MediConnect)*

Note: Due to DMHC reporting requirements, these instructions are subject to change.

The Cal MediConnect is an integrated program for benefit recipients who are dually eligible for both Medicare and Medi-Cal.

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Cal MediConnect	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	 CMS_Qtr_ProvDispute_Rpt_Final_012019  ICE_Claims_ComlQtrProvDisputesRpt_10

3. *Principal Officer Form*

The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Line of Business (LOB)	Due Date	Report Template (double click icon)
All LOBs	Reports are due by the end of September each year (annually). Also, submit updated reports whenever changes occur to Principal Officer(s) at the delegated entity.	 PrincipalOfficer Form.doc

4. ***Service Authorization Requests, Appeals, and Grievances (SARAG)***

- Include all requests to the MMP processed as both contract and non-contract provider denied claims and paid claims from non-contract providers only.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for members who are not enrolled on the date of service, claims denied due to recoupment of payment. Submit provider payment requests (claims) based on the date the claim was paid or denied, or should have been paid or denied (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Cal Medi-Connect	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the 5th of the month following the end of the reported quarter. If the 5th falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 5th • Q2 report due July 5th • Q3 report due October 5th • Q4 report due January 5th of the following year	BSC SARAG Report Template (v.6-2020).›

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