February 23, 2022

Subject: **Notification of May 2022 Updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual* and *Blue Shield HMO Benefit Guidelines***

Dear IPA/medical group:

We have revised our *HMO IPA/Medical Group Procedures Manual* and *HMO Benefit Guidelines.* The changes listed in the following provider manual sections are effective May 1, 2022.

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 manuals 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* and *HMO Benefit Guidelines* are 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* or the *HMO Benefit Guidelines* 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 May 2022 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

T12418 (02/22)

UPDATES TO THE MAY 2022
HMO IPA/MEDICAL GROUP PROCEDURES MANUAL

Section 2.6 Exclusions and Limitations

GENERAL EXCLUSIONS AND LIMITATIONS

***Updated** the exclusions/limitations in boldface type below:*

38. For inpatient and Other Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA except for medical services for the treatment of gender dysphoria, eating disorder and substance use disorder treatment which are the responsibility of the IPA/medical group and **Blue Shield.**

Section 4.1 Network Administration

PROVIDER STATUS CHANGES

***Added** the following language to comply with California Health and Safety Code 1367.27.*

Open/Closed Status Changes

The IPA/medical group must notify Blue Shield no less than five days in advance of either of the following:

- A provider is not accepting new patients.
- If a provider had previously not accepted new patients, the provider is currently accepting new patients.

*The subsections below have been **deleted and replaced** with the following to align with the Consolidated Appropriations Act, Section 113.*

Specialist/Specialty Group Termination Notification Requirements

Blue Shield recognizes the importance of timely member notification of termination of a regularly seen specialist or specialty group.

- In accordance with accreditation and state regulatory standards, Blue Shield members are required to receive at least 60 days' prior notice of an upcoming physician termination, including specialist or specialty group termination.
- Federal law, however, requires that members be notified at the time of the provider's contract termination or the employer group's termination of its Blue Shield contract.

Therefore, to comply with all notification requirements, members must receive notices both 60 days prior to the specialist termination and again at the time of termination on a timely basis. Because Blue Shield does not assign members to specialist physicians/specialty groups, but rather relies on the IPA/medical group to coordinate the member's specialty care arrangements, the responsibility to notify the member of specialist terminations rests with the IPA/medical group.

The specifics of the requirements are as follows:

1. All Blue Shield contracting IPA/medical groups must notify members seen regularly by a specialist or specialty group whose contract is terminated at least 60 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. (Please refer to the Continuity of Care Guidelines in this section for members qualifying for continuity of care).

2. Contracting IPA/medical groups must have policies that define members seen regularly by a specialist or specialty group and which outline the IPA/medical group'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 IPA/medical group does not provide Blue Shield affected members with 60 days advance written notice, the IPA/medical group is responsible for ensuring the specialist and/or specialty group continues to provide medical services to affected members until a 60-day advance notice of the termination is given.

Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; including those who are undergoing a course of institutional or inpatient care; or who are children from birth to 36 months of age; or who have received authorization from a terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield provider network. The IPA/medical group is required to notify each enrollee who qualifies for continuity of care that they may elect for transitional care from a terminating provider, other than a PCP, from the IPA/medical group."

Continuity of Care for Members by Non-Contracted Providers

Newly covered members who do not have out-of-network benefits, and who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the member's coverage became effective under their Blue Shield plan. Provider must agree to Blue Shield pricing by region.

Existing Blue Shield members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; including those who are undergoing a course of institutional or inpatient care; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the provider's contract with Blue Shield terminated for up to ninety (90) days or completion of care, whichever is sooner.

A member can request continuity of care services by completing Blue Shield's Request for Continuity of Care Services form, available by calling Blue Shield Member Services or downloading from blueshieldca.com, then either mailing or faxing the completed form for review to the address or fax number listed on the form at least thirty (30) days before the health plan takes effect or as soon as the member becomes aware of the need for continuity of care services. Members can also request that Blue Shield file the continuity of care request for them by calling the Customer Services number listed on their ID card.

Section 4.2 Member Rights and Responsibilities

Added *the following language pertaining to AB 347 Step Therapy:*

EXTERNAL EXCEPTION REVIEW

If Blue Shield denies an exception request for coverage of a Non-Formulary Drug, Step Therapy or a Prescription Drug Prior Authorization, the member, authorized representative, or the provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances.

Section 4.5 Provider Appeals and Dispute Resolution

UNFAIR BILLING AND PAYMENT PATTERNS

Required Information/Appeal

Added *the following to required information that a written appeal must contain:*

- Proof of participation in the IPA's provider appeal process and when the original determination was made by the IPA (such as a copy of the IPA Appeal denial letter and or denial letter EOB), when applicable.

CAPITATED ENTITY (IPA/MG/CAPITATED HOSPITAL) APPEAL RESOLUTION REQUIREMENTS

Provider Appeal Documentation

Added *the following language:*

Providing all supporting documentation at the time the initial appeal is submitted will help ensure timely processing.

Section 5.1 Utilization Management

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Added *clarifying language in boldface type to the paragraph below:*

The responsibility for authorizing mental health and substance use disorder services for Blue Shield Medicare Advantage plan members remains with the delegated IPA/medical group. **If Medicare behavioral health utilization management is not delegated to the IPA/medical group, Blue Shield retains the responsibility for authorizing mental health and substance use disorder services**. Mental Health services are covered in accordance with Medicare coverage guidelines.

Added *language to this section and the* **Blue Shield Mental Health Service Administrator (MHSA) Covered Services and Financial Responsibility** *subsection, as follows:*

The MHSA only provides authorization for commercial and limited Group MAPD members, not for Individual MAPD members.

The subsections below have been ***deleted and replaced*** *with the following:*

MEMBER SELF-REFERRAL NUMBER

Blue Shield members can self-refer for behavioral health services by calling the Customer Service or Mental Health Customer Service number on the back of their Blue Shield ID card.

PRIMARY CARE PHYSICIAN CONSULTATION LINE

For Commercial and Group Medicare members, the Blue Shield MHSA offers a Primary Care Physician (PCP) Consultation Line at (877) 263-9870 to facilitate PCP discussion with a Board-Certified psychiatrist regarding mental health and substance use disorder issues, prescribing of psychotropic medication and coordination of care issues.

Section 6.1 Blue Shield Medicare Advantage Plan Overview

BLUE SHIELD MEDICARE ADVANTAGE PLAN SERVICE AREAS

Added *the following service areas to the* **Individual Blue Shield Medicare Advantage Plan Service Areas:**

- Merced County
- San Joaquin County
- Santa Clara County
- Stanislaus County

Added *the following service areas to the* **Group Blue Shield Medicare Advantage Plan Service Areas:**

- Alameda County
- Merced County
- Stanislaus County

Added *the following service areas to the* **Dual Eligible Special Needs Plan (D-SNP) Service Areas:**

- Merced County

Appendices

APPENDIX 5-B CREDENTIALING/RECREDENTIALING STANDARDS

Updated/added *the following language to comply with current NCQA standards:*

I. <u>Credentialing and Recredentialing Policies and Procedures</u>

7. Process for notifying practitioners if information obtained during the credentialing process varies substantially from the information they provided to the IPA/medical group.
15. Credentialing System Controls Oversight: At least annually, demonstrates that it monitors compliance with its CR controls, as described in item 14.e above, by:
    a. Identifying all modifications to credentialing and recredentialing information that did not meet the IPA/medical group's policies and procedures for modifications.
    b. Analyzing all instances of modifications that did not meet the IPA/medical group's policies and procedures for modifications.
    c. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters**.**

VIII. <u>Sub-Delegated Credentialing/Recredentialing Activities</u>

Added *the following language to comply with current NCQA standards:*

6. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policy and procedures at least annually.
7. Annually acts on all finding from item 6 above for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.
8. If the IPA/medical group contract with delegates that store, create, modify, or use credentialing data on the IPA/medical group's behalf, the agreement describes:
    - The delegate's CR system security controls in place to protect data from unauthorized modification as outlined in the Credentialing System Controls item/factor 4.
    - How the delegate monitors its credentialing system security controls at least annually as required in item 6 above (CR8, Element C, factor 5).
    - How the IPA/medical group monitors the delegate's credentialing system security controls at least annually, as required in item 6 above (CR8, Element C, factor 5).

Physician Services

Added *the following language to comply with California Health and Safety Code Section 1367.34:*

Adverse Childhood Experiences (ACEs) Screening

An ACEs screening, as defined by California Health and Safety Code Section 1367.34, is a screening for all individuals covered under fully-insured plans with Blue Shield. Training to perform ACEs screenings, approved by the California Department of Healthcare Services, is available on the ACEs website at https://www.acesaware.org/wp-content/uploads/2019/12/ACE-Clinical-Workflows-Algorithms-and-ACE-Associated-Health-Conditions.pdf.

Coverage for ACEs screenings for commercial fully-insured plans is based on the requirements set forth in California Health and Safety Code Section 1367.34. Consistent with those requirements, the ACEs screenings will be covered as follows:

- An ACEs screening is covered and included as part of the annual health appraisal for members based on time utilization. There is no separate reimbursement for an ACEs screening. (See the Preventive Benefit Policy on Provider Connection at blueshieldca.com/provider for annual health appraisal procedure codes.)
- If the ACEs screening is performed as the only covered service performed, the ACEs screening can be billed as an office visit based on time utilization utilizing Evaluation and Management codes published by the American Medical Association.