blue california
Promise Health Plan

3840 Kilroy Airport Way
Long Beach, CA 90806

October 13, 2023

Subject: **Notification of January 2024 Updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

Blue Shield Promise is revising the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2024.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at www.blueshieldca.com/en/bsp/providers. Click on *Provider manuals* under the *policies & guidelines* heading in the middle of the page.

You may also request a PDF version of the revised *Blue Shield Promise Health Plan Medi-Cal Provider Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is included by reference in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice or about the revisions that will be published in the January 2024 version of this Manual, please contact Blue Shield Promise Provider Customer Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Section 3: Benefit Plans and Programs

3.2 Managed Long-Term Services and Supports (MLTSS)

3.2.2: Long-Term Care (LTC)

Added entire sub-section, detailing information about Intermediate Care Facilities for Developmental Disabilities (ICF/DD) and the Lanterman Developmental Services Act.

3.2.2.3: Continuity of Care

Corrected APL 18-008 to APL 22-032 throughout Sub-section 3.2.2.3, which details the continuity of care process for SNF placement.

3.4: Home-Based Palliative Care Program

3.4.1: Enrolling/Disenrolling members in the Home-Based Palliative Care Program

Deleted *and* ***replaced*** the "Member Eligibility" sub-section, which lists conditions that make members eligible for the Palliative Care Program, with the following:

Member Eligibility

Members with any of the following conditions are eligible for the Palliative Care Program:

- Advanced medical conditions including, but not limited to congestive heart failure, chronic obstructive pulmonary disease, liver disease, and advanced cancer
- Children, defined as members under the age of 21, with serious medical conditions
- The member is likely to, or has started to, use the hospital or emergency department as a means to manage their advanced disease.
- The member's death within a year would not be unexpected based on clinical status.
- The member is not enrolled in Hospice or has declined Hospice.

Added entire "Evaluation of Eligibility and Enrollment" sub-section, which delineates the process the provider must take, upon receiving a palliative care referral.

Updated the sub-section detailing the process for disenrolling a member from the Home-Based Palliative Care Program, as follows:

Member Disenrollment

To ensure Blue Shield Promise has an accurate list of members enrolled in the Program, providers must notify Blue Shield Promise within 3 business days of a member's disenrollment from the Program. The provider will send an email notification to Bscpalliativecare@blueshieldca.com, notifying Blue Shield of the reason for disenrollment as well as the effective disenrollment date. A member may be disenrolled for several reasons, including member's condition improving, member declining services or member enrolling in hospice services.

Case rate payments for the disenrolled member will be discontinued the month following disenrollment in the program.

3.4.2: Covered Services

Updated the following language concerning the Medi-Cal Home-Based Palliative Care Program, in boldface type:

Members enrolled in the Medi-Cal Home-Based Palliative Care Program are not charged copays or coinsurance for palliative care services and can receive services including **but not limited to:**

3.6: Community Health Worker

Deleted *and* ***replaced*** entire Section 3.6, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), which describes Community Health Worker and Asthma Preventive Services.

3.6.1 Asthma Preventive Services

Added entire sub-section 3.6.1, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), which describe Asthma Preventive Services (APS), which is comprised of clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments for eligible beneficiaries of any age, as medically necessary, subject to applicable utilization controls.

3.8: Annual Cognitive Health Assessment

Deleted and ***replaced*** entire section in accordance with APL 22-025, Section 3.8, which describes the Annual Cognitive Health Assessment, as follows:

In accordance with APL 22-025, Blue Shield Promise provides coverage for annual cognitive health assessments for members who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare program.

This assessment may be performed by any licensed health care professional contracted with Blue Shield Promise who is enrolled as a Medi-Cal provider, is acting within their scope of practice, and is eligible to bill Evaluation and Management (E&M) codes.

Contracted providers must complete the following steps in order to bill and receive reimbursement for these annual assessments:

- Complete the DHCS Dementia Care Aware cognitive health assessment training prior to performing the assessments.
- Administer the assessments as part of E&M visits.
- Create required documentation and have records available upon request.
- Use appropriate CPT codes.

Providers must use at least one of the required cognitive assessment tools below to bill screenings administered to members:

Patient assessment tools:

- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog

Information tools (family members and close friends)

- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly

Billing requires that the completed assessment was reviewed, the appropriate assessment tool was used, results documented and interpreted, results were discussed with the member and/or family, and any clinically appropriate actions were documented.

Providers who administer an assessment should use the following code for reimbursement:

Coverage	Visit Type	Billing Code	Note
Medi-Cal only	Cognitive health assessment	1494F	Provider must complete the Dementia Care Aware CHA to use this billing code.

Providers are advised to continue to provide assessments and treatments as needed to members under 65 years of age who show or report symptoms of cognitive decline.

Blue Shield Promise will also conduct a yearly chart review of randomly selected charts to ensure that appropriate Annual Cognitive Health Assessment services are documented in the medical records.

For questions about the Annual Cognitive Health Assessment, please contact the Blue Shield Promise Provider Services Department at (800) 468-9935 from 6 a.m. to 6:30 p.m., Monday through Friday.

3.9: Street Medicine

Added, in accordance with DHCS APL 22-023, Section 3.9 and Sub-sections 3.9.1 to 3.9.6, which describe Street Medicine definitions, requirements, providers, authorization information, billing and reimbursement, data sharing, reporting and administration requirements.

Section 7: Utilization Management

7.1: Utilization Management Program

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Deleted *and* ***replaced*** a large portion of Section 7.12, which details the Approval/denial data files (hospital authorization log) submission process.

7.3. Primary Care Physician Scope of Care

Added the following language explaining the primary care physician's obligation to provide routine care:

Primary Care Physicians (PCPs) are responsible for providing all routine health care services, including preventive care, to their enrolled members.

7.5: Emergency Services and Admission Review

7.5.1: Emergency Services

Added the following language, explaining timely access to care for members receiving a medical screening exam:

For members who have been screened in the emergency room and do not require emergency care, timely access to Medically Necessary follow-ups including appropriate referrals to Primary Care, Behavioral Health Services, and social services per our Access and Availability of Services policies and procedures is available.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information

7.8.4: Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) / Medi-Cal for Kids & Teens

Added, in accordance with the new EPSDT APL 23-005, the following language explaining how members under the age of 21 must be provided EPSDT preventive services:

…All members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. PCPs must provide members with appropriate referrals for diagnosis and treatment without delay. PCPs are also responsible for ensuring members under the age of 21 have timely access to all Medically Necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

7.8.11: Mental Health (Medi-Cal Managed Care)

Added language to specify that Blue Shield Promise members may directly access specialty mental health services through Los Angeles or San Diego County Departments of Mental Health.

Removed the following bullet point from list of duties for which the primary care physician is responsible:

- Initial Health Appointment (IHA) and Individual Health Education Behavior Assessment (IHEBA) using an age appropriate DHCS approved assessment tool

Section 9: Quality Improvement

9.1: Quality Improvement Program

Updated the following bullet point indicating the types of providers the Quality Improvement Program covers:

- All directly contracted providers and all delegated or subcontracted providers

9.1.1: Program Structure Governing Body

Added items in boldface type below to list of scope of the Quality Management Committee and its sub-committees:

8. Reviewing reports of subcommittees (Medical Services, **Promise Behavioral Health** and Access & Availability, others reporting as necessary).

9.1.3: Quality Improvement Process

Updated bullet points in a list of data sources to monitor, analyze, and evaluate quality improvement goals and objectives, as follows:

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:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)Customer Service call data
- Pertinent Medical Records (minimum necessary)
- Appointment access surveys and geo-access data
- Encounter and claims data
- Member and provider complaint data including grievances and quality of care issues (see next section)
- Appeal information
- Pharmacy data
- Case Management/care coordination data
- Utilization reports and case review data, including over-and-under utilization
- Authorization and denial reporting
- Delegation oversight audits
- Statistical, epidemiological, and demographic member information
- Enrollment and disenrollment data
- Language and cultural data, race and ethnicity data, sexual orientation, and gender identity data
- Vendor performance data including competency assessment results for language assistance, and behavioral health data
- Member grievances and quality of care issues (see more below)
- Practitioner/Provider Satisfaction Surveys

Added language in boldface type below to paragraph explaining requirements for providers to participate in the quality studies process, as follows:

… All network providers are required to participate in the quality studies process. This includes providing medical records upon request and at no cost to Blue Shield Promise (including network providers using an outside medical record vendor), in the requested time frames for the purposes of performance reporting and audits for the Healthcare Effectiveness Data and Information Set (HEDIS), Managed Care Accountability Set (MCAS), **and DHCS' validation of Encounter Data.**

9.4: Clinical Practice Guidelines

Updated the following section detailing clinical practice guidelines in boldface type:

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. **Members and providers are educated on these guidelines through member and provider newsletters and via the Blue Shield Promise Health Plan website.**

Guidelines are distributed to all contracted Primary Care Practitioners (PCPs), specialists, and delegated IPAs as they are developed and/or revised through educational sessions, mailings, newsletters, and updates to the Practitioner Manual. In addition, any guideline(s) revisions will be included by the following methods:

- **As part of the new Provider Orientation process**
- **Included in the Provider Newsletters**
- **Included in Annual Notifications which are distributed to Providers in the Quality Outreach Packets**
- **Posted on the Provider website.**

9.8: Access to Care

Added the following language to the "After Hours Care and Emergencies" sub-section:

… 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.

9.8.3: Advanced Access

Deleted *and* ***replaced*** with the following language describing how Blue Shield may collect information because of providers' Advanced Access Programs:

Blue Shield may collect information from participating providers, participating medical groups ("PMGs"), and independent practice associations ("IPAs") on an ongoing basis as a means to identify those providers, PMGs, and IPAs with affiliated primary care practitioners who are compliant with California's appointment availability standards because of their Advanced Access Program or practices. Blue Shield recognizes the definition of advanced access from the Knox Keene Act's regulations (see Rule 1300.67.2.2, subd. (b)(1)); the definition is as follows: "Advanced access" means the provision, by a network provider, or by the provider group to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

9.13: Credentialing Program

9.13.2: Minimum Credentials Criteria

Deleted *and* ***replaced*** entire sub-section "Summary Suspension of a Practitioner's Privileges" and moved it to Section 9.13.5 "Termination of Practitioners/Providers" as below.

9.13.5: Termination of Practitioners/Providers

Automatic Termination of Practitioners/Providers

Blue Shield Promise shall terminate any practitioner/provider (whether directly contracted, delegated, or subcontracted), the effect of which is to immediately prohibit the provider from treating Members, upon the occurrence of any of the following events, and such termination shall not give rise to any procedural rights under Blue Shield Promise's Fair Hearing policy:

- A practitioner/provider's suspension or revocation of licensure as a physician in California or for disciplinary cause in any other state, whether or not stayed or subject to probation;
- A practitioner/provider's failure to maintain a valid and unrestricted license;
- A practitioner/provider's conviction of a felony or criminal offense relating to practice or fitness as a physician, fraud, or moral turpitude;
- An action taken by any federal or state agency administering a program providing health benefits that terminates or restricts the practitioner/provider's right to participate in such program for reasons related to the practitioner/provider's professional competence or conduct.

Suspension, Restriction, and/or Termination of Practitioners/Providers

The following events constitute grounds for suspension, restriction and/or termination of a practitioner/provider (whether directly contracted, delegated, or subcontracted) by Blue Shield Promise. Except as otherwise specified in this Provider Manual, Blue Shield Promise's suspension, restriction, and/or termination of any practitioner/provider's right to treat Members entitles the provider to the procedural rights set forth in Blue Shield Promise's Fair Hearing policy if the action is taken for medical disciplinary cause or reason and if the final imposition of the action requires Blue Shield Promise to report its action to the appropriate licensing board under Business and Professions Code Section 805 or to the National Practitioner Data Bank.

- A practitioner/provider's diagnosis, including a good faith belief that the provider has been diagnosed, as suffering from a severe mental or emotional disturbance that detrimentally affects the practitioner/provider's ability to provide services in a manner consistent with generally accepted professional standards;
- A practitioner/provider's professional incompetence, including a good faith belief in the provider's professional incompetence, non-cooperation with this Provider Manual, or non-performance of professional responsibilities;
- A practitioner/provider's addiction, including a good faith belief in the practitioner/provider's addiction, to alcohol, narcotics, or other drugs or physical disability that impairs the provider's ability to practice their profession in a competent manner;
- A practitioner/provider's failure to provide satisfactory personal or professional references and credentials, or to provide verifiable information regarding past employment, training, hospital affiliation or professional licensing;
- A practitioner/provider being a party to malpractice or other litigation or arbitration that has resulted in one or more substantial judgments, settlements, or awards against the provider; and

- A practitioner/provider's conduct, including a good faith belief that the practitioner/provider has engaged in conduct that is inappropriate, unprofessional, and/or violates state or federal law, or that constitutes good cause for suspension, restriction, or termination of the practitioner/provider's participation in Blue Shield Promise provider networks.

Section 10: Pharmacy and Medications

Added the following language about covered pharmacy services:

Covered pharmacy services that have historically been carved out of managed care health plans, include blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat a substance disorder. As of January 1, 2022, these drugs continue to be carved out of the medical benefits for managed care plans and may be covered under Medi-Cal Fee For Service (FFS) Fiscal Intermediary (FI) via a Treatment Authorization Request (TAR) at (800)-541-5555.

10.2: Specialty Pharmaceuticals

Clarified that medical benefit specialty pharmaceuticals prescribed for members associated with a non-risk medical group will require prior authorization review if listed on the Prior Authorization List.

Added/deleted in boldface and strikethrough font the steps for IPA/Medical Groups Not Retaining Specialty Pharmaceutical Risk and Blue Shield Promise Directly Contracted Physicians, as follows:

Procedure

9. Upon notice of an authorized prescription, **the provider shall use the buy and bill process. In rare instances, in which a medication may be a limited distribution drug or other exception, a provider may request assistance from the Plan to use a network** specialty pharmacy, then the prescription **will be processed** in accordance with their dispensing procedures. The dispensing process will include coordination of delivery with the physician, facility, or home infusion provider.~~ unless the provider is using the buy and bill process.~~
10. **If applicable**, the specialty pharmacy will be responsible for verifying ongoing member eligibility and an IPA/medical group assignment for all new and refill prescriptions. If the member is no longer eligible with Blue Shield Promise, then subsequent authorizations and dispensing of the specialty pharmaceutical will be based on the procedures established by the newly assigned health plan.

~~11. In the event that the physician needs to utilize a medication stocked in his/her office thru the buy and bill process, he or she will need to indicate this on the prior authorization form. If the medication and the in-office stock use are approved the physician will receive an approval notice for the drug so that it may be billed to Blue Shield Promise.~~

Section 11: Health Education

11.1: Health Education Program

Updated the Health Education Program Purpose to state that educational interventions also address health categories and topics that align with findings from Blue Shield Promise's Population Health Strategy requirements.

11.2: Scope of the Health Education Program

11.2.1: Member Education

Updated, in accordance with Population Health Management mandate. (2023 PHM Policy Guide), the paragraph explaining how Blue Shield Promise provides health education programs, to the following:

…Additionally, Blue Shield Promise provides health education programs at various locations and virtually. Class topics include asthma, diabetes, hypertension, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), tobacco cessation, weight management for adults and children, healthy nutrition for families, mental health awareness and the Healthier Living Program (chronic disease self-management), developed by Stanford University. Frequency of these classes varies depending on requests from providers and members. Most classes are implemented in English and Spanish. Some classes are implemented in Cantonese and Mandarin. Blue Shield Promise provides individual counseling in English, Spanish, Cantonese, and Mandarin. Access to an over-the-phone interpreter service is available for members requiring interpretation in other languages. Counseling topics include heart health and healthy nutrition for adults and children, in addition to the in-person class topics. Health Education programs are available to adults and families.

11.2.2: Mandated Health Education Topics

Added, in accordance with Population Health Management mandate. (2023 PHM Policy Guide), the following language with information about health education materials that are offered:

…Additionally, the HE department offers materials on CHF, COPD, and mental health awareness.

Section 12: Provider Services

12.7: Provider Network Changes

12.7.9: Practice Locations

Added the following language regarding practice location limitations to which all Blue Shield Promise providers must adhere, according to a state and/or federal legal requirement:

- Providers agree to limit their number of **reported practice locations** to the following:
    - Primary Care Physician/Practitioner (PCP): When a PCP practices at multiple practice locations, practitioner or medical group will ensure that reported locations per practitioner shall be limited to seven (7) in-person practice locations. Where stricter limits are imposed relative to the number of practice locations for reasons including, but not limited to, regulatory or other constraints on a particular geography and/or benefit program, Blue Shield Promise will accordingly limit members' enrollment options to a smaller subset of the practitioner's approved practice locations.
    - Specialty Care Practitioner/Subspecialty Care Practitioner (SCP): If a SCP practices at multiple practice locations, practitioner or medical group will ensure that reported locations per physician specialists, subspecialists, or other clinicians (e.g., chiropractors,

acupuncturists, occupational therapists, speech therapists, physical therapist, etc.) shall be limited to eleven (11) in-person practice locations.

12.7.10: Telehealth

Added the following language on Telehealth:

Blue Shield Promise utilizes telehealth as an option for members to obtain access to necessary health care services.

Blue Shield Promise and its Delegates must ensure that all providers comply with applicable state and federal laws and regulations and contractual requirements when providing telehealth services.

See the DHCS's policy on Telehealth at https://www.dhcs.ca.gov/provgovpart/Documents/mednetele2023.pdf.

Section 14: Claims

14.1 Claims Submission

Updated the mailing address for a paper claim to the following:

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

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS

Updated the following paragraph describing how providers may share patient language data, in boldface type:

Blue Shield Promise and its subcontractors will fully comply with federal and state regulations, DHCS, L.A. Care, and DMHC contract requirements relating to CLAS. Blue Shield Promise does not delegate overall responsibility for culturally and linguistically appropriate services provided to plan members to IPA/medical groups and other providers. **Blue Shield Promise may share individual patient language data directly with providers. We share member data on the service area population for the top threshold languages and the U.S. Census data for the state of California to bring awareness of the language needs of our members. California population language data from the United States Census can be accessed online at** https://www.census.gov/quickfacts/facts/table/CA/PST045221.

17.4: Cultural Competency and Health Equity Training

Updated sub-section describing how providers are offered training on equity, cultural competency, bias, diversity, and inclusion, to the following:

Blue Shield Promise offers our providers training on equity, cultural competency, bias, diversity, inclusion, and more, including translation and interpretation services that are also available to our members.

Cultural competency, sensitivity, health equity, diversity, and inclusion 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).

Blue Shield Promise is dedicated to reducing healthcare disparities among cultural minority groups that exist within our communities. To increase knowledge and awareness of cultural and linguistically appropriate services (CLAS), we are sharing the following free e-learning accredited program. This program provides Continuing Education Units (CEU) credits for physicians, physician assistants, nurse practitioners, and any other direct service providers interested in learning about CLAS.

We encourage you to attend "A Physician's Practical Guide to Culturally Competent Care." This training covers the fundamentals of CLAS, communication, and language assistance, including how to work effectively with an interpreter, and much more. Please visit the following website to access this free online training for providers: http://thinkculturalhealth.hhs.gov/education/physicians.

Additional free provider trainings and webinars are available on our Provider Learning Resources webpage.

17.9: Online Resources

Updated language explaining how the Blue Shield Promise website is offered in multiple language formats, to the following:

Multilingual Resources

- The Blue Shield Promise website is offered in multiple language formats. Members can click the global icon located on the top left corner of our homepage to select their desired threshold language.
- Members can request confidential information using multilingual request forms on our Confidential Communications Request page.
- Please visit our Cultural awareness and linguistics program website to download a copy of the Language Assistance Sign.

Appendices

Appendix 4: Access to Care Standards

Updated the Access to Care Standards Chart, to the following:

Type of Care and Service	Blue Shield Promise Health Plan Standard
Non-urgent and routine follow-up visits with behavioral health non-physician practitioners	Within ten (10) business days of the request.
Non-urgent and routine follow-up visits with behavioral health physicians	Within fifteen (15) business days of the request.
Behavioral Health initial non-urgent appointments with non-physician practitioners	Within ten (10) business days of the request (NCQA).
Behavioral Health initial non -urgent appointments with behavioral health physicians	Within ten (10) business days of the request (NCQA).

Appendix 9: Delegation Oversight Claims, Compliance, IT System Integrity - Auditing and Monitoring

Updated language concerning the process of conducting periodic audits of claims and provider disputes to ensure compliance with regulatory requirements, to the following:

Audits and Audit Preparation

…**Blue Shield Promise will perform an annual audit for claims and compliance oversight which include internal controls and IT system security**. Blue Shield Promise will provide a notification of the annual audit that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization.

Blue Shield Promise will require a walk through and demonstration of the Delegated Entity's operations. This will include a demonstration of the life of a claim from end to end **(mailroom/EDI receipt of claim to** disposition of payment and/or denial) which will include operational systems and interviews of staff associated with specific functional areas. To assure end to end processes are formally documented Blue Shield Promise requires submission of Policy and Procedures (P&P) noted in the industry standard **(HICE)** questionnaire as well as P&Ps requested during the audit claims assessment questions interview on the scheduled audit day. As part of the assessment Blue Shield Promise evaluates that P&Ps are reviewed annually via evidence that they were approved via committee or appropriate authority signature and dated.

If required claims documentation is not received, the audit is incomplete and will be scored as non-compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

Blue Shield Promise will provide the Delegated Entity with written results within 30 **calendar** days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause, **remediation,** and **evidence of** remediation within 30 **calendar** days of receipt of audit results. **If supporting documentation/evidence is not provided the CAP will be closed as non-compliant.**

Moved language and ***updated*** language concerning delegated entities' responsibility to date-stamp claims, acknowledgement of receipt, and payment accuracy, to the following:

Date Stamping

Delegated Entities must date stamp all paper claims, including facsimiles, with the date the claim was received. The stamp should identify the specific Delegated Entity. Blue Shield Promise recommends that each page of the paper claim including any attachments be date stamped. If a paper claim is received and then scanned for audit purposes, it should be batched for scanning by the original received date and include a unique identifier of the received date on the image. 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.

Acknowledgement of Receipt

The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of date of receipt of the claim and paper claims within 15 working days of date of receipt of the claim.

Acknowledgement timeframes are based on the date of receipt. The acknowledgment date for electronic submission claims should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic delivery.

Acknowledgement must be in the same manner as the claim was submitted or provided by electronic means, by phone, website, or another mutually agreed upon accessible method of notification. (CCR Title 28 Section 1300.71(c)).

Blue Shield Promise will validate Delegated Entity/MSO website to assure that directions are provided for a non-contracted provider regarding how they can confirm receipt of claim.

Payment Accuracy

Payment accuracy includes: (1) proper payment of interest, (2) proper use of a reasonable and customary fee schedule for non-contracted providers, (3) applying appropriate contract fee schedules, and (4) system configuration All four criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Contested Claim

Added, in accordance with Claims Settlement Practices Title 28 Section 1300.71(a)(8)(H) and (I), the following language, delineating the requirements for contesting a claim:

Delegated Entity will be audited against and must maintain compliance with Claims Settlement Practices in accordance with Title 28 Section 1300.71 (a)(8)(H) and (I) contesting claims for Medical Records.

(H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

Added the following language explaining the information that delegated entities need to include in their Evidence of Payment (EOP)/Remittance Advice (RA):

Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entities needs to include the following information in their EOP/RA:

- PDR Verbiage

  California Code of Regulations, Title 28 Section 1300.71.38 (b)
  - (b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address for a filing a provider dispute.
  - The right to dispute a claim using the approved PDR request form.
  - The dispute must be submitted within 365 calendar days from last claim action.
  - Written determination of the dispute must be made consistent with applicable state and federal law, within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
  - A provider has the right to submit an appeal if they do not agree with this resolution of this claims dispute. The language should include "you have the right to appeal directly to Blue Shield of California within 60 working days from the Date of Determination." This appeal would only be for Medical Necessity *de novo* review.

Corrective Action/Follow Up Audits

Added the following language explaining possible corrective action for non-compliant Delegated Entities:

If a Delegated Entity continues to be non-compliant, Delegated Entity will be referred to Delegation Oversight Committee for continuous monitoring. This would include on-site visits, scheduled meetings, focal audits, and remediation project plan oversight.

Newly Contracted Provider Training Oversight Audit

Added entire sub-section explaining the Delegated Entities' requirement, in accordance with the DHCS and L.A. Care Contract, to provide training for providers.

Added language explaining how a Delegated Entity must provide **unrestricted** access to provider manuals, clinical protocols, evidence-based guidelines, and any other pertinent information to out-of-network providers. Unrestricted access means Delegated Entities website allowing the out of network provider access to Delegated Entities website/portal to obtain these training material, protocols, and guidelines.

Compliance Program Effectiveness Oversight Audit

Added the following language:

CMS, DHCS and DMHC mandate that each health plan and its Delegated Entities have a Compliance, Fraud, Waste, and Abuse program in place and further mandates that all employees are required to take the training, at a minimum, annually. To ensure Blue Shield Promise is meeting all CMS, DHCS and DMHC requirements, Delegated Compliance Oversight will perform an annual review of each Delegated Entity's Compliance Program, including a Fraud, Waste, and Abuse program and assurance that all employees have taken Compliance Program training.

IT System Integrity Oversight

Added the following language detailing the IT system integrity audit:

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

- Operational effectiveness
- Access to programs and data access rights definition
- Access to programs and data access control mechanisms and password complexity
- Program changes/standard change management
- Computer operations (backup, recovery, and resumption)/HIPAA compliance
- Program changes
- Access to IT privileged functions

Oversight Monitoring-System Integrity, Compliance, Organizational Oversight

Added the following language detailing oversight monitoring:

Delegated Entity shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud:

- Group shall not allow the same person or departments to have the ability to pay claims and enter or update new providers, vendors and/or eligibility.
- Group shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times.
- Group shall maintain a compliance program, and that the program is independent of fiscal and administrative management.
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements.
- Group shall ensure that any and all changes made to data contained in entities; databases are logged and audited.

Appendix 11: Community Supports Criteria and Exclusion Guide

Deleted from and ***updated*** the "Meals/Medically Tailored Meals (MTM)" sub-section of the "Community Supports Criteria" Chart, with population eligibility criteria.

Appendix 13: Utilization Management Timeliness Standards

Updated the following requests within the Utilization Management Timeliness Standards chart:

- Routine (Non-urgent) Pre-Service – Extension Needed
- Expedited Authorization (Pre- Service) - Extension Needed

Appendix 14: HEDIS Guidelines

Updated the HEDIS Measurements chart, with information about measure, criteria, and description.