601 12th Street
Oakland, CA 94607

October 14, 2022

Subject: **Notification of January 2023 Updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

We have revised our *HMO IPA/Medical Group Procedures Manual.* The changes listed in the following provider manual sections are effective January 1, 2023.

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

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

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

If you have any questions regarding this notice about the revisions that will be published in the January 2023 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

UPDATES TO THE JANUARY 2023
HMO IPA/MEDICAL GROUP PROCEDURES MANUAL

General Reminders

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

Section 2.8: Benefits and Benefit Programs

Wellness and Prevention Programs

Deleted the CareTips Clinical Messaging section as this is no longer a program that Blue Shield supports.

Wellvolution

Revised entire section to reflect changes in our Wellvolution Program.

Added the following bullet point to list of programs offered through Wellvolution:

- Mental Health Programs – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.

Pharmaceutical Benefits

Drug Formulary

Updated language in boldface and strikethrough type below:

For drugs that require prior authorization or an exception to benefit or coverage rules, coverage decisions are based on the medication coverage policies approved by Blue Shield's P&T Committee and the following will be considered during the review for coverage **and will be approved if satisfied:**

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of formulary alternative(s) **or required prescription drugs** have not achieved therapeutic goals **(drug was discontinued due to lack of efficacy or effectiveness, diminished effect, sub-optimal results, or an adverse reaction)** or are inappropriate for the specific member's situation.
3. Treatment is stable ~~and a change to an alternative treatment may cause clinical decompensation or immediate harm~~ on the prescribed drug.
4. Relevant clinical information provided with the authorization request supports the use of the requested medication over formulary drug alternatives.

Pharmaceuticals in the Medical Benefit

Office/Facility-Administered Medications

Updated language to reflect that medications are updated to various risk allocation classifications on a quarterly basis when CMS assigns the drug it unique HCPCS code.

Updated language with additions in boldface type below:

The criteria for classification of High-Cost injectables includes those FDA-approved in 1998 or later with an estimated treatment cost per patient at or above $10,000 average wholesale price (AWP) per year. **For newly released drugs, the high cost drug classification is based on average weight or body surface area of adult males and females based on the FDA approved dosage.** A validation and reconciliation of the high-cost category will be conducted annually based on the previous years' Blue Shield utilization data using updated AWP pricing information and historical claims data to determine average dosing including duration of therapy. **The validation process will determine if specific drugs are removed or added to the high cost drug category based on actual claims experience which reflects aggregate drug utilization for Blue Shield members. The high cost drug category does not take into consideration differences in weight, weight, dosage, or specific duration of therapy at a member level since many drugs are weight based.** A complete list of High-Cost Injectables and corresponding HCPCS Codes that meet the classification criteria is posted quarterly on Provider Connection at blueshieldca.com/provider under *Claims*, then *Policies & guidelines*, then *Medications*. You may also contact your Provider Relations Coordinator for a listing.

Section 4.1: Network Administration

Practitioner Credentialing

Added the following:

Practitioners are required to notify their IPA/medical group and Blue Shield when the practice is closed, and member care must be transferred.

Provider Status Changes

Updated with language in boldface type below:

- Demographic/Administrative Changes

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

Updated the following in list of minimum required data for new providers in boldface and strikethrough font below:

- California license number **or certification identifier as applicable**
- Languages spoken **by practitioner**
- **Languages spoken by others in the practice**
- ~~Identification of the IPA to which the practitioner should be added~~
- IRS **reporting** number
- NPI **identifiers (practitioner and entity as applicable)**
- **Identification of the IPA to which the practitioner should be added**

Deleted the Open/Closed Status Changes section indicating that the IPA/medical group notify The IPA/medical group must notify Blue Shield no less than five days in advance of a provider not accepting new patients or currently accepting new patients after previously not having accepted them. This is no longer a Blue Shield requirement.

Provider Status Changes

Primary Care Provider Termination Notification Requirements

Deleted and ***replaced*** numbers 1-3 of the following section:

Blue Shield has established procedures to ensure that our HMO members (Commercial and Medicare) are provided timely written notification in the event that a Blue Shield HMO primary care provider terminates. This policy and procedure is specific to individual PCP terminations only. The following are requirements for Primary Care Provider Termination Notification:

1. Contracting IPA/medical groups must provide at least 90 days' advance written notice of a termination in accordance with Blue Shield's contractual requirements and the 1997 Balanced Budget Act (for Medicare Advantage members).
2. Notification to Blue Shield must include the following: termination reason (deceased, retirement from all practice, closed practice site, left IPA, etc.). Terminating provider identifiers such as name and NPI or California license number. When applicable, the name and NPI of the receiving PCP may be included for consideration in member reassignment.
3. Blue Shield provides affected members at least 60 calendar days' advance written notice of their primary care provider's termination which aligns with standard accreditation and regulatory requirements. The letter to the member includes notification of the PCP's termination, the termination date, their new PCP and/or IPA/medical group and the procedures for selecting another PCP by calling the Member Services toll free number.

   In very limited circumstances the IPA/medical group may be unable to provide the required advance notice of a primary care physician termination. In these circumstances, the IPA/medical group must work with the assigned Provider Relations Representative contact to facilitate the expedited transfer of impacted members to a new PCP.

   In such cases where the IPA/medical group is not the source of a PCP termination, Blue Shield will notify and reassign members as outlined in section Termination of Providers.

   The limited circumstances or exceptions referenced above include:

- Death
- Status change of medical license, or Medicare sanction and debarment, or any other sanction status which results in administrative termination due to the practitioner being ineligible to render care.
- A determination by Blue Shield's Credentialing or Legal Departments after an investigation of "Grossly unprofessional conduct", which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse).
- Relocation of practice out of the area without adequate notice.
- Practice closure without adequate notice.
- The physician is an employee of a medical group and resigns or is terminated effective immediately.

Compliance with Quality Improvement Programs

Updated examples of activities to comply with Blue Shield's Quality Improvement (QI) Programs in boldface and strikethrough below:

2. Review patterns and trends and participate in outcome measurement activities **and joint initiatives** ~~with respect to~~ **that improve** care and service **for Blue Shield of California members**.

3. Respond to identified adverse outcomes as quality improvement indicators**. Initiate, when requested, corrective action to address adverse outcomes.**

5. Cooperate with Blue Shield by participating in activities regarding preventive service utilization, quality improvement **initiatives including activities to improve HEDIS® effectiveness of care measures,** ~~and~~ **including supplemental data submissions,** guideline development and monitoring, patient safety activities, clinical pilot studies, and chronic condition management. All Blue Shield providers are required to participate in quality management activities **by identifying a qualified designee responsible for quality and by** providing, to the extent allowed by applicable state and federal law, member information and medical records for review of quality of care and service.

Other IPA/Medical Group Responsibilities

Provider Directory

Deleted and ***replaced*** with the following language:

In preparation for inclusion in Blue Shield's Directory publications, the IPA/medical group is required to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA).

All providers with a contracted relationship with Blue Shield will display in the Blue Shield *Find a Doctor* online directory.

IPA/medical groups have an opportunity to leverage Provider Connection online tools to support the process of attestation and submitting provider directory information updates. Non-responsive providers will be suppressed from the directory until they have attested to their information.

There are two ways to update data:

1) Make changes directly on Provider Connection in the Provider & Practitioner Profiles section;
2) Download your data via Provider Data Validation Spreadsheet and upload revisions to the site.

To discuss the information shared about your organization in the Blue Shield *Find a Doctor* online directory, please contact the Provider Information and Enrollment team at (800) 258-3091, from 6 a.m. to 6:30 p.m., Monday through Friday.

If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the Department of Managed Health Care or Department of Insurance to report any inaccuracy with the plan's directory or directories.

In order to reduce administrative burden on providers, Blue Shield may delegate some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the IPA/medical group may work with the vendor in lieu of Blue Shield to complete directory maintenance tasks.

Section 4.2: Member Rights and Responsibilities

Statement of Member Rights and Responsibilities

Updated Member Rights and Responsibilities to align with current *Evidence of Coverage* (EOCs).

Section 4.4: Claims Administration

Claims Processing

Electronic Submission

Updated instructions on claims submissions with additions in boldface type below:

For faster processing and turnaround, please submit all claims electronically. Electronically submitted claims **receipt** will be **electronically** acknowledged within 2 days. Claims/encounters must be submitted in **HIPAA compliant ASC X12N** 837P and -837I formats. Check with your programming staff or vendor to determine whether they have connectivity to Blue Shield.

Section 4.5: Provider Appeals and Dispute Resolution

Provider Appeals and Dispute Resolution

Added the following language as part of instructions for submitting an initial and final appeal:

Please submit on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

UM Criteria and Guidelines

Updated section with additions in boldface type below:

Blue Shield requires that all delegated IPA/medical groups adhere to Blue Shield Medical & Medication Policies which may include step therapy **requiring the use of preferred agents including generic or biosimilar drugs** and site of administration criteria.

Blue Shield Medical & Medication Policies

Medication Policy

Deleted and ***replaced*** the list of criteria that drug products must meet to be eligible for coverage below:

1. The pharmaceutical product is approved by the U.S. Food and Drug Administration for marketing in the U.S.

2. The formulary placement and medication coverage policy recommendations are based on the principles of evidence-based medicine, which is a review of scientific evidence from peer-reviewed published medical literature.

    a. Multi-center, randomized, prospective clinical trial results published in the peer-reviewed literature demonstrating the treatment to be at least as safe and effective as other established modalities of therapy are considered as best evidence.

    b. In absence of randomized controlled trials, lesser level of evidence, such as observational studies, medical society guidelines, and accepted community standard of practice will be considered.

Medication Policy

Added language, in boldface type below, that a provider will not receive payment if the provider fails to adhere to Blue Shield policies.

If Blue Shield determines that a previously rendered service is not medically necessary, **does not adhere to Blue Shields policies** or does not qualify for coverage, the provider will not be paid for the service and will not be able to collect payment from the member without a signed notice of non-coverage. If questions arise about Blue Shield Medical Policy or IPA/medical groups require specific guidelines, please contact Provider Information & Enrollment at (800) 258-3091.

Emergency Ambulance

Rewrote section for clarify:

Blue Shield and its delegates determine medical necessity for ambulance transportation independent of medical necessity criteria for emergency room services retrospectively. Payment or denial of emergency ambulance services, including paramedic services rendered at the scene, will be subject to review according to medical necessity and the "reasonable person" standard. Blue Shield defines the "reasonable person" standard to mean that urgent or

emergency services are covered when a non-medically trained individual using reasonable judgment would believe that an urgent or emergent situation exists.

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.

Emergency ambulance services are covered from the site of the medical emergency to the nearest appropriate facility or between facilities when a higher level of care is required to stabilize and treat an emergency medical condition.

Medical Benefit Drugs

Added language to indicate that some drugs may require prior authorization, based on place of administration.

Updated section with additional language about the IPA/medical group's requirement to follow step therapy with preferred agents and biosimilar drugs.

Added language to indicate that drugs costing over $100K per dose are subject to review for coverage.

Mental Health and Substance Use Disorder Services

IPA/Medical Group Covered Services and Financial Responsibility

Updated bullet point in list of services for which the IPA/medical group remains responsible for, when member's mental health and substance use disorder benefits are being managed by Blue Shield's MHSA below:

- Decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group. In making utilization management decisions, the IPA/medical group will utilize ASAM **criteria**, LOCUS **assessment**, CALOCUS **assessment**, **WPATH Standards of Care**, and ECSII for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Prior Authorization

Updated list of services that may require prior authorization in boldface type below:

3. IV infusion **or injectable therapy** including high-cost medications such as CAR-T and Gene therapy **or drugs costing more than $100,000 per single dose.**

20. **IV or injectable Medication** administration at an outpatient hospital facility.

Section 5.2: Quality Management Programs

Provider Responsibilities for Quality Management and Improvement

Deleted and ***replaced*** list of Quality Management and Improvement activities that Blue Shield solicits its providers to participate in below:

- QI Committees
- Credentialing, peer review, and utilization management determinations
- Clinical QI workgroups
- Focus groups
- QI studies
- Investigation of member grievances and quality of care issues

Quality Management and Improvement Program Requirements - Delegate Responsibilities

Updated bullet points in list of items that a QI Program Description shall include in boldface type below:

- Organizational structure including the role and function of the IPA/medical group's governing body, quality committees and subcommittees, **qualified, trained** staff responsible for QI activities, and the frequency of their meetings
- **Specify a qualified individual responsible for quality initiatives & activities including partnership to close HEDIS care gaps**

Quality Improvement

Updated bullet points with additions in boldface type below:

- Provide **designated**, adequate staff who have the knowledge, skills, and experience to perform quality improvement activities
- Work with Blue Shield to perform quality improvement activities**, including closing HEDIS care gaps** and allow Blue Shield access to its members' medical records
- Comply with applicable NCQA standards, guidelines and **HEDIS measures**

Quality of Care Activities

Updated bullet points in list of Quality of Care activities that providers are required to work with Blue Shield on with additions in boldface type below:

- Healthcare Effectiveness Data and Information Set (HEDIS) data collection **and initiatives to improve HEDIS measure rates**
- Disease management **and preventive service programs**
- Process for maintaining confidentiality of member's **protected** health information

Quality of Care Reviews

Deleted and ***replaced*** with the following language:

Blue Shield has a comprehensive review system to address quality of care issues. A quality of care issue arising from a member grievance, or an internal department is forwarded to the Blue Shield Clinical Quality Review Department where a clinical quality review nurse investigates and compiles a care summary from clinical documentation including, but not limited to, medical records and a provider written response. If a nurse identifies a potential quality of care issue, the case will be forwarded to a Blue Shield Medical Director to determine if a quality of care issue exists and assign a severity level. A case review may also include referral to the Blue

Shield Peer Review Committee if indicated. Review by a like-peer specialist may also occur at the discretion of the Blue Shield Medical Director or Peer Review Committee.

During the review process, information is obtained from an IPA/medical group or directly from the involved provider. Upon review completion, dependent upon the severity of any quality findings identified, follow-up actions may be taken to include a request for corrective action or an educational letter. Patient safety concerns or patterns of poor care may be considered during Blue Shield recredentialing activities or reviewed in more detail by the Blue Shield Credentialing Committee and may result in termination from the Blue Shield network.

Blue Shield providers are obligated to participate in the quality of care review process and must provide documents, including medical records and corrective action plans upon request. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157.

Provider Responsibilities for Quality Management and Improvement

Updated section with language that IPA/medical groups are required to share supplemental data for care rendered to members.

Delegation of Credentialing

Credentialing Oversight

Added the following section:

4. Oversight of Credentialing System Controls will be conducted as follows:

   Blue Shield will annually monitor the IPA/medical group's credentialing systems security controls to ensure that the IPA/Medical group monitors its compliance and monitors any subdelegates compliance with the delegation agreement or with the delegates procedures at least annually. Monitoring will be conducted by the IPA/medical group submitting a monitoring report of their credentialing system controls oversight process. At a minimum, the report will include:

   - Name of Delegate
   - Person/Title of who conducted the oversight
   - Date of Oversight
   - Timer period of oversight
   - Type of review: Electronic, Paper or both
   - Audit Frequency
   - A brief description of the method utilized to ensure compliance with their policies/procedures for each factor (1-4)
   - Results of the review
   - Follow-up on findings, if applicable

   If noncompliant modifications were identified, the IPA/medical group will complete a Monitoring and Reporting of Inappropriate Modification Report form. At a minimum, the report

will include the name of the delegate, staff member and title that conducted the oversight and the time period of the review. The report will indicate the type of review Paper files, Electronic System, or both. The report will document the following information from the delegate: and the plan will conduct its own review and follow-up for three (3) consecutive months:

1. Date non-compliant modification was made.
2. Identifier (delegate to provide something that can be used as an identifier of the record that was noncompliant for modifications, e.g., practitioner last name, initials, unique system #, etc.).
3. Provide a description of the modification that did not meet the delegates policies, procedures and/or delegation agreement (each modification needs a line item).
4. Describe Actions taken to correct the modifications that did not meet the delegates policies, procedures and/or delegation agreement.
5. Qualitative Review: An examination of the underlying reason for (root cause analysis) the results, including identifying any deficiencies or processes that may create barriers to improvement or cause additional failures.
6. Quantitative Review: A comparison of numeric results against a standard or benchmark, (# of modifications vs # noncompliant modifications) trended over time. Must draw conclusions about what the results mean.
7. Date of Quarterly monitoring on the findings.
8. Results of Quarterly Monitoring.

The Blue Shield will conduct its own review of all noncompliant findings and monitor compliance quarterly until the IPA/medical group or the Group's Subdelegate demonstrates improvement for one finding over three (3) consecutive quarter.

Delegation of Credentialing

Required Submissions/Notifications of Credentialing Program Activity

Updated language to indicate that credentialing reports should be submitted by the IPA/medical group utilizing the Health Industry Collaboration Effort (HICE) reporting tools found on the HICE website.

Submission of Laboratory Results Data

Updated the contact information for the HEDIS Supplemental data team to HEDISSUPPDATA@Blueshieldca.com.

Behavioral Health Geographic Access Standards

Deleted and *replaced* cells containing information about access standards for behavioral health providers with the following cells:

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health Individual Practitioners including: - Psychologists - Psychiatrists - Master's Level Therapists	Urban: 1 within 10 miles of each member Suburban: 1 within 20 miles of each member Rural: 1 within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Behavioral Health Member Ratio including: - Top 3 HVS and Substance Use practitioner	1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 20,000 members	Urban100% Suburban: 100% Rural: 100%

Provider Availability Standards for Commercial Products

Deleted and *replaced* with the following sections of the Geographic Distribution chart:

CATEGORY	PRODUCT TYPE*	STANDARD
SPC to Member Ratio	HMO PPO – DMHC IFP ePPO	1 OB/GYN to 5,000 (female commercial members only) 1 High-Volume Specialty of each type and 1 High-Impact Specialty to 10,000 members
Availability of Ancillary Care Providers	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	Pharmacy: 1 in 10 miles DME: 1 in 15 miles Radiology/Lab/ASC/SNF: 1 in 30 miles Urgent Care/Dialysis: Urban 1 in 15 miles, Suburban 1 in 20 miles, Rural 1 in 30 miles

Additional Measurements for Multidimensional Analysis for Commercial Products

Deleted and *replaced* with the following cells in the chart:

METRICS	PRODUCT	STANDARD	FREQUENCY
Access and availability related member complaints and grievances	HMO/POS PPO	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Semi-Annually against Standard

6.2: Blue Shield Medicare Advantage Plan Benefits and Exclusions

Medicare Part D Covered Drug

Added language to the section about coverage for Medicare Part D drugs below:

In essence, if the drug is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. CMS' understanding that the practice of

"brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. The following drug categories are covered by Medicare Part B and therefore excluded from Part D:

1) Any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., injectable chemotherapy); or
2) Any injectable or infusible drug that there exists a safety concern such that it would go against accepted medical practice for a particular injectable or infusible to be dispensed directly to a patient based on medical literature.

Blue Shield Medicare Advantage Plan Benefits

Medication Therapy Management Program

Updated list of criteria members must meet in order to qualify for MTMP, as follows:

- Have **three** of the following conditions:
    - Chronic Heart Failure (CHF)
    - Diabetes
    - Hypertension
    - Osteoporosis
    - Respiratory Disease
- Receive **eight** or more different covered Part D maintenance medications monthly

Hearing Services

Updated language to reflect that for select plans, hearing aid examinations and fittings are covered. Depending on the plan, the member may have the choice to go to a provider of their choosing or must go to a network provider with EPIC Hearing Healthcare.

Exclusions to Blue Shield Medicare Advantage Plan Benefits

Prescription Drug Benefit Exclusions

Updated bullet point in list of Blue Shield Medicare Advantage plan prescription drug benefit exclusions, with additions in boldface below:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. **This includes any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., chemotherapy and supportive/adjunctive injectable drugs), any drug that is administered to the member or dispensed within the four walls of a provider's office or facility, or any drug Blue Shield has determined, based on medical literature, there exist safety concerns such that it would go against accepted medical practice for a particular injectable or infusible drug to be dispensed directly to a patient.**

6.4: Blue Shield Medicare Advantage Plan Network Administration

IPA/Medical Group Responsibilities

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members

Moved the following language from "Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members" section to the "Continuation of Benefits" section:

In the unlikely event that one of the following extreme conditions arises, Blue Shield Medicare Advantage plan may have to discontinue benefits:

- Epidemic, riot, war, or major disaster.
- Complete or partial destruction of facilities.
- Loss or disability of a large number of our providers.

Under these extreme conditions, Blue Shield Medicare Advantage plan contracted hospitals and contracted providers will continue to make their best efforts to provide services. The member may go to the nearest medical facility for medically necessary services and will be reimbursed by Blue Shield for those charges.

Division of Financial Responsibility

Added language in boldface type below:

Note: It is not possible to list all medical/pharmacy services that may be provided to members. Financial responsibility for medical/pharmacy services not listed in the DOFR found in the Blue Shield contract shall follow Medicare guidelines for all product lines. Accordingly, medical/pharmacy services covered under Medicare Part A are the Capitated Hospital or Shared Savings financial responsibility and medical/pharmacy services covered under Medicare Part B are the group's financial responsibility. **This includes drugs that administered to the member or dispensed within the four walls of a provider's office or facility.**

6.6: Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

Member Rights and Responsibilities

Updated Member Rights and Responsibilities to align with current *Evidence of Coverage* (EOCs).

Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring

Measuring Timeliness and Accuracy

Fee Schedule Accuracy - Commercial

Updated section to reflect that "POS enrollees" were removed from the list of enrollees that could receive non-emergency services provided by non-contracted providers, at the amount set forth in the enrollee's *Evidence of Coverage*.

Measuring Timeliness

Added the following language about commercial claims processing:

If a Management Service Organization (MSO), that manages several delegated entities, receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Claims Delegate Reporting Instructions

Deleted and *replaced* to include updated instructions on how to submit reports, report naming conventions, submission schedules and sample reports.

Appendix 4-C: 2023 Actuarial Cost Model

Updated the model with 2023 data.

Appendix 5-A: Utilization Management Delegation Standards

UM System Controls

Deleted and *replaced* with the following language:

IPA/medical groups are required to have policies and procedures describing system controls specific to UM denial notification includes the below:

- Defines the date of receipt consistent with NCQA requirements.
- Defines the date of written notification consistent with NCQA requirements.
- Describes the process for recording dates in systems.
- Specifies titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
- Specifies how the system tracks modified dates.
- Describes system security controls in place to protect data from unauthorized modification.
    - Limiting physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware and physical records and files.
    - Preventing unauthorized access and changes to system data.
    - Password-protecting electronic systems.
    - Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.

- Describes how the organization monitors its compliance with the policies and procedures in factors 1–6 (all content above) at least annually and takes appropriate action, when applicable.

UM Systems Controls Compliance

Deleted and ***replaced*** with the following language:

At least annually, the organization demonstrates that it monitors compliance or audits reports with its UM denials controls by:

- Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.
- Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.
- Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.
- Documentation indicates the staff roles or department involved in the audit.
- The organization uses one of the following methods to audit files, if sampling it utilized:
    - 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately.
    - The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Appendix 5-B: Credentialing/Recredentialing Standards

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