Medi-Cal Provider Manual

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Welcome

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

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is intended for network providers of Blue Shield Promise Medi-Cal Plans. It is to be used for the provision of covered services to Blue Shield Promise Health Plan members. This manual contains policies, procedures, and general reference information including minimum standards of care that are required of Blue Shield Promise Health Plan providers. Specific information on benefits, eligibility, enrollment, and co-payments are outlined within this manual.

We hope this information will help you better understand our operations. Should you or a staff member have questions about information contained in this manual or need additional information about Blue Shield Promise Health Plan, please feel free to contact our Provider Services Department or your Provider Relations Representative.

We look forward to working with you and your staff to provide quality managed-healthcare service to Blue Shield Promise Health Plan members.

Blue Shield of California Promise Health Plan

Blue Shield Promise Health Plan acts as a "gatekeeper" for its member's healthcare needs, providing managed health care services to our members. Blue Shield Promise Health Plan is responsible for monitoring the coordination and delivery of the health care our members receive through follow-up care, pre-authorization approval of referred services, ordering of therapy, consultation, pharmaceutical services, and admission to hospitals.

Medi-Cal

Medi-Cal in California (known as Medicaid in other states) is administered by the Department of Health Care Services (DHCS). It was established in 1965 to provide the necessary medical services for those eligible individuals whose income and resources were insufficient to provide for their health care. In California, the Medi-Cal program falls under the provisions of Title 22 of the California Code of Regulations. Since 1998, significant portions of the Medi-Cal population have been enrolled into managed care organizations on a mandatory basis.

Section 1: Introduction

Regulatory Agencies

Blue Shield Promise Health Plan is subject to government regulations at local, state, and federal levels including the following:

- The Centers for Medicare & Medicaid Services (CMS) - Administers the regulations under which a Prepaid Health Plan operates as a Federally Qualified Health Maintenance Organization.
- The California Department of Managed Health Care (DMHC) - Establishes many requirements in the areas of financial reporting, required services, and continuity of care. It administers the Knox-Keene Act and the Knox-Mills Health Plan Act.
- The California Department of Health Care Services (DHCS) - Establishes requirements for the Medi-Cal Managed Care program. Blue Shield Promise Health Plan's contract with DHCS for San Diego County and with L.A. Care Health Plan for Los Angeles County, make Blue Shield Promise Health Plan subject to these regulations.

Regulatory Requirements for Network Providers

Network providers, as defined in 42 CFR Section 438.2 and in the *Medi-Cal Managed Care Contract* (Exhibit E, Attachment 1, Definitions), must:

1. Have an executed written Network Provider Agreement with the managed care plan (MCP) or a subcontractor of the MCP that meets all the requirements set forth in Attachment A of All Plan Letter (APL) 19-001;
2. Be enrolled in accordance with APL 17-019, the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, and any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and
4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

Mission

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

Section 2: Mission Statement

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3.1: Covered Benefits

Blue Shield of California Promise Health Plan is contracted with the Local Initiative Health Authority of Los Angeles County (L.A. Care), and the Department of Health Care Services (San Diego) to provide Medi-Cal health benefits to its Medi-Cal recipients.

In order to provide the best health care services and practices, Blue Shield Promise has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield Promise Medi-Cal plans are described in the Member Handbook (also called *Evidence of Coverage).* Providers can view these documents online by visiting the Blue Shield Promise website at www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/medi-cal-members/plan-documents/member-handbook. To request printed copies of the publications, please contact the Provider Customer Services Department at (800) 468-9935.

3.2: Basic Population Health Management (BPHM)

Basic Population Health Management (BPHM) is a comprehensive package of services and supports that are intended for all Blue Shield Promise members to access at the right time and in the right setting in order to enable and sustain improved health outcomes and overall wellbeing. These services and supports are available to all Blue Shield Promise members regardless of their level of need.

As required by the DHCS CalAIM: Population Health Management (PHM) Policy Guide, BPHM includes "access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on maternal health outcomes, and care coordination and case management services for children under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)." More detail about these services and supports is listed in the following subsections.

For members assigned to Complex Care Management (CCM) and Enhanced Care Management (ECM) Care Managers, those Care Managers are responsible for ensuring that BPHM are part of care management provided to members.

Blue Shield Promise is contracted with providers to provide certain components of BPHM, while providing oversight in meeting required responsibilities and functions. All BPHM services aim to promote health equity and align with National Standards for Culturally and Linguistically Appropriate Services (CLAS). See **Section 17: Culturally and Linguistically Appropriate Services (CLAS)** for more information on Blue Shield Promise's CLAS policy.

To enable access to providers that provide BPHM services and supports, Blue Shield Promise covers Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to and from Plan-approved locations. See **Section 5.12: Transportation** for more information.

3.2: Basic Population Health Management (BPHM) *(cont'd.)*

3.2.1: Access, Utilization, and Engagement with Primary Care

All members must have an ongoing source of primary care and be engaged with their chosen/self-selected or assigned PCPs. To establish a relationship with their PCP and enable members to obtain necessary preventive services, all newly enrolled members must receive an Initial Health Appointment (IHA) with their PCP within 120 days of enrollment. See **9.5: Initial Health Appointment** for more information on IHA requirements.

3.2.2: Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports

All members must have access to necessary services that address all of their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs. Blue Shield Promise partners with primary care and other delivery systems to guarantee members' needs are addressed, which includes ensuring assigned PCPs play a key role in coordinating care, ensuring members have sufficient care coordination and continuity of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided.

Community Supports are services or settings that Blue Shield Promise may offer in place of services or settings covered under the California Medicaid State Plan that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Examples of Community Supports include asthma remediation, day habilitation programs, environmental accessibility adaptations, housing transition navigation services, personal care, medically tailored meals, and sobering centers. See **7.8.24: Community Supports** for more information.

Blue Shield Promise assists members in navigation, provider referrals, and coordination of health and services across Plans, settings, and delivery systems. To enable care coordination, data sharing, and non-duplication of services, Blue Shield Promise has established Memorandums of Understanding (MOUs) with Local Health Departments (LHDs), Local Education Agencies (LEAs), Local Government Agencies (LGAs), County Mental Health Plans (MHPs), and Third-Party Entities. These MOUs set forth the responsibilities and obligations of Blue Shield Promise and other parties to coordinate and facilitate provision of services to members when members are served by multiple parties. MOUs are reviewed regularly for any needed modification or renewals of responsibilities and obligations.

3.2: Basic Population Health Management (BPHM) *(cont'd.)*

3.2.2: Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports *(cont'd.)*

Starting in January 2025, Plans ensure services are provided, in compliance with all federal and state laws, via **closed loop referrals**, which means coordinating and referring members to available community resources and following up to ensure services were rendered. These closed loop referrals must be made to:

- ECM;
- Community Supports;
- Services provided by Community Health Workers, peer counselors, and community organizations;
- Dental providers;
- California Children's Services (CCS);
- Developmental Services (DD);
- CalFresh;
- WIC providers;
- County social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other home- and community-based services (HCBS);
- The appropriate delivery system for specialty mental health services to ensure members receive timely mental health services without delay, regardless of where they initially seek care, in accordance with DHCS' "No Wrong Door" policy; and
- The appropriate delivery system for SUD services.

Starting in January 2025, Blue Shield Promise will also coordinate with local health departments and other public benefits programs including, but not limited to, CalWORKs, Early Start, and Supplemental Security Income (SSI).

In addition, Blue Shield Promise's Quality Program works to ensure availability and access to care, clinical services, care coordination, and care management to members. See **9.1: Quality Improvement Program** for more information.

3.2.3: Information Sharing

To support effective BPHM, providers are expected to share and exchange member information and medical records with Blue Shield Promise in accordance with professional standards and state and federal privacy laws and regulations.

3.2: Basic Population Health Management (BPHM) *(cont'd.)*

3.2.4: Community Health Worker (CHW) Services

Community Health Workers (CHWs) are trusted community members that may be able to address various health and health-related issues that support BPHM including, but not limited to, supporting members' engagement with their PCP, identifying and connecting members to services that address social drivers of health, promoting wellness and prevention, helping manage their chronic disease, and supporting efforts that improve maternal and child health. See **3.7: Community Health Worker** for more information on the CHW scope and services.

3.2.5: Wellness and Prevention Programs

Blue Shield Promise provides comprehensive wellness and prevention programs to support members in a range of subject areas, such as healthy weight maintenance, smoking and tobacco use cessation, physical activity, healthy eating, stress management, avoiding at-risk drinking, and identifying depressive symptoms.

To address these areas, members have access to various digital offerings, including:

- A health and wellness portal where they can access evidence-based self-management tools and resources
- A publicly available library of health education resources and self-management tools on the Promise website
- Wellvolution, a member-facing platform that offers personalized, digital whole health programs to support general wellbeing, address stress, sleep, and other mental health concerns, and help prevent or reverse the course of serious chronic conditions.

See **Section 11: Health Education** for more information about these wellness and prevention programs and services. Blue Shield Promise's Health Education Program is committed to ensuring members receive high-quality, culturally sensitive, and linguistically appropriate health education services. The program works to increase knowledge and skills and promote behavior change to increase members' feelings of self-efficacy in managing chronic disease and maintaining optimal health for themselves and their families.

In partnership with L.A. Care, Blue Shield Promise also operates Community Resource Centers in Los Angeles County that serve as one-stop hubs for members to access free fitness, health and wellness classes and services to help them stay active, healthy, and informed.

3.2: Basic Population Health Management (BPHM) *(cont'd.)*

3.2.6: Programs Addressing Chronic Disease

Blue Shield Promise offers disease management programs for chronic lung conditions/asthma, cardiovascular disease, depression, congestive heart failure, and diabetes. In addition, there are evidence-based chronic disease self-management programs that incorporate health education interventions, identify members for engagement, and seek to close care gaps, with a focus on improving equity and reducing health disparities. Class topics include diabetes, cardiovascular disease, asthma, depression, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). These programs are informed by the Population Needs Assessment and are connected to other community programs, such as local health jurisdiction chronic disease initiatives. Lastly, the Wellvolution platform includes chronic disease prevention and management programs, including adult weight management, the Diabetes Prevention Program (DPP) and diabetes management, tobacco/vaping cessation, and behavioral health. See **Section 11: Health Education** for more information on these various programs.

In addition, many of the services and supports listed in **Section 3.7: Community Health Worker** and serve to support members in controlling and preventing chronic conditions. Specific **Community Supports (in section 7.9.24)**, such as Asthma Remediation and Medically Tailored Meals, are also targeted to address needs of members with chronic conditions.

3.2.7: Programs to Address Maternal Health Outcomes

Blue Shield Promise is required to meet all requirements for perinatal and postpartum individuals, including covering provision of all medically necessary services for perinatal and postpartum birthing people, implementing and administrating a comprehensive risk assessment tool that is comparable to the American College of Obstetricians and Gynecologists (ACOG) and standards per Title 22 C.C.R. Section 51348, developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups. See **7.9.4: Comprehensive Perinatal Services Program (CPSP)** for more information on CPSP requirements and required obstetric provider care for all pregnant and postpartum Blue Shield Promise members.

Additionally, Blue Shield Promise has developed a Maternal Mental Health Program to assist network practitioners, as well as delegated entities that contract with individual practitioners, who are providing prenatal or postpartum care to Promise members to comply with the requirement that the members are offered a screening, or are appropriately screened, for any type of mental health conditions that may be occurring. See **7.8.3: Direct OB/GYN Access** for more information.

Blue Shield Promise also provides a Maternal Health Program that provides care that is patient-centered, timely, and efficient. This cross-functional program includes Licensed Clinical Social Workers, RN Care Managers, Clinical Support Coordinators, Pharmacy, and

3.2: Basic Population Health Management (BPHM) *(cont'd.)*

3.2.7: Programs to Address Maternal Health Outcomes *(cont'd.)*

Medical Directors. RN Care Managers provide coordination of care, education, and condition management for all birthing members including members experiencing high-risk pregnancies. Providers can provide direct referrals to this program. Members verbally consent to participate and have the option to opt out.

Finally, in alignment with DHCS' Comprehensive Quality Strategy Bold Goal to improve maternity outcomes and birth equity, Blue Shield Promise offers a doula benefit to improve culturally sensitive birth care and reduce health disparities. Doula services encompass health education, advocacy, and physical, emotional, and non-medical support provided before, during and after childbirth or end of a pregnancy. Blue Shield Promise is committed to building an integrated network, centering partnerships with community-based organizations to make Doula services accessible to members. See **3.8: Doula Services** for more information.

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

All children under age 21 enrolled in Medi-Cal are entitled to the **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) / Medi-Cal for Kids & Teens** benefit under federal and state law. This benefit requires them to receive all recommended screening, preventive, and medically necessary diagnostic and treatment services regardless of whether the service is included in the Medicaid State Plan as available to adults. As part of BPHM, Blue Shield Promise must meet all EPSDT requirements related to timely access to services. See **7.4.1: Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) / Medi-Cal for Kids & Teens** for more information.

Blue Shield Promise partners with providers to ensure that the following are provided to all members under age 21 (and their families as appropriate):

- Initial Health Appointment(s) within 120 calendar days of enrollment or within the schedule for children aged 18 months and younger, whichever is sooner.
- Preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule.
- All medically necessary services, including those that are not covered for adults, as long as they could be Medicaid-covered services.
- Coordination of health and social services between settings of care and across other MCPs and delivery systems in order to access medically necessary physical, behavioral, and dental health services, as well as social and educational services.
- Information/resources on **EPSDT / Medi-Cal for Kids & Teens** screenings and preventive services.
- Care Management services for children receiving Private Duty Nursing (PDN) services.

3.2: Basic Population Health Management (BPHM) *(cont'd.)*

3.2.8: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) / Medi-Cal for Kids & Teens / PHM for Children *(cont'd.)*

To enable access to **EPSDT / Medi-Cal for Kids & Teens** services, all members under 21 years of age have access to the Child Health and Disability Prevention (CHDP) stand-alone programs such as Children's Presumptive Eligibility (CPE) to receive temporary preventative, primary and specialty health coverage through Medi-Cal Fee-For-Service (FFS) delivery system and the responsibility for local administration of the Health Care Program for Children in Foster Care (HCPCFC).

As part of care management and BPHM for members under age 21, Blue Shield Promise partners with providers to ensure provision of services to Children with Special Health Care Needs (CSHCN) via the California Children's Services Program, as well as those who may be eligible to receive services from the Early Start program. See **7.9.1: California Children's Services (CCS)** and **7.9.2: Regional Centers,** respectively, for more information about these programs.

3.3: Managed Long-Term Services and Supports (MLTSS)

Managed Long-Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports, coordinated and overseen by Blue Shield Promise. Programs range from services that support the members living in the community or in Long-Term Care. Community-Based Adult Services (CBAS) support members living in the community. Long-Term Care (LTC)/custodial care is provided in skilled nursing facilities. The following provides a more detailed description of these programs.

Blue Shield Promise providers may refer a member to the health plan for consideration to receive MLTSS. Each of these programs are subject to their own eligibility criteria, and a submitted referral does not guarantee approval of service. See the Social Services Referral Form which can be accessed on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers in the *Forms* section.

MLTSS programs include:

3.3.1: Community-Based Adult Services (CBAS)

CBAS is a community-based day health program that provides services to individuals 18 years of age or older that have a chronic medical, cognitive, or mental health condition and/or disabilities that place them at-risk of needing institutional care. The purpose is to delay or prevent institutionalization and maintain individuals in their homes and communities for as long as possible. Services promote personal independence, address the individual's specific health and social needs in a safe, positive, and caring environment. Services provided at the center include the following:

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.1: Community-Based Adult Services (CBAS) *(cont'd.)*

- Professional nursing services
- Physical, occupational and speech therapies
- Therapeutic activities
- Social services
- Personal care
- Hot meals and nutritional counseling
- Mental health services
- Transportation to and from the participant's residence

3.3.1.1: Accessing CBAS

Members must be assessed for program eligibility using the state mandated CBAS Eligibility Determination Tool ("CEDT"). To request a CEDT assessment, the member should be referred to a CBAS center of their choice. Alternately, the PCP or member may also contact Blue Shield Promise Social Services department to obtain a list of CBAS centers near the member's home (877) 221-0208, from 8 a.m. to 5 p.m., Monday through Friday or providers can complete and submit the Blue Shield Promise Social Services Referral Form which can be accessed on the Blue Shield Promise provider website in the *Forms* section. CBAS centers will request the member's medical history and physical in addition to an order for CBAS services from the member's PCP to enroll the member for CBAS services.

A provider who believes that a member needs CBAS should complete a CBAS Treatment Authorization Request (TAR) Form, and along with required documentation, submit it to Blue Shield Promise MLTSS/Long-Term Care Department for review, or fax it to (855) 699-9876 (Los Angeles County) or (619) 219-3308 (San Diego County). For questions, please call Blue Shield Promise at (855) 622-2755. This TAR form(s) can be accessed on the Blue Shield Promise provider website in the *Forms* section.

3.3.1.2: CBAS Emergency Remote Service (ERS)

Blue Shield Promise offers Emergency Remote Services (ERS) to allow for immediate response to address the continuity of care needs of members participating in CBAS when an emergency restricts or prevents them from receiving services at their center.

The provision of ERS supports and services is temporary and time-limited, and specifically either:

1. Short-term: members may receive ERS for an emergency occurrence for up to three consecutive months. CBAS providers and Blue Shield Promise will coordinate to ensure duration of ERS is appropriate during the member's current authorized period and, as necessary, for reauthorization into a new period;

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.1: Community-Based Adult Services (CBAS) *(cont'd.)*

3.3.1.2: CBAS Emergency Remote Service (ERS) *(cont'd.)*

2. Beyond Three Consecutive Months: ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. CBAS providers and Blue Shield Promise will coordinate on requests for authorization of ERS that exceed three consecutive months. Participants may need and/or be appropriate for ERS beyond three months.

Two types of "unique circumstances" listed in the 1115 Waiver Special Terms and Conditions that may result in need for ERS are:

1. Public Emergencies, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc.
2. Personal Emergencies, such as serious illness or injury, crises, or care transitions, as defined below. Specific personal emergencies may include serious illness or injury, crises, care transitions such as to/from a nursing facility, hospital, and home.
    - "Serious Illness or Injury" means that the illness or injury is preventing the member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address, or prevent significant illness or disability, and/or to alleviate pain. CBAS providers make the initial assessment regarding whether their participant has both experienced an emergency as defined in ERS policy AND per STC22, "assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting."
    - "Crises" means that the member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises would be the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
    - "Care Transitions" means transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. If a CBAS participant is hospitalized or admitted to a SNF, the participant would not be attending the CBAS center for services or eligible for ERS. ERS may be appropriate as the participant transitions home and, once home, has need for remote CBAS supports and services appropriate and feasible at that time. ERS provided during care transitions should address service gaps and member/caregiver needs and not duplicate responsibilities assigned to intake or discharging entities.

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC)

LTC is the provision of medical, social, and personal care services in either an institution or private home. Most LTC services are provided in skilled nursing facilities ("SNFs"). The primary purpose of LTC is to assist the member with activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparing special diets and supervision of medication that can usually be self-administered.

To qualify for LTC, members must meet all criteria below:

- Be a Medi-Cal beneficiary
- Require 24-hour long or short-term medical care
- Eligible to receive services in a Skilled Nursing Facility

3.3.2.a: Intermediate Care Facilities for Developmental Disabilities (ICF/DD)

- The ICF/DD Home living arrangement is a Medi-Cal Covered Service offered to individuals with intellectual and developmental disabilities who are eligible for services and support through the Regional Center service system. The Lanterman Developmental Disabilities Services Act (Lanterman Act) provides an entitlement to services and support for individuals with intellectual and developmental disabilities and their families. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled Nursing (ICF/DD-N) Homes. The ICF/DD benefit is covered by Medi-Cal and offered to Individuals with Developmental Disabilities (IDD) who are eligible for services and supports through the Regional Center system.
- The Lanterman Act outlines (1) The rights of individuals with developmental disabilities and their families, (2) How the Regional Centers and service Providers can help these individuals, (3) What services and supports individuals and family members can obtain, (4) How to use the Individualized Program Plan (IPP) to get needed services, (5) Additional important information and rights. California's Regional Center delivery system established under the Lanterman Act provides lifelong services and supports to assist those served to lead the most independent and productive lives in their chosen communities. Required functions of the Regional Center system include intake, assessment, eligibility determination, person-centered planning, case management, and the purchase of necessary services and supports for eligible individuals.

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.a: Intermediate Care Facilities for Developmental Disabilities (ICF/DD) *(cont'd.)*

- Regional Centers develop an IPP for each Regional Center member, based on the member's person-centered goals and needs. The IPP serves as a contract between the Regional Center and its members and identifies (1) all services and supports the member needs and is entitled to receive, and (2) whether the Regional Center will provide, supervise, or pay for the services, or another agency will. The IPP includes all services and supports the individual needs, even if a service will be provided by another source, such as Medi-Cal. The Lanterman Act dictates that the IPP process is centered on the individual, and if appropriate, the individual's parents, legal guardian or conservator, or authorized representative. The individual may choose whomever they wish to take part in their IPP meeting. The facility's interdisciplinary professional staff/team develops the Individual Service Plan (ISP) and includes participation of the member, direct care staff, and should include all relevant staff of other agencies involved in serving the member.
- To be eligible for Regional Center services, an individual must have a developmental disability that originates before 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability but shall not include other handicapping conditions that are solely physical in nature. The IPP will be shared by the Home with Blue Shield Promise so that Blue Shield Promise can ensure all medically necessary services are provided and coordinated, as appropriate, and ensure no duplication of services.
- Blue Shield Promise will coordinate benefits with other healthcare coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post Payment Recovery for Other Health Coverage. Such coordination of benefits must include recognizing OHC as primary and conducting post-payment recovery for the reasonable value of the services if the OHC is identified retroactively, if the member has an OHC indicator of A, or if the service is required to be pay and chase.

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.a: Intermediate Care Facilities for Developmental Disabilities (ICF/DD) *(cont'd.)*

- ICF/DD facilities and Homes are not Medicare Providers, and the per diem is not Medicare eligible. For members who are dually Medicare and Medi-Cal covered, or who have OHC, Blue Shield Promise will coordinate care and address coverage needs, regardless of payor source. Blue Shield Promise will ensure that the ICF/DD Home and their Network Providers have appropriate training on benefits coordination, including balanced billing prohibitions. Day Program and related transportation (referenced in the ICF-DD State Plan Amendment19) will continue to be provided by ICF/DD-N Homes and are not the responsibility of Blue Shield Promise.
- Because it is Regional Centers' duty to ensure their members residing in ICF/DD Homes receive all services and supports identified in the IPPs. Blue Shield Promise will inform Regional Centers of which services will be provided by Blue Shield Promise. A Memorandum of Understanding between Regional Centers and Blue Shield Promise that includes coordination for ICF/DD members will support this coordination effort.

3.3.2.1: Accessing LTC Services

Referrals for LTC can come from a PCP, Discharge Planner, Family Caregiver or Interdisciplinary Care Team (ICT). A PCP who believes a member needs LTC should write an order to admit under Custodial Level of Care and must include a completed LTC Authorization Request Form and submit it to Blue Shield Promise MLTSS/Long-Term Care Department for review via phone at (855) 622-2755 or via fax at (844) 200-0121. This form can be accessed on the Blue Shield Promise provider website in the *Forms* section.

A Blue Shield Promise authorization request for Medi-Cal long-term care must be submitted on our long-term care treatment authorization request (LTC TAR) form, along with the **required** information listed below, to request an initial approval.

1. Face sheet
2. Name of physician(s)
3. State treatment authorization request
4. Preadmission screening resident review (PASARR)
5. Durable Power of Attorney (DPOA) and/or Delegation of Parental Authorization (DOPA), if any
6. Interdisciplinary team meeting notes
7. Medication list
8. Specialty list
9. Minimum DATA SET Assessment

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.1: Accessing LTC Services *(cont'd.)*

10. Current history and physical or physician's progress notes
11. Medi-Cal Long-Term Care Facility Admission and Discharge Notification (MC 171)
12. Certification for Special Treatment Program Services form HS231, if requesting intermediate care facility/developmentally disabled (ICF/DD)

Once the LTC referral and physician order for Custodial Care have been received, Blue Shield Promise will notify the referral source of the LTC referral outcome within three (3) calendar days for routine situations and 72 hours for urgent situations. Blue Shield Promise MLTSS Department assists members with LTC by monitoring member progress, assisting with transitions outside of LTC, and coordinating LTC services with other health plan benefits.

Blue Shield Promise LTC clinicians will support the assigned physician with facilitation and coordination of care needs. Blue Shield Promise LTC clinicians also conduct regular telephonic and written clinical review of members in the Long-Term Care facility up to every six (6) months.

3.3.2.2: Bed Hold and Leave of Absence

"**Bed hold**" means the facility's policy for retaining a bed or room for a resident during the time that the resident is temporarily absent from the facility; the policy shall include time frames for the bed hold, acceptable conditions for the bed hold and any associated charges.

Blue Shield Promise strongly encourages and asks the collaboration of its facility partners to notify the member or the member's authorized representative in writing of the right to exercise the bed hold provision.

The following requirements shall be met:

1. Acute hospitalization for the beneficiary shall be ordered by the attending physician.
    a. Developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries Blue Shield Promise will authorize up to a total of seven (7) calendar days per hospitalization.
2. The facility shall hold a bed vacant during the entire bed hold period, except when notified, in writing, by the attending physician that the patient requires more than seven days of hospitalization. If so notified, the facility is no longer required to hold the bed available and shall not bill Medi-Cal for any remaining days of bed hold.
3. The day of departure shall be counted as one day of bed hold and the day of return shall be counted as one day of inpatient care.
4. Bed hold shall be terminated and payment shall not be made on the day of death of the beneficiary.
5. Facility claims shall identify the inclusive dates of bed hold.

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.2: Bed Hold and Leave of Absence *(cont'd.)*

6. The beneficiary's records maintained in the facility shall show the name and address of the acute care hospital to which the beneficiary has been admitted.

Leave of absence is defined as follows for patients who are on approved leave of absence.

1. Developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries: 73 days. A physician signature is required for an LOA only when a member is participating in a summer camp for the developmentally disabled.
2. Patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic and rehabilitative program approved and certified by a local mental health director: 30 days.
3. For All other patients: 18 days. Up to 12 additional days of leave per year may be approved when the request for additional days of leave is in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.

Leave of absence may be approved for:

- A visit with relatives or friends.
- Participation by developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries in an organized summer camp for developmentally disabled persons. A physician signature is required for an LOA only when a member is participating in a summer camp for the developmentally disabled.

All of the following requirements shall be met:

- Written approval and instructions for leave of absence shall be provided as follows:
    - In the individual program plan for developmentally disabled patients in intermediate care facilities for the developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing.
    - In the individual patient care plan for patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic and rehabilitative program approved and certified by a local mental health officer.
    - By the patient's attending physician for all other patients and in the individual patient care plan for those leaves involving the up to 12 additional days described in (a)(3).

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.2: Bed Hold and Leave of Absence *(cont'd.)*

The facility shall hold the bed vacant during leave.

- The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.
- Leave shall be terminated on the day of the death of the patient. Leave shall be terminated if the patient is admitted as an inpatient to any other facility, or if the patient exceeds the approved period of leave of absence and is determined to be absent without leave.
- Failure to return from leave of absence within the approved period shall not invalidate an approved treatment authorization request. There shall be no requirement to file a new treatment authorization request if the patient fails to return from leave within the approved period.
- The patient's records maintained in the skilled nursing facility, intermediate care facility, intermediate care facility for the developmentally disabled, intermediate care facility for the developmentally disabled habilitative, or intermediate care facility for the developmentally disabled-nursing shall show the address of the intended leave destination and the inclusive dates of leave.

3.3.2.3: Continuity of Care

A member newly enrolling into Blue Shield Promise and are residing in a SNF after June 30, 2023, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 22-032, or any superseding APL. MCPs must notify the member or their authorized representative and furnish a copy of the notification to the SNF in which the member resides, of the member's right to request continuity of care, consistent with APL 22-032, or any superseding APL.

3.3.2.4: Long-Term Services and Supports Liaison

- Blue Shield Promise will identify an individual or set of individuals as part of their Provider Relations or related functions to serve as the liaison for LTSS Providers
- Blue Shield Promise Liaisons are trained on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, Provider resolutions policies and procedures, and care management, coordination, and transition policies.

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.4: Long-Term Services and Supports Liaison *(cont'd.)*

- Blue Shield Promise LTSS liaisons will assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support members' needs.
- LTSS liaisons do not have to be clinical licensed professionals, they may be fulfilled with non-licensed staff. Blue Shield Promise will identify these individuals and disseminate their contact information to relevant Network Providers, including SNFs that are within Network.

3.3.2.5: The Preadmission Screening and Resident Review (PASRR) Requirements

PASRR are required to prevent a member's inappropriate nursing facility admission and retention of members. These PASRR requirements are for all Medi-Cal certified nursing facilities for all admissions to ensure that members who may be admitted into a nursing facility for a long-term stay be preliminarily assessed for serious mental illness and/or intellectual/developmental disability or related conditions. Blue Shield Promise will work with DHCS and Network Providers, including discharging facilities or admitting nursing facilities to obtain documentation validating PASRR process completions and will follow any further implementation guidance published by DHCS.

3.3.2.6: Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)

The Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP) replaces the former fee-for-service delivery system's Quality and Accountability Supplemental Payment (QASP) program. Through the SNF WQIP, Blue Shield Promise will distribute incentive payments to SNFs who meet performance and quality requirements, as determined by the DHCS.

Documented in All Plan Letter (APL) 25-002, payments are made by MCPs to facilities starting in Calendar Year (CY) 2024 for utilization/performance in CY 2023. The program applies to dates of service from January 1, 2023, through December 31, 2025.

Program Year (PY)	PY 1	PY 2	PY 3
Calendar Year (CY)	2023	2024	2025

How will SNF WQIP payment amounts be determined by Blue Shield Promise?

1. DHCS will calculate a per diem incentive amount for the program year for each SNF provider using metrics established for the workforce, clinical quality, and equity domains. A provider's WQIP score will be based on an aggregate of all the services they provided across all the MCPs they support. (SNFs will not receive separate scores for each MCP.) Please refer to the SNF WQIP Technical Program Guide (link in the Resources section below) for Program Year 1 for more information.

3.3: Managed Long-Term Services and Supports (MLTSS) *(cont'd.)*

3.3.2: Long-Term Care (LTC) *(cont'd.)*

3.3.2.6: Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP) *(cont'd.)*

2. Blue Shield Promise will calculate the number of eligible bed days for each qualifying SNF based on the applicable criteria and use that calculation in conjunction with the per diem incentive amount provided by DHCS to calculate the payment amount for each qualifying facility for which Blue Shield Promise is the responsible payer.

How will SNF WQIP payments be processed by Blue Shield Promise?

All payments will be calculated based on the per diem incentive amounts determined by DHCS and the criteria for eligibility contained in APL 25-002. They will be processed twice for each program year, once as an interim payment and again, as the final payment for each program year.

Blue Shield Promise will make SNF WQIP payments to providers directly, based on the number of qualifying bed days received from the provider for the incentive payment period. The payments will be processed and issued within 45 calendar days of receiving payment exhibits from DHCS or within 30 calendar days of receiving a clean claim from the provider, whichever is later.

SNF WQIP payments will be issued with a detailed cover letter describing the payments, whom to contact with any questions, and how to file a grievance. Along with the payment cover letter, providers will also receive a detailed report showing the data upon which the payments were calculated.

Quarterly Reconciliation Process

Blue Shield Promise sends each qualified facility a SNF WQIP bed day summary data file listing all qualifying bed days for the facility. This file is sent quarterly. Providers are encouraged to review this data carefully to determine if any claims are missing or incorrect. If missing claims are identified, providers should submit them via the normal Blue Shield Promise claims process.

What if I need to file a dispute or grievance?

For questions about your SNF WQIP payment, please send an email to PHPSNFProvInquiries@blueshieldca.com.

Resources

- Visit the www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx
- www.dhcs.ca.gov/services/Pages/WQIP-Key-Documents-2023-to-Current.aspx
- www.dhcs.ca.gov/services/Documents/WQIP-PY-2-Technical-Program-Guide.pdf
- www.blueshieldca.com/en/bsp/providers/programs/snf-wqip

3.4: Long-Term Services and Supports (LTSS)

Additional Long-Term Services and Supports that help members live in the community include In-Home Supportive Services (IHSS) and Multipurpose Senior Services and Programs (MSSP). IHSS and MSSP are services managed and paid by entities outside of Blue Shield Promise.

3.4.1: In-Home Supportive Services (IHSS)

LTSS programs include:

IHSS is a program managed by the state that pays for homecare services allowing seniors and individuals with disabilities (including children) to remain safely in their own homes and avoid institutionalization. Members who qualify hire their own IHSS caregiver to assist with personal care services, including the following:

- Personal Care (Bathing, grooming, dressing, feeding, incontinence care, toileting, fall prevention)
- Domestic services (cooking, light cleaning, laundry, grocery shopping)
- Paramedical services (medication management, medical appointment reminders)
- Protective supervision

To qualify for IHSS, a member must be a legal resident of California, living in his/her own home, receiving (or eligible to receive) Supplemental Security Income/State Supplemental Payment ("SSI/SSP") or Medi-Cal benefits, and 65 years of age or older, legally blind, or disabled by Social Security standards. The member must also submit a Health Care Certification Form (SOC 873) signed by a licensed health care professional indicating that they need assistance to stay living at home. This form is provided to members when they begin the application process.

3.4.1.1: Accessing IHSS

IHSS program eligibility and service authorizations are determined by the Los Angeles/San Diego County Department of Public Social Services (DPSS). Once approved for services, a member is responsible for hiring, training, and supervising the IHSS caregiver. The Blue Shield Promise Social Services Department can assist members with the following:

- Coordinating and navigating the IHSS application, assessment, and re-assessment processes
- Connecting the member to resources that can assist with locating a homecare worker

Physicians may refer members to the appropriate IHSS hotline based on the member's county of residence; Los Angeles County IHSS Application Hotline at (888) 944-4477, San Diego County at (800) 339-4661, or by completing and submitting the Blue Shield Promise Social Services Referral Form which can be accessed on the Blue Shield Promise provider website in the *Forms* section. Physicians will also need to complete the required IHSS forms and provide members with other documentation to support their need for IHSS.

3.4: Long-Term Services and Supports (LTSS) *(cont'd.)*

3.4.2: Multipurpose Senior Services Program (MSSP)

The Multipurpose Senior Services Program (MSSP) provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older, disabled, and that live within an MSSP site service area; services are an alternative to nursing facility placement allowing individuals to remain safely in their home. There are five (5) MSSP providers in Los Angeles County and one (1) MSSP provider in San Diego County who are responsible for determining program eligibility. Services provided include:

- Case Management
- Personal Care Services
- Respite Care (in-home and out-of-home)
- Environmental Accessibility Adaptations
- Housing Assistance/ Minor Home Repair, etc.
- Transportation
- Chore Services
- Personal Emergency Response System (PERS)/ Communication Device
- Adult Day Care / Support Center / Health Care
- Protective Supervision
- Meal Services - Congregate / Home Delivered
- Social Reassurance / Therapeutic Counseling
- Money Management
- Communication Services: Translation / Interpretation

3.4.2.1: Accessing MSSP Services

A physician who believes a member might benefit from MSSP services can refer the member directly to the MSSP site serving the member's area or can refer to the Blue Shield Promise Social Services Department by completing and submitting the Blue Shield Promise Social Services Referral Form.

Los Angeles County MSSP sites:
Human Services Association
Huntington Hospital
Jewish Family Services
Partners in Care Foundation
Senior Care Action Network (SCAN)

San Diego County MSSP site:
Aging & Independence Services

The Blue Shield Promise Social Services Department will work with members who do not meet MSSP eligibility requirements to identify alternative services.

3.5: Home-Based Palliative Care Program

Blue Shield Promise's Medi-Cal Home-Based Palliative Care Program uses an interdisciplinary team approach that provides tightly integrated, longitudinal in-home palliative care services as well as assessment and provision of medical care in line with the patient's goals. The Program incorporates:

- Treatment decision support
- Care plan development and shared decision-making
- Pain and symptom management

3.5.1: Enrolling/Disenrolling Members in the Home-Based Palliative Care Program

Member Eligibility

Members with either 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 **AND:**
- 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
- The member and/or medical decision maker is willing to:
    - Participate in Advance Care Planning discussions
    - Attempt care in home or outpatient setting, when appropriate, prior to going to the Emergency Department
- Children, defined as members under the age of 21, with serious medical conditions

Member Referral

Members have several ways to learn about and receive a referral to the Program.

- Blue Shield runs a monthly report to identify members that may qualify for palliative care services. The report algorithm is aligned with the general and disease-specific eligibility criteria
- Blue Shield Promise members can self-refer to the Program by contacting Blue Shield Promise Customer Care at (800) 605-2556
- PCPs and Specialists can refer members for a full Palliative Care Program Evaluation by completing the Palliative Care Patient Eligibility Screening Tool form. The form can be found on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers in the *Policies, Guidelines, Standards and Forms* section, then *Other patient care forms*. Submit the completed form to Blue Shield Promise by fax at 844-893-1206 or secure email at BSCpalliativecare@blueshieldca.com

All of the above processes and referrals are overseen by the Blue Shield Palliative Care Team.

3.5: Home-Based Palliative Care Program *(cont'd.)*

3.5.1: Enrolling/Disenrolling Members in the Home-Based Palliative Care Program *(cont'd.)*

Evaluation of Eligibility and Enrollment

Upon receiving a palliative care referral, the Blue Shield Palliative Care Team will review to confirm member eligibility for the benefit. A Blue Shield Promise contracted palliative care provider will outreach to the member to offer palliative care services. Upon the members acceptance to be evaluated for the Program, the palliative care agency will schedule an initial assessment with the member.

The provider must notify Blue Shield Promise via email to BSCPalliativeCare@blueshieldca.com within three (3) business days of completing an assessment with the status of the member.

The status options are as follows:

1. Enrolled (Please use enrollment notification format described below)
2. Accepted pending enrollment
3. Enrolled in hospice
4. Not eligible for the program
5. Member declined program

Enrolling a Member

A notification of enrollment must be emailed to the Blue Shield email BSCPalliativeCare@blueshieldca.com listed below within three (3) business days of a member's enrollment.

Enrollment Notification must contain the following information:

- Member's Blue Shield of California Promise Subscriber ID number
- Member First Name
- Member Last Name
- Member DOB
- Member Diagnosis (ICD-10 Code)
- Date of Enrollment into the program
- Palliative Care treating provider name
- Referral Date
- Referral Source
- AD & POLST status
- Is the patient enrolling in hospice? (yes/no)

3.5: Home-Based Palliative Care Program *(cont'd.)*

3.5.1: Enrolling/Disenrolling Members in the Home-Based Palliative Care Program *(cont'd.)*

Submission of Required Documentation Upon Enrollment

Providers are required to submit a copy of the initial clinical assessment upon member enrollment. Providers are also required to submit monthly clinical notes for all currently enrolled members. Please submit clinical notes to BSCPalliativeCare@blueshieldca.com.

Member Disenrollment

To ensure Blue Shield Promise has an accurate list of members enrolled in the Program, providers must notify Blue Shield Promise within three (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 Promise 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, member enrolling in hospice services, or member has died.

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

3.5.2: Covered Services

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:

- Advanced care planning-related activities
- Palliative care evaluation (prior to enrollment), ongoing needs assessment and consultation once the member is enrolled
- Care plan development incorporating both palliative and curative care, created with the engagement of member and/or member's representative
- Participation of a palliative care team responsible for providing medical care and psychosocial support for mental, emotional, social, and spiritual well-being
- Assigned nurse case manager to coordinate medical care
- Pain and symptom management via medications, physical therapy, and other medically necessary services
- Mental health and medical social services to help minimize the stress and psychological problems that arise from a serious illness, related conditions, and the dying process

3.5: Home-Based Palliative Care Program *(cont'd.)*

3.5.2: Covered Services *(cont'd.)*

- Needed services such as: home-based palliative care visits, either in person or via videoconferencing; 24/7 telephonic support; caregiver support; and assistance with transitions across care settings

Enrollment in the Program will not eliminate or reduce any covered benefits or services. Additionally, it will not affect a member's eligibility to receive services they were eligible for prior to Program enrollment, including home health services.

3.6: Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered. ECM is designed to:

- Improve care coordination;
- Integrate services;
- Facilitate community resources;
- Improve health outcomes; and
- Decrease inappropriate utilization and duplication of services.

To accomplish these goals, ECM will be interdisciplinary, high-touch, person-centered and provided primarily through in-person interactions with members where they live, seek care, and prefer to access services. Members keep their Medi-Cal plan and PCP, but now have an added layer of services and supports. The seven core services included in ECM are:

- Outreach and engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Coordination of Care
- Health promotion
- Comprehensive transitional care
- Member and family support
- Coordination of and referral to community and social support services

3.6: Enhanced Care Management *(cont'd.)*

ECM Target Populations

The Department of Health Care Services (DHCS) has identified mandatory ECM "populations of focus." These populations are listed below:

January 2022

- Adults and their Families Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (formerly "High Utilizers")
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Individuals Transitioning from Incarceration (some Whole-Person Care (WPC) counties)

January 2023

- Adults Living in the Community and At Risk for Institutionalization and Eligible for Long Term Care (LTC) Institutionalization
- Adults who are Nursing Facility Residents Transitioning to the Community

July 2023

- Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
- Children and Youth Populations of Focus:
  - Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
  - Children and Youth At Risk for Avoidable Hospital or ED Utilization
  - Children and Youth with Serious Mental Health and/or SUD Needs
  - Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition
  - Children and Youth Involved in Child Welfare

January 2024

- Birth Equity Population of Focus
- Individuals Transitioning from Incarceration (post release services statewide, inclusive of the former WPC counties that already went live on January 1, 2022)

[1] ECM has been available for adults with developmental needs from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. As of December 2022, DHCS has clarified that Individuals with I/DD is a distinct Population of Focus to provide more prominence to the availability of ECM for this population. Members in this category must also qualify for eligibility in any other ECM Population of Focus.

[2] ECM has been available to pregnant and postpartum adults from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. As of December 2022, DHCS is clarifying that "Pregnant and Postpartum Individuals" is a distinct Population of Focus to provide more prominence to the availability of ECM for this population. Members in this category must also qualify for eligibility in any other ECM Population of Focus.

3.6: Enhanced Care Management *(cont'd.)*

October 2024

- Individuals Transitioning from Incarceration (pre-release services)
    - Pre-release services will be phased in and completed by September 30, 2026

Please note the specific eligibility dates listed above as DHCS has provided a phased roll out of the populations eligible for ECM in 2022, 2023, and 2024.

ECM will be available to some members dually eligible for Medicare and Medicaid if they are enrolled in a Blue Shield Promise plan and otherwise meet criteria. From 2023 onwards, DHCS has phased out Medi-Cal ECM eligibility for Medi-Cal MCP members who are also enrolled in D-SNPs.

For more information regarding eligibility or to refer a member to ECM, please contact ECM@blueshieldca.com or visit www.blueshieldca.com/en/provider/guidelines-resources/patient-care-resources/enhanced-care-management.

Some members eligible for ECM may also be eligible for Community Supports, (non-benefits) that Blue Shield Promise may offer to eligible Medi-Cal members. For additional information about Community Supports, see Section 7.9.24.

Submission of Claims for Enhanced Care Management Reimbursement

Providers of ECM services have two options for submitting claims. Claims can be submitted through a Clearinghouse or on paper using the current version of the CMS 1500 form. These methods are described in detail in Section 14.1 Claim Submission.

3.6: Enhanced Care Management *(cont'd.)*

The ECM services available for selection correspond to the following HCPCS codes:

HCPCS Code	Modifier	Care Program Enrollee Status/Substatus	Encounter data Activity Type
ECM Outreach			
G9008	U8	Open/Pending	Outreach In Person Provided by Clinical Staff-
G9008	U8, GQ	Open/Pending	Outreach Telephonic/Electronic Provided by Clinical Staff
G9012	U8	Open/Pending	Outreach In Person Provided by Non-Clinical Staff
G9012	U8, GQ	Open/Pending	Outreach Telephonic/Electronic Provided by Non-Clinical Staff
ECM Services			
G9008	U1	Open/Engaged	In-Person Provided by Clinical Staff -
G9008	U1, GQ	Open/Engaged	Phone/Telehealth Provided by Clinical Staff -
G9012	U2	Open/Engaged	In-Person: Provided by Non-Clinical Staff -
G9012	U2, GQ	Open/Engaged	Phone/Telehealth: Provided by Non-Clinical Staff -

3.6.1: Enhanced Care Management for the Justice-Involved Population of Focus

The Justice-Involved (JI) Initiative allows eligible Californians who are incarcerated to enroll in Medi-Cal and receive a targeted set of services in the 90 days before their release, which is paid for on a Fee-For-Service (FFS) basis by Medi-Cal. This initiative aims to ensure continuity of health care coverage and services between the time they are incarcerated and when they are released.

Care management by ECM providers is a critical component of the CalAIM Justice-Involved (JI) Initiative, which is intended to (1) support the coordination of services delivered during the pre-release period and upon reentry into the community; (2) ensure warm handoffs to services and supports; and (3) arrange appointments and timely access to appropriate care delivered in the community. All JI ECM providers must meet the standard ECM provider requirements and the JI ECM provider minimum requirements to be considered a JI ECM provider in accordance with Department of Health Care Services (DHCS) guidance.

3.6: Enhanced Care Management *(cont'd.)*

3.6.1: Enhanced Care Management for the Justice-Involved Population of Focus *(cont'd.)*

The care management model has four primary goals:

- Develop and facilitate a care plan to help stabilize conditions prior to release
- Build trusted relationships between the member who is incarcerated and the care manager, who will support the member's transition back to the community
- Create and implement a reentry care plan in consultation and collaboration with the member and other providers
- Maximize continuity of care management and access to services, to the extent possible, as members transition between incarceration and reentry into the community

Pre-Release ECM Services and Warm Handoffs

Correctional facilities in each county will utilize either an embedded or an in-reach model. In the embedded model, the correctional facility employs or contracts directly with care management providers to deliver pre-release services. A warm handoff occurs between the correctional facility's pre-release care manager and the post-release ECM Lead Care Manager during the pre-release period. In cases where the warm handoff cannot occur during the pre-release period (e.g., the member is incarcerated for only 48 hours, or the member is released unexpectantly from court), providers must conduct the warm handoff in the post-release period, within one week of release. Where the pre-release and post-release care managers are not the same, their collaboration is vital to ensure continuity of care between pre- and post-release periods.

In the in-reach model, the JI ECM provider delivers pre-release care management services to members in correctional facilities, either in person or via telehealth, in addition to post-release care management services. If the in-reach pre-release care manager cannot continue to serve as the individual's post-release ECM Lead Care Manager, they must conduct a warm handoff to the post-release ECM Lead Care Manager.

Pre-release services include the following:

- Completion of a whole-person needs assessment
- Creating linkages with community-based providers
- Participating in warm handoffs (face-to-face or via telehealth)
- Completing a final reentry care plan

3.6: Enhanced Care Management *(cont'd.)*

3.6.1: Enhanced Care Management for the Justice-Involved Population of Focus *(cont'd.)*

Post-Release ECM

A member who receives pre-release services must be presumptively/retroactively authorized to receive ECM services on the day of release or, if Blue Shield Promise enrollment is effectuated after release, on the day of Blue Shield Promise enrollment. All members who receive pre-release services will reenter the community with a Reentry Care Plan which will become the member's care management plan upon release.

JI ECM providers must have experience serving the JI Population of Focus (POF) and a JI specific model of care. They should meet the individual at release if possible, or within two business days of release. JI ECM providers must also conduct a second follow-up appointment within one week of release to ensure continuity of care and to monitor the implementation of the reentry care plan. Additionally, JI ECM providers must participate in warm handoffs between behavioral health providers and follow up on missed appointments.

Billing and Reimbursement

All JI ECM providers must ensure that claims for any pre-release care management services and/or warm handoffs rendered by their providers are submitted under Fee-For-Service (FFS). To meet this requirement, all JI ECM providers must either enroll through the Provider Application and Validation for Enrollment (PAVE) system to provide FFS Medi-Cal services or contract directly with correctional facilities to provide services as a contracted embedded care manager, which includes being able to bill under the correctional facility (CF) National Provider Identifier (NPI).

Eligible Justice Involved members may begin to access ECM services as soon as their enrollment in Blue Shield Promise has been effectuated, which will occur at or shortly after release. Until the member can access ECM services, their post-release ECM Lead Care Manager may continue to provide care management services for which they can bill through Medi-Cal FFS. Once member enrollment has been effectuated, the JI ECM provider will provide ECM services and Blue Shield Promise will pay according to the capitation rates outlined in their contract.

Community Health Workers (CHW) are permitted and encouraged to provide services to Justice Involved members. Payment for CHW activities associated with ECM are included in the ECM rate and such activities may not be billed separately. JI ECM providers must adhere to requirements as outlined in section 3.5 above for submission of encounter data for ECM.

3.7: Community Health Worker

Medi-Cal covers community health worker (CHW) services pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Community Health Worker (CHW) services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health.

CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. CHWs must have lived experience that aligns with and provides a connection between the CHW, and the member or population being served.

CHW services may assist with a health-related needs impacting Blue Shield Promise members, including but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and the need for preventive services. Additionally, CHW services can help Blue Shield Promise members receive appropriate services related to perinatal care, Asthma Preventive Services as well as other preventive services, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence, and other violence prevention services.

CHW Provider Requirements and Qualifications

CHWs must have lived experience that aligns with and provides a connection between the CHW, and the member or population being served. This may include but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use disorders, or being a survivor of domestic, or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

Supervising Providers (the organizations employing or otherwise overseeing the CHWs with which Blue Shield Promise contracts, as described below) are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising Providers must maintain evidence of this experience.

In addition to one of the pathways described below, CHWs must complete a minimum of six hours of additional relevant training annually, which can be in the core competencies or specialty area. The Supervising Provider must maintain evidence of this training. Supervising Providers may provide and/or require additional training, as identified by the Supervising Provider. The Supervising Provider will be required to provide annual attestations to Blue Shield Promise confirming evidence of CHW qualifications and training.

3.7: Community Health Worker *(cont'd.)*

CHWs must demonstrate, and Supervising Providers must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the Supervising Provider:

- **Certificate Pathway:** CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
    - **CHW Certificate:** A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in the Department of Health Care Services APL 22-016, including violence prevention services.
    - **Violence Prevention Professional Certificate**: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by the Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.
- **Work Experience Pathway:** An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined, and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Blue Shield Promise member.

CHW as Asthma Preventive Service Providers

CHWs may provide CHW services to individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by CHWs who have completed either a certificate from the California Department of Public Health Asthma Management Academy, or a certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma. These services may also be rendered by a licensed provider within their scope of practice. See additional details about the "Asthma Preventive Services" benefit below.

3.7: Community Health Worker *(cont'd.)*

Supervising Provider Requirements and Qualifications

A supervising provider is an enrolled Medi-Cal provider employing or otherwise overseeing the CHW, with whom Blue Shield Promise contracts. The Supervising Provider ensures that CHWs meet the qualifications listed above, oversees CHWs and the services delivered to Blue Shield Promise members, tracks and submits data required for reporting, and submits claims for services provided by CHWs. The supervising provider must be a licensed provider, pharmacist, a hospital, including the emergency department, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

The supervising provider is not required to have a licensed provider on staff in order to contract with Blue Shield Promise to bill for CHW services. The supervising provider does not need to be the same entity as the provider who made the recommendation for CHW services. Supervising providers do not need to be physically present at the location when CHWs provide services to Blue Shield Promise members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the supervising provider. However, the supervising provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.

Supervising providers must provide direct or indirect oversight to CHWs. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes but is not limited to ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

Blue Shield Promise must ensure that supervising providers or their Subcontractors contracting with or employing CHWs to provide covered CHW services to Blue Shield Promise members verify that CHWs have adequate supervision and training.

Member Eligibility Criteria for CHW Services

CHW services require a written recommendation submitted to Blue Shield Promise via the Community Health Worker Recommendation Form. Written recommendations will be sent to Blue Shield Promise Social Service Department via fax at (844) 742-1152 by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. For CHW services rendered in the Emergency Department, the treating provider may verbally recommend CHWs to initiate services and later document the recommendation in the member's medical record of the Emergency Department visit. The recommending licensed provider does not need to be: 1) Enrolled in Medi-Cal, 2) A network provider with Blue Shield Promise, or 3) Employed by the supervising provider. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

3.7: Community Health Worker *(cont'd.)*

The required recommendation can be provided by written recommendation placed in the member's record or a standing recommendation by Blue Shield Promise based on eligibility criteria for CHW services as described in this manual.

Claims and Billing

Please note that while a recommendation for CHWs services is required to be submitted to Blue Shield Promise, Blue Shield Promise does not require prior authorization for CHW services as preventive services for the first 12 units in 12 months or 4 units in one day. For members that need additional CHW units, the recommending provider must submit a CHW Benefit Extension Request Form.

Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes and modifier(s) as outlined below. CHW services must be reimbursed through a CHW Supervising Provider in accordance with its provider contract. All Network Providers and Subcontractors must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit. Therefore, Blue Shield Promise reserves the right to ensure that providers do not bill for CHW services and ECM (or other duplicative services) for the same member for the same time period and deny payment or seek recoupment of payment for any duplicative services rendered.

Tribal clinics may bill Blue Shield Promise for CHW services at the Medi-Cal Fee-for-Service rates using the CPT codes as outlined below. Pursuant to Welfare and Institutions Code (WIC) 14087.325(d)21, Blue Shield Promise will reimburse contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that the Blue Shield Promise would make for the same scope of services if the services were furnished by another Provider type that is not an FQHC or RHC.

For billing, call Blue Shield Promise Customer Care to check eligibility, and, if eligible, send the claim and recommendation to Blue Shield Promise.

CHW services must be submitted by the Supervising Provider with the following allowable CPT/HCPCS codes:

- Providers will use **modifier U2** with the below CPT codes to denote services rendered by Community Health Workers.
- Providers will use **modifier U3** with the below CPT codes to denote services rendered for asthma preventive services.
- Both **U2** and **U3** modifiers must be present along with the below CPT codes to denote services rendered for asthma preventive services by CHWs.

CPT/HCPCS Code	CPT/HCPCS Description	Modifier(s)	Modifier Description
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	U2 U3 93 95	Used to denote services rendered by Community Health Workers Used to denote services rendered by Asthma Preventive Service Providers Used to denote services delivered via synchronous, telephone or other interactive audio-only telecommunications systems Used to denote services delivered via synchronous, interactive audio/visual, telecommunications systems
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	U2 U3	Used to denote services rendered by Community Health Workers Used to denote services rendered by Asthma Preventive Service Providers

CPT/HCPCS Code	CPT/HCPCS Description	Modifier(s)	Modifier Description
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	U2 U3	Used to denote services rendered by Community Health Workers Used to denote services rendered by Asthma Preventive Service Providers
G0019	Community health integration services, 60 minutes per calendar month	U2	Used to denote services rendered by Community Health Workers
G0022	Community health integration services, each additional 30 minutes per calendar month (list separately in addition to G0019)	U2	Used to denote services rendered by Community Health Workers
T1025	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs	U2 U3	Used to denote services rendered by Community Health Workers Used to denote services rendered by APS provider

- The maximum frequency of CHW services is four units (two hours) per beneficiary, any provider. Additional units per day may be provided with an approved CHW Benefit Extension Request Form for medical necessity. CHW Benefit Extension Request Forms for additional CHW services required the same day may be submitted after the service was provided. The annual maximum limit for CHW services is 12 units (six hours) in the 12 months following the first CHW date of service.

3.7: Community Health Worker *(cont'd.)*

- HCPCS code G0019 maximum frequency is one unit (60 minutes) per calendar month, per member, any provider. It cannot be billed during the same calendar month as CPT 98960 by the same provider.
- HCPCS code G0022 maximum frequency is four units (two hours) per calendar month, per member, per provider. Additional units per month may be provided with an approved Benefits Extension Request for medical necessity. Benefit Extension Requests may be submitted after the service was provided.
- **Note**: The HCPCS codes for individual Medi-Cal member have additional requirements that are not required when billing the CPT codes. Please refer to the DHCS Medi-Cal Provider Manual: Community Health Worker Preventive Services for additional billing instructions.
- **Note:** Enhanced Care Management (ECM) services include CHW services. Members who are currently enrolled in ECM cannot simultaneously receive CHW services.

Provider Recommendations

The recommending licensed provider must ensure that a Blue Shield Promise member meets eligibility criteria before recommending CHW services. CHW services are considered medically necessary for Blue Shield Promise members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, and who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending provider must fax the Community Health Worker Recommendation Form to (844) 742-1152 to ensure that there are no issues with claims payments.

For CHW services rendered in the Emergency Department, the treating Provider may verbally recommend CHWs to initiate services and later document the recommendation in the member's medical record of the Emergency Department visit.

The recommending provider must determine whether a Blue Shield Promise member meets the eligibility criteria for CHW services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels, or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition
- Any stressful life event presented via the Adverse Childhood Events screening

3.7: Community Health Worker *(cont'd.)*

- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of an SDOH screening that indicates unmet health-related social needs, such as housing or food insecurity
- One or more visits to a hospital emergency department (ED) within the previous six months
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization
- One or more stays at a detox facility within the previous year
- Two or more missed medical appointments within the previous six months
- The member expressed the need for support in health system navigation or resource coordination services
- Need for recommended preventive services, including updated immunizations, annual dental visits, and well childcare visits for children

CHW violence prevention services are available to members who meet any of the following circumstances as determined by a licensed practitioner:

- The member has been violently injured as a result of community violence.
- The member is at significant risk of experiencing violent injury as a result of community violence.
- The member has experienced chronic exposure to community violence.

Documentation Requirements

CHWs are required to document the dates and time/duration of services provided to Blue Shield Promise members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. Documentation must be accessible to the Supervising Provider upon their request. Documentation should be integrated into the member's medical record and available for encounter data reporting. Documentation must be made available to Blue Shield Promise upon request.

Benefit Extension

The CHW Benefit Extension Request Form is required for payment of (a) CHW units exceeding twelve (12) units of the preventative benefit of CHW services in a 12-month period and (b) when exceeding the daily maximum units of four (4) units per day at any time. All CHW Benefit Extension Request Forms must be submitted with a signed and dated Plan of Care for Blue Shield Promise members. The CHW Benefit Extension Request Form exceeding four (4) hours per day is referred to as an extension of benefit and may be requested retrospectively. The CHW Benefit Extension Request Form and Plan of Care must be submitted via fax to (844) 742-1152.

3.7: Community Health Worker *(cont'd.)*

Plan of Care

For Blue Shield Promise members who need multiple ongoing CHW services or continued CHW services after a) 12 units of service within one year from initial CHW preventative service date or b) when exceeding the daily maximum units of four (4) units per day, a written care plan must be written by one or more individual licensed providers, with the exception of services provided in the emergency department. Licensed providers may include the recommending provider and other licensed providers affiliated with the CHW Supervising Provider. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the member's care team and/or other providers referenced in this section. The plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Include a list of other healthcare professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.

A licensed provider must review the member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition, providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

3.7.1 Asthma Preventive Services

Asthma Preventive Services (APS) 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. Pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), asthma preventive services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

3.7: Community Health Worker *(cont'd.)*

3.7.1 Asthma Preventive Services *(cont'd.)*

APS is defined as information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms.

In-home environmental trigger assessments are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment will guide the self-management education about actions to mitigate or control environmental exposures.

APS Eligibility Criteria

To receive asthma self-management education, all beneficiaries must have a diagnosis of asthma. Beneficiaries must have a current diagnosis of poorly controlled asthma, or on the recommendation of a licensed physician, nurse practitioner (NP), or physician assistant (PA), in order to receive an "in-home environmental trigger assessment." Written recommendations must be sent to Blue Shield Promise Social Service Department via fax at (844) 742-1152.

"Poorly controlled asthma" is defined as having one of the following:

1. A score of 19 or lower on the Asthma Control Test, or
2. An asthma-related emergency department visit or hospitalization or two instances of sick or urgent care asthma-related visits in the past 12 months

APS Provider Qualification

CHWs who have not met the qualifications listed below may not provide asthma education or in-home environmental trigger assessments, but they may provide CHW services for health education and navigation, as defined in this manual, to individuals with asthma. Unlicensed asthma preventive service providers must be supervised by either a physician, physician assistant, nurse practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

Asthma preventive service providers must have completed either of the following:

- A certificate from the California Department of Public Health Asthma Management Academy, or
- A certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma with core competences in the following areas:
    - Basic facts of asthma's impact on the human body, including asthma control
    - Roles of medications
    - Environmental control measures
    - Teaching individuals about asthma self-monitoring
    - Implementation of a plan of care

3.7: Community Health Worker *(cont'd.)*

3.7.1 Asthma Preventive Services *(cont'd.)*

  - Effective communication strategies including at a minimum cultural and linguistic competency and motivational interviewing
  - Roles of a care team and community referrals
- And both of the following:
  - Completed a minimum of 16 hours of face-to-face client contact focused on asthma management and prevention.
  - Four hours annually of continuing education on asthma.

Billing Codes for Asthma Preventive Services Education

Claims for CHW APS education services (not including the environmental trigger assessment) must be submitted by the Supervising Provider with the CPT codes 98960, 98961, or 98962 as described above.

The maximum frequency is four units daily per beneficiary, any provider, up to two times a year. Additional visits may be provided with an approved CHW Benefit Extension Request Form for medical necessity. The CHW Benefit Extension Request Form must be submitted via fax to (844) 742-1152.

Billing Codes for Assessment of Environmental Triggers
HCPCS code T1028 (assessment of home, physical and family environment, to determine suitability to meet patient's medical needs) is used for environmental trigger assessment. In-home assessments may be provided by unlicensed asthma preventive service providers and by licensed providers.

In-home environmental trigger assessment visits for eligible beneficiaries are limited to two visits per year, subject to an override by a CHW Benefit Extension Request Form demonstrating medical necessity for additional visits and/or when there has been a change of primary residence.

Place of service for HCPCS code T1028 is: 12 (home), 13 (Assisted Living Facility), 14 (Group home)

Providers should use **modifier U3** with the above CPT codes and HCPCS code to denote services rendered by APS Providers.

Supervising Providers for CHW Services should use **modifier U2** along with **modifier U3** with the above CPT codes and HCPCS code to denote services rendered by a CHW.

3.8: Doula Services

Per State Plan Amendment (SPA) 22-0002, Blue Shield Promise provides doula services as preventive services pursuant to Title 42 Code of Federal Regulations (CFR) Section 440.130(c).

Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of members while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

According to a recent review by Sobczak and colleagues (2023) doula care was associated with positive delivery outcomes including a reduction in caesarean sections, epidural use, length of labor, low-birthweight and premature deliveries. Additionally, the emotional support provided by doulas lowered stress and anxiety during the labor period.

Studies examining the impact of continuous support by doulas report increased empowerment and autonomy during birth, high overall satisfaction with the birthing process, and improved breastfeeding success and duration (Sobczak et al., 2023).

Description of Doula Services

Doulas are birth workers who provide health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth, and abortion in accordance with APL 24-003.

Doula services encompass health education, advocacy, and physical, emotional, and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period. Doula services also include personal support for beneficiaries' families.

Doula services are considered a preventive benefit and require a written recommendation from a physician and or other licensed practitioner of the healing arts. To increase access to services, DHCS Medical Director, Karen Mark, MD, issued a standing recommendation for the initial set of doula services for any Medi-Cal member who is pregnant or was pregnant within the past year.

Postpartum period: Doulas may provide services for up to 12 months from the end of pregnancy. Beneficiaries are eligible to receive full-scope Medi-Cal coverage for at least 12 months after pregnancy.

Doula Qualifications

All doulas must be at least 18 years old, possess an adult/infant Cardiopulmonary Resuscitation (CPR) certification from the American Red Cross or American Heart Association, and attest they have completed basic Health Insurance Portability and Accountability Act (HIPAA) training.

3.8: Doula Services *(cont'd.)*

In addition, a doula must meet either of the following qualification pathways:

Training Pathway:

- Complete a minimum of 16 hours of training in the following areas:
  - Lactation support
  - Childbirth education
  - Foundations on anatomy of pregnancy and childbirth
  - Nonmedical comfort measures, prenatal support, and labor support techniques
  - Developing a community resource list
- Attest that they have provided support at a minimum of three births
- Doulas are not required to have a certificate from a specific organization as long as they meet the Doula Minimum Qualifications as listed in the DHCS Medi-Cal Provider Manual: Doula Services. Additional information regarding enrollment is available on the Doula Application Information webpage.

Experience Pathway:

- All of the following:
  - Attest that they have provided services in the capacity of a doula either a paid or volunteer capacity for at least five years. The five years of active doula experience occurred within the previous seven years.

Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization, or an enrolled doula. "Enrolled doula" means a doula enrolled either through DHCS or through a Managed Care Plan (MCP). Doulas must complete three hours of continuing education in maternal, perinatal and/or infant care every three years. Doulas shall maintain evidence of completed training to be made available to DHCS and Blue Shield Promise upon request. Doulas are not licensed or clinical providers, and they do not require supervision.

Covered Services

Effective January 1, 2023, Blue Shield Promise provides doula services for prenatal, perinatal, and postpartum members. Doula services can be provided virtually or in-person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.

As a preventive benefit, doula services require a written recommendation from a physician or other licensed practitioner of the healing arts. To increase access to services, DHCS Medical Director Karen Mark, MD, PhD, issued a Recommendation for Doula Services that fulfills the requirement for a recommendation for an individual who is pregnant or was pregnant within the past year.

3.8: Doula Services *(cont'd.)*

The initial recommendation for doula services authorizes the following services:

- One initial visit
- 8 additional visits that can be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery and postpartum (including labor and delivery resulting in a stillbirth), abortion or miscarriage
- 2 extended three-hour postpartum visits

All visits are limited to one per day, per member. More than one doula may provide services during a member's pregnancy and postpartum period. However, the total number of visits that a member may receive are per pregnancy and not per doula.
One prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula.

The extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation. The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual provided on separate days.

Recommendation for Doula Services

A member would meet the criteria for a recommendation for doula services if they are pregnant, or were pregnant within the past year, and would either benefit from doula services or they request doula services. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.

Documentation Requirements

Doula services require a written recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

The Department of Health Care Services (DHCS) issued a statewide standing recommendation November 1, 2023, that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from receiving doula services from a Medi-Cal enrolled doula provider. This recommendation fulfills the federal requirements in Section 440.130(c) of Title 42 of the Code of Federal Regulations for a physician or other licensed practitioner of the health arts acting within their scope of practice to provide a written recommendation for preventive services. The standing recommendation for doula services is signed by DHCS Medical Director, Karen Mark, MD, PhD. The initial recommendation can be provided through the following methods:

- Written recommendation in member's record.
- Standing recommendation for doula services by MCP, physician group, or other group by a licensed provider.
    - The standing recommendation issued by DHCS on November 1, 2023 fulfills this requirement until the time it is rescinded or modified.

3.8: Doula Services *(cont'd.)*

- Standard form signed by a physician or other licensed practitioner that a member can provide to the doula.

The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a network provider within the member's managed care plan (MCP).

This standing recommendation does not authorize additional postpartum visits beyond the eight visits that may be provided during either the prenatal or postpartum period. Members may receive up to nine additional postpartum visits with an additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice. The standing recommendation should note the standing recommendation in members records. This recommendation remains in effect until rescinded or modified.

A second recommendation is required for additional visits during the postpartum period. A recommendation for additional visits during the postpartum period cannot be established by standing order. The additional recommendation authorizes nine or fewer additional postpartum visits. This recommendation can be noted in the member's medical record by the recommending licensed provider, or a member can ask a licensed provider to complete a Standard form, such as the DHCS Medi-Cal Doula Services Recommendation form. The standing recommendation from DHCS cannot be used for additional postpartum visits.

Doulas are required to maintain records of provider recommendation documentation for auditing purposes.

Please note that while a recommendation for doula services is required, Blue Shield Promise does not require prior authorization for doula services as a preventive service.

Member Eligibility Criteria for Doula Services

Doulas must verify the Blue Shield Promise member's Medi-Cal eligibility for the month of service. Doulas must contact Blue Shield Promise to verify eligibility. A member who is pregnant, or was pregnant within the past year, and would either benefit from doula services or requests doula services, would meet the medical necessity criteria for a recommendation for doula services. Doula services may only be provided during pregnancy; during labor and delivery, miscarriage, and abortion; and within one year of the end of a beneficiary's pregnancy.

Place of Service

There are no Place of Service restrictions for doula services.
Doula services can be provided virtually or in person with locations in any setting including, but not limited to

- Homes
    - a doula may assist with home births provided by a licensed provider.
- office visits
- hospitals or
- alternative birth centers

3.8: Doula Services *(cont'd.)*

Doula services provided virtually must be billed consistently with DHCS telehealth policy as outlined in the Medicine:Telehealth section of the Medi-Cal Provider Manual. This includes billing with modifier 93 for synchronous audio-only or modifier 95 for synchronous video.

- Services rendered via text, email, chat, or modalities other than audio-visual or audio-only are not reimbursable.
- All doula services provided via telehealth must meet federal requirements for privacy, including the Health Insurance Portability and Accountability Act.

Billing Codes and Modifier

Doulas should refer to DHCS Medi-Cal Provider Manual for Doula Services for specific billing codes to be used for each covered service.

All claims must be submitted with Modifier XP (separate practitioner: a service that is distinct because it was performed by a different practitioner), appended to the billing code. This is to distinguish the claim from the services by the medical provider.

Doula providers have four options for submitting claims. Claims can be submitted through a Clearinghouse or on paper using the current version of the CMS 1500 forms. These methods are described in detail in Section 14.1 Claims Submission.

Doula providers can submit claims by logging on to Blue Shield Promise's Provider Portal at https://www.blueshieldca.com/en/provider and navigating to the *Claims* section, then *Submit via SympliSend.* Providers can submit digital paper claims, itemization requests, and digital correspondence related to previously processed or in process claims using SympliSend.

Claims and Billing

Doula providers can also submit a Doula Transaction Log which is detailed below.

Transaction

A transaction is a record of a health care visit which includes information about services rendered. Health plans use transaction data to pay provider groups who provide services to the plan's members.

Doula Transaction Log

Doulas and doula groups use the Doula Transaction Log to collect and record transaction information. Then, they submit the transaction log to Blue Shield Promise for reimbursement.

The log is designed to be consistent with the CMS 1500 form for submitting claims.

Blue Shield Promise will only accept Doula Transaction Logs from individual doulas and doula groups and who have an active Single Case Letter of Agreement (LOA) with the plan.

If you are an individual doula and do not have an active LOA with Blue Shield Promise, but your group does, we cannot accept Doula Transaction Log from you directly. Please submit a transaction log through your doula group.

3.8: Doula Services *(cont'd.)*

Doulas will submit a completed comprehensive transaction log once a month, on the 12th day of the month, or before the 12th day of the following month.

The completed transaction log should contain all the services that have been provided to Blue Shield Promise members within the course of the 30-day period by each doula in the group.

How to submit a Doula Transaction Log

1. Blue Shield Promise will send you a blank Doula Transaction Log via secured email.
2. Save and rename the transaction log file to include the date of submission and the time period of services covered.
    a. Example filename: For a submission on May 1, 2023, including services covered from April 1 to April 30, 2023:

"Doula_ Transactions_ 050123_0401_0430.xls"

1. Enter your data into the Doula Transaction Log according to the instructions in this guide.
2. Send the completed transaction log to the Blue Shield Promise Doula Program office by email to: BSCPromiseDoula@blueshieldca.com.
3. Submit completed transaction logs once a month, on the 12th day of the month, or before the 12th day of the following month.
4. Do not alter the formatting of the transaction log in any of the following ways:
    - Columns
    - Add or delete columns or rows
    - Change Move field color

If you need additional help, please contact the Blue Shield Promise Doula benefit office by phone or email: (888) 373-2752 or BSCPromiseDoula@blueshieldca.com.

Telehealth

Doulas should refer to the Telehealth section in Part 2 of the DHCS Doula Provider Manual for guidance regarding providing services via telehealth for prenatal or postpartum visits, labor and delivery support, and for abortion and miscarriage support. Doulas may bill for services provided by telehealth using either Modifier 93 for synchronous audio-only or Modifier 95 for synchronous video.

Doula referral through Maternity Program

To refer Blue Shield Promise members to our Maternity Program and to connect members to doula services:

Please complete the Maternity Program Referral Form and fax it to (844) 893-1211 or call (888) 802-4410.

3.8: Doula Services *(cont'd.)*

Informing Blue Shield Promise members about Services by Non-Doula Providers

If a member requests or requires one of the pregnancy-related services listed below that is not covered under the doula benefit, the doula should inform the member that another Medi-Cal provider is able to render the requested service. These services include, but are not limited to, the following Medi-Cal services that are not part of the doula benefit:

- Behavioral health services
- Belly binding after cesarean section by clinical personnel
- Clinical case coordination
- Health care services related to pregnancy, birth, and the postpartum period
- Childbirth education group classes
- Comprehensive health education, including orientation, assessment, planning (Comprehensive Perinatal Services Program services)
- Hypnotherapy (non-specialty mental health service)
- Lactation consulting, group classes, and supplies
- Nutrition services (assessment, counseling, and development of care plan)
- Transportation

A doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit, as long as the visit is face-to-face, the assistive or supportive service is incidental to doula services provided during the prenatal or postpartum visit, and the beneficiary is not billed for the assistive or supportive service.

Documentation of Services Rendered

Blue Shield Promise requests the provision of Covered Doula Services be documented and coded accurately. Documentation must accurately reflect the Covered Doula Services provided to Blue Shield Promise members during the claim submission period. Plan will only reimburse for Covered Doula Services. In addition to information documented and coded on the claim, Doula must comply with DHCS submission requirements for other information regarding services rendered. A "Doula Visit Detail Log" can be found on the Blue Shield Promise provider portal and will be updated, as necessary.

Blue Shield Promise will periodically monitor and audit doula documentation regarding the dates, times, and duration of services provided to members.

How to submit "Doula Visit Detail Log"

Doulas should refer to the Doula Resource Guide for instructions on how to complete the Doula Visit Detail Log. Doulas can complete and submit the log to the Blue Shield Promise Doula Program office via secured email BSCPromiseDoula@blueshieldca.com.

3.8: Doula Services *(cont'd.)*

Birth Outcome Report

Blue Shield Promise requests that doulas track specific post-birth outcome data elements for each assigned member and submit a Birth Outcome Report.

How to submit Birth Outcome Report

- Doulas must submit the Birth Outcome Report within 60 Days of member's birth.

Blue Shield Promise will provide doulas with a Birth Outcomes Report form. Doulas can complete and submit the report to the Blue Shield Promise Doula Program office via secured email BSCPromiseDoula@blueshieldca.com.

All doula reporting templates can now be found on the Blue Shield Promise Maternity Care Program webpage.

Program Referrals Doulas may refer Blue Shield Promise members to the following programs for assistance related to housing and food insecurity, intimate partner violence, lack of resources for newborn, and other community supports as appropriate.

- Blue Shield Promise Case Management program
  - Phone: (800) 468-9935
  - Case Management Referral form
- Blue Shield Promise Maternity Care Management program
  - Phone: (888) 802-4410
  - Maternity Care Management Referral form

For questions about the Blue Shield Promise doula program, doula organizations may email BSCPromiseDoula@blueshieldca.com.

3.9: Annual Cognitive Health Assessment

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.

3.9: Annual Cognitive Health Assessment *(cont'd.)*

- 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.

Please refer to Section 14.2 for additional claims impacts.

3.10: Street Medicine

3.10.1: Street Medicine Definition

As defined in the DHCS APL 24-001, Street Medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.

The fundamental approach of Street Medicine is to engage Blue Shield Promise members experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Typically, Street Medicine is provided to a member experiencing unsheltered homelessness in their lived environment, places that are not intended for human habitation.

3.10: Street Medicine *(cont'd.)*

3.10.1: Street Medicine Definition *(cont'd.)*

Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location does not qualify as Street Medicine, it is considered mobile medicine, as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location. Note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered Street Medicine.

Street Medicine offers an opportunity to provide needed services to Blue Shield Promise members who are experiencing unsheltered homelessness by meeting them where they are and utilizing a whole person, patient centered approach to provide medically necessary health care services, as well as address social drivers of health that impede health care access. Street Medicine services are meant to be a harm reduction tool and integral to avoiding an emergency department visit or hospitalization, providing access to medically necessary health care services, and connecting Blue Shield Promise members to Community Supports that they may not otherwise access.

3.10.2: Street Medicine Provider Requirements

A Street Medicine Provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).

For a non-physician medical practitioner (PA, NP, and CNM), Blue Shield Promise will ensure compliance with state law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of street medicine, a supervising Physician must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols.

3.10.3: Direct Contracting with Street Medicine Providers

Blue Shield Promise will contract directly with Street Medicine Providers to provide Street Medicine services. The payment arrangement will be between Blue Shield Promise and the Street Medicine Provider. The Street Medicine provider will be subject to Blue Shield Promise administrative processes (e.g., billing protocols, credentialing requirements, authorization guidelines, etc.).

Under this contracting arrangement, the Street Medicine Provider must have the ability to refer members to Medically Necessary Covered Services within the Blue Shield Promise network, and must coordinate care with Blue Shield Promise, Subcontractor, and/or IPA as appropriate.

Blue Shield Promise will ensure members have access to all Medically Necessary Covered Services and have appropriate referral and authorization mechanisms in place to facilitate access to needed services in the Blue Shield Promise Network.

3.10: Street Medicine *(cont'd.)*

3.10.4: Prior Authorization

Prior Authorization for members to see a Street Medicine Provider is not needed if the member seeks services directly from a Street Medicine Provider related to the member's primary care. For those contracted Street Medicine Providers that meet all Blue Shield Promise required administrative processes, Street Medicine services can be provided to an eligible Blue Shield Promise member and receive payment for these services, even if the member is assigned to a Subcontractor, such as a medical group or Independent Practice Association (IPA).

3.10.5: Provider Billing and Reimbursement

Street Medicine Providers are required to verify the Blue Shield Promise eligibility of individuals they encounter in the provision of health care services. Services rendered to Blue Shield Promise eligible individuals will be paid at the relevant contracted rates established between Blue Shield Promise and contracted Street Medicine Providers or paid at the established Medi-Cal rates for non-contracted providers.

Street Medicine providers are responsible for ensuring Blue Shield Promise member eligibility. To be eligible for payment, the Blue Shield Promise member must be eligible during the time of service and the claim must be complete and accurate following Medi-Cal billing guidelines. The Street Medicine provider may assist in enrolling the member in Medi-Cal during the Street Medicine visit or shortly thereafter. Street Medicine Providers have 180 calendar days from the date of service to submit claims and avoid untimely filing denials.

Street Medicine Providers rendering services to Blue Shield Promise eligible individuals are to bill Blue Shield Promise based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street Medicine Providers must comply with the billing provisions for Street Medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual. For the Provider to be reimbursed for Street Medicine Services, the Provider must bill using Place of Service Code 27 (Outreach Site/Street).

If the Street Medicine Provider is a provider in an FQHC, they can be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the member is located. The FQHC would be paid their applicable PPS rate when the Street Medicine Provider is a billable clinic provider.

Street Medicine Providers can also be reimbursed for providing State Plan benefits, including the use of Community Health Worker (CHW) services as defined in 42 CFR 440.130(c) and APL 22-016. Blue Shield Promise is responsible for ensuring non-duplication of services provided by a CHW and any other covered benefit, program, and/or delivery system.

In the event a Street Medicine Provider is also contracted to provide other healthcare services in a separate contract, the Street Medicine contract will function independently from the other contract. Non-Street Medicine services will be billed according to the existing provider contract or paid at the established Medi-Cal rate for a non-contracted provider. Street Medicine services, and only these services, will be billed using the Street Medicine direct contracting agreement when the appropriate diagnosis code and place of service code are utilized.

3.10: Street Medicine *(cont'd.)*

3.10.6: Provider Data Sharing, Reporting and Administration Requirements

Blue Shield Promise Contracted Street Medicine Providers must comply with all applicable Blue Shield Promise data sharing and reporting and administrative requirements in accordance with federal and state laws and the Blue Shield Promise Contract based on provider contracting type. For additional information on these requirements, refer to the following sections of this provider manual:

- Section 6: Grievances, Appeals, and Disputes
- Section 7: Utilization Management (Referrals, Authorizations)
- Section 9: Quality Improvement (Performance Improvement)
- Section 9.7: Medical Records
- Section 9.8: Access to Care (After Hours Care, Timely Access)
- Section 12.10: Provider Grievances

For questions about becoming a Blue Shield Promise Street Medicine Services Provider, Providers can contact Provider Services at (800) 468-9935, 6 a.m. to 6:30 p.m., Monday through Friday.

3.11: Non-Specialty Mental Health Services (Medi-Cal Managed Care)

Non-Specialty Mental Health Services Access

Blue Shield Promise members may access Non-Specialty Mental Health Services (NSMHS) directly via our no wrong door policy. No prior authorization is required for evaluation or treatment of a mental health condition. PCPs, specialty providers, County Departments, Community Based Organizations, and case managers are welcome to refer members to the Blue Shield Promise network. The completed Blue Shield Promise Social Services and Mental Health Referral Form, which can be accessed on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers in the *Forms* section, should be emailed to Blue Shield Promise at MediCalmentalhealth@blueshieldca.com, or faxed to (323) 889-2109 (Los Angeles County) or (619) 219-3320 (San Diego County). The Blue Shield Promise Social Services team is available Monday through Friday from 8 a.m. to 5 p.m. for NSMHS coordinated access to our network of NSMHS providers by phone at (877) 221-0208.

Medi-Cal Managed Care Plan Mental Health Benefits and Services

It is the responsibility of Blue Shield Promise Health Plan to provide Medi-Cal Managed Care Plan (MMCP) Mental Health Benefits for members defined by the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.

Blue Shield Promise is responsible for outpatient services for members defined by the current DSM resulting in mild to moderate distress or impairment of mental health, emotional, or behavioral functioning provided by Blue Shield Promise's directly contracted behavioral health network.

3.11: Non-Specialty Mental Health Services (Medi-Cal Managed Care) *(cont'd.)*

Mental Health Services

Mental health services will be provided by independent practice level licensed mental health care providers acting within the scope of their license. The services include:

1. Individual/group mental health evaluation and treatment (psychotherapy).
2. Psychological testing when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purpose of monitoring drug therapy.
4. Psychiatric consultation for medication management.
5. Outpatient laboratory, medications, supplies, and supplements.
6. Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders as appropriate to provider's scope of practice.

County Behavioral Health Transition of Care Tool

Blue Shield Promise understands the importance of coordinating care for our members. If a Medi-Cal member requires a higher level of care, refer to Section 7.9.8 Specialty Mental Health Services (Medi-Cal Managed Care) of this manual. All NSMHS providers are required to complete a Transition of Care Tool for Medi-Cal Mental Health Services.

Payment Integrity Policy

Blue Shield Promise will deny payment of Psychotherapy add-on codes 90833, 90836 and 90838, when billed with the high-level E/M codes 99204, 99205, 99214 or 99215, for the same member, by the same provider and on the same date of service, as it is unlikely that the combined time for both services would be significant enough to allow separate reimbursement.

Frequency Limits

DHCS has frequency limits for psychological testing and neuropsychological testing. NSMHS providers should refer to the guidance published by the DHCS at Non-Specialty Mental Health Services: Psychiatric and Psychological Services.

4.1: Member Rights and Responsibilities

Purpose

To clearly outline Blue Shield Promise's commitment to providing quality health care to its members and to communicate to Members, Providers, and Staff the Member's Right and Responsibilities.

Policy

It is Blue Shield Promise's policy to provide quality health care to its members. To assure members of this commitment, Blue Shield Promise has established these Member Rights and Responsibilities.

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

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

Member Rights and Responsibilities

What are your health care rights? You have the right to know.

- To know your rights and responsibilities.
- To know about our services, doctors, and specialists and be informed when your doctor is no longer contracted with Blue Shield Promise.
- To know about all our other caregivers.
- To be able to see your medical records. You have to follow the State and Federal laws that apply.
- To have an honest talk with your doctor about all treatment options for your condition, regardless of cost or benefit coverage.

You have the right to be treated well.

- To always be treated with respect.
- To have your privacy kept safe by everyone in our health plan.
- To know that we keep all your information private.

4.1: Member Rights and Responsibilities *(cont'd.)*

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

- To choose your primary care doctor.
- To say no to care from your primary care doctor or other caregivers.
- To be able to make choices about your health care.
- To make a living will (also called an advance directive).
- To voice complaints or appeals about Blue Shield Promise or the care it provides including the right to file a grievance if you do not receive services in the preferred language or alternative format (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) that you have requested.
- To wait no more than 10 minutes to speak to a customer service representative during Blue Shield Promise's normal business hours.
- To get an appointment within a reasonable amount of time.

You have the right to get a range of services.

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

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

- To tell us what you don't like about our health plan.
- To tell us what you don't like about the health care you get.
- To question our decisions about your health care.
- To tell us what you don't like about our rights and responsibilities policy.
- To ask the Department of Social Services for a Fair Hearing.

4.1: Member Rights and Responsibilities *(cont'd.)*

- To ask the Department of Managed Health Care for an Independent Medical Review.
- To choose to leave our health plan.

What are your responsibilities as a health care member?

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

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

We want you to understand your health plan.

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

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5.1: Eligibility

Eligible members must reside within the Blue Shield Promise approved service area and meet the requirements for Medi-Cal benefits. As eligibility may change at any time, providers are required to verify member eligibility at time of service. Eligibility may change at any time, so providers are reminded to check member eligibility at the time of each visit.

5.2: Member Enrollment

The Health Care Options (HCO) Program, under the California Department of Health Care Services (DHCS), is responsible for the process of member enrollment and disenrollment into and out of Medi-Cal.

In Los Angeles, the contracted plans are the local initiative plan, L.A. Care Health Plan (L.A. Care), and the commercial plan, Health Net in partner with Molina and Universal Care. A member can choose his/her plan by completing a Health Care Options (HCO) plan selection form. If selected, L.A. Care is responsible for assigning members into one of the five plan partners including Blue Shield Promise Health Plan. The five plan partners are Blue Shield Promise Health Plan, Community Health Plan, Kaiser Permanente, Blue Cross of California, and LA Care Health Plan.

5.3: Member Health Plan Selection

Medi-Cal beneficiaries in mandatory aid codes will be sent an enrollment package by HCO. The enrollment package will contain information on the local initiative plan and the commercial plan, as well as provider directories for each. Medi-Cal beneficiaries who receive an enrollment package have 30 days to select a plan and a primary care physician. The enrollment package will also contain a toll-free telephone number for HCO.

To enroll for membership in L.A. Care/Blue Shield Promise Health Plan, a Medi-Cal recipient must complete a Medi-Cal Benefit Choice form (HCO form) which is available through Blue Shield Promise, Health Care Options, or any Welfare Office. Members may call Blue Shield Promise Member Services to obtain an HCO form at (800) 605-2556 or (TTY 711). To join Blue Shield Promise Health Plan, the member must request L.A. Care/ Blue Shield Promise Health Plan on the HCO form under the “Plan” section. They must also note the requested PCP license number which is the PCP number followed by the letter “F.” Forms must be mailed by the member directly to HCO. Providers are not allowed to have blank HCO forms in their offices. The provider may assist a member when a member comes to the provider’s office and asks for assistance in completing the HCO form that they have received.

Individuals in mandatory aid codes who do not select a plan will be defaulted into either of the two plans using a special assignment algorithm. If a member defaults to L.A. Care, they will be assigned by HCO to one of the five plan partners. Recipients in voluntary aid codes may choose to be enrolled in a managed care health plan like Blue Shield Promise Health Plan if they so desire.

5.3: Member Health Plan Selection *(cont'd.)*

HCO is also responsible for disenrolling members from Medi-Cal managed care when their Medi-Cal eligibility is lost or when an exemption request is submitted and accepted.

L.A. Care/Blue Shield Promise Health Plan is not responsible for any issue regarding Medi-Cal eligibility.

5.4: Coverage

Member coverage will begin at 12:01 a.m. on the first day of the calendar month for which the beneficiary's name is added to the approved list of members furnished by L.A. Care to Blue Shield Promise Health Plan. All eligibility determination issues must be referred to the member's County Department of Public Social Services (DPSS) eligibility worker.

5.5: Newborn Coverage

Coverage of the newborn begins at birth. The newborn is covered under the mother's Medi-Cal by Blue Shield Promise Health Plan for the month of birth and the month following as long as the mother's Medi-Cal eligibility remains active. The newborn is covered under the mother's Medi-Cal capitation payment to Blue Shield Promise Health Plan and its providers. In order to retain coverage for a newborn, parents must first apply for a social security number (SSN) for the newborn. After receiving a receipt for the SSN, the mother must apply for Medi-Cal coverage for the newborn, or the newborn will lose coverage after their initial eligibility expires.

5.6: Change of Primary Care Physician

5.6.1: Member Initiated Change

Members may request a primary care physician (PCP) change during any given month. A member may request a PCP transfer by calling Member Services. Each eligible member in a family may select a different PCP.

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

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

5.6: Change of Primary Care Physician *(cont'd.)*

5.6.1: Member Initiated Change *(cont'd.)*

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

5.6.2: Primary Care Physician Initiated Change

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

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

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

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

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

5.7: Eligibility List

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

1. Month of Eligibility
2. Provider Name and Address, Provider Number
3. Member's Subscriber Number
4. Member's Last Name
5. Member's First Name
6. Date of Birth
7. Age
8. Social Security Number (new members only)
9. Member's Address (new members only)
10. Member's Telephone number (new members only)
11. IPA/medical group Effective Date
12. Member's Medi-Cal Aid Code
13. Sex
14. Special Remarks
15. Member Language

5.8: Eligibility Verification

Member eligibility should be verified from the Eligibility Roster at each visit. Should you have any questions about a member's eligibility that cannot be answered through the Provider Connection site, after you have logged onto your account page, please call the Blue Shield Promise Provider Customer Service at (800) 468-9935.

Eligibility Status (Class) Codes

01 = Eligible Member - Capitation paid

05 = Member on Hold Status - No Capitation Paid (Call Member Services for possible hold release)

59 = Member on Hold - Pending termination 09 = Member Disenrolled - No Capitation paid

00 = Member Voluntarily Disenrolled - No Capitation paid

99 = Disenrolled Member - No Capitation paid

Dep = Dependent Child-Covered under mother's cap for month of birth and following month

5.9: Identification Cards

Blue Shield Promise will furnish each new member with materials within the first seven (7) calendar days of enrollment including:

- A welcome letter
- A Member Identification Card with the 24-hour emergency numbers for their primary care physician (PCP)
- Blue Shield Promise Health Plan Member Handbook (*Evidence of Coverage*)
- Reminder card requesting the member call and make their first (120-day health assessment) appointment.
- Fraud postcard containing phone numbers to report fraud.

The Member Identification Card is for identification purposes only and does not guarantee eligibility for Blue Shield Promise or L.A. Care providers. You should always refer to your Eligibility Roster for current eligibility information or call the Blue Shield Promise Provider Customer Service at (800) 468-9935 for eligibility verification.

In addition to the Blue Shield Promise identification card, the member will continue to use his/her Medi-Cal benefit information card (BIC) to receive services that may not be covered by Blue Shield Promise Health Plan or L.A. Care such as mental health services and glasses.

5.10: Disenrollment

Disenrollment refers to the termination of a member's enrollment in L.A. Care and/or Blue Shield Promise Health Plan. It does not refer to a member transferring from one primary care physician to another. Members may disenroll from Blue Shield Promise Health Plan and/or L.A. Care at their own discretion.

Under certain circumstances it may be mandatory to disenroll a member from Medi-Cal Managed Care. Circumstances include a loss of Medi-Cal eligibility, relocation outside of Los Angeles County, or a change of aid code to a managed care ineligible code. Certain medical conditions, such as the need for major organ transplantation, result in mandatory disenrollment as well. For cases in which a disenrolled member reverts to fee-for-service Medi-Cal, the former member could feasibly continue to receive care from the same provider(s) on a fee-for-service basis. The disenrollment request will be processed by HCO and not through Blue Shield Promise or L.A. Care's grievance process. Members are to send completed disenrollment forms directly to HCO.

5.11: Plan Initiated Disenrollment

Plan initiated request for disenrollment must be based on documentation validating that there has been a breakdown in the relationship between Blue Shield Promise Health Plan and the member, or between the provider and the patient.

Request for disenrollment resulting from a breakdown in the provider/patient relationship must include documentation of any one of the following circumstances:

1. The member is verbally or physically abusive to the provider, administrative staff, or other members.
2. The member fails to follow prescribed treatment or repeatedly fails to keep scheduled appointments.
3. The member repeatedly uses providers not affiliated with Blue Shield Promise Health Plan for non-emergency services without prior authorization.
4. The member persists in conduct that interferes with the effective rendition of health care.
5. The member allows someone else to use their Blue Shield Promise Health Plan Identification Card.

Reasonable efforts should be made to:

1. Counsel or modify the member's behavior.
2. Provide the member the opportunity to develop an acceptable provider/patient relationship with another provider with the primary medical group.

These efforts must be documented and indicate that counseling has been unsuccessful if in fact that is the case. This will begin the member's involuntary disenrollment process, which must also go through the grievance process.

5.12: Transportation

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) are provided to ensure members have access to their providers. Transportation is offered to and from plan approved locations. Arrangements should be made at least 24 hours prior to the appointment by calling Blue Shield Promise at (877) 433-2178 (TTY 711).

NEMT is a covered benefit when a member needs to obtain medically necessary covered services and when prescribed in writing via a Physician Certification Statement form (PCS). Medically appropriate NEMT services via ambulance, litter van, wheelchair van or air are provided when the member's medical and/or physical condition does not allow for transport by ordinary means of public or private transportation.

5.12: Transportation *(cont'd.)*

The PCS form must be completed and submitted before NEMT services can be scheduled and provided to the member. The PCS form includes the components in the *DHCS All Plan Letter 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses* and is available to download from the Blue Shield Promise provider website under *Authorization Request Forms* in the *Provider Forms* section. Blue Shield Promise cannot modify an NEMT authorization once the treating physician prescribes the form of transportation.

NMT is a covered benefit for members to obtain medically necessary services, pick up drug prescriptions that cannot be mailed directly to the member, or pick up medical supplies, prosthetics, orthotics, and other equipment. NMT includes round trip transportation by passenger car, taxicab, or other form of public or private conveyance, as well as mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets. For private conveyance, a member must attest to Blue Shield Promise in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. Members using a wheelchair may utilize NMT services if they are able to ambulate without assistance from the driver. A PCS form is not required for NMT.

Related Travel Expenses

Reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services may be covered in addition to NEMT or NMT. Prior authorization or utilization management review may apply. If an accompanying attendant is determined to be needed, the related travel expenses of the attendant may also be provided. Coverage for services may be provided in the form of pre-payment or reimbursement per Internal Revenue Service per diem rates for lodging, meals and other related, approved expenses.

5.13: Translation Services/California Relay Services

Blue Shield Promise members are culturally and linguistically diverse, representing many different countries and ethnic groups. Providers may access telephonic interpreters for all languages by calling Blue Shield Promise Member Services. This service is available 24 hours a day, seven (7) days a week. Assistance for the hearing impaired can be accessed telephonically through the California Relay Service.

Face-to-face interpretive services are also available for Blue Shield Promise members, including the hearing impaired, by calling Blue Shield Promise Member Services at (800) 605-2556 (TTY 711) no less than 5 – 7 days in advance.

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6.1: Member Grievances

Purpose

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

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

Procedure

Members are encouraged to speak with their IPA/medical group/PCP regarding any questions or concerns they may have. If the PCP, IPA/Medical group receives any member grievance, they are required to forward to the Health Plan all records and member interaction details related to the grievance supporting the Plans timely resolution of the grievance, within 48 hours for standard and immediately for expedited request.

Members may also communicate their concerns directly to Blue Shield Promise Member Services by telephone at (800) 605-2556 (TTY: 711) for Los Angeles County and (855) 699-5557 for San Diego County. Grievances can also be filed by in person, in writing by mail or fax, or online at www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/medi-cal-members/medi-cal-members under *Get to Know Your Medi-Cal program,* then *Submit a grievance form online*.

Blue Shield Promise will acknowledge receipt of all written formal grievances within five (5) calendar days. Blue Shield Promise will resolve grievances within 30 calendar days and provide a resolution letter to the member. Providers and IPA/medical groups are required to provide medical records, authorizations, or responses within 7 calendar days of the request (or sooner in the case of expedited grievances) in order to resolve the grievance within the regulatory timelines.

If a member has a grievance against Blue Shield Promise, the member should first use the Blue Shield Promise grievance process before contacting the Department of Managed Health Care (DMHC). Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the member.

Members may also be eligible for an Independent Medical Review (IMR) to provide an impartial review of medical decisions made by a health plan. The IMR will determine the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. See Section 6.3. A revised Independent Medical Review/Complaint Form is available in English and the 16 threshold languages on the DMHC website at: www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx

6.1: Member Grievances *(cont'd.)*

If the resolution of the appeal/grievance is not acceptable to the member, the member needs assistance with a grievance, or if a grievance has remained unresolved for more than 30 days, the member has the right to contact the DMHC for assistance at (888) 466-2219 (TTY (877) 688- 9891) or www.dmhc.ca.gov. The DMHC is responsible for regulating health care service plans. Instructions, complaint forms, and IMR application forms are available on the DMHC website.

Medi-Cal members also have the right to request a State Fair Hearing within 120 calendar days of the Notice of Appeal Resolution (NAR). Members have the right to request continuation of benefits during a State Fair Hearing. For more information about State Hearing requests, members may call the California Department of Social Services (CDSS) at (800) 952-5253 (TTY (800) 952- 8349). The Ombudsman Office of the California Department of Health Care Services (DHCS) is also available to Medi-Cal beneficiaries for help with grievances at (888) 452-8609.

Grievances concerning quality of care issues are reported immediately to the Quality Management (QM) Department. The QM Department logs the grievance, gathers medical records/information concerning the grievance, and reviews the case for quality of care. All quality related grievances are reviewed by the Medical Director. All grievances are tracked by type/category and by provider and are reviewed regularly by the QM Committee for potential quality of care issues. Blue Shield Promise is primarily responsible for establishing and administering grievance procedures. However, the IPA/medical group and/or the PCP must participate with Blue Shield Promise by providing assistance and information. Grievance forms shall be made available to members at each PCP site. Additionally, providers are given the opportunity to review all member concerns and respond to the issues identified.

Letters of resolution on all levels of the dispute process will include detailed instructions about the Ombudsman program, the option of filing a State Fair Hearing Request with the California Department of Social Services (CDSS), and/or how to request an IMR with the Department of Managed Health Care (DMHC).

Expedited Grievance

The member may request an expedited grievance when an imminent and serious threat to the health of the beneficiary exists, including but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, but are urgent in nature.

6.2: Member Appeals Requests

The Member Appeals Process is designed to allow members, authorized member representatives or providers to file, on their behalf, a complete and timely review within 30 calendar days of Blue Shield Promise's receipt of the request. Appeals filed by the provider on behalf of the member require written consent from the member. Members have the right to request continuation of benefits during the appeals process.

6.2: Member Appeals Requests *(cont'd.)*

If the PCP, IPA/Medical group receives any member appeal, within 48 hours, they are required to forward to the Health Plan all records and member interaction details related to the appeal supporting the Plan's timely resolution of the appeal.
Providers and IPA/medical groups are required to provide medical records, authorizations and/or responses within 3 calendar days of the request for non-urgent cases in order to resolve the issue within the regulatory timelines.

The definition of an "***Appeal***" is a delay, modification, or denial of services based on medical necessity, or a determination that the requested services was not a covered benefit.

Examples of Appeals are:

1. Benefit Appeals – Involving care the plan specifically excludes from coverage (e.g., circumcision, cosmetic surgery etc.).
2. Medical Necessity – Covered Services that are necessary and appropriate for the treatment of a member's illness or injury according to professionally recognized standards of practice.

Appeals can be:

Pre-Service – Prior to the member receiving the requested item or service.

Post-Service – The service has been rendered and there is a dispute about non- coverage of a claim.

Standard – Resolved in 30 calendar days.

Expedited – Resolved in 72 hours. When the member's life, health, or ability to attain, maintain or regain maximum function is at risk.

Each Appeal begins the process anew to establish the story including:

1. The member's perception
2. The summary of the issue
3. The authorization request
4. The denial notice
5. The evidence including Medical Records, clinical notes, submissions by member or provider
6. A summary of the state rules, regulations, and laws
7. A Summary of the Blue Shield Promise plan benefits (*Evidence of Coverage*), Medical Policies and manuals

6.2: Member Appeals Requests *(cont'd.)*

The staff involved in preparing and reviewing an appeal will not have been involved in the initial adverse decision/denial, or a subordinate/directly supervised by such person. In addition, for appeals involving clinical issues, the health care practitioner must have appropriate training and experience in the field of medicine involved in the medical judgment that requested the service.

6.2.1: Expedited Appeal

A provider, on behalf of a member, or a member may file an expedited appeal to an adverse benefit determination and ask to have it processed expeditiously. Expedited appeals are resolved within 72 hours.

This type of appeal is generally used in a continued stay or continued treatment situation, and when indicated based on the critical clinical condition of the member. The following circumstances may constitute, but are not limited to, an expedited appeal:

- The member has been issued a denial for service.
- The member is scheduled for ongoing services or admission to a hospital within 72 hours.
- The member suffers from a terminal illness.
- The Attending Physician indicates in writing that the member's health will suffer adverse consequence from the denial decision.

All requests for expedited appeals will be triaged by licensed personnel to determine whether the appeal meets expedited criteria.

Documentation will be collected and presented to a Medical Director so that the case can be resolved and closed to the member within 72 hours.

6.3: Independent Medical Review

The independent medical review (IMR) process is an expansion of the appeal process for health plan enrollees. Independent reviews are conducted through the Department of Managed Health Care (DMHC) by an accredited impartial independent review organization to perform the medical review of a Plan/IPA/medical group's decision to deny, modify or delay health care services, based in whole or in part on a finding that the disputed services are not medically necessary.

The enrollee may request the IMR within six (6) months of any qualifying periods or events. The enrollee shall pay no application or processing fee of any kind.

6.3: Independent Medical Review *(cont'd.)*

Upon notice to the Plan from the department that an enrollee has applied for an IMR, the Plan and the Plan's contracted provider shall provide to the IMR organization all of the following documents within 24 hours if expedited or -3 Business days if standard:

A copy of the members medical records that is relevant to the following:

1. The member's medical condition.
2. The healthcare services being provided by the Plan and its contracted provider for the condition.
3. The disputed health care services requested by the enrollee for the condition.

Members are eligible for an independent medical review if the member has not presented the disputed health care service for resolution by the Medi-Cal State Fair Hearing process. Reviews shall be conducted in accordance with the statutes and regulations of the Medi-Cal program.

Independent Medical Review for Experimental/Investigational Procedures

The IMR also includes therapies, which have been denied by the Plan as experimental or investigational. Experimental/investigational procedures or treatments are a limitation to the Health Plan's evidence of coverage. These IMR requests do not have to first go through the Blue Shield Promise Appeal process.

Members That Qualify to Request the Experimental & Investigational Review Process

The external independent review process applies to Blue Shield Promise members that meet all of the following criteria:

1. The member has a life threatening or seriously debilitating condition. ***"Life threatening"*** is defined as either or both of the following:
   a. Diseases or conditions where likelihood of death is high unless the course of the disease is interrupted.
   b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

   "Seriously debilitating" Is defined as diseases or conditions that cause major irreversible morbidity, i.e., there is an imminent and serious threat to the health of the member including severe pain, the potential loss of limb, or major bodily function.
2. The member's physician certifies that the member has a condition, as defined in Criteria 1 (above), for which standard therapies have not been effective in improving the condition of the member, or for which standard therapies would not be medically appropriate for the member, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to Criteria 3 (below); and

6.3: Independent Medical Review *(cont'd.)*

3. Either (a) the member's physician, who is under contract with or employed by Blue Shield Promise, has recommended a drug , device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies; or (b) the member, or member's physician who is a licensed board-certified or board- eligible physician qualified to practice in the area of practice appropriate to treat the member 's condition, has requested a therapy that, based on two (2) document s which meet the definition of " medical and scientific evidence" as defined by Health and Safety Code 1370.4 subsection d, is more likely to be more beneficial for the member than any available standard therapy; and
4. The member has been denied coverage by Blue Shield Promise for a drug, device, procedure, or other therapy recommended or requested.
5. The specific drug, device, procedure, or other therapy recommended would be a covered service, except for a Blue Shield Promise determination that the therapy is experimental or investigational.

Criteria Determining Experimental/Investigational Status

In making a determination that any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply is "experimental or investigational" by the Plan, the Plan shall refer to evidence from the national medical community, which may include one or more of the following sources:

1. Evidence from national medical organizations, such as the National Centers of Health Service Research.
2. Peer-reviewed medical and scientific literature.
3. Publications from organizations, such as the American Medical Association (AMA).
4. Professionals, specialists, and experts.
5. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment.
6. An expert physician panel selected by one of two organizations, the Managed Care Ombudsman Program of the Medical Care Management Corporation or the Department of Managed Health Care.

6.4: Provider Disputes – Claims Processing

Purpose

To establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with H&S §1371.37, 1371.38 and 1371.39.

6.4: Provider Disputes – Claims Processing *(cont'd.)*

6.4.1: Provider Questions, Concerns and Disputes

Providers can communicate questions and issues regarding their contract or that are not payment related to the Blue Shield Promise Provider Network Operations (PNO) Department.

All provider payment-related issues should be directed to the Provider Dispute Resolution (PDR) Department in writing, either online via Provider Connection at https://www.blueshieldca.com/en/home, or via USPS mail services. A claim number is required for a dispute to be filed online. Examples of a payment related dispute are non-payment or underpayment of claims by IPA/medical groups. All payment disputes are entered in the PDR database, investigated and a response will be provided in writing within the regulatory timeframe.

Disputes are acknowledged within two (2) working days for disputes submitted online via Provider Connection, and within (15) working days for disputes submitted via USPS mail services. A resolution letter will be sent within 45 working days.

If there is a dispute with the County Mental Health Plan, Providers can submit their provider dispute to the County Mental Health Plan. Should additional assistance be requested, providers can contact the PNO Department.

6.4.2: Reconsiderations

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

6.4.3: Provider Disputes Policy and Procedure

If a provider needs to submit a dispute, they can either submit in writing to the Blue Shield Promise Provider Dispute Department or via the Provider Connection at blueshieldca.com/provider-dispute. Disputes may pertain to issues such as post-service authorization or denial of a service; non-payment or underpayment of a claim; or disputes with our delegated entities. If a provider attempts to file a provider dispute via telephone, fax or via digital media such as compact discs, USB data keys, flash drives, Blue Shield Promise staff will instruct the provider to submit the provider dispute to Blue Shield Promise in writing. Any digital media received by Blue Shield Promise will be destroyed without review or further notice to the submitting party.

6.4: Provider Disputes – Claims Processing *(cont'd.)*

6.4.3: Provider Disputes Policy and Procedure *(cont'd.)*

All written, formal disputes will be responded to in writing. Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within two (2) working days for disputes submitted online via Provider Connection, and within 15 working days for disputes submitted via USPS mail services.

Information about how to file a dispute can be found on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/medi-cal-provider-disputes. For the Provider Dispute Resolution Request Form, click on *Provider dispute forms* in the *Forms* section.

6.4.4: First Level Dispute

A provider may appeal the decision made at Blue Shield Promise or one of its IPA/medical groups.

1. The Provider shall be notified of receipt of written dispute within two (2) working days for disputes submitted online via Provider Connection, and within fifteen (15) working days for disputes submitted via USPS mail services, and a determination will be made within (45) working days from the date that Blue Shield Promise received the dispute.
2. A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information. The amended dispute will be resolved within forty-five (45) working days of the receipt of the amended dispute.
3. All records shall be evaluated by the appropriate Plan personnel who will render a decision. The Blue Shield Promise Provider Dispute Department shall send a written determination letter outlining its conclusions with background information within 45 working days of receipt of the dispute. Language in the letter will include any available next steps the provider can take with the dispute.
4. The Provider Dispute Resolution process is available on Provider Connection at https://www.blueshieldca.com/en/home.

6.4.5: Second Level Dispute - L.A. County

After completing a first level dispute, for L.A. County Medi-Cal only, the provider may submit a second level dispute. A second level dispute must be filed within 60 working days of receipt of the Blue Shield Promise determination letter. It can also be used when Blue Shield Promise has failed to act within the deadlines set forth above.

6.4: Provider Disputes – Claims Processing *(cont'd.)*

6.4.5: Second Level Dispute - L.A. County *(cont'd.)*

Medi-Cal providers seeking a second level dispute can file it with Blue Shield Promise or L.A. Care. If it is sent to Blue Shield Promise, the Provider Dispute Unit will forward the request to L.A. Care with all material and documentation utilized in the First Level Dispute upon request.

If a Provider submits a written dispute directly to L.A. Care, the written dispute must contain:

1. A letter requesting a review of the first level dispute.
2. A copy of the letter sent to Blue Shield Promise requesting a first-level dispute.
3. A copy of the original documents submitted to Blue Shield Promise.
4. A copy of the first level dispute - denial determination letter.
5. A copy of any other correspondence between Blue Shield Promise and the provider that documents timely submission and the validity of the dispute.

L.A. Care shall acknowledge and provide determination of the Second Level Dispute requested by the provider.

6.4.6: Second Level Dispute - All Other Counties

After completing a first level dispute, the provider may submit a Provider Complaint to the Department of Managed Health Care (DMHC). The Provider Complaint can also be used when Blue Shield Promise has failed to act within the deadlines set forth above.

Additionally, Providers may contact the DMHC Provider Complaint toll free number at (877) 525-1295.

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7.1: Utilization Management Program

Mission Statement

The Blue Shield Promise Utilization Management (UM) Department is committed to providing healthcare that is medically excellent, ethically driven, and delivered in a member-centered environment. It recognizes the positive relationship between health education, a culture of wellness, and an emphasis on prevention and the cost-effective delivery of care.

Purpose

The purpose of the UM Program is to ensure consistent delivery of the highest quality health care and to optimize member outcomes. This is accomplished through the establishment of fully integrated multidisciplinary healthcare networks and coordination of all clinical and administrative services under the provisions of the Blue Shield Promise UM Program.

UM provides inpatient utilization management 7 days a week from 8 a.m. to 5 p.m., except for company designated holidays, and after hours to assist with repatriation of members from a non-contracted to a contracted facility.

Goals

- Consistently apply UM standards, guidelines, and policy/procedures in the evaluation of medical care and services on a prospective, concurrent, and retrospective basis.
- Provide access to quality healthcare services delivered in the most appropriate manner considering all care settings appropriate to the member's condition, needs, preferences and circumstances.
- Facilitate and ensure continuity of care for Blue Shield Promise members within and outside of the Blue Shield Promise provider network.

7.1.1: Physician, Member and Provider Responsibilities

All members may select or will be assigned to a Primary Care Physician (PCP). The PCP coordinates the entire spectrum of care for assigned members. This includes direct provision of all primary healthcare services, including preventive health services.

Additional activities and responsibilities include:

- Provide appropriate and consistent care with the Blue Shield Promise UM Program, its protocols, standards, and guidelines.
- Submit complete and timely claims/encounters to Blue Shield Promise for processing. Information generated from this data will be shared with provider participants at the discretion of the UM Committee. Blue Shield Promise shall have access at reasonable times and upon reasonable demand to the participating physicians' books, medical records, and papers (consultation reports, x-rays, test results, charts, operative reports, etc.).

7.1: Utilization Management Program *(cont'd.)*

7.1.1: Physician, Member, and Provider Responsibilities *(cont'd.)*

- Refer members within the Blue Shield Promise Health Plan contracted network to the fullest and most reasonable extent possible. (Out-of-network referrals require prior approval).
- Assist in the evaluation of medical appropriateness of care provided to their members or of care provided by other networks or non-network physicians, either on an individual basis or as part of the UM Committee.
- Ensure providers have accurate contact information for the member and all network providers involved in the member's case.

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Authorization logs must be sent to Blue Shield Promise, based on the criteria below:

- **Hospital:** Authorization Logs are to be submitted to Blue Shield Promise either immediately prior to, or at the time of a Hospital admission, discharge, or transfer for all Promise members and Blue Shield Dual Special needs Plan (DSNP) members.
- **IPA Medical Groups**: IPA/medical group approvals, denials and partial denials should be delivered weekly together on one file.

Approval/denial data files: ("Authorization Logs") must be delivered in the IPA9 file layout via the Provider Connection Portal at www.blueshieldca.com/providerwebapp/authorization/IPAFileUpload. Providers must be registered on Provider Connection to view this page. If an IPA/medical group is currently submitting logs via IPA10 format, no changes are required.

- **SNF**: Authorization Logs are to be submitted to Blue Shield Promise within 48 hours of a SNF admission for all Promise members and Blue Shield Dual Special Needs Plan (DSNP) members.

  Authorization Logs are to be submitted to Blue Shield Promise in advance or at time of a member's SNF discharge or transfer for all Promise members and Blue Shield Dual Special Needs Plan (DSNP) members.

Approval/denial data files ("Authorization Logs") must be delivered via Provider Connection at (https://www.blueshieldca.com/providerwebapp/authorization/IPAFileUpload) using the IPA9 file layout.

To obtain the IPA9 Blue Shield standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com.

- If an IPA/medical group is currently submitting logs via IPA10 format, no changes are required.

7.1: Utilization Management Program *(cont'd.)*

7.1.2: UM Reporting Requirements for IPA/Medical Groups *(cont'd.)*

The following information is required on the Authorization Log. Please do not modify (add or subtract) any of these data elements from the Authorization Log. Wherever not applicable the field can be left blank.

Blue Shield Promise Member Number	Diag Code 4	Proc Code 8	Servicing Provider NPI #
Blue Shield Promise Member Name	Primary Procedure Code	Units Proc8	Facility Name
Member's DOB	Units Proc1	Proc Code 9	Facility NPI #
Health Plan (CMC, Medi-Cal, Medicare, Commercial)	Proc Code 2	Units Proc9	Requesting/Referring Provider Name
Type of Service (Inpatient, Outpatient, Medication)	Units Proc2	Proc Code 10	Requesting/Referring Provider NPI #
Place of Service (Inpatient Hospital, Office, SNF, ASC, Hospice, Home, etc.)	Proc Code 3	Units Proc10	IPA Authorization Number
LOC1	Units Proc3	Proc Code 11	Blue Shield IPA PIN ID #
LOC2	Proc Code 4	Units Proc11	Receipt Date of Request
LOC3	Units Proc4	Proc Code 12	Auth Decision (Approved/Denied/ Voided)
LOC4	Proc Code 5	Units Proc12	Denial Reason
Start/Admit Date	Units Proc5	Proc Code 13	Decision Date
End/Discharge Date	Proc Code 6	Units Proc13	Discharge Diagnosis (For Inpt Auth)
Primary Diagnosis Code	Units Proc6	Proc Code 14	Discharge Status (For Inpt Auth)
Diag Code 2	Proc Code 7	Units Proc14	
Diag Code 3	Units Proc7	Servicing Provider Name	

7.1: Utilization Management Program *(cont'd.)*

7.1.2: UM Reporting Requirements for IPA/Medical Groups *(cont'd.)*

The Authorization log in IPA9 format should adhere to the following requirements when submitted via Provider Connect Portal:

1) The file must be in .xls or .xlsx format.
2) The filename must begin with IPA9.
3) The file should not be password protected.
4) The file should have a single worksheet.

7.1.3: Organization of Health Care Delivery Services

Health care services are provided through a combination of direct contracts, a full and shared risk network model, structured to provide a continuum of care. Contracted network providers include, but are not limited to, PCPs, specialty physicians, behavioral health providers, community and tertiary hospitals, skilled nursing facilities, home health agencies, pharmacies, laboratories, durable medical equipment providers, and others.

Non-emergent care other than self-referable, direct-access care may require authorization by the Blue Shield Promise UM Department or by the delegated financially responsible entity. Whenever medically appropriate, services will be arranged with network providers. This does not preclude the use of non-network providers when medically appropriate, as defined in other areas of this document.

7.1.4: Medical Services Committee Structure and Membership

The Medical Services Committee is chaired by the Blue Shield Promise Chief Medical Officer (CMO). Membership is assigned and includes PCPs and a representative sample of specialty care physicians. The term of membership is one (1) year with reappointment by the Committee and approval by the Board of Directors. There is no limit on the number of consecutive terms that assigned physicians may serve.

7.1: Utilization Management Program *(cont'd.)*

7.1.4: Medical Services Committee Structure and Membership *(cont'd.)*

Meetings

The Medical Services Committee meets on a quarterly basis and is responsible for the following:

- Reviewing and discussing administrative information presented to the members.
- Reviewing Utilization Management statistics.
- Receiving, reviewing, evaluating, and making recommendations regarding UM activities.
- Reviewing proposed member treatment plans that require input beyond the expertise of the CMO with specialty advisors.
- Coordinating educational opportunities for physicians regarding UM procedures and processes.

Confidentiality

All committee members and participants, including medical staff, participating providers, consultants, and others will maintain the standards of ethics and confidentiality regarding both member information and proprietary information.

Reports

The following reports are reviewed by the UM Committee and the Board of Directors:

- Total hospital bed days per 1000
- Total number of referrals by specialty
- Total number of referrals approved, denied and modified
- Turnaround time studies
- Appeals
- E.R. (Emergency Room) Utilization
- CCS Cases
- Outpatient Mental Health
- Applied Behavior Analysis (ABA)/Behavioral Health Treatment (BHT)
- Pharmacy Utilization

7.1: Utilization Management Program *(cont'd.)*

7.1.5: UM Review Process for Appropriateness of Care

Desk level procedures are utilized by staff for the review process. Benefit algorithms have been developed to allow certain types of referrals to be automatically authorized by the UM coordinators. This process can reduce the number of referrals not requiring clinical expertise for determination. Referrals that involve clinical information and require clinical decisions are routed to the UM Clinician and/or Physician Reviewers.

Physician Reviewers will conduct a review for medical appropriateness on any denial. When necessary, the CMO will consult with physicians from the appropriate specialty areas of medicine and surgery, who are certified by the applicable American Board of Medical Specialists, for any medical decision that requires this level of expertise. A list of these physician consultants is also available to the CMO for second opinions, reconsiderations, and appeal requests.

All IPA/medical groups contracted with Blue Shield Promise may only utilize Blue Shield Promise approved criteria as listed below. IPA/medical groups must first use Medi-Cal Guidelines for medical necessity determination and only use the others when Medi-Cal Guidelines are not available. The following is a complete list of the Blue Shield Promise approved guidelines or sources that may be utilized for issuing approvals, denials, or modifications. IPA/medical/MSO Internal Policy or guidelines should not be used for any medical necessity determination on a Blue Shield Promise member, all benefit denials should either reference a Medi-Cal source or the Blue Shield Promise Health Plan *Explanation of Coverage (EOC).*

Medi-Cal
Pharmacy and Therapeutics (P&T) Committee Approved Criteria
Medi-Cal Guidelines
Blue Shield Promise Medical policy, as applicable
MCG 27th Edition
NCCN (National Comprehensive Cancer Network)
Blue Shield Promise Health Plan *Evidence of Coverage* (EOC)
Other nationally accredited resources and professional medical associations (e.g., American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP), The American College of Obstetricians and Gynecologists (ACOG))
Blue Shield Promise Medical policy, as applicable

Medical necessity is determined by the review of medical information provided by the requesting provider, hospital medical records, and provider to physician communication. The reviews may be done prospectively, concurrently and/or retrospectively.

Reviewer Availability

The Chief Medical Officer (CMO) is available to discuss any UM decision. Practitioners can call the CMO at (800) 468-9935 from 9 a.m. to 6 p.m. Monday through Friday.

7.1: Utilization Management Program *(cont'd.)*

7.1.6: Review Criteria

The UM Department uses nationally recognized evidenced based review criteria, i.e., MCG 27th Edition, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, Comprehensive Perinatal Service Program Guidelines, and Title 22. A review of criterion is updated on an ongoing basis.

Nationally recognized criteria sets will be renewed at least every two (2) years. The criteria set alone cannot ensure consistent UM decision making across the organization. Additionally, Blue Shield Promise recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan's delivery system.

The UM review criteria or guidelines used to make a determination for a member's care is available to the requesting provider and the member upon request either in writing or by contacting Blue Shield Promise UM Department at (800) 468-9935.

Upon request by the public, at no cost to you, a copy of the Blue Shield Promise's non-proprietary clinical and administrative policies and procedures will be disclosed. To request the criteria or guidelines for a specific procedure or conditions requested, please contact the UM Department at (800) 468-9935. In addition, this information can also be found on www.blueshieldca.com/en/bsp/providers under *Medical policies and procedures*.

The Blue Shield Promise UM Program consists of the following functions and activities. Each is individually explained in specific policy and procedure:

- California Children's Services
- Children's Health and Disability Prevention (CHDP)
- Concurrent Utilization Review
- Denials
- Dental
- Discharge Planning
- Early Periodic Screening, Diagnostic, Treatment (EPSDT) / Medi-Cal Kids & Teens
- Early Start
- Emergency Services Utilization Review
- Expedited Appeals Review
- Experimental and Investigational Therapies
- Family Planning Services
- Grievance and Appeal Process
- Hospice
- Inpatient Readmissions
- Long Term Care
- Organ Transplants
- Out-of-Network Services

7.1: Utilization Management Program *(cont'd.)*

7.1.6: Review Criteria *(cont'd.)*

- Pharmacy and Medication Utilization Review
- Postpartum Health Mother and Baby Program
- Reconsideration
- Reconstructive Surgery
- Retrospective Utilization Review
- Second Opinions
- Sensitive Services
- Sexually Transmitted Disease Services
- Specialty Care Referral Management
- Standing Referral/Extended
- Sterilizations
- Tuberculosis (TB)
- UM Decision Time Frames
- Vision Care

7.2: Complex Case Management Program

Mission Statement

To work collaboratively with healthcare providers across a full spectrum of healthcare settings by focusing on the attainment of optimal health outcomes through the identification and management of high-risk enrollees with catastrophic illnesses, complex diagnoses, and/or selected disease related conditions.

Purpose

The Blue Shield Promise Case Management Program is developed as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs. This purpose is implemented through communication and use of available resources to promote quality and cost-effective outcomes. The Blue Shield Promise Case Management Program is developed to specifically address the needs of the members with high cost, high volume, and high-risk health care experiences.

The Case Management Program is established to specifically identify eligible candidates that may benefit from the program by diagnostic/symptomatic categorization at initial points of service, with a focus on early identification of risk factors and conducting needs assessment. The goal is to identify and intervene early to affect the best outcome for the catastrophically impacted, chronically ill, injured, or high chronically ill, injured, or high-risk OB members.

7.2: Complex Case Management Program *(cont'd.)*

7.2.1: The Role of the Case Manager

Case Managers will work with PCPs to evaluate a member for the program and assess the member's condition and social situation for a need's determination. An eligibility benefits determination will be made and compared with the members' needs. A comprehensive program will then be developed to identify benefit and community resource utilization. Members will be referred to Complex Case Management in the community from various sources, via pre-certification, during hospitalization, while receiving ancillary services or claims.

Once accepted into the Case Management Program and member consent is obtained, the Case Manager will develop a plan of care. Appropriate referrals will be made to community resources. The Case Manager will monitor and evaluate the case and revise the plan as appropriate until its conclusion. The case will be closed for the following but not limited to:

- No longer meets medical necessity for the benefit
- Terminates from the plan
- Expires
- Refuses further case management services
- The plan or the member requests disenrollment from case management services due to irreconcilable breakdown in the case manager-member relationship, or for any other reasons determined by the department to constitute "good cause".
    - "Good cause" can include: persistent and/or unrealistic demands, member refusing to comply with reasonable accommodations or appropriate solutions, lack of courteous and respectful interactions leading to disruption of regular operations, verbal or physical intimidation, violence or threat of violence towards any plan staff.
    - In the event a case manager and the member have experienced an irreconcilable breakdown in their working relationship, which has caused disruption and an inability to continue case management services the following will occur:
        - Documentation of the request for disenrollment and the initiator of said request.
        - Documentation of all available resources provided to the member in an effort to resolve member's concerns, provide care, and successfully reestablish a collaborative case manager-member relationship.
        - Documentation of the irreconcilable breakdown in the case manager-member relationship, including the use of the plan's problem resolution process, verbal or written warnings provided to the member following any disruptive behavior, etc.

7.2: Complex Case Management Program *(cont'd.)*

7.2.1: The Role of the Case Manager *(cont'd.)*

NOTE: Use of the plan's problem resolution process shall not be required in situations where a member's behavior presents physical risk to plan staff, a provider, or staff at a provider site, and the plan or provider has filed a police report regarding the physical risk

7.2.2: Case Management in the Ambulatory Setting

A Case Management Program referral may be received from several sources including, but not limited to:

- Referral Coordinator
- Member Services
- Quality Assurance
- PCP office setting
- Family telephone call with request for Case Management
- Referral from Claims Department
- Referral from Pharmacy Department

Information will be collected about the member and the case including: demographic information (name, birth-date, most recent address and telephone number, nearest relative with a telephone number, significant person/caretaker); social history (employment, education and training, life style, religious concerns which may impact any case management plan, in-home family structure, residing in a facility, receiving day care or in-home supportive services); and clinical information (should consist of a history and recent clinical information that is related to the diagnoses being evaluated for case management).

This information may be obtained by/from many sources, including:

- PCP office nurse or other staff. A request for medical information may be sent to the PCP office staff that may fax or send the information for the care management record. If the information is needed on an emergent basis, the information may be obtained over the telephone. Use the request for information letter, if appropriate.
- Current service provider(s): Occupational/Physical/Speech Therapy, Home Health, surgery, etc. These providers often have complete records.
- The member and/or their responsible party/caretaker.
- Specialist(s) involved in the case.

A case management problem can be identified from a variety of sources such as diagnoses and contracted benefit(s). For example:

- Fractured wrist with surgical repair = suture/wound care, dressings or not, equipment needs, caregiver with instruction, PT/OT needs
- Depression = mental health care

7.2: Complex Case Management Program *(cont'd.)*

7.2.2: Case Management in the Ambulatory Setting *(cont'd.)*

- Fractured leg with cast = PT, crutch, transportation
- Abdominal wound = home health, dressings, and teaching/caregiver
- Absorption/digestive problems = nasogastric/gastrostomy tube and related
- Supplies, liquid nutritional product, instructions to caregiver, monitoring by physician, (Gastroenterologist vs. PCP)
- Major musculoskeletal abnormalities = durable medical equipment and supplies, OT/PT/Speech, caretaker issues/respite, educational needs, incontinent supplies, ADL adaptations
- High-risk OB with symptoms = fetal monitoring, complete bed rest at home, IV therapy

A care management problem can also be one of the following social/clinical issues, which will impact the ability of the members to overcome the current problem:

- Inadequate parent knowledge
- Parent illness
- Lives alone, or only adult in the household while enduring illness
- Lack of transportation
- Refusal of service
- Treatment recommended is contrary to client belief system
- Mental illness/substance or chemical addiction
- Violent home
- Homeless, living in a shelter or residential treatment center

A benefit evaluation will measure which resource can best provide for the needs of the client:

- CCS
- WIC
- Regional Center
- Alcohol and substance abuse program
- Mental Health
- HIV/AIDs programs
- Waiver program
- Dental services
- Genetically Handicapped Disability Program
- Vision care

7.2: Complex Case Management Program *(cont'd.)*

7.2.2: Case Management in the Ambulatory Setting *(cont'd.)*

- Home Health
- Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP), Early Intervention/Early Start/Developmental Disabilities Services (EI/EI/DDS)
- Organ Transplant benefits for recipient and Living Donor including Organ transplant evaluation

7.2.3: Utilization Management (UM) Clinicians in the Inpatient Setting

All network providers, hospitals, institutions, and facilities must educate their Discharge Planning staff on the services, supplies, medications, and DME needing prior authorization. In addition, providers must ensure that medication reconciliation is conducted upon admission and prior to discharge.

Inpatient review is conducted by licensed clinicians who are responsible for the daily utilization review of acute hospital, skilled nursing, psychiatric, and rehabilitation inpatient stays. UM Clinicians interface with the in-house physicians, facility case managers/social services, discharge planners, and the Chief Medical Officer to assure continuity of care in the most appropriate setting.

Immediately upon notification of admission they begin the process of case assessment and the coordination of discharge planning with the focus of medical necessity. Additional functions are as follows:

- Monitor, document, and report pertinent clinical criteria as established per UM Policy and Procedures to Medical Director and other designated sources.
- Identify and report to quality management referral indicators and submit data for ongoing studies.
- Interface frequently with hospital employed discharge planners, Case Managers, and social workers to collaborate and coordinate all identified members' needs to promote the most expeditious return of their optimal level of function prior to hospitalization.
- Coordinate all services for discharge in a timely manner and with contracted providers.
- Provide after-hours support to assist with member repatriation from a non-contracted to a contracted facility.

7.3 Transitional Care Services (TCS)

The goal of Transitional Care Services (TCS) is to ensure that Blue Shield Promise members receive the highest-level of care from the time of admission to post discharge until they have been successfully connected to all needed services and supports. The following requirements are referenced from the DHCS CalAIM: Population Health Management (PHM) Policy Guide and build upon existing facility requirements. These requirements are meant to ensure coordination of care, continuity of care, and optimum outcomes for Plan members in their care transitions. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

7.3.1. Admission, Discharge, and Transfer (ADT) Data

In accordance with CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CalHHS Data Exchange Framework (DxF), general acute care hospitals and emergency departments, as defined by California's Health & Safety Code §1250, (together "Participating Facilities"), must send admission, discharge, or transfer (ADT) notifications to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the admission, discharge, or transfer event (ADT Event).

Participating Facilities are required to send notification of ADT Events unless prohibited by applicable law.

They must also accept notification of ADT Events from any other participant and send notification of ADT Events as requested using a HIPAA-compliant method and in a format acceptable and supported by the requesting participant. These DxF requirements will support Blue Shield Promise capabilities to receive ADT notifications from a variety of Participating Facilities.

7.3.2. Requirements for High- vs. Lower-Risk Transitioning Members

Minimum TCS requirements vary for high-risk and lower-risk transitioning members as described below. "High-risk" transitioning members means all members listed in the DHCS PHM Policy Guide as:

- Those with Long-Term Services and Supports (LTSS) needs;
- Those in or entering Complex Care Management (CCM) or Enhanced Care Management (ECM);
- Children with special health care needs (CSHCN);
- Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to the delivery;

7.3 Transitional Care Services (TCS) *(cont'd.)*

7.3.2. Requirements for High- vs. Lower-Risk Transitioning Members *(cont'd.)*

- Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing DHCS APL 22-024; and
- Other members assessed as high-risk by Risk Stratification Segmentation and Tiering (RSST).

In addition to these groups, discharging facilities must also consider the following members "high-risk" for the purposes of TCS:

- Any member who has been served by county Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by Blue Shield Promise or discharging facility;
- Any member transitioning to or from a SNF; and
- Any member that is identified as high-risk by the discharging facility and thus is referred to or recommended by the facility for high-risk TCS.

7.3.2.a. Notifying a Care Manager

I. High-Risk Members

Once a member has been identified as being admitted as high-risk, Blue Shield Promise will assign a Care Manager responsible for TCS, who is the single point of contact responsible for ensuring completion of TCS requirements across all settings and delivery systems.

Members may choose to have limited or no contact with the care manager. In these cases, the discharging facilities must, at minimum, comply with federal and state discharge planning requirements listed below and assist in care coordination with the Care Manager, the Primary Care Provider (PCP), and any other identified follow-up providers.

For high-risk members in transition, their assigned Care Managers (including ECM and CCM) must be notified within 24 hours of admission, transfer, or discharge when an ADT feed is available, or within 24 hours of Blue Shield Promise being aware of any planned admissions, or of any admissions, discharges, or transfers for instances where no ADT feed exists (such as for SNF admissions). However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

II. Lower-Risk Members

Blue Shield Promise will provide a dedicated TCS team available to lower-risk members in transition that is available via phone at (877) 702-5566 from 8 a.m. to 5 p.m. Monday through Friday.

The discharging facility must incorporate the Blue Shield Promise TCS phone number (877) 702-5566 into the discharge documents for lower-risk members. Lower-risk members will have access to the dedicated TCS team for at least 30 days from discharge.

7.3 Transitional Care Services (TCS) *(cont'd.)*

7.3.2.b. Discharge Risk Assessment and Discharge Planning

Discharge planning is required for all members experiencing a care transition. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.

At the time of the member's discharge, all necessary services that require a prior authorization are processed within the time frames outlined below. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process. All prior authorizations required for the member's post-discharge services are processed within time frames consistent with the urgency of the member's condition, not to exceed five (5) working days for routine authorizations, or 72 hours for expedited authorizations. The discharge planning requirements below should be considered when transfers occur between discharging facilities (general acute care hospital, long-term acute care, and skilled nursing facilities).

All discharging facilities must carry out a discharge planning process that includes the elements outlined below.

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution, or facility.
- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Discharging facility must ensure each member is evaluated for all care settings appropriate to the member's condition, needs, preferences, and circumstances.
- Members are not to be discharged to a setting that does not meet their medical and/or mental health needs.
- Facility utilizes consistent discharge risk assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with discharging facilities' current processes.
    - For high-risk members, discharging facility must share this information with Blue Shield Promise assigned care manager and have processes in place to screen and refer members to longer-term Care Management programs (ECM or CCM) and/or Community Supports, as needed.
    - For members not already classified as high-risk by Blue Shield Promise per above definitions, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to Blue Shield Promise for:

7.3 Transitional Care Services (TCS) *(cont'd.)*

7.3.2.b. Discharge Risk Assessment and Discharge Planning *(cont'd.)*

  - Any member who has a specialty mental health need or substance use disorder.
  - Any member who is eligible for an ECM Population of Focus.
  - Any member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
- Ensures the facility will share discharge instructions/summaries with a Blue Shield Promise assigned Care Manager and member's PCP in a timely manner.
- The Care Manager will work with discharging facilities to ensure the Care Manager's name and contact number is included in key discharge documents. The state mandates that Blue Shield Promise follow-up with:
  - High-risk members within **7 days** post discharge
  - Lower-risk members within **30 days** post discharge
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with discharging facilities' current requirements.
- Notifies post-discharge providers and share clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
- Sends a discharge notification letter to the Primary Care Physician of record within 24 hours of discharge.
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
- Discharge summaries and medication lists must be shared with the Blue Shield Promise Care Manager, the member, the member's caregivers, PCP, and treating providers.
  - This must include a pre-discharge medication reconciliation completed upon discharge that includes education and counseling about the member's medications.
  - A second medication reconciliation must be completed after discharge once the member is in their new setting (post-discharge) and this can be completed by a follow-up provider, such as the PCP, care manager, or another provider with the appropriate license.

7.3 Transitional Care Services (TCS) *(cont'd.)*

7.3.3 Oversight and Monitoring

Blue Shield Promise is accountable for providing all known and identified TCS services in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. For managing care transitions, discharging facilities (general acute care hospitals, long-term acute care hospitals, and skilled nursing facilities) must follow all applicable Code of Federal Regulations, California state laws, Joint Commission requirements, and relevant Blue Shield Promise policies and procedures (e.g., Discharge Planning Policy and Managing Care Transitions Policy).

The hospital/discharging facility's responsibility to perform discharge planning does not supplant the need for TCS. Discharging facilities are required to have their own published policies and procedures that account for the above requirements and those noted in the DHCS PHM Policy Guide to support effective care transitions. Blue Shield Promise will conduct routine oversight and monitoring activities to ensure compliance with DHCS requirements and that key protocols are being followed to provide the highest level of care and services to our members.

7.4. Primary Care Physician Scope of Care

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

PCPs must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for members less than 21 years of age required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) / Medi-Cal for Kids & Teens benefit. All preventive health visits for all members less than 21 years of age at times specified by the most recent AAP Bright Futures periodicity schedule and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. The PCP must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

In addition to preventive services for all enrolled members, the list below includes, but is not limited to, services considered PCP functions. A PCP's scope of care is dependent on the level of training the physician has received, the limitations of scope of practice, and uniformity with state and federal rules and regulations and in accordance with the United States Preventative Services Taskforce (USPSTF) "A" and "B" recommendations. These guidelines are based on routine uncomplicated cases that are ordinarily seen by a PCP.

See www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

7.4. Primary Care Physician Scope of Care *(cont'd.)*

Office/Clinic

Allergy:

- Allergy history
- Asthma, (chronic/acute) active with or without co-existing infection
- Environmental counseling
- Minor insect bites/stings
- Peak flow monitoring
- Treat seasonal allergies, hives, and chronic rhinitis

Behavioral Health Screening and Brief Counseling:

- Annual cognitive health assessments for eligible members 65 years of age or older to identify signs of Alzheimer's disease or related dementias
- Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders as appropriate to provider's scope of practice
- Prescribing of psychotherapeutic drugs
- Referrals for additional assessment and treatment
- Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT): Screen members ages 11 and older, including pregnant women, for unhealthy alcohol and drug use using validated screening tools. Brief behavioral/counseling intervention(s) and appropriate referrals for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable alcohol use disorder (AUD) or Substance Use Disorder (SUD).
- Screening for depression
- Screening for mental health conditions
- Screening for prenatal and postpartum mental health conditions and referrals for mental health services for all pregnant women or women who have delivered in the previous 12 months, as appropriate. Refer to Section 7.8.3: Direct OB/GYN Access for additional information.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

Behavioral Health Screening and Brief Counseling *(cont'd.)*

- Trauma screenings: As required by the DHCS, PCPs must screen children and adults for Adverse Childhood Experiences (ACEs) which research shows are strongly associated with increased health and social risks. Early detection of ACEs and timely intervention can help prevent or reduce these risks and support healing. Screen children for ACEs using a clinically appropriate trauma screening tool at least once per year, and adults at least once per lifetime, in accordance with DHCS' trauma screening guidelines. For more detailed information, visit www.acesaware.org/ and the Blue Shield Promise provider website at www.blueshieldca.com/provider.

Cardiology:

- Evaluate and treat CHF, stable angina, non-life-threatening arrhythmias
- Evaluate and treat coronary risk factors, including smoking, hyperlipidemia, diabetes, HTN, lifestyle
- Evaluate chest pain, murmurs, palpitations
- Evaluate syncope (cardiac and non-cardiac)
- Perform and interpret electrocardiograms
- Provide education and prophylaxis against rheumatic fever or bacterial endocarditis when appropriate

Dermatology:

- Common hair problems including fungal infections, ingrown hairs, virializing causes of hirsutism, or alopecia as a result of scarring or endocrine effects
- Common nail problems including trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails
- Counsel members regarding removal of cosmetic (non-covered) lesions
- Dermal injuries including minor burns, lacerations, and treatment of bites and stings
- Diagnose and treat common hair and nail problems and dermal injuries
- Diagnose and treat common rashes including Contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, seborrheic dermatitis, and tinea versicolor
- Diagnose and treat irritated seborrheic keratosis
- Identify suspicious moles
- Manage mild stasis ulcers
- Screen for basal or squamous cell carcinomas

7.4: Primary Care Physician Scope of Care *(cont'd.)*

Dermatology *(cont'd.)*

- Treat acne (acute and recurrent)
- Treat actinic keratosis excluding face with liquid nitrogen or Efudex
- Treat irritated skin tags < 5
- Treat warts with topical suspensions, electrocautery, liquid nitrogen

Endocrinology:

- Diabetic management and education including Type I and Type II patient
- Diagnose and treat thyroid disorders including multi-nodular goiter
- Member education
- Identify and treat hyperlipidemia
- Obesity management, diet instruction, exercise instruction
- Provide member education and treatment for osteoporosis
- Supervision of Home Blood Glucose Monitoring Testing (coordinate telephonically with member or via home health nurse)

Gastroenterology:

- Diagnose and treat acute diarrhea
- Diagnose and treat chronic ascites under SCP recommendations
- Diagnose and treat chronic jaundice under SCP recommendations
- Diagnose and treat heartburn, upper abdominal pain, pancreatitis, hiatal hernia, acid peptic disease, reflux
- Diagnose and treat functional bowel syndrome
- Diagnose and treat lower abdominal pain
- Diagnose and treat symptomatic, bleeding, or prolapsed hemorrhoids
- Diagnose and treat uncomplicated hepatitis
- Diagnostic endoscopy
- Manage stable inflammatory bowel disease under SCP recommendations
- Occult blood testing
- Screen for colon cancer according to recommended schedule
- Treat protracted vomiting

7.4: Primary Care Physician Scope of Care *(cont'd.)*

General Surgery:

- Diagnose symptomatic gallbladder disease
- Evaluate and follow small breast lumps
- Evaluate hernias (incisional, inguinal, femoral, ventral)
- Incision and drainage of simple soft tissue infections
- Local minor surgery for hemorrhoids
- Order screening mammogram according to approved schedule
- Suture removal

Gynecology:

- Diagnose and treat abnormal vaginal bleeding (excluding post-menopausal bleeding)
- Diagnose and treat vaginitis sexually transmitted diseases including pelvic inflammatory disease
- Diagnose pelvic masses and fibroids
- Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes
- Manage premenstrual syndrome with non-steroidal anti-inflammatory agents, diuretics, and other symptomatic treatment
- Manage post-menopausal syndrome
- Manage stable endometriosis with analgesics and NSAIDs
- Perform routine pelvic exams, PAP smears, birth control, and breast exam
- Provide counseling and manage estrogen replacement therapy
- Screen for prenatal and postpartum mental health conditions and refer for mental health services as appropriate

Hematology:

- Evaluation and treatment of stable Sickle Cell Disease
- Initial differential diagnosis of anemia
- Recognize anemia of chronic disease
- Treat iron deficiency, B12, and folic acid deficiency

Immunizations:

- Immunizations

7.4: Primary Care Physician Scope of Care *(cont'd.)*

Infectious Disease:

- Common infectious diseases (respiratory, gastro-intestinal, dermatological, venereal, urological, gynecological)
- Initial evaluation for HIV positive
- Tuberculosis treatment and prophylaxis
- Viral disorders

Initial Health Appointment:

- An initial health appointment at a minimum must include:
  - a history of the member's physical and mental health,
  - an identification of risks,
  - an assessment of need for preventive screens or services and health education,
  - a physical examination, and
  - the diagnosis and plan for treatment of any diseases.

Nephrology:

- Evaluate and treat common electrolyte and acid-base abnormalities
- Evaluate proteinuria
- Evaluate renal failure

Neurology:

- Annual cognitive assessment of members 65 years or older to identify signs of Alzheimer's disease or related dementias
- Diagnose and treat psycho-physiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, and radiculopathies
- Diagnose and treat tension and migraine headaches
- Manage degenerative neurological disorders with respect to general medical care
- Manage dementia, and stable Parkinson's disease
- Treat stroke and TIA members
- Treat syncope (cardiac and non-cardiac)
- Treat uncomplicated seizure disorders after SPC neurological evaluation

7.4: Primary Care Physician Scope of Care *(cont'd.)*

Ophthalmology:

- Diagnose and treat common eye conditions including viral, bacterial, and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctival hemorrhage, dacryocystitis, and styes
- Perform common eye related services including distant/near testing, gross visual field testing by confrontation, alternate cover testing, direct fundoscopy without dilation, extra ocular muscle function evaluation, red reflex testing in pediatric member
- Perform thorough ophthalmologic history including symptoms and subjective visual acuity
- Removal of simple superficial corneal foreign bodies (i.e., eyelash)

Orthopedics:

- Conservative treatment of chronic knee problems
- Manage chronic pain problems
- Treat cervical, thoracic, and lumbar back pain
- Treat inflammatory conditions
- Treat sprains, strains, pulled muscles, overuse syndromes

Otolaryngology:

- Diagnose and treat acute parotitis and acute salivary gland infections
- Evaluate and treat epistaxis
- Evaluate and treat oropharyngeal infections: Stomatitis, Herpes simplex
- Evaluate neck masses
- Evaluate tympanograms/audiograms
- Perform throat cultures
- Treat acute and chronic sinusitis
- Treat acute otitis media and otitis external
- Treat allergic or vasomotor rhinitis
- Treat serous effusion
- Treat tonsillitis and streptococcal infections
- Remove ear wax, ear irrigations

7.4: Primary Care Physician Scope of Care *(cont'd.)*

Podiatry:

- Basic diabetic foot care and counseling
- Diagnose and treat common foot problems: corns/calluses, bunions
- Initial management of ingrown toenail, to include soaking, trimming and antibiotic treatment

Pulmonology:

- Diagnose and treat asthma, acute bronchitis, pneumonia
- Diagnose and treat chronic bronchitis
- Diagnose and treat chronic obstructive pulmonary disease and emphysema
- Manage home aerosol medications and oxygen
- Promote smoking cessation
- Work up possible tuberculosis or fungal infections

Rheumatology:

- Diagnose and treat degenerative joint disease
- Diagnose and treat inflammatory arthritic diseases
- Diagnose and treat mild rheumatoid arthritis
- Diagnose and treat non-articular musculoskeletal problems: Overuse syndromes, injuries and trauma, soft tissue syndromes, bursitis, or tendonitis
- Diagnose and treat uncomplicated collagen diseases
- Diagnose gout, pseudo-gout
- Manage osteoarthritis.

Urology/Nephrology:

- Diagnose and treat epididymitis and prostatitis
- Diagnose and treat initial and recurrent urinary tract infections including pyelonephritis
- Diagnose and treat urethritis
- Differentiate scrotal or peritesticular masses from testicular masses
- Evaluate and manage BPH
- Evaluate and manage impotence

7.4: Primary Care Physician Scope of Care *(cont'd.)*

Urology/Nephrology: *(cont'd.)*

- Evaluate and treat hematospermia
- Evaluate hematuria
- Evaluate incontinence
- Evaluate prostatism and prostatic nodules
- Initiate evaluation of urinary stones
- Provide long term chemoprophylaxis for recurrent UTI

Vascular:

- Diagnose abdominal aortic/thoracic aneurysm
- Diagnose transient ischemic attacks
- Evaluate and treat varicose veins
- Evaluate carotid bruits
- Evaluate peripheral vascular disease
- Manage intermittent claudication

If the PCP wishes to refer the member to a specialist, prior authorization must be obtained from the delegated IPA/medical group or Blue Shield Promise if the provider is directly contracted (with the exception of self-referable services as outlined in the self-referable section under Utilization Management).

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

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program has been renamed by DHCS in 2023 to "Medi-Cal for Kids & Teens." The Medi-Cal for Kids & Teens benefits and services include the provision of prevention, screening, diagnostic, and treatment services for infants, children, and youth under the age of 21. Medi-Cal for Kids & Teens services are key to ensuring that infants, children, and youth under the age of 21 receive age-appropriate preventive services, including screening for medical, dental, vision, hearing, and mental health, and for substance use disorders, as well as receiving developmental screenings and specialty services.

DHCS uses the American Academy of Pediatrics' (AAP) Bright Futures periodicity schedule and anticipatory guidance to define the required age-appropriate preventive services for infants, children, and youth.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.1: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Medi-Cal for Kids & Teens *(cont'd.)*

Medi-Cal Kids & Teens screening and preventive services cover a broad range of services, including but not limited to:

- Services assigned a grade "A" or "B" recommended by the United States Preventive Services Task Force (USPSTF).
- Advisory Committee on Immunization Practices (ACIP) recommended vaccines.
- Preventive care and screening for infants and children recommended by Health Resources and Services Administration's (HRSA's)/AAP's Bright Futures periodicity schedule and anticipatory guidance.

When a screening indicates the need for further evaluation and follow-up, Medi-Cal Kids & Teens covers diagnostic and treatment services. Necessary referrals should be made without delay and with any and all necessary follow-up to ensure a complete diagnostic evaluation and treatment services are received whenever potential risk is identified. Any necessary health care services to control, correct, or improve health problems discovered by any screening and diagnostic procedures are covered and should be provided.

Treatment services are covered when the services are determined to be "medically necessary" to correct or ameliorate defects and physical and mental illness or conditions, and a service need not cure a condition to be covered under the Medi-Cal Kids & Teens benefits and services that maintain or improve the eligible member under the age of 21 current health condition are also covered under Medi-Cal Kids & Teens because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Maintenance services are covered when they prevent a condition from worsening or prevent the development of additional health problems.

All members under the age of 21 must receive EPSDT/Medi-Cal Kids & Teens 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.

EPSDT/Medi-Cal Kids & Teens benefits also ensures assistance with scheduling appointments and arranging transportation for Medi-Cal covered appointments.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.1: Early Periodic, Screening, Diagnostic, and Treatment (EPSDT)/Medi-Cal for Kids & Teens *(cont'd.)*

EPSDT/Medi-Cal Kids & Teens covered services include the following:

- Audiology
- Case management services
- Cochlear implants
- DME (in certain instances)
- Hearing aids
- Home nursing
- Medical nutrition services assessment and therapy
- Mental health evaluation and services
- Occupational therapy
- Orthodontics
- Pharmacy
- Physical therapy evolution and services
- Psychology
- Pulse oximeters
- Speech therapy

Services for Medi-Cal beneficiaries under age 21 are available when medically necessary and when covered by Medicaid, even if such services are not included in California's Medicaid State Plan (Medi-Cal). Medi-Cal beneficiaries are also eligible for assistance with scheduling appointments and arranging transportation for Medi-Cal covered appointments.

Requested EPSDT/Medi-Cal Kids & Teens services must meet the following medical necessity criteria:

- The services requested meet specific requirements for orthodontic dental services or the provision of hearing aids or other hearing services.
- The services requested are to correct or ameliorate a defect, or physical or mental illness, discovered by an EPSDT/Medi-Cal Kids & Teens screening.
- The supplies, items and/or equipment requested are medical in nature.
- The services requested are not solely for the convenience of the member, the family, the physician, or any other provider of service.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.1: Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)/Medi-Cal for Kids & Teens *(cont'd.)*

- The services requested are not primarily cosmetic in nature or designed to primarily improve the member's appearance.
- The services requested are safe and are not experimental and are recognized as an accepted modality of medical practice.
- The services requested, when compared with alternatively acceptable and available modes of treatment, are the most cost-effective.
- The services requested are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the medical condition of the member.
- The service requested improves the overall health outcome as much as, or more than, the established alternatives.
- The predicted beneficial outcome outweighs the potential harmful effects.

Providers may contact Blue Shield Promise with questions regarding EPSDT/Medi-Cal Kids & Teens or EPSDT/ Medi-Cal Kids & Teens Supplemental Services by calling our Provider Services dedicated number at (800) 468-9935 6 a.m. to 6:30 p.m., Monday through Friday.

7.4.2. Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA)

Medi-Cal covers all medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This includes, but is not limited to, children with autism spectrum disorder (ASD) as well as children for whom a physician or psychologist determines it is medically necessary. Consistent with state and federal requirements, a physician or a psychologist must recommend BHT services as medically necessary based on whether BHT services will correct or ameliorate any physical and/or behavioral conditions.

BHT services include applied behavior analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.

Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.2. Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) *(cont'd.)*

As an exception, Blue Shield Promise is not responsible for payment for services provided under California Children's Services (CCS), or for case management services provided by a state-conducted referral provider such as a regional center.

To recommend BHT/ABA services for a member, an ABA Recommendation Form, completed by a physician or psychologist, should be faxed to 844-283-3298 and our Behavioral Health Treatment team will coordinate a referral and provide authorization to obtain services.

Providers with care coordination questions about Behavioral Health Treatment can contact our BHT Program Team at (888) 297-1325, 8:30 a.m. to 5 p.m., Monday through Friday.

7.4.3: Child Health and Disability Prevention Program (CHDP)

The purpose of the Child Health and Disability Prevention (CHDP) program is to provide all low-income children and youth under 21 years of age complete health assessments for the early detection and prevention of disease and disability in accordance with state and federal requirements.

The Department of Health Care Services (DHCS) transitioned portions of the CHDP Program effective July 1, 2024, to the Medi-Cal managed care plans. Transitioning portions of the CHDP Program aligns with the Department's goal under California Advancing and Innovating Medi-Cal (CalAIM) to reduce administrative complexities, enhance coordination of care and whole person care approach, and increase standardization of care across Medi-Cal by consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.

The CHDP Gateway to Presumptive Eligibility (PE) services granting Medi-Cal benefits for qualifying low-income children and youth are continuing and expanding under the new Children's Presumptive Eligibility (CPE) program, and PE services for individuals over the age of 19 will continue under Hospital Presumptive Eligibility (HPE). The CPE is utilized by

Medi-Cal providers to provide temporary, full-scope Medi-Cal services to low-income children and youth who meet the following criteria for Medi-Cal pre-enrollment:

- Residents of California;
- Younger than 19 years of age;
- Members of a family whose income is at or below 266 percent of the federal poverty guidelines;
- Do not have Medi-Cal eligibility;
- The applicant has not exceeded two PE enrollment periods in the last 12 months; and

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.3: Child Health and Disability Prevention Program (CHDP) *(cont'd.)*

- Additionally, if a child's mother was enrolled in Medi-Cal when going through the PE process, the child will also be deemed eligible. Under PE, a family can quickly and easily enroll their child in temporary full scope Medi-Cal based on a simple attestation of their circumstances. They must then file a full Medi-Cal application to ensure that they are in fact eligible to maintain coverage, but, in the interim, the child can secure prompt access to care for up to a 60-day time period.

To locate a CPE qualified Medi-Cal Provider to apply for Children's Presumptive Eligibility, you must visit a provider who participates, known as a "Qualified Provider."

You can find a "Qualified Provider" online: DHCS CPE Approved Qualified Providers List Childrens-Presumptive-Eligibility (ca.gov).

The DHCS transition of CHDP programs and services does not result in a loss of EPSDT/Medi-Cal Kids and Teens services, as these services are covered in both the Medi-Cal managed care delivery systems and Fee-For-Service (FFS) systems. The provision of EPSDT/Medi-Cal Kids and Teens services is accomplished through Blue Shield Promise providers and/or local health department and/or Local Education Agencies in accordance with Blue Shield Promise or L.A. Care's Memoranda of Understanding (MOU). Blue Shield Promise and Blue Shield Promise providers will ensure the identification, diagnostic screening, assessment, treatment and any necessary specialist referrals of low-income children/youth under the age of 21 years, and to establish effective linkages, care coordination and non-duplication of services for members who are already receiving services from local health department, Local Education Agencies (LEA) such as school districts, county offices of education, charter schools, community colleges, and university campuses, or community-based organizations.

Blue Shield Promise providers are responsible for providing all newly enrolled Medi-Cal members with an Initial Health Appointment (IHA) within 120 days of enrollment. The Initial Health Appointment (IHA) for all members under the age of 21 years consists of a comprehensive health history and physical examination and includes an age-appropriate health education behavioral assessments and screenings as recommended by the Bright Futures American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, also known as the "**Periodicity Schedule**,". a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. Periodicity Schedule guidelines include screenings, assessments, and immunizations schedules for specific age groups recommended at each well-child visit from infancy through adolescence. Please refer to the *AAP Periodicity Schedule https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf for detailed descriptions of these schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence recommendations.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.3: Child Health and Disability Prevention Program (CHDP) *(cont'd.)*

CHDP-Childhood Lead Poisoning Prevention Program (CHDP-CLPP) activities have transitioned to the Medi-Cal managed care plans and the California Department of Public Health (CDPH) Lead Poisoning Prevention Program Branch. DHCS continues to share childhood lead poisoning data with CDPH. The Health Care Program for Children in Foster Care (HCPCFC) public health nursing program located in county child welfare service agencies and probation departments continues to provide public health nurse (PHN) expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care. HCPCFC is a standalone, locally self-administered program. The local CHDP Program is administratively responsible for the HCPCFC. This includes the management of the required interdepartmental Memorandum of Understanding with the local child welfare service agency, probation and health departments.

All members under 21 years of age are to receive an Initial Health Appointment IHA within 120 days of enrollment. An Initial Health Appointment (IHA) consists of a comprehensive health history, assessment of health education needs, complete physical examination, psychosocial/behavioral assessments, and screenings, lab tests, and immunizations appropriate to age and gender. and physical examination and includes an age-appropriate health education behavioral assessment.

Comprehensive Health History and Physical Examination

• Social/Cultural	• Allergies
• Environment	• Illnesses
• Family Health	• Accident
• Prenatal, Birth, Neonatal Development	• Hospitalizations
• Physical Growth	• Immunizations*
• Nutrition	• Communicable Diseases

CHDP standards include screening and immunization schedules for specific age groups. The CHDP health screening also includes a comprehensive health history that collects information on the following areas:

The physical examination must be given while the member is unclothed. Attention, therefore, should be given to the age of the member and their need for privacy.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.3: Child Health and Disability Prevention Program (CHDP) *(cont'd.)*

The physical examination must include, but is not limited to:

• Abdomen	• Hair	• Nose, Throat
• Blood Pressure	• Head Circumference	• Palpation of femoral pulse
• Dental	• Heart	• Screen brachial/radial pulse
• Ears (Audiometry)	• Height and weight, chest	• Skin
• Extremities*	• Lungs	• Spine
• Eyes (Vision Testing)	• Mouth, Gums	
• Genitals (pelvic exam) *	• Neck	

*According to periodicity schedules

Tests are to include the following:

- Risk assessment screening for tuberculosis, with tuberculin test if risks are identified
- Cholesterol screening
- STD screening
- Risk assessment screening for anemia and Hepatitis B, with testing if warranted
- Testing for Sickle Cell Trait
- Lead screening (lead level checks at ages 12 months and 24 months, or between 24 months and 72 months when a child has not had a documented lead screening.

7.4.4: California Regulatory Required Programs

California Statutes and Regulations for Lead Screening for Providers Caring for Children 6 Months to 6 Years of Age

California state statutes and regulations impose specific responsibilities on doctors, nurse practitioners, and physician's assistants doing periodic health care assessments on children between the ages of 6 months and 72 months. These providers must provide oral or written anticipatory guidance to a parent or guardian of the child, including, at a minimum, the information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from 6 months of age to 72 months of age. The anticipatory guidance must be provided at each periodic health assessment, starting at 6 months of age until 72 months of age. In the State of California, "lead screening" means testing an asymptomatic child for lead poisoning by analyzing the child's blood for concentration of lead. California regulations require a blood lead test at 12 and 24 months, or between 24 months and 72 months when a child has not had a documented lead screening. These provider responsibilities apply to all physicians, nurse practitioners, and physician's assistants, and are only a summary of the provider responsibilities.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.4: California Regulatory Required Programs *(cont'd.)*

The blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods. All confirmatory and follow-up blood lead level testing must be performed using blood samples taken through the venous blood sampling method. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a provider may determine additional services that fall within the EPSDT benefit are medically necessary.

Network providers are not required to perform a blood lead screening test if either of the following applies:

a) In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
b) If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

The network provider must document the reason(s) for not performing the blood lead screening test in the child member's medical record. In cases where consent has been withheld, the network provider must document this in the child member's medical record by obtaining a signed statement of voluntary refusal. If the network provider is unable to obtain a signed statement of voluntary refusal because the parent/guardian withheld consent: 1) refuses or declines to sign it, or 2) is unable to sign it (e.g., service provided via telehealth modality), the network provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.

Network providers must follow the current California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. Refer to www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB for the most current guidelines.

Federal Refugee Guidelines for Lead Screening

Refugee health guidelines for lead screening are as follows. Refer to www.cdc.gov/immigrantrefugeehealth/ for more information.

- Initial lead exposure screening with blood test on:
  - All refugee infants and children ≤ 16 years old.
  - Refugee adolescents > 16 years of age if there is a high index of suspicion, or clinical signs/symptoms of lead exposure.
  - All pregnant and lactating women and girls.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.4: California Regulatory Required Programs *(cont'd.)*

- Follow-up testing with blood test 3-6 months after initial testing on:
  - All refugee infants and children ≤6 years, regardless of initial screening blood lead level.
  - Refugee children and adolescents 7-16 years of age who had blood lead levels (BLLs) ≥3.5 mcg/dL.
  - Any child older than 7 years of age who has a risk factor (e.g., sibling with BLL ≥3.5 µg/dL, environmental exposure risk factors) regardless of initial test result.
  - Pregnant or lactating adolescents (<18 years of age) who had BLLs ≥3.5 µg/dL at initial screening.
- All newly arrived pregnant or breastfeeding women should be prescribed a prenatal or multivitamin with adequate iron and calcium. Referral to a healthcare provider with expertise in high-risk lead exposure treatment and management may be indicated for BLLs at or above 3.5 µg/dL.

California Vaccines for Children (VFC) Program

- The California Vaccines for Children (VFC) program supplies free vaccines to children less than 19 years old who qualify for Medi-Cal, are uninsured, or are American Indian or Alaska Native. The VFC program supplies vaccines at no cost to enrolled providers to administer to eligible children between the ages of 0-18 years. All CHDP providers are required to participate in the VFC program in California and be in good standing. Blue Shield Promise strongly encourages all providers who provide immunizations to children 0-18 years to participate in the VFC program and promotes and supports enrollment in the VFC program by including information about the California Vaccines for Children program (California Vaccine Programs – California Vaccines for Children (VFC) (https://eziz.org/vfc/).

All Blue Shield Promise providers must maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities in an acceptable and timely manner, engage with local health departments, and implement directives from the public health authorities as required by law.

All Blue Shield Promise providers must implement directives from the public health authorities in a timely fashion.

All Blue Shield Promise providers are required to comply with California state regulations regarding the mandatory reporting of specific diseases and conditions. A list of reportable diseases, the form on which the diseases and conditions should be reported, and reporting instructions can be found on the California Department of Public Health website at www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph110a.pdf.

7.4: Primary Care Physician Scope of Care *(cont'd.)*

7.4.4: California Regulatory Required Programs *(cont'd.)*

1. Please note that a health care provider's failure to report those diseases and conditions mandated by Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, 1364.10 and 1364.11). In addition, failure to report is a citable offense and subject to civil penalty ($250) per Health and Safety Code 105200. Please consult the California Department of Public Health website at www.cdph.ca.gov for additional information about California state regulations regarding the mandatory reporting of specific diseases and conditions and consult with your local county public health departments for county specific mandatory reporting information.

7.5: Authorization and Review Process

7.5.1: Authorization Time Frames

Inpatient and outpatient referral requests for Blue Shield Promise members that are received from primary care and specialty care physicians will be processed according to priority status within the following designated time frames.

Emergency Post-Stabilization Service Request: Within **30 minutes** of verbal request.

Emergency Care Request: Requires no prior authorization

Standard Request: Within five (5) working days of the receipt received within the UM Department of the information reasonably necessary to make a determination.

Urgent Request: Within 72 hours of the receipt received within the UM Department of the information reasonably necessary to make a determination.

Urgent referrals received by telephone will be either processed immediately by non-clinical staff (based on extension of authority under which certain requests can be administratively approved) or directed to a UM Clinician or to the CMO when mandated, in order to make an immediate decision. The provider will be instructed to follow up with a faxed copy of the request with all medically necessary and appropriate information to justify the request.

Urgent referrals are immediately forwarded for processing. The requesting provider's office will be contacted telephonically or via fax within 24 hours of determination informing them of the authorization decision for the requested service(s). Providers and members will be sent written confirmation of the determination within two (2) calendar days of decision.

Refer to Appendix 12: Utilization Management Timeliness Standards for the standards for each type of request.

7.5: Authorization and Review Process *(cont'd.)*

7.5.2: Authorization Validity

Authorizations are generally approved for 180 days with a disclaimer stating that authorizations are valid only if the member is eligible on the actual date of service. Due to the fact that member eligibility is on a month-to-month basis, Blue Shield Promise Health Plan providers must verify member eligibility prior to delivery of non-emergency services. Eligibility can be verified for most members 24 hours a day, seven (7) days a week by calling Blue Shield Promise Member Services at (800) 605-2556 (TTY (800) 735-2929). Providers are responsible for re-verifying eligibility and obtaining an updated authorization once it has expired.

7.5.3: Specialty Referrals

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

When, in the opinion of the PCP, a member referral to a specialist is indicated, a request shall be submitted to the member's assigned IPA/medical group's UM Department for review and authorization. Treatment requests for members assigned to Blue Shield Promise Direct are to be faxed to the Blue Shield Promise UM Department with the exception of services established as no prior authorization required under the direct referral process. Out-of-Network requests require prior authorization.

The following information must be provided in order to process the pre-authorization request:

- Working diagnosis
- PCP evaluation to date
- Treatments performed to date
- Clinical justification for the referral request
- Any other relevant medical history

Urgent requests may be received via fax or telephone. If a request is received via telephone, it is to be followed by a fax.

The PCP's office shall maintain a log indicating the member information, date of request, type of specialist, clinical reason for referral and the authorization number. The specialist is required to send a completed consultation report to the PCP.

After the review of the consultation results and recommendations, the PCP may request additional treatment authorization if clinically indicated. Contracted specialists also have the option to request additional treatment/care directly from the UM Department, providing the specialist forward the consultation/ follow up care and treatment results to the member's PCP to be added as part of the member's medical record.

7.5: Authorization and Review Process *(cont'd.)*

7.5.4: Ancillary Referrals

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

Ancillary services may be requested by a practitioner other than the member's assigned PCP only if the requesting party is a participating physician to whom the member has a current authorization by the UM Department for consultation and treatment.

7.5.5: Outpatient Services

Ambulatory services and outpatient surgery procedures require authorization by the UM Department. Providers can be held financially at risk for non-emergent services performed at their facilities without prior authorization. Services must be provided by the member's PCP or the designated physician that has been given authorization by the UM Department for consultation and treatment. In the event that the service cannot be provided in network, an authorization will be conditionally approved by the Plan. Further information regarding out-of-network providers is covered subsequently in the manual.

The clinical staff will use clinically sound, medically appropriate criteria sets to evaluate necessity for outpatient and inpatient surgery. The ability to perform surgery on an outpatient basis merely indicates that post-operative care does not require overnight stay in an acute care hospital. A facility authorization for routine outpatient surgery can be obtained through the Blue Shield Promise UM Department.

IPA/medical groups are required to submit the approved IPA/medical group authorization requests to the UM Department prior to scheduling the procedures, with the exception of full risk IPA/medical groups.

If an outpatient surgery of an acute hospital based ambulatory procedure is performed on an urgent/emergent basis, authorization will be obtained in the same manner as any urgent/emergent service.

When the authorization number is given, the caller will be advised that the number is for outpatient surgery only and that if the member requires an inpatient admission status the Blue Shield Promise UM Department must be notified.

When the Blue Shield Promise UM Department is notified that a scheduled outpatient surgery has been converted to an inpatient status, a Clinician will implement the admission and concurrent review procedures.

7.5: Authorization and Review Process *(cont'd.)*

7.5.6: Elective Admission Requests

All elective inpatient admissions require authorization by the Blue Shield Promise UM Department. Requests for elective inpatient admissions must be obtained from either the member's PCP or from another physician/provider to whom the member has current authorization from the UM Department for consultation and treatment. A request for an elective admission will be communicated to the Blue Shield Promise UM Department by fax or telephone, as indicated by the urgency/timeliness of the request. Whenever possible, these requests should be made no less than five (5) business days prior to projected elective inpatient confinement.

If there is sufficient clinical information to determine that admission criteria are satisfied, the admission will be authorized. The Plan uses MCG Guidelines. Pre-determined lengths of stays are not assigned. Consideration has been given to the fact that each case may have different circumstances and that the recommended LOS (Length of Stay) serves as a guideline only.

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

7.6: Emergency Services and Admission Review

7.6.1: Emergency Services

Emergency Medical Condition means a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain, such that a reasonable person would expect that the absence of immediate medical attention could result in imminent and serious threat to health including (1) placing the member's health in serious jeopardy due to potential loss of life, limb, or other bodily function, or serious dysfunction of any bodily organ or part; (2) with respect to a pregnant woman who is having contractions, an emergency medical condition is also a situation in which (a) there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) transfer may pose a threat to the health or safety of the woman or the unborn child; or (3) a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function, and does NOT require prior authorization.

Emergency Psychiatric emergency medical condition means a mental health disorder that manifests itself by an acute symptom of sufficient severity that it renders the patient as being either of the following regardless of whether the patient is voluntary or involuntary detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division of the Welfare and Institutions Code):

(A) An immediate danger to themselves or others.

7.6: Emergency Services and Admission Review *(cont'd.)*

7.6.1: Emergency Services *(cont'd.)*

(B) Immediately unable to provide for, or utilize, food, shelter or clothing, due to the entalmental health disorder.

Psychiatric emergency medical condition is considered a mental disorder that manifests itself by acute symptoms of sufficient severity to render the patient either an immediate danger to himself or others, or immediately unable to provide for, or utilize food, shelter, or clothing, due to the mental disorder. This may include admission or transfer to a psychiatric unit within a general acute care hospital, or to an acute psychiatric hospital.

Emergency Services and Care means medical screening, examination, evaluation, and treatment to relieve and eliminate the emergency medical condition by a physician, or other appropriate personnel to the extent permitted by applicable law and within the scope of their licensure and privileges. It also means additional screening, examination and evaluation and treatment to relieve or eliminate the psychiatric emergency medical condition by a physician, or other appropriate personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.

Life Threatening or Disabling Emergency

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

Medical Screening Exam is the hospital emergency departments under Federal and State laws are mandated to perform a medical screening exam (MSE) on all patients presenting to the Emergency Department (ED). Emergency services include additional screening examination and evaluation needed to determine if an emergency medical condition exists. Blue Shield of California Promise will cover emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

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.

Business Hours

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

7.6: Emergency Services and Admission Review *(cont'd.)*

7.6.1: Emergency Services *(cont'd.)*

If the PCP intends to refer the member to an ED, the PCP must call the ED to authorize the treatment. The physician's name, date, and time of the authorization will be documented in the ED medical record. If the member seeks treatment at an ED without prior approval from the PCP, the ED will triage the member and call the PCP for approval to treat the member. It is the responsibility of the PCP to grant the authorization for treatment under these circumstances.

After Business Hours

After regular Blue Shield Promise business hours, member eligibility is obtained, and notification is made by calling the 800 number on the member ID card. The 800 number connects to a 24-hour multilingual information service, which is available to members as well as to providers. Blue Shield Promise UM Clinicians are available after hours to assist with post-stabilization care transitions. Blue Shield Provider Customer Service 24/7 contact is 800-468-9935. **THIS IS NOT A MEDICAL ADVICE SERVICE**. In the event that a member calls for advice relating to a clinical condition that they are experiencing and believe based on their perception that it is urgent/emergent, the member will be advised to go to the nearest emergency room or to call 911.

The following are some of the key services the on-call UM Clinicians will provide:

- Facilitate urgent/emergent treatment authorization numbers to providers.
- Facilitate member transfers from emergency departments to contracted hospitals or California Children's Services (CCS) paneled facilities when applicable.
- Arrange facility transfer ambulance transport services.
- Provide providers with network resource information.
- Link Blue Shield Promise contracted physicians to ED physicians when necessary.

For additional support, the on-call nurse has access to the covering physician, or an alternate covering physician, to assist in physician related issues. A Blue Shield Promise Medical Director or licensed physician acting on behalf of the medical director is available 24 hours a day, seven days a week to assist with access issues. A Blue Shield Promise Medical Director is available should there be a need for a Peer-to-Peer review. Upon receipt of a request for authorization from an emergency provider, a decision will be rendered by Blue Shield Promise within 30 minutes, or the request will be deemed as approved. If assistance is necessary for directing or obtaining authorization for care after the immediate emergency is stabilized, the on-call nurse will assist as the liaison to PCPs, specialists, and all other providers to ensure timely access and the effective coordination of all medically necessary care for the member.

7.6: Emergency Services and Admission Review *(cont'd.)*

7.6.2: Urgent/Emergent Admissions

Prior authorization is not required for emergency room admissions (see Emergency Services for definition of "emergency medical condition and emergency psychiatric condition"). If the ER post-stabilization results in an inpatient admission, the provider is required to notify Blue Shield Promise within 24 hours of the admission. For San Diego County members, notification can be made by fax at (619) 219-3301 or phone at (800) 468-9935. For Los Angeles County members, notification can be made by fax at (323) 889-6579 or phone at (800) 468-9935. PCP admission notification will be sent within 24 hours of the admission. If a provider requests authorization for post-stabilization care, Blue Shield Promise shall render a determination on behalf of a member within 30 minutes of the request.

If not done within the required time frame, the authorization request will be deemed approved. If the post-stabilization care, received within or outside the network, fails to be approved or disapproved within 30 minutes of a complete request submitted to Blue Shield Promise, the medical care will be deemed authorized.

- The attending emergency physician or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor.
- If there is a disagreement between Blue Shield Promise and the treating physician regarding the need for necessary medical care, following stabilization of the enrollee, Blue Shield Promise will assume responsibility by collaborating with the emergency provider.
- If assistance is needed in directing or obtaining authorization for care after the immediate emergency is stabilized, the on-call nurse will assist as the liaison to PCPs, specialists, and all other providers to ensure timely access and the effective coordination of all medically necessary, or under circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.

Blue Shield Promise's Chief Medical Officer or a covering physician is available 24 hours per day 7 days per week to consult with the on-call UM clinician or emergency room personnel.

PCP Notification

The member's PCP is to be contacted, if at all possible, prior to urgent/emergent hospital admission to discuss medical appropriateness and routing of the admission. Upon contact, the PCP will discuss the member's case with the ED physician. If the case meets admission criteria, the PCP will authorize the admission under their care or opt to call in another physician of their choice. If the member is in a non-contracted hospital, the PCP at that time may determine if the member is medically stable for transfer to a contracted facility.

Plan Notification

All contracted per-diem hospitals are responsible to notify inpatient admissions to the Blue Shield Promise UM Department within 24 hours of admission. Upon receipt of the hospital admission notification, the UM Department will respond back to the hospital with a Blue

7.6: Emergency Services and Admission Review *(cont'd.)*

7.6.2: Urgent/Emergent Admissions *(cont'd.)*

Shield tracking or authorization number within 24 hours of notification.

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

7.6.3: Concurrent Review

Blue Shield Promise provides for continual reassessment of all acute inpatient care. Other levels of care, such as partial day hospitalization or skilled nursing care may also require concurrent review at the discretion of Blue Shield Promise. Review may be performed telephonically, through access of a facilities Electronic Medical Record (EMR) or by reviewing clinical records faxed into Blue Shield Promise. Upon admission notification, contracted providers are given approval for the admission day. In addition, an admission notification letter is sent to the documented PCP. Concurrent review is conducted thereafter to ensure medical necessity and the member's care is delivered in the most appropriate setting. The date of the first concurrent review will generally occur on the second hospital day. The benefit of this process is to identify further discharge planning needs the member may have due to unforeseen complications and/or circumstances.

Clinical information may be obtained from the admitting physician, the hospital electronic medical record, or the hospital Utilization Review (UR) Nurse. The Blue Shield Promise UM Clinician established medical necessity using evidence based clinical guidelines and provides the determination for the request within regulatory turnaround times. If the member remains an inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized are variable and are based on the medical necessity for each day of the member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the UM Clinician and the CMO.

7.6.4: Retrospective Review

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

All retrospective review referrals are to be turned around within 30 working days of obtaining all necessary information. Notification of retrospective review denials will be in writing to the member and the provider.

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

7.7: Authorization Denials, Deferrals, and Modifications

A denial, deferral, and/or modification of a treatment authorization request may occur so that more information can be obtained, or a recommendation of alternative care may be made during the authorization process. Other than when the member is not eligible, only physicians will make denial of service determinations. The signature of the Chief Medical Officer (CMO) or the reviewing physician is required on the denied referral request authorization form.

At the request of the Primary Care Physician (PCP), providing physician, member or member representative, such decisions may be referred for reconsideration or appeal for additional review and determination.

Blue Shield Promise or the delegated IPA/medical group will send written notification of an authorization request denial, deferral, and/or modification to the member, the member's PCP, and/or Attending Physicians according to the provisions below:

- The PCP and/or the requesting provider will be notified within 24 hours of determination; and sent a written or electronic confirmation within two (2) working days of the determination.
- The communication to the provider shall include the name and telephone number of the health care professional responsible. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
- The member will be sent written confirmation within 2 working days of the determination.
- For concurrent care within 72 hours of the request, electronic or written.
- Denial of services rationale includes a reference to the specific clinical guideline that was used to make the determination. Providers and members can request a copy of the specific criteria set used.
- The disclosure shall be accompanied by the following notice: "The guidelines that were used by Blue Shield Promise for your case are used by the Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need."
- Criteria/guidelines, specific to the care being delivered or requested, will be made available upon request to the provider or member via phone to the UM Department at (800) 468-9935, via fax to the UM Department at (800) 889-6577, or request via mail to UM Department at Blue Shield Promise Health Plan, 3840 Kilroy Airport Way, Long Beach, CA 90806-2452. The written notification shall include the following elements:
- The notice to the member will inform the member that they may file an appeal concerning the determination using the appeal process (as prescribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process.

7.7: Authorization Denials, Deferrals, and Modifications *(cont'd.)*

- How to initiate an expedited appeal at the time they are notified of the denial.
- The member's right to, and method for obtaining, a State Fair Hearing.
- The member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel or another spokesperson.
- The name and address of the entity making the determination.
- The State's toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Corporation's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the member's satisfaction.

Included within the denial letter to members and providers are the specific reason(s) for the denial in clear and concise language, including reference to the provision, guidelines, protocol, or other similar criterion on which the denial determination and, if possible, alternative treatments or care. The reason(s) for the denial must be translated into the member's preferred language or alternative format (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files).

No authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reasons including, but not limited to subsequent rescissions, cancellations, or modification of the member's contract or when the Plan did not make an accurate determination of the member's eligibility.

7.8: Referrals

7.8.1: Second Opinion

The member, the PCP, or a participating health professional that is treating an enrollee may on occasion request a second opinion for an office visit consultation prior to surgery to evaluate treatment options, assist with a diagnosis, or validate the need for specific procedures. The CMO will evaluate the medical necessity of an authorization referral request that is submitted formally for a second opinion consultation. An expert panel list is maintained and utilized for second opinion consultation referrals consisting of a board-certified specialist in each area of medicine.

Second opinions **when medically necessary** will be done by an "appropriately qualified healthcare professional" not previously involved in the member's treatment plan.

"Appropriately qualified health care professional" is defined as a Primary Care Physician or specialist acting within his or her scope of practice, and with a clinical background including training and expertise related to the condition associated with the second opinion request.

7.8: Referrals *(cont'd.)*

7.8.1: Second Opinion *(cont'd.)*

Second opinion referral requests will be processed within a standard time frame based on the status of the request. When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function or timeliness that would be detrimental to the member's ability to regain maximum function, the second opinion determination shall be rendered as followed:

- **Urgent** - Within 72 hours
- **Routine** - Within 5 working days

Reasons for a second opinion shall include, but are not limited to, the following:

- If the member questions the reasonableness or necessity of a recommended surgical procedure.
- If the member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including (but not limited to) a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- If the member was not approved for an organ transplant program.

7.8.2: Self-Referable Services (Medi-Cal)

Blue Shield Promise Medi-Cal members have freedom of choice in obtaining certain specified services such as family planning, HIV testing, and care for sexually transmitted diseases (STDs). These services are self-referable both in-network and out-of-network. If the member chooses to self-refer to any willing provider, including out-of-network providers, these services will be covered without pre-authorization.

7.8: Referrals *(cont'd.)*

7.8.2: Self-Referable Services (Medi-Cal) *(cont'd.)*

The following list includes services that-will be covered without prior authorization.

Description
Abortion Services (in accordance with APL 24-003)
Family Planning
HIV Testing
Sensitive Services for Minors (in accordance with APL 24-019)
Sexually Transmitted Diseases (STDs) Treatment

Blue Shield Promise maintains a list of preferred providers for highly specialized tertiary level care. All reasonable attempts will be made to route non-network care to these providers when applicable.

In most cases, payment for self-referable out-of-network services will be limited to the Medi-Cal fee schedule. As necessary, please refer to the State published document (MMCD Letter No. 94-13) on family planning and STDs. A copy of the document will be furnished to Blue Shield Promise providers upon request.

7.8.3: Direct OB/GYN Access

Blue Shield Promise members have the option to seek obstetrical and gynecological (OB/GYN) physician visits directly from an obstetrician and gynecologist or directly from a family practice physician providing obstetrical and gynecological services without prior approval from another physician, another provider, or the health care plan on an unlimited basis, as defined under the evidence of coverage in the Member Handbook.

Blue Shield Promise's policy is to use contracted/participating providers, as well as medical necessity utilization protocols for any OB/GYN services rendered to a member by a participating physician. The OB/GYN will be required to communicate to the member's PCP all pertinent medical information that has occurred from such an encounter in order to maintain the continuity of care for that member. An outline of the required provisions is as follows:

1. Referrals must be made to Blue Shield Promise contracted OB/GYN physicians only.
2. Routine and preventive health care services including breast exams, mammograms, and pap tests.
3. Payment for the level of the consultation/follow-up that is indicated on the claim shall be established from the documentation sent along with the claim to substantiate the medical necessity for payment at that level.
4. Any recommended treatments, procedures or surgeries will require prior authorization.

7.8: Referrals *(cont'd.)*

7.8.3: Direct OB/GYN Access *(cont'd.)*

5. Any OB/GYN who is also a PCP will be able to self-refer directly for OB services. Further treatments, procedures, or surgeries will require prior authorization from the Blue Shield Promise UM Department.
6. Any OB/GYN who is a PCP will provide all GYN services, other than prior authorized surgeries and procedures included under the capitated primary care services payment agreement contract.

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

Blue Shield Promise has developed a Maternal Mental Health Program to assist participating practitioners and delegated entities in implementing the requirement. In compliance with SB 1207, this Maternal Mental Health Program is consistent with sound clinical principles and processes, and includes quality measures that encourage screening, diagnosis treatment and referral.

Providers may visit the Blue Shield Promise provider website Maternal Mental Health Services Program link at https://www.blueshieldca.com/en/bsp/providers/programs/maternity-program to view information on required frequency of maternal mental health screenings, approved screening tools, and the appropriate codes to submit with encounters data once the screening has occurred. Blue Shield Promise must ensure that providers conduct at least one mental health screening during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings as medically necessary.

Providers may also reference Section 7.9.4 to view information on the required Comprehensive Perinatal Services Program (CPSP) in addition to required obstetric provider care for all pregnant and postpartum Blue Shield Promise members.

7.8.4: Independent Medical Review

The independent medical review (IMR) is an expansion of the appeal process. Refer to Section 6.3: Independent Medical Review.

7.8: Referrals *(cont'd.)*

7.8.5: Continuity of Care

Blue Shield Promise will ensure that a member with the following conditions can request to remain with a terminated/non-contracted provider until a safe transfer to a Blue Shield Promise provider can be made, and it is consistent with good medical practice.

1. Acute Condition
2. Serious Chronic Condition
3. Pregnancy: defined as the three trimesters of pregnancy and the immediate postpartum period, including maternity mental health. Completion of covered services shall be provided for the duration of the pregnancy; the completion of covered services shall not exceed 12 months. The postpartum period begins immediately after childbirth and extends for 12 months.
4. Terminal Illness
5. The care of a newborn child between birth and age 36 months
6. Performance of a surgery or other procedure that is authorized by the plan
7. OON Specialty Mental Health Services (SMHS) provider where member's mental health condition has stabilized, and member no longer qualifies for SMHS Services

Definitions

"Acute condition" Is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

"Continuity of care" Is ensuring that a member's care is appropriately managed as the member moves through the health care delivery system, follow up care is provided, and the member's medical records and history follows the member from provider to provider.

"Delegated" Defers responsibility for the activity as defined by contractual agreement.

"Serious chronic condition" Is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

1. Persists without full cure or worsens over an extended period of time.
2. Requires ongoing treatment to maintain remission or prevent deterioration.

"Terminated provider" Is a provider/physician whose contract to provide services to Blue Shield Promise members is terminated or not renewed by the Plan or one of the Plan's contracting provider groups.

1. If the provider was contracted with Blue Shield Promise or the IPA/medical group and the contract was terminated, the fee will be based on the contractual agreement prior to the termination.

7.8: Referrals *(cont'd.)*

7.8.5: Continuity of Care *(cont'd.)*

2. The time frame for members undergoing continued care with a terminated or non-contracted provider is up to 12 months. This time frame may be extended in order for the member's care to be transferred safely.

Process

1. Acknowledgment of the Continuity of Care request will be made within the timeframes specified below, advising the member that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. Notification to the member will be using the member's known preference of communication or by notifying the member using one of these methods in the following order: telephone call, text message, email, and then notice by mail:
    - For non-urgent requests, within seven (7) calendar days of the decision.
    - For urgent requests, within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three (3) calendar days of the decision.
2. Continuity of care considerations will be made in accordance with the urgency of the member's condition at the time of such a request.
3. Continuity of care considerations are applicable only to those circumstances when the member has an acute or serious chronic condition, high risk or late term pregnancy, terminal illness, care of a newborn up to 36 months, and/or performance of a surgery or other procedure that is authorized by the plan. Continuity of care is provided through the postpartum period for members in their second or third trimester of pregnancy.
4. If it is a non-contracted provider and there is no agreement between Blue Shield Promise and the provider, then Blue Shield Promise or the IPA/medical group shall pay the provider similar rates as those paid to similar providers for similar services within a similar geographical region.
5. If the provider does not accept the payment rate, then Blue Shield Promise or the IPA/medical group is not obligated to continue care with the provider.
6. The provider shall be bound to Blue Shield Promise's contractual requirements for quality assurance, utilization review and credentialing.
7. Blue Shield Promise will monitor the care provided by requiring the provider to submit ongoing treatment plans, progress notes and other appropriate medical record information.
8. Blue Shield Promise will coordinate the exchange of the member's medical record information from the non-contracted/terminated provider to the Blue Shield Promise provider when the member's condition allows for such a transition.
9. Members may file requests with Blue Shield Promise or the IPA/medical group for continuity of care when they are SPD (Seniors & Persons with Disabilities) members, newly enrolled converting from Medi-Cal Fee for Service via telephone, facsimile, or by mail.

7.8: Referrals *(cont'd.)*

7.8.6: Reconstructive Surgery

Reconstructive surgery, as defined below, is a covered benefit for Blue Shield Promise members; however, coverage for cosmetic surgery as defined is excluded.

Definitions

"Reconstructive surgery" Is defined as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, tumors, infections, trauma, or disease to do either of the following:

1. Improve function.
2. Create a normal appearance, to the extent possible.
3. In the case of transgender members, gender dysphoria is treated as a "developmental abnormality" for purposes of the reconstructive statute and "normal" appearance is to be determined by referencing the gender with which the member identifies. (See UM Policy 10.2.28 Transgender Services.)

"Cosmetic surgery" Is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

A procedure might be considered either cosmetic or medical depending on the reason for it (e.g., breast reduction surgery for pain).

Requests for reconstructive surgery for members to correct a condition which has resulted in a functional defect or has resulted from injury or surgery and has produced a major effect on the member's appearance will generally require review by the Chief Medical Officer (CMO) or a physician reviewer.

Submitted documentation of medical necessity should include all of the following:

1. Brief medical history
2. Condition being corrected
3. Date of injury (if applicable)
4. Symptoms
5. Length of time symptoms were present
6. Previous treatment attempted
7. Applicable operative reports
8. Applicable photographs

Physician Reviewer Evaluation

The reviewing physician may forward the case to a Blue Shield Promise specialty advisor for evaluation and determination.

7.8: Referrals *(cont'd.)*

7.8.7: Standing Referral

Blue Shield Promise members that require ongoing extended access to specialty care for chronic, disabling, life-threatening or degenerative conditions will qualify for the standing referral policy. The policy applies to those circumstances where the coordination of the specialty care for such a condition has become the principal care for the member.

A request for a standing referral to a specialist may be initiated by the member, the PCP, or the Specialty Care Physician (SCP), when the member has a chronic, disabling, life threatening or degenerative condition requiring extended access for continued treatment and care, and it has been deemed necessary by Blue Shield Promise.

Provisions for Requesting a Standing Referral

1. Request is made by the member's PCP, SCP, or the member.
2. Request is to be made to a Blue Shield Promise Contracted Specialist.
3. Request will be reviewed and agreed to between the PCP and SCP and submitted to the Plan or delegated medical group.

Standing referral requests will include:

1. Member diagnosis.
2. Required treatment.
3. Requested frequency and time period.
4. Relevant medical records.

Provisions for Requesting Extended Access to a Specialist

1. Request is made by the member's PCP or Specialist.
2. Request is related to a life threatening or degenerative condition, or there are disabling factors involved in the request.
3. Request will be reviewed and agreed to by both the PCP and Specialist and submitted to the plan or delegated Medical Group.
4. Requesting PCP or Specialist will indicate the health care services the Specialist will be managing and detail those that will be managed by the PCP.

Review and Determination

1. Authorizations are only required for services identified on the Prior Authorization List or if the provider is out of network (OON).
2. Requests are reviewed by the CMO or medical director designee.
3. Determination will be provided within three (3) business days of receiving all necessary records and information.
4. Communication of the determination to the member and involved practitioners will be provided within two (2) business days of the determination.

7.8: Referrals *(cont'd.)*

7.8.7: Standing Referral *(cont'd.)*

5. Approvals shall include:
   a. Number of visits approved.
   b. Time period for which the approval will be made.
   c. Extension request process.
   d. Standard reporting required from the Specialist to the PCP and /or the Plan delegated group physician reviewer.
   e. Process for requesting further referrals, if needed.
   f. Clause specifying: "… member eligibility is to be determined at the time services are provided…"

Specialist Communication Guidelines to Primary Care Physician

1. Specialists will provide information to the PCP on the progress and or any significant changes in the member's condition.
2. PCP will maintain all communicated information in the member's medical record.

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

7.9.1: California Children's Services (CCS)

California Children's Services (CCS) is a Medi-Cal benefit provided by the State in partnership with County Public Health Departments. Blue Shield Promise coordinates the benefits for eligible members. The CCS program provides medical case management, diagnostic and treatment services, and physical and occupational therapy services to children under the age 21 with CCS eligible medical conditions managed by CCS paneled providers. The program's goal is to provide medical and allied services necessary to achieve maximum physical and social function for children. Members identified with CCS-eligible conditions are referred to the County CCS program immediately upon identification.

When a member is identified as meeting the criteria for the CCS Program, the member/ member's family or designee will be contacted by a Blue Shield Promise employee to discuss the CCS Program. For newly enrolled members, or existing Medi-Cal beneficiaries transitioning to Blue Shield Promise, Blue Shield Promise maintains a process by which a CCS-eligible child or youth may maintain access to CCS providers and receive assistance in coordination with the new PCP. For children/youth with an established relationship with an out-of-network provider and are requesting continuity of care, Blue Shield Promise will follow the health plan benefits eligibility guidelines based on Department of Health Care Services (DHCS) requirements.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.1: California Children's Services (CCS) *(cont'd.)*

7.9.1.1 CCS Provider Training

The CCS Program maintains mechanisms to ensure that all contracted providers are informed of and adhere to the following:

- CCS program eligibility requirements
- The need to identify potentially eligible children
- How to refer to the CCS program

For all new providers and IPAs, program training will be presented in the New Provider Training material as well as upon request of a provider or IPA. Training opportunities can also be identified during the annual delegation oversight audits. At a minimum, training will occur at least annually in the form of provider updates emails, newsletters, or e-broadcasts via the Blue Shield Promise Provider Connection website. Blue Shield Promise maintains a process to review Blue Shield Promise provider's qualifications for CCS provider panel participation and encourages those qualified to become paneled. Blue Shield Promise also maintains access to a list of those facilities designated with CCS approval, including hospitals and Special Care Centers.

7.9.1.2 Provider Communications

Blue Shield Promise is responsible for ensuring the provider network is aware of members eligible for or receiving services through the CCS program. Blue Shield Promise shall be responsible for generating and distributing to its IPAs, a report of members identified as being eligible or authorized to receive CCS services received from CCS. Blue Shield Promise will send these reports to its delegated IPAs and contracted providers on a monthly basis. Blue Shield Promise and its delegated IPAs and contracted providers will work with the local CCS office to ensure the member is receiving appropriate medical care and that coordination of care is documented in the member's medical record and/or its delegated IPAs will undertake regular activities, such as review of encounter data necessary to identify members with potential CCS conditions and ensure appropriate referrals to CCS. Blue Shield Promise CCS Nurses are responsible for informing the member's PCP of the member's CCS eligibility.

7.9.1.3 CCS Program Referrals

Initial referrals of members with CCS-eligible conditions are made to the local CCS program by telephone, same-day, or fax. Followed by receipt of supporting medical records, to allow for eligibility determination by the local CCS program. Blue Shield Promise providers are responsible for continuing to provide all medically necessary covered services to the member until CCS eligibility is confirmed.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.1: California Children's Services (CCS) *(cont'd.)*

7.9.1.3 CCS Program Referrals *(cont'd.)*

Once eligibility for the CCS program is established for a member, Blue Shield Promise providers shall continue to provide all medically necessary covered services that are not authorized by CCS. Blue Shield Promise shall ensure the exchange of medical record information, coordination of services and joint case management between the PCP, the CCS specialty providers, and the local CCS program.

If the local CCS program does not approve eligibility, Blue Shield Promise remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, Blue Shield Promise remains responsible for obtaining and paying for the services provided.

Blue Shield Promise's contracted physicians or IPA Health Services staff shall assist in the coordination of care between PCP's, CCS Specialty providers, and the local CCS program. All members who are referred to CCS or confirmed to have a CCS-eligible condition shall be managed monitored and offered by Case Management services. The CCS program authorizes payments to Blue Shield Promise network physicians who are CCS Paneled and provide services related to the CCS eligible condition. Blue Shield Promise shall submit information to the CCS program of those members who have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by Blue Shield Promise or a network physician shall be allowed until the next working day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

7.9.1.4 CCS Care Management

The Blue Shield Promise CCS Program will be responsible for needed case management of all identified CCS-eligible members and authorized medically necessary care. When a member meets criteria for the CCS Program, the member/member's family or designee is contacted telephonically or via mail by a Blue Shield Promise employee to discuss their condition and enroll them in the CCS Children's Care Management Program. The CCS Program will be responsible for case management of all identified CCS-eligible members and authorizes medically necessary care.

The Blue Shield Promise UM Department and Population Health Management Children's Services can serve as a link between Blue Shield Promise PCPs, providers, and specialists as appropriate and the CCS Program. This will be done by appropriately identifying and channeling all potential/applicable referrals to CCS in accordance with the specified program standards.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.1: California Children's Services (CCS) *(cont'd.)*

7.9.1.5 CCS Age Out and Transition of Care Coordination Program

Blue Shield Promise maintains a care management coordination program to assist CCS-eligible members nearing the age of 21 years or who are transitioning out of CCS due to the completion of CCS services. The age-out program begins once a member reaches 17 years of age and remains on the CCS report as CCS-eligible members will receive communication informing them of the available services in assisting the member/member's family or designee in planning toward the upcoming transition to an adult care provider.

CCS Blue Shield Promise Case Managers are available to assist the family in identifying appropriate options available to the member, such as specialty services, specialty hospitals, medications, durable medical equipment, etc. For unmet social needs, members/member's families may be referred to a PHP Social Worker for assistance. 60 days prior to the member's 21st birthday, members/member's families or their designee will receive a call from the Blue Shield Promise Case Manager to ensure the care planning is in process or completed. If the assistance is needed, the Blue Shield Promise Case Manager will assist in locating an appropriate specialist as well as addressing any other needs.

For complex care needs requiring specialty services not currently available in-network, the Blue Shield Promise Case Manager will collaborate with the CCS Case Manager, treating specialist or SCC (Special Care Center) and the Blue Shield Promise Provider Network team to locate an appropriate provider.

7.9.1.6 CCS Continuity of Care

For newly enrolled members or existing Medi-Cal beneficiaries transitioning to Blue Shield Promise, Blue Shield Promise maintains a process by which a CCS-eligible child or youth may maintain access to CCS providers and receive assistance in coordination with the new PCP. For children/youth that have an existing relationship with an out-of-network provider and is requesting continuity of care, Blue Shield Promise will follow the health plan responsibilities identified in the DHCS regulatory requirements.

Reporting Diseases and Conditions to Public Health Authorities

All Blue Shield Promise providers must be compliant with the California regulatory requirement to report specific diseases and conditions to local and state public health authorities, as part of the state's Department of Public Health Disease Surveillance programs per California Code of Regulations (CCR), Title 17, Section 2500, 1500(a)(14), 2500(b), 2500(c),2500(h)(i)(j), 2505, 2508, 2593, 2641.5-2643.20, 2800-2812.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.2: Regional Centers

Regional centers provide overall case coordination for eligible consumers and their families to ensure access to health, developmental, social, educational, and vocational services. Services are provided on a case-by-case basis, taking into consideration the availability of generic services appropriate to the consumer's needs.

Blue Shield Promise members who appear to qualify for regional center services will be appropriately identified and referred in accordance with the specifications of the Regional Center Program. This applies to the following:

1. Persons three (3) years of age and older with or suspected to have a developmental disability.
2. Persons from birth to 36 months who are at risk of developing a developmental disability.
3. Persons at risk of parenting a child with a developmental disability (genetic).
4. Behavioral Health Treatment (BHT) for persons 21 years of age and over when determined medically necessary and based upon a recommendation from a physician or a psychologist.
5. Individuals with a medical diagnosis which includes:
    - Early Start (Birth to Three)
        - Has substantial delay in one or more areas of cognitive, physical, and motor, communication, social or emotional, or adaptive development.
        - Infants and toddlers who are at high risk of having a substantial disability due to a combination of biomedical risk factors that have been diagnosed by a qualified.
    - Aged three and above: Children and adults over the age of 3 diagnosed with a developmental disability such as:
        - Autism
        - Cerebral Palsy
        - Epilepsy
        - Intellectual Disability

Other handicapping conditions closely related to mental retardation intellectual disability and requiring treatment similar to that required by persons with mental retardation intellectual disability.

Other applicable factors are that the condition:

- Must manifest prior to age 18
- Is likely to continue indefinitely
- Constitutes a substantial handicap

Factors that do ***not*** apply:

- Solely psychiatric disorders
- Solely learning disabilities
- Solely physical in nature (i.e., hearing impairment, vision impairment, orthopedic, etc.)

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.2: Regional Centers *(cont'd.)*

As an exception, Blue Shield Promise is not responsible for payment for services provided under CCS, or for case management services provided by a state-conducted referral provider such as a regional center.

7.9.2.1: Early Intervention Early Start Developmental Disability Services (EIES DDS) Provider Training

The Blue Shield Promise maintains mechanisms to ensure that all contracted providers are informed of and adhere to the following:

- Regional Center program eligibility requirements
- The need to identify potentially eligible children
- How to refer to the Regional Center

For all new providers and IPAs, program training will be presented in the New Provider Training material as well as upon request of a provider or IPA. Training opportunities can also be identified during the annual delegation oversight audits. At a minimum, training will occur at least annually in the form of provider updates emails, newsletters, or e-broadcasts via the Blue Shield Promise Provider Connection website

7.9.2.2: Provider Communications

Blue Shield Promise is responsible for ensuring the provider network is aware of members eligible for or receiving services through the DDS program. Blue Shield Promise shall be responsible for generating and distributing to its IPAs, a report of members identified as being eligible or authorized to receive DDS services received from DDS. Blue Shield Promise will send these reports to its delegated IPAs and contracted providers on a monthly basis. Blue Shield Promise and its delegated IPAs and contracted providers will work with the local DDS office to ensure the member is receiving appropriate medical care and that coordination of care is documented in the member's medical record and/or its delegated IPAs will undertake regular activities, such as review of encounter data necessary to identify members with potential DDS conditions and ensure appropriate referrals to DDS. Blue Shield Promise Nurses are responsible for informing the member's PCP of the member's Regional Center eligibility.

7.9.2.3: EIES DDS Care Management

Blue Shield Promise shall offer care coordination/care management for all identified EIES DDS eligible members. When a member meets criteria for the Regional Center , the member/member's family or designee is contacted telephonically or via mail by a Blue Shield Promise employee to discuss their condition and enroll them in the appropriate Care Management Program.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.2: Regional Centers *(cont'd.)*

7.9.2.3: EIES DDS Care Management *(cont'd.)*

Blue Shield Promise will be responsible for needed case management of all identified EIES DDS-eligible members and authorizes medically necessary care. The Blue Shield Promise UM Department and Population Health Management teams can serve as a link between Blue Shield Promise PCPs, providers, and specialists as appropriate and the EIES DDS Program. This will be done by appropriately identifying and channeling all potential/applicable referrals to the Regional Centers in accordance with the specified program standards.

7.9.3: Women, Infants, and Children Program (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides temporary nutrition, education and assistance for needy woman, infants, and children.

Supplemental foods are selected to meet specific nutritional needs of pregnant or breastfeeding women and young children by using WIC vouchers. WIC is a free service for members who meet eligibility requirements.

All WIC eligible Blue Shield Promise members who are pregnant, breastfeeding, postpartum, infants and children will be referred to WIC.

Screening of Nutritional Needs and WIC Eligibility Identification and Referral

PCPs are to identify pregnant, breastfeeding, or postpartum women, and children under the age of five who are eligible for WIC supplemental food services.

PCPs are to perform a nutritional assessment and hemoglobin or hematocrit laboratory tests; and assess for a history of frequent illness or a general poor state of health.

In the case of pregnant women, PCPs may refer members to nutritionists for further assessment.

The PCP or nutritionist is to initiate the referral to WIC, if appropriate. Test results reported on the CPSP assessment tool for OB members, or on the CHDP Form PM-160 for children, are to be provided to the WIC Program with all referrals.

The PCP must document the WIC referral in the member's medical record.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP)

Pregnancy and Postpartum Services

All pregnant and postpartum members are to be provided optimal, comprehensive, multidisciplinary pregnancy and postpartum services with case coordination by Blue Shield Promise contracted obstetric (OB) providers.

All pregnancy and postpartum services must be in accordance with the standards of the American College of Obstetrics and Gynecology (ACOG). All pregnant and post-partum members must be offered and provided services that meet Comprehensive Perinatal Services Program (CPSP) standards, per Title 22 of the California Code of Regulations (CCR), Section 51348. In addition, Blue Shield Promise contracted OB providers must establish mechanisms to refer pregnant and post-partum members to appropriate providers, and to track, monitor, authorize, and report the utilization of these services.

Comprehensive pregnancy and postpartum services, at a minimum, include the following:

Pregnancy Care

1. The initial prenatal visit must be available within (7) seven business days of the initial referral or request for pregnancy-related services.
2. ACOG's Guidelines for Perinatal Care (8th edition), 2017, recommends the following - examination schedule for woman with an uncomplicated pregnancy:
    a. Every four (4) weeks for the first 28 weeks
    b. Every two (2) to three (3) weeks until thirty-six (36) weeks gestation
    c. Weekly thereafter
    d. Postpartum, with an initial visit within 3 weeks after delivery and a follow-up comprehensive visit no later than 12 weeks after birth
3. The risk assessments (medical/obstetrical, nutrition, psychosocial, and health education) are completed on all pregnant members at the initial prenatal visit, and at each subsequent trimester and post-partum. All identified risk conditions are followed up by interventions designed to ameliorate or remedy the condition or problem in a prioritized manner, which must be documented in the medical record.
4. Women with medical/obstetrical, nutrition, psychosocial, and health education risk may require closer surveillance. The OB provider, according to the nature and severity of the risk and /or identified problems determines the appropriate interval between visits.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

Recommended intervals for routine tests for individual patients during pregnancy is as follows:

Time (Weeks Gestation)	Assessment / Service
Initial (as early as possible)	• Hemoglobin or hematocrit measurement
	• Bacteriuria screening
	• Examination and infection screen
	• Blood Group and RH type determination
	• Antibody Screen
	• Rubella antibody titer measurement
	• Syphilis screen (VDRL/RPR)
	• Cervical cytology
	• Hepatitis "B" virus screen
	• HIV education, counseling, and voluntary testing
	• Tuberculosis testing
	• Chlamydia testing and gonorrhea culture
	• Blood pressure
	• Complete medical/obstetrical history including genetic risk assessment and review of systems. Complete physical examination
	• Dental examination and referral of pregnant women at risk for oral health problems
	• Orientation to CPSP prescription and/or dispensing 300-day supply of vitamins /mineral supplements as indicated, counseling related to danger signs: what to do in an emergency, seat belt, safety, teratogens, smoking, alcohol, and other substance use
	• Referral to WIC
	• Recommend vaccinations: Influenza, COVID-19
	• Comprehensive risk assessment tool completed at the initiation of pregnancy-related services.
	• Individualized Care Plan (ICP): Documentation to include obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. • Assessments to include screenings for maternal mental health, substance use/abuse, intimate partner violence (IPV), and social needs. • At least one maternal mental health screening during the

	pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgment of the treating provider. • ACOG recommends that screening for perinatal depression and anxiety should take place during the first prenatal visit using a standardized and validated tool.
8 – 18 weeks	• Ultrasound if indicated, amniocentesis if indicated, Chorionic villus sampling if indicated.
16 - 18 weeks	• Maternal serum alpha-fetoprotein (by California law, must be offered to all pregnant women entering prenatal care prior to the 20th completed weeks of gestation).
27 weeks	• Re-assessment of nutritional, psychosocial, and health education needs.
26 - 28 weeks	• Diabetes screening at 26-28 weeks is appropriate for all pregnant women assessed to be at low risk for developing gestational diabetes. However, pregnant women at high risk for developing gestational diabetes, should be screened earlier. Pregnant women at high risk for developing gestational diabetes, would include: a. Members with a history of gestational diabetes b. Family history of diabetes c. Obesity d. Medical conditions associated with the development of gestational diabetes which includes metabolic syndrome or polycystic ovary syndrome.
28 weeks	• Repeat antibody test for un-sensitized Rh-negative patients
	• Recommend vaccination: Tdap (at 27-36 weeks for each pregnancy)
	• Prophylactic administration of Rho (D) immune globulin if needed.
32 - 36 weeks	• Ultrasound if indicated
	• Recommend vaccination: Pfizer RSV (respiratory syncytial virus)
	• Repeat testing for sexually transmitted disease, if indicated
	• Repeat hemoglobin or hematocrit if indicated
	• Family planning counseling/plan offer
	• HIV tests again if previously refused or continued high-risk health behaviors.
	• ACOG recommends that screening for perinatal depression and anxiety should take place later in the pregnancy using a standardized and validated tool.
By 39 weeks	• Re-assessment of nutrition, psychosocial, and health education needs
Every Prenatal Visit	• Urine checks for glucose and protein. • After quickening, report of fetal movement, blood pressure, weight,

	uterine size, fetal heart rate, edema, • Leopold's maneuvers interval history. Opportunity for questions. • Continual risk assessment and update of the individualized Care Plan (ICP) and referral as indicated, including to support services and Case Management
Initial Postpartum: –within 3 weeks following delivery AND Follow-up Comprehensive visit no later than 12 weeks after birth	Physical exam to include: 1. Breast examination. 2. Recto vaginal evaluation. 3. Bi-manual examination of the uterus and adnexa. 4. Weight, blood pressure. 5. Abdominal examination. 6. Interval history/adaptation to a newborn. 7. Discussion of normal symptoms vs. warning of postpartum depression. 8. Family adaptation. 9. Immunization status (especially rubella for non-immune women). 10. Breastfeeding inquiries. 11. Counseling regarding future health and pregnancies (gestational diabetes, vaginal birth after cesarean, genetic anomalies, hypertension, etc. Laboratory as indicated (Hemoglobin, if anemic on discharge from hospital, etc.) 12. Family planning counseling/prescription. 13. Well childcare inquiry/referral. 14. AB 1936 requires maternal mental health screening to be conducted during the first six (6) weeks of the postpartum period, and additional postpartum screenings, if determined to be medical necessary and clinically appropriate. 15. ACOG recommends that screening for perinatal depression and anxiety should take place at the postpartum appointment using a standardized and validated tool. 16. Re-assessment of nutrition, psychosocial, and health education needs-revise or close ICP as indicated. CPSP support services are available to members for up to (60) days postpartum. 17. Medical, gynecological, nutritional, psychosocial, and/or health education needs/problems persisting beyond this period are communicated to the members PCP for further follow-up and service coordination. This is accomplished by the transfer of a copy of the ICP, which clearly indicates unresolved problems/needs, and interventions to date, from the perinatal provider to the PCP.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

At-Risk Pregnancy/Postpartum Conditions

Identification of risk factors is critical to minimizing maternal and neonatal morbidity and mortality. Blue Shield Promise contracted OB providers are responsible for identifying women with a high risk of poor pregnancy outcome conditions and providing appropriate referrals to perinatal specialists, coordinating other medically necessary services, and making appropriate referrals to public health programs, social services, and community support agencies at any time during the pregnancy when the high-risk indicator is identified. Blue Shield Promise contracted OB providers are required to follow the "Early Pregnancy Risk Identification for Consultation" Guidelines for Perinatal Care, 8th Edition, American College of Obstetricians and Gynecologists (ACOG) 2017 regarding identifying women with a high risk of poor pregnancy outcome conditions and providing appropriate referrals.

Comprehensive Perinatal and Postpartum Risk Assessment Tools

Blue Shield Promise contracted OB providers must implement a comprehensive risk assessment tool for all pregnant members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Blue Shield Promise contracted OB providers must maintain the results of this assessment as part of the member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.

If administration of the risk assessment tool is missed at the appropriate time frames, then the Blue Shield Promise contracted obstetric providers must ensure case management and care coordination are working directly with the member to accomplish the assessment. Blue Shield Promise contracted obstetric providers must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the member's Medical Record. The risk assessment may be completed virtually through a telehealth visit with the member's consent.

Blue Shield Promise selected and implemented the following comprehensive perinatal and postpartum risk assessment tools and recommends that our contracted obstetric providers utilize the following CPSP Perinatal and Postpartum Risk Assessment tools:

- CPSP Perinatal Assessment Reassessment and Individualized Care Plan LA County 2017
  http://publichealth.lacounty.gov/mch/cpsp/forms/Prenatal%20Assessment%20&%20ICP%20LAC%20CPSP%202017.pdf

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

- CPSP Postpartum Assessment Reassessment and Individualized Care Plan LA County 2017
  http://publichealth.lacounty.gov/mch/cpsp/forms/Postpartum%20Assessment%20&%20ICP%20tool%20LAC%20CPSP%202017.pdf

Obstetric providers may obtain a copy of the above comprehensive perinatal and postpartum risk assessment tools by contacting Blue Shield Promise Provider Relations.

Individualized Care Plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors.

The Blue Shield Promise obstetric provider is responsible for the personal supervision of the members' Individualized Care Plan to ensure that all identified risk conditions are followed up with interventions expected to ameliorate or remedy the condition or problem in a prioritized manner. This supervision is the obstetric responsibility whether the support services (nutrition, psychosocial, and health education), assessment and interventions are accomplished in his/her practice or are conducted at another location.

Case Coordination Elements

Case coordination is the responsibility of the Blue Shield Promise contracted OB providers although care coordination may be delegated to a member of the OB provider's staff who is directly accountable to the OB provider.

Components of Case Coordination

Case coordination includes all clinical aspects of care, as well as record keeping and communication, as detailed below. Every part of the multidisciplinary system should support personal attention to the member and interaction with the Blue Shield Promise contracted OB provider.

- Assessments (obstetrical, nutrition, health education, and psychosocial).
- Written, individualized care plan based on all assessments.
- Appropriate interventions/treatments provided according to the care plan and approved protocols.
- Continuous assessments of the member's status and progress relative to care plan interventions, with appropriate revision of care plan when necessary.
- Case conferences, or other appropriate communications, involving all team members regarding each member's care.
- Comprehensive record system where all information relating to member care is documented and is available to all team members.
- Screening for prenatal and postpartum mental health conditions and referrals for mental health services, as appropriate.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

Multidisciplinary Conditions/Issues

Common pregnancy and postpartum conditions and issues for multidisciplinary team discussion/ action include areas of nutrition (N), psychosocial conditions and services (PS), or health education (HE) such as those listed below:

Pregnancy Conditions/Issues

- Fear of physicians, hospitals, and medical personnel (HE)
- Housing and transportation problems (PS)
- Lack of basic reproductive awareness (HE)
- Language barriers (HE)
- Multiple gestation (HE), (PS), (N)
- Need for bed rest during pregnancy (PS), (HE)
- No previous contact with health care systems (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)
- Previous receipt of unfriendly health care services (HE)
- Teenage pregnancy (PS)
- Unintended or unwanted pregnancy (PS)

Postpartum Conditions/Issues

- Breastfeeding difficulties (HE)
- Housing, food, and transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Postpartum blues, postpartum depression (PS)
- Severe anemia (N)
- Sexual pain/difficulties (HE)

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

Conditions Requiring Medical Referrals

- Alcohol or Drug Abuse
- Diabetes
- Epilepsy or Neurological Disorder
- Genetic Problems
- Hepatitis
- HIV Infection
- Hypertension
- Maternal Cardiac Disorders
- Renal Disease
- Thyroid or Other Endocrine Disorders

Conditions/Issues Requiring Social Work Referrals

- Chemical Abuse
- Family Abuse
- Financial Problems
- Insufficient home care resources/capabilities
- Psychiatric Problems
- Related Programs (e.g., CPSP, WIC, family planning and dental services).

Blue Shield Promise contracted OB providers are to inform members of pregnancy and prenatal related programs and refer members to them when appropriate.

Monitoring and Oversight

Blue Shield Promise needs your assistance to ensure that our members get optimal perinatal care and the best possible pregnancy outcomes. In addition, we must maintain compliance with the Department of Health Care Services (DHCS) Policy Letter (PL) 12-003 Obstetrical Care–Perinatal Services.

Blue Shield Promise is required to ensure that our providers are following American College of Obstetricians and Gynecologists (ACOG) practice guidelines and are compliant with the Comprehensive Perinatal Services Program (CPSP). Blue Shield Promise conducts medical record reviews of Blue Shield Promise contracted OB provider medical records to monitor compliance with this requirement.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.4: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

If a Blue Shield Promise contracted OB provider receives a request from Blue Shield Promise for medical records for a CPSP monitoring audit, please return the requested medical records as soon as possible. Please notify us via email at CPSPMonitoring@blueshieldca.com if requests for your medical records are to be sent to a specific contact, centralized location, or if access to your electronic medical record (EMR) system is available, or if you have any other questions.

The CPSP Medical Record Review Tool will be included with medical record requests and is available upon request. Once we have completed our medical record review, we will share your results with you. Blue Shield Promise contracted OB providers must achieve a score of 80% or higher to receive a passing score. Any score lower than 80% or noted trending deficiencies may require a Corrective Action Plan (CAP). In the event a CAP is required, Blue Shield Promise will provide additional training and resources as needed. Compliance gaps in Blue Shield Promise's provider network will be tracked, trended, and reported in Quality Management Committee meetings.

The Maternal Health Oversight and Monitoring Program is one component of the overall Maternal Health Program, which includes Blue Shield Promise's Quality, Delegation Oversight, and Care Management Programs.

For more information about the California Department of Public Health (CDPH) Comprehensive Perinatal Services Program (CPSP) and/or the American College of Obstetricians and Gynecologists (ACOG) see below.

Resources

https://www.blueshieldca.com/en/bsp/providers/programs/maternity-program

www.cdph.ca.gov/programs/cfh/dmcah/cpsp/pages/default.aspx

www.acog.org/

7.9.5: Family Planning

Family planning includes the following services:

- Health education and counseling services necessary for members to make informed choices and understand contraceptive methods.
- Limited history taking and physical examinations. PCPs or OB/GYNs are responsible for the comprehensive history taking and physical examinations.
- Laboratory tests, if medically indicated for the chosen contraceptive method. Pap smears, if not provided per USTF guidelines by PCPs or OB/GYNs.

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.5: Family Planning *(cont'd.)*

- Diagnosis and treatment of sexually transmitted diseases, if medically indicated, pursuant to the sexually transmitted diseases section of this manual.
- Screening, testing, and counseling of individuals at-risk for HIV and referral for treatment for HIV-infected members.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Provision of contraceptive pills, devices, and supplies, as approved by Medi-Cal.

Providers will be required to obtain informed consent for all contraceptive devices.

- Pregnancy testing and counseling
- Tubal ligation
- Vasectomies

The stipulations below apply to the provision of family planning services:

1. Each physician/provider must be licensed in the state of California and have training/ experience in family planning.
2. A Medical Director who meets at least the above qualifications must oversee, if services are provided in a clinic setting, the clinic and all services provided there.
3. Informed consent must be obtained, in writing, from all members for the provision of all-contraceptive devices and/or procedures. This consent will be filed in the member's medical records.
4. In general, OB/GYN, family practice, or internal medicine physicians and nurse practitioners will provide family planning services to members.

Members may receive care from:

- Their own Blue Shield Promise PCP or OB/GYN
- A Blue Shield Promise Participating Family Planning provider
- Any out-of-plan Family Planning provider (This is limited to Medi-Cal members only.)

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.6: Sensitive Services

"Sensitive services" are health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

Benefit Coverage

Members 12 years of age and older may sign an Authorization for Treatment form for any sensitive services (without parental consent). Parental or guardian consent is required for members under 12 years of age who seek substance or alcohol abuse treatment services, or for treatment of sexually transmitted diseases.

The member's PCP should encourage members to use in-plan services to enhance coordination of care. However, members may access sensitive services through out-of-network providers without prior authorization.

Family Planning (sensitive) services shall include, but not be limited to:

- Medical treatment and procedures defined as family planning services under current Medi-Cal scope of benefits
- Medical contraceptive services including diagnosis, treatment, supplies, and follow-up
- Informational and education services

In compliance with federal regulations, Blue Shield Promise members have free access to confidential family planning services from any family planning provider or agency without obtaining authorization for these services. Access to sensitive services will be timely. Services to treat sexually transmitted diseases or referrals to substance and alcohol treatment are confidential.

Examples of Covered Services:

- Birth control pills
- Contraceptive foam, male and female condoms, cervical caps, sponges, etc.
- Depo-Provera as routine birth control
- Diaphragm
- Elective therapeutic abortions
- Elective tubal ligation
- Elective vasectomy
- Intra-uterine device (IUD) including device, insertion, and removal
- "Morning after pill" to avoid pregnancy is approved by the FDA for emergency treatment only (e.g., rape, incest, etc.)
- Routine pregnancy testing

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.6: Sensitive Services *(cont'd.)*

Office visits for education and instruction for birth control, including symptom-thermal method, billings method, rhythm method; and instruction and education regarding the methods and devices listed above.

- HIV screening, testing, diagnosis, education, and referrals for treatment
- STD screening, testing, diagnosis, education, and referrals for treatment

Non-Specialty Mental Health Services for minors 12 years of age or older

Minors 12 years of age or older may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient services. For more information please follow the guidance outlined in APL 24-019.

7.9.7: Sexually Transmitted Disease (STD)

Blue Shield Promise will provide members with confidential sexually transmitted disease (STD) screening and testing, diagnosis, treatment, follow-up, counseling, education, and preventive care. Members should be encouraged to obtain these services from their PCPs. However, members have the right to receive some services outside of the PCP without prior authorization.

STD Reporting

State law mandates that specified STDs be reported to local health departments. All diagnosed members that fail to complete treatment must also be reported to the applicable local health department.

7.9.8: Specialty Mental Health Services (Medi-Cal Managed Care)

Inpatient and specialty outpatient mental health services are carved-out of the Blue Shield Promise Medi-Cal benefit agreement.

These services include:

1. Mental health services (assessments, plan development, therapy, rehabilitation, and collateral)
2. Medication support services
3. Day treatment intensive services
4. Day rehabilitation services
5. Crisis intervention services
6. Crisis stabilization services
7. Targeted case management services
8. Therapeutic behavioral services

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.8: Specialty Mental Health Services (Medi-Cal Managed Care) *(cont'd.)*

9. Adult residential treatment services
10. Crisis residential treatment services
11. Acute psychiatric inpatient hospital services
12. Psychiatric inpatient hospital professional services
13. Psychiatric health facility services

Blue Shield Promise members may directly access specialty mental health services through Los Angeles or San Diego County Department of Mental Health.

If the PCP determines that the members need access to specialty mental health services, often evidenced by severe mental impairment, the PCP should refer directly to the county mental health plan. The PCP may also refer to the Blue Shield Promise Social Services team for screening to determine the most appropriate level of care.

Resources for Specialty Mental Health Services

- For coordinated access to the San Diego Specialty Mental Health Services please call or have the member call the San Diego Access and Crisis line at (888) 724-7240 or text 988.
- For coordinated access to the Los Angeles Specialty Mental Health Services please call or have the member call the Los Angeles ACCESS Center at (800) 854-7771 or text 988.

7.9.9: Alcohol and Drug Treatment

Any member identified with possible alcohol or substance use disorders shall be referred to the County Alcohol and Drug Program in the county where the member resides for evaluation and treatment.

Resources for Substance Use Disorder (SUD) Services

- SUD Directories www.dhcs.ca.gov/provgovpart/Pages/sud-directories.aspx
- Los Angeles County Substance Abuse Service Helpline: (844) 804-7500
- San Diego County Drug-Medi-Cal Organized Delivery System: (888) 724-7240 TTY 711

7.9.10: Vision

Blue Shield Promise members are eligible to receive vision care services, including the provision of examinations and eyewear at the same location.

Blue Shield Promise is contracted with a network of participating ophthalmologists, optometrists, hospital outpatient departments, and organized outpatient clinics, strategically throughout Los Angeles County, in order to provide enrolled members with convenient access to vision care services. If the member belongs to a contracted IPA/medical group, the PCP should submit the referral to the IPA/medical group.

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.10: Vision *(cont'd.)*

Participating vision care providers are authorized to submit claims for vision care services and appliances to Blue Shield Promise, in accordance with Medi-Cal vision care policies and billing instructions.

Members may obtain, as a covered benefit, one pair of corrective lenses every two (2) years. Additional services and lenses are to be provided based on medical necessity.

If the optometrist for any reason feels the member should be referred to an ophthalmologist or other physician, they must call the member's PCP for a telephone referral authorization. This is necessary to ensure the PCP is aware of any potential conditions that may be related to the general health of the member (such as diabetes).

7.9.11: Dental

PCPs will conduct primary care dental screenings and facilitate appropriate and timely referrals to dental providers. Services delivered by dental providers are carved-out of the Blue Shield Promise benefit agreement.

PCPs shall perform an inspection of the teeth and gums for any signs of infection, abnormalities, malocclusion, and inflammation of gums, plaque deposits, caries, or missing teeth. If any of the above conditions are observed, PCPs should instruct the member to make an appointment to see a dentist. Blue Shield Promise maintains a current list of Medi-Cal dental providers and will be available to assist PCPs in the dental referral process.

As part of the Child Health and Disability Prevention (CHDP) health assessment, children are to be referred to a Medi-Cal dentist if a dentist has not seen them within the prior six (6) months. Dental screenings of adults are accomplished, at a minimum, as part of the periodic examinations recommended by the United States Preventive Services Task Force (USPSTF) in addition to the course of other encounters. PCPs are encouraged to educate members about the importance of dental care and to make corrective and preventive referrals.

PCPs are to document screenings and referrals in the member's medical record.

7.9.12: Organ Transplant

Blue Shield Promise is required to cover the Major Organ Transplant (MOT) benefit for adult and non-California Children's Services (CCS) eligible pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.12: Organ Transplant *(cont'd.)*

Blue Shield Promise will refer, coordinate, and authorize the delivery of the MOT benefit and all medically necessary services associated with MOTs, including, but not limited to:

- Care coordination
- Discharge planning
- Hospitalization
- Medications
- Organ procurement costs
- Post-operative services
- Pre-transplantation assessments and appointments
- Readmissions from complications
- Surgery

Blue Shield Promise will cover all medically necessary services for both living donors and cadaver organ transplants. Blue Shield Promise will only authorize MOTs to be performed in approved transplant programs located within a Medi-Cal approved Center of Excellence (COE) or hospital that meets the Department of Health Care Services' (DHCS) criteria. Blue Shield Promise must directly refer adult members and authorize referrals to a transplant program that meets Medi-Cal for an evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for the organ transplant.

All covered benefits related to the following major organs will be provided for at a Medi-Cal approved COE:

- Bone marrow
- Combined liver and small bowel
- Heart
- Heart-lung
- Liver
- Lung
- Pancreas
- Simultaneous kidney-pancreas
- Small bowel

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.12: Organ Transplant *(cont'd.)*

California Children's Services (CCS) and Transplant

Blue Shield Promise must refer pediatric members to the County CCS program for CCS eligibility determination within 72 hours of the member's PCP or specialist identifying the member as potential candidate for the MOT. Blue Shield Promise will assist in referring and coordinating the delivery of the MOT benefit and all medically necessary services associated with MOT. Blue Shield Promise will not be required to pay for costs associated with transplants that qualify as a CCS-eligible condition. The County CCS program will be responsible for referring the CCS-eligible member to the transplant SCC. Blue Shield Promise will provide case management and care coordination. If the CCS program determines that the member is not eligible for the CCS program, but the MOT is medically necessary, Blue Shield Promise will be responsible for authorizing the MOT.

Authorization Time Frames

CCS MOT Service Authorization Requests (SARs) are typically authorized for one year. Non-CCS Treatment Authorization Requests (TARs) are authorized according to the type of MOT in the table below:

Transplant	Duration of TAR Authorization
Liver with Hepatocellular Carcinoma	4 Months
Cirrhosis	6 Months
Bone Marrow	6 Months
Heart	6 Months
Lungs	6 Months
All else	1 Year

7.9.13: Long Term Care (LTC)

For members that meet long-term care criteria, Blue Shield Promise UM Department will authorize, when medically appropriate, the admission and continued stay to the LTC facility including standardization on Skilled Nursing Facility (SNF), rehabilitation facility, or intermediate-care facility.

Blue Shield Promise will provide continuity of care for members that are transferred from an LTC to a general acute care hospital and then require a return to an LTC level of care due to medical necessity.

Under CalAIM, Blue Shield Promise will cover and coordinate Medi-Cal institutional Long-Term Care (LTC). This will provide all LTC residents with access to coordinated and integrated care and make coverage consistent across California. The goal of the LTC carve-in is to better integrate care across institutional and home- and community-based settings as well as to make the LTC delivery system consistent.

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.14: Tuberculosis

Blue Shield Promise and its providers will work in close coordination with the local health departments in the treatment and management of Blue Shield Promise members with tuberculosis (TB).

All efforts will be made to identify cases of tuberculosis among members as early as possible, to render infectious cases of TB to non-infectious as rapidly as possible, and to prevent non-infectious cases from becoming infectious. This will be done in accordance with the Los Angeles County Department of Health Services TB Control Program's developed guidelines and policies for suspected TB cases.

Primary Care Physicians (PCPs) are responsible for screening for TB, identifying active cases, notifying the Local Health Department (LHD), assessing the need for Directly Observed Therapy (DOT), and referring cases for DOT to the LHD TB Control Officer. Assembly Bill (AB) 2132, effective January 1, 2025, requires all PCPs to evaluate adult patients for TB and offer a TB screening test, including, but not limited to, assessment for tuberculosis risk and appropriate follow up, if risk factors are identified.

All K-12 students entering a new school district in Los Angeles County must be screened and cleared for TB.

Blue Shield Promise UM Case Managers will participate in a supportive role in coordinating, referring, reporting, contacting and the assessment of assessing the needs for of any identified member that is suspected of having or has TB.

PCPs are required to refer members with active TB who may be non-compliant to the DOT program.

More information can be found on the County of Los Angeles Public Health website: information: http://ph.lacounty.gov/tb/healthpro.htm

7.9.15: Waiver Program

Waiver Programs provide services in the home for members who are currently receiving care in acute or skilled nursing facilities. Members meeting criteria for waiver services will be referred to those programs. Blue Shield Promise will efficiently arrange the member's disenrollment and transfer of care to fee-for-service Medi-Cal, thereby enabling the member to receive care appropriately and safely in a home environment rather than an institution.

Members suitable for the Medi-Cal Waiver Program are:

- Members who have been in a skilled nursing facility (SNF) beyond 30 days without improvement and unable to maintain self-care.
- Members in custodial care.
- Members with an AIDS diagnosis.
- Members with other factors as noted in specific waiver criteria.

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.16: Phenylketonuria (PKU)

The treatment and testing of PKU are covered benefits under the Medi-Cal Program. The benefit includes formula and special food products that are medically necessary for the treatment of PKU. The screening of PKU is provided through the Plan's contracted hospital after birth, but prior to discharge of the newborn.

Metabolic diseases may be a carve-out benefit and may be covered through California Children's Services (CCS). Infants and children up to the age of 21 years that are identified as having PKU will be referred by the Plan to CCS for case management.

7.9.17: Enteral Nutrition

Medically Necessary Enteral Nutrition Products shall be sent from the pharmacy provider are primarily reviewed and authorized by the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (Magellan). However, the service may be provided through the medical benefit through an authorization process when the Medi-Cal Rx approved List of Enteral Nutrition Products does not meet the member's needs. Medical necessity must be documented for products not covered through the Medi-Cal Rx benefit.

"***Therapeutic Medical Food***" is defined as food formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

Enteral nutrition products reviewed and evaluated are those that can be used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food.

7.9.18: Cancer Screening

Cancer screening tests are covered benefits under the Medi-Cal Program. Blue Shield Promise follows the standards established by the United States Preventive Services Task Force (USPSTF) as outlined in Section 9.5 of this provider manual. In addition, annual cervical screenings include the conventional Pap test and the option of any cervical cancer screening test approved by the FDA upon the referral of the member's health care provider.

7.9.19: Biomarker Testing

Prior authorization is not required for FDA approved Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer (includes progression/reoccurrence of the above mentioned). Coverage policy for Cancer Biomarker Testing is to not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial.

7.9: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.19: Biomarker Testing *(cont'd.)*

Blue Shield Promise covers medically necessary biomarker testing for the diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Coverage includes biomarker tests that meet any of the following:

1. A labeled indication for a test that has been approved by the FDA or is an indicated test for an FDA-approved drug.
2. A national coverage determination made by the federal Centers for Medicare and Medicaid Services.
3. A local coverage determination made by a Medicare Administrative Contractor for California.
4. Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-review scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
5. Standards set by the National Academy of Medicine.

7.9.20: Pharmacogenomic Testing

Pharmacogenomic testing is a covered Medi-Cal benefit as set forth in the Welfare and Institutions Code (W&I) § 14132.11 and is subject to utilization review and evidence-based clinical practice guidelines.

7.9.21: Cancer Clinical Trials

Blue Shield Promise covers routine member care services that are related to the clinical trial for a member diagnosed with cancer and accepted into a phase I, phase II, or phase III clinical trial for cancer. The clinical trial program's endpoint shall be defined to test toxicity, and to have a therapeutic intent. The treatment shall be provided in a clinical trial that either (a) involves a drug that is exempt under federal regulations from a new drug application, or (b) is approved by one of the following:

- One of the National Institutes of Health (NIH)
- The Food and Drug Administration (FDA) in the form of an investigation new drug application
- The United States Department of Defense (DOD)
- The United States Veterans' Administration (VA)

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.21: Cancer Clinical Trials *(cont'd.)*

- Submitted prior authorization documentation of medical necessity should include the "Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for authorization of the clinical trial. The attestation form must include the following information:
    - The member's name and client identification number;
    - The national clinical trial number;
    - A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
    - A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

7.9.22: AIDS Vaccine Coverage

In the event the FDA approves a vaccine for AIDS, it will be covered.

7.9.23: Services Under the End-of-Life Options Act (ABx2-15) for Medi-Cal Members

End of life services (EOL Services) under this Act, patient consultation by a physician and prescription of aid-in-dying medication, are carved out from Medi-Cal health plans like Blue Shield Promise. Medi-Cal Fee-For-Service (FFS) will provide coverage and reimbursement for physicians who provide EOL Services.

Provision of these services by health care providers is voluntary. Physicians enrolled in the Medi-Cal FFS program may voluntarily provide Blue Shield Promise Medi-Cal members with EOL Services under the Medi-Cal FFS services, not under your contract with Blue Shield Promise, and seek payment for EOL consultations from the Medi-Cal FFS program.

Physicians are responsible for documenting an oral request by a Blue Shield Promise Medi-Cal member for EOL Services whether or not you volunteer to provide these services to the member.

7.9.24: Community Supports

Community Supports are services or settings that Blue Shield Promise may offer in place of services or settings covered under the California Medicaid State Plan that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for health plans to offer and for members to utilize.

Blue Shield Promise may not require members to use Community Support instead of a service or setting listed in the Medicaid State Plan.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.24: Community Supports *(cont'd.)*

These services are available to eligible Blue Shield Promise Medi-Cal members and provide additional support above and beyond Long Term Care Support Services (LTSS) to enhance member's care, allowing them to stay in their homes safely and preventing institutionalization. They can also be an additional part of care for members enrolled in Enhanced Care Management (ECM). Community Supports services are available for some Medi-Cal members not enrolled in ECM that need additional support in the community. These services will vary based on a member's needs and Blue Shield Promise's established Community Supports criteria and exclusions.

Blue Shield Promise offers the following Community Supports to eligible Medi-Cal members in Los Angeles and San Diego Counties:

- Assisted Living Facility (ALF) Transitions
- Asthma Remediation
- Community Transition Services/Nursing Facility Transition to a Home or Home Transition Services
- Day Habilitation Programs
- Environmental Accessibility Adaptations (Home Modifications)
- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals (MTMs)/Medically-Supportive Food (MSF)
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Personal Care and Homemaker Services
- Recuperative Care (Medical Respite)
- Respite Services
- Short-Term Post-Hospitalization Housing
- Sobering Centers
- Transitional Rent

Providers may reference the Community Supports Referral form on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers in the *Forms* section to determine a member's eligibility and submit a referral. Alternatively, the online referral form (www.blueshieldca.com/providerwebapp/connect/#/provider/community_support) can be utilized to submit a referral. Although these services are not Medi-Cal benefits, they are subject to Blue Shield Promise's grievance and appeals process in the event a concern arises regarding access to services.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.9.24: Community Supports *(cont'd.)*

Submission of Claims for Community Supports Reimbursement

Providers of Community Supports services have two options for submitting claims. Claims can be submitted through a Clearinghouse or on paper using the current version of the CMS 1500 form. These methods are described in detail in Section 14.1 Claim Submission.

DHCS Community Supports HCPCS Coding Guidance

HCPCS Code	HCPC Description	Modifier	Modifier Description
Housing Transition Navigation Services (HTNS)			
H0043	Supported housing; per diem	U6	Used with HCPCS code H0043 to indicate Community Supports Housing Transition Navigation Services
H2016	Comprehensive community support services; per diem	U6	Used with HCPCS code H2016 to indicate Community Supports Housing Transition Navigation Services
Housing Deposits			
H0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter.	U2	Used with HCPCS code H0044 to indicate Community Supports Housing Deposit. Modifier used to differentiate Housing Deposits from Short-Term Post-Hospitalization Housing.
Housing Tenancy and Sustaining Services (HTSS)			
T2040	Financial management, self-directed; per 15 minutes	U6	Used with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services

T2050	Financial management, self-directed; per diem	U6	Used with HCPCS code T2050 to indicate Community Supports Housing Tenancy and Sustaining Services
T2041	Support brokerage, self-directed; per 15 minutes	U6	Used with HCPCS code T2041 to indicate Community Supports Housing Tenancy and Sustaining Services
T2051	Support brokerage, self-directed; per diem	U6	Used with HCPCS code T2051 to indicate Community Supports Housing Tenancy and Sustaining Services
Day Habilitation Programs			
T2012	Habilitation, educational; per diem	U6	Used with HCPCS code T2012 to indicate Community Supports Day Habilitation Programs
T2014	Habilitation, prevocational; per diem	U6	Used with HCPCS code T2014 to indicate Community Supports Day Habilitation Programs
T2018	Habilitation, supported employment; per diem	U6	Used with HCPCS code T2018 to indicate Community Supports Day Habilitation Programs
T2020	Day habilitation; per diem	U6	Used with HCPCS code T2020 to indicate Community Supports Day Habilitation Programs
H2014	Skills training and development; per 15 minutes[3]	U6	Used with HCPCS code H2014 to indicate Community Supports Day Habilitation Programs
H2038	Skills training and development; per diem	U6	Used with HCPCS code H2038 to indicate Community Supports Day Habilitation Programs

H2024	Supported employment; per diem	U6	Used with HCPCS code H2024 to indicate Community Supports Day Habilitation Programs
H2026	Ongoing support to maintain employment; per diem	U6	Used with HCPCS code H2026 to indicate Community Supports Day Habilitation Programs
Recuperative Care (Medical Respite)			
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	U6	Used with HCPCS code T2033 to indicate Community Supports Recuperative Care (Medical Respite)
Short-Term Post-Hospitalization Housing			
H0043	Supported housing; per diem.	U3	Used with HCPCS code H0043 to indicate Community Supports Short-Term Post-Hospitalization Housing. Modifier used to differentiate Short-Term Post-Hospitalization Housing from Housing Transition Navigation Services.
H0044	Support housing, per month.	U3	Used with HCPCS code H0044 to indicate Community Supports Short-Term Post-Hospitalization Housing. Modifier used to differentiate Short-Term Post-Hospitalization Housing from Housing Deposits.
Transitional Rent			
H0044	Supported housing, per month	U6	Permanent Settings (e.g., apartments, single family homes, etc.)
H0043	Supported housing, per diem	U6	interim Settings (e.g., non-congregate shelters, hotel/motel rooms, etc.)

Respite Services			
H0045	Respite care services, not in the home, per diem	U6	Used with HCPCS code H0045 to indicate Community Supports Respite Services
S5151	Unskilled respite care, not hospice; per diem	U6	Used with HCPCS code S5151 to indicate Community Supports Respite Services
S9125	Respite care, in the home; per diem	U6	Used with HCPCS code S9125 to indicate Community Supports Respite Services
Assisted Living Facility (ALF) Transitions			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Community or Home Transition Services	U4	Used with HCPCS code T2038 to indicate Community Supports Assisted Living Facility Transitions
H2022	Community wrap-around services, per diem. Requires billed amount(s) to be reported on the encounter.	U5	Used with HCPCS code H2022 to indicate Community Supports Assisted Living Facility Transitions
Community or Home Transition Services			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Assisted Living Facility Transitions.	U5	Used with HCPCS code T2038 to indicate Community Supports Community or Home Transition Services
Personal Care and Homemaker Services			

S5130	Homemaker services; per 15 minutes	U6	Used with HCPCS code S5130 to indicate Community Supports Personal Care/Homemaker Services
T1019	Personal care services; per 15 minutes	U6	Used with HCPCS code T1019 to indicate Community Supports Personal Care/Homemaker Services
Environmental Accessibility Adaptations (Home Modifications)			
S5165	Home modifications; per service. Requires billed amount(s) to be reported on the encounter.	U6	Used with HCPCS code S5165 to indicate Community Supports Environmental Accessibility Adaptations/Home Modifications
Medically Tailored Meals (MTMs)/Medically Supportive Food (MSF)			
S5170	Home delivered prepared meal	U6	Used with HCPCS code S5170 to indicate Community Supports Medically Tailored Meals/Medically Supportive Food
S9470	Nutritional counseling, diet	U6	Used with HCPCS code S9470 to indicate Community Supports Medically Tailored Meals/Medically Supportive Food

S9977	Meals; per diem, not otherwise specified	U6	Used with HCPCS code S9977 to indicate Community Supports Medically Tailored Meals/Medically Supportive Food
Sobering Centers			
H0014	Alcohol and/or drug services; ambulatory detoxification	U6	Used with HCPCS code H0014 to indicate Community Supports Sobering Centers
Asthma Remediation			
S5165	Home modifications; per service	U5	Used with HCPCS code S5165 to indicate Community Supports Services Asthma Remediation

For more information, refer to Appendix 9: DHCS Community Supports Categories and Definitions and Appendix 10: Community Supports Eligibility Criteria and Restrictions/Limitations Guide.

7.10: Delegated UM Reporting Requirements (IPA/Medical Groups Only)

The purpose of UM reports is to provide ongoing monitoring for delegated UM functions and to ensure that services and decisions rendered by the delegated IPA/medical group are appropriate and meet DHCS, DMHC, and Blue Shield Promise standards. All delegated IPA/medical groups must report and submit UM information to Blue Shield Promise as described below. Reports must be submitted via secure email or via SFTP site. See also Appendix 1: Delegation of Utilization Management Responsibilities.

Monthly Reporting Requirements

Reports due to Blue Shield Promise by the 15th of the month following the month in which services were rendered or denials made, and include the following:

1. Authorization Turnaround Time Tracking Report – Include authorization, member name, requested date, approval date, provider notification date, diagnosis, and requested services.

7.10: Delegated UM Reporting Requirements (IPA/Medical Groups Only) *(cont'd.)*

2. Denials and Modifications – Include a complete copy of denial/modification letter, authorization/referral, doctor's notes, criteria used, and a copy of the DMHC self-addressed envelope. Ensure the file contains the member's name, requested date, provider notification date, and requested services.

Quarterly Reporting Requirements

Reports must be submitted to Blue Shield Promise 45 days after the end of the quarter (May 15th, August 15th, October 15th, and February 15th).

1. UM HICE Work Plan Report – Include, at a minimum, UM activities, trending of utilization activities for under- and over-utilization, member and provider satisfaction activities and inter-rater reliability activities and improvement.

Annual Reporting Requirements

Reports must be submitted annually to Blue Shield Promise by February 15th of each calendar year:

1. UM Program Description – Reassessment of the UM Program description must be done on an annual basis by the UM/ QM Committee.
2. UM Work Plan – Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The work plan should include planned audits, follow-up activities and interventions related to the identified problem areas.
3. UM Program Annual Evaluation – The evaluation should include a description, trending, analysis, and evaluation of the overall effectiveness of the UM Program.

All reports must be submitted to Blue Shield Promise within the time frames specified. There must be separate reports generated for Medi-Cal members. Consistent failure to submit required reports may result in action that includes, but is not limited to, request for a corrective action plan (CAP), freezing of new member enrollment, or termination of the Blue Shield Promise Health Plan Agreement. APL

8.1: Encounter Data - Medi-Cal

Policy and Procedures

Encounters include all services for which the medical group (IPA, MSO, PPG, Hospital, etc.) is responsible. Medical groups shall submit encounter data at least once monthly, but more frequently is preferred. Medical groups shall submit complete and accurate data in 837P, 837I & 837D formats using the national standard codes acceptable by Blue Shield Promise within thirty (30) calendar days from the Date of Service ("DOS") for Medi-Cal Los Angeles, and within sixty (60) calendar days from the DOS for Medi-Cal San Diego in which care was rendered. The medical group must meet all data quality measurements established by Blue Shield Promise Health Plan, as stated in this document and the provider contract, and is responsible for correcting and re-submitting all rejections to Blue Shield Promise within 10 days of notice received.

It is your obligation to submit data that is accurate, complete, and within the required time frame. Failure to do so may result in being placed on a corrective action plan which can include one or more of the following:

- Closure of panel
- Withhold incentive payments
- Withhold ACO shared savings payments, if applicable
- Enforcement of penalties outlined in your contract with Blue Shield Promise
- Reduction in monthly capitation payment, as stated in your provider contract
- De-delegation
- Termination of contract

All encounters must be submitted electronically using the 837 5010 format. Standardized 5010 EDI Response files will be provided for all encounter files received.

Encounter Data submissions must meet all requirements outlined in the Companion Guides and are exchanged through the established secure server. The Companion Guides can be found on the Provider Portal at EDI Companion Guides.

Providers who are contracted with Blue Shield Promise through a delegated IPA/medical group must submit encounter data to their affiliated IPA/medical group in the format and within the timeframes established by the IPA/medical group.

On an annual basis, Blue Shield Promise re-evaluates the accuracy and completeness standards based on state and federal regulatory changes, results of the Healthcare Effectiveness Data and Information Set (HEDIS®) audit and historical encounter data experience.

Blue Shield Promise continually monitors regulatory policy and any changes to policy that may occur.

If a change is necessary to the policy outside the regular update schedule, Blue Shield Promise will make a mid-cycle/special update to stay in compliance.

Blue Shield Promise must conform with the Department of Health Care Services (DHCS) Quality Measures for Encounter Data. Additional information can be found on the DHCS website at www.dhcs.ca.gov/dataandstats/data/Pages/MMCDClmsEncDataRpt.aspx.

8.1: Encounter Data - Medi-Cal *(cont'd.)*

8.1.1 Compliance Guidelines

Volume of the Data

It is important to comply with encounter submission requirements and to report all services to meet established encounter data quantity targets.

Complete Submission

Blue Shield Promise will measure encounter submissions based on a rolling year of utilization data.

National Drug Code (NDC)

Blue Shield Promise validates National Drug Codes using the sources noted below. Only submit an NDC if required:

- Department of Health Care Services (DHCS) Medi-Cal Rx Approved NDC List
- US Food and Drug Administration (FDA) 240 National Drug Code Directory

Note: Blue Shield Promise requires claims and encounters reporting Physician Administered Drugs (PADs) to include both the Healthcare Common Procedure Coding System (HCPCS) code and a valid National Drug Code (NDC) for Medi-Cal members.

Services that include the use of 340B Physician Administered Drugs should be reported accurately with the proper procedure code, National Drug Code, drug unit, and drug quantity to Blue Shield Promise. The "UD" modifier must be included in one of the four available modifier positions (2400 SV101-3, 4, 5 or 6) within the electronic transmission (837).

Performance

Blue Shield Promise will provide an Encounter Performance Summary Report to the medical group on a regular basis and will use the data to evaluate encounter performance. Submission requirements can be found in the Blue Shield Promise Companion Guides.

Encounter submission performance goals and outlined in the Encounter Performance Summary Report are as follows:

Timeliness of Data

Medi-Cal Los Angeles: 65% received within 30 calendar days from the date of service

Medi-Cal San Diego: 65% received within 60 calendar days from the date of service

Accuracy/Quality of the Data

Data acceptance rate shall not be less than 95% of all data submitted.

Resubmissions

The medical group is responsible for correcting the rejections and re-submitting the corrections to Blue Shield Promise within 10 days of notice received.

8.1: Encounter Data - Medi-Cal *(cont'd.)*

8.1.1 Compliance Guidelines *(cont'd.)*

Failure to meet these requirements may result in being placed on a corrective action plan as described in Section 8.1, Encounter Data Medi-Cal Policy and Procedures.

It is your obligation to submit data that is accurate, complete, and within the required time frame. Failure to do so may result in being placed on a corrective action plan which can include one or more of the following:

- Closure of panel
- Withhold incentive payments
- Withhold ACO shared savings payments, if applicable
- Enforcement of penalties outlined in your contract with Blue Shield Promise
- Reduction in monthly capitation payment, as stated in your provider contract
- De-delegation
- Termination of contract

Corrective Action Plan

When encounter data does not meet the submission requirements within a rolling three (3) months, Blue Shield Promise may request a corrective action plan (CAP) from the provider to remedy the problem, as follows:

1. Blue Shield Promise sends a letter to the provider requesting a CAP. The letter details the following:
    a. The months that the encounter data did not meet the requirements.
    b. The dates when the encounter data was due to Blue Shield Promise, if applicable.
    c. The file names for all encounter data files that did not meet the requirements.
    d. The reasons the encounter data did not meet the requirements, whether it be timeliness, accuracy, or a combination of the two (2).
    e. The date the CAP is due to Blue Shield Promise.
    f. Request for submission of accurate and complete encounter data for the timeframes in question.
2. to Blue Shield Promise within thirty (30) days from the date of the CAP Request letter. The CAP must include the following:
    a. The name of the IPA/Medical Group
    b. The name of the person responsible for implementing the CAP, along with title, contact email and contact phone number
    c. A list of specific actions to be taken to ensure that encounter data meets the submission requirements.
    d. Completion dates for each of the corrective actions.
    e. An accurate and complete encounter data file(s).

8.1: Encounter Data - Medi-Cal *(cont'd.)*

8.1.1 Compliance Guidelines *(cont'd.)*

3. Blue Shield Promise sends the Capitated provider a letter of acceptance or rejection of the CAP within thirty (30) days of receipt of the CAP.
    a. Blue Shield Promise includes the specific reasons for rejection of any CAP.
    b. Any rejected CAP must be resubmitted within fifteen (15) days to Blue Shield Promise.
    c. Timeframes can be altered at the discretion of Blue Shield Promise depending on specific circumstances.
4. Capitated providers who fail to submit an acceptable CAP within the required timeframes and/or accurate and complete encounter data, shall be subject to:
    - Closure of panel
    - Withhold incentive payments
    - Withhold ACO shared savings payments, if applicable
    - Enforcement of penalties outlined in your contract with Blue Shield Promise
    - Reduction in monthly capitation payment, as stated in your provider contract
    - De-delegation
    - Termination of contract
5. In accordance with the terms of the provider agreement and this provider manual. Blue Shield Promise shall provide thirty (30) days written notice prior to the capitation deduction. Capitation deduction shall be retroactive to the date of non-compliant encounter data submission. The enrollment freeze and capitation deduction shall remain in effect until such time that the CAP and/or encounter data is approved and meets standards.

Federally Qualified Health Centers (FQHCs)/Alternate Payment Methodology (APM)

Federally Qualified Health Centers (FQHCs) participating in Alternate Payment Methodology (APM) program must conform with the Department of Health Care Services (DHCS) FQHC APM Program Guide for Encounter Data.

The responsibility for Encounter Data reporting as outlined above continues until all services rendered during the timeframe of the provider's agreement have been reported.

9.1: Quality Improvement Program

Mission Statement

Blue Shield Promise's mission is to ensure all Californians have access to high-quality health care at an affordable price. Blue Shield Promise's Quality Program is committed to promoting continuous and coordinated care in a patient-centered environment that recognizes the positive relationship between health education, a culture of wellness, and an emphasis on prevention and affordable healthcare.

Blue Shield Promise's Quality Program is comprehensive and designed to systematically and continuously monitor, evaluate, and improve the quality of care and/or services delivered to all Blue Shield Promise members and providers. Quality improvement activities are conducted in all areas and dimensions of clinical and non-clinical member care and service.

Performance improvement projects and activities are selected and conducted using methodologies and practices that conform to respected health services research entities, as well as standards and best practices established by regulatory and accrediting bodies.

The quality program goals are reviewed and updated on an annual basis and approved by the appropriate committees in May of each year.

Accreditation

Blue Shield Promise has received The National Committee for Quality Assurance (NCQA) Health Plan and Health Equity accreditation. The NCQA accreditation survey evaluates a health plan's organizational structure, operational processes, clinical quality, and patient satisfaction every three years.

Scope

The scope of the Quality Program is to monitor care and service and identify opportunities for improvement of care and services to both our members and providers. This is accomplished by evaluating data and leading or supporting the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. A formal evaluation of the Quality Program is performed annually. Specific elements of the Quality Program include but are not limited to Effective and Efficient Quality of Clinical Care; Safety; Equity; Quality of Service and Timeliness of Care; Provider Support (provider experience, engagement, and performance); Patient-Centered member Experience and Satisfaction. Topics in these domains include:

- Quality Improvement Initiatives
- Continuity, Coordination, and Transitions of Care
- Population Health Management
- Care Management
- Wellness Initiatives and Preventive Care
- Delegation Oversight of credentialing entities; utilization management and claims processing entities

9.1: Quality Improvement Program *(cont'd.)*

- Pharmacy initiatives to improve safety and avoid harm
- Individual and Organizational Provider Credentialing
- Potential Quality Issues
- Medical record documentation review
- Member experience and satisfaction initiatives
- Cultural & Linguistic Services
- Appeals and grievances analysis.
- Health Equity
- Access & Availability of Services
- Cost Data Transparency
- Customer Call Center
- Utilization management timeliness
- Provider Collaborations
- Provider Incentives
- Value-based programs
- Provider group engagement

The Quality Program covers:

- All Blue Shield Promise members
- All types of covered services; including, but not limited to preventive, primary, specialty, emergency, inpatient, behavioral health (including parity), ancillary care, and long-term services and supports (LTSS).
- All professional and institutional care in all settings including provider offices, hospitals, skilled nursing facilities, outpatient facilities, emergency facilities, ancillary providers, pathology and laboratory facilities, urgent care, home health, and telehealth.
- All directly contracted providers and all delegated or subcontracted providers.

Confidentiality and Conflict of Interest

All information related to the quality improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and reviews, are stored in designated, secured locations and access is granted based on minimum necessary standards. All aspects of a quality review are deemed confidential. All people involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All quality improvement activities including correspondence, documentation, and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPPA) for patient confidentiality. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

9.1: Quality Improvement Program *(cont'd.)*

The Quality Management Committee is a forum to discuss development, oversight, guidance and coordination of Blue Shield Promise quality activities which require open dialogue and discussion. Members of the Committee may have access to sensitive data to further the Committee goals. Blue Shield Promise employees follow the Code of Conduct when dealing with sensitive data. External Committee members are required to sign a confidentiality statement annually.

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

9.1.1: Program Structure Governing Body

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

Committees

Quality Management Committee (QMC)

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

The following sub-committees report to Quality Management Committee:

- Access and Availability Committee
- Medical Policy Committee
- Medical Services Committee
- Peer Review Committee

Scope (includes but not limited to):

1. Directing all Quality Improvement activities.
2. Monitoring, evaluating, and directing the overall compliance with the Quality Improvement Program.

9.1: Quality Improvement Program *(cont'd.)*

9.1.1: Program Structure Governing Body *(cont'd.)*

3. Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
4. Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols. Recommending policy decisions.
5. Reviewing, analyzing, and evaluating Quality Improvement activity.
6. Ensuring practitioner participation in the QI program through planning, design, implementation, and review.
7. Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA, and L.A. Care.
8. Reviewing reports of subcommittees that report directly to QMC.
9. Overseeing standing subcommittees through the review of regular reports and required action if necessary; evaluates subcommittees for potential changes in scope or the need for ad hoc task forces/workgroups.
10. Evaluating and giving recommendations concerning Quality Improvement Initiatives' audit results, member satisfaction surveys, and provider satisfaction surveys.
11. Evaluating and giving recommendations from analysis and trending reports, including appeals and grievances, potential quality investigations, member service metrics, Initial Health Appointments, and Facility Site Review.
12. Ensuring follow-up, as appropriate.

Delegation Oversight Committee (DOC)

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

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

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

9.1: Quality Improvement Program *(cont'd.)*

9.1.2: Standards of Practice

Blue Shield Promise reviews and adopts standards of practice from professionally recognized sources in the development and implementation of criteria, policies and procedures, metrics, indicators, protocols, clinical practice guidelines, review standards, or benchmarks in its quality program. Sources include, but are not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Evidence-based medical literature
- State and federal requirements

Accepted thresholds and targets derived from these standards and norms will be:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines
- Valuable to the assessment quality or the potential improvement of quality for our member population

9.1.3: Quality Improvement Process

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

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

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Provider access and availability data, and satisfaction surveys
- Customer Service call data
- Pertinent Medical Records (minimum necessary)

9.1: Quality Improvement Program *(cont'd.)*

9.1.3: Quality Improvement Process *(cont'd.)*

- 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
- Laboratory data
- 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
- Health Information Exchanges

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

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

Quality of Care Reviews

- Blue Shield Promise has a comprehensive review system to address potential quality of care issues. A potential quality issue arising from a member grievance, an internal department or external provider/IPA (on the provided external PQI form) is forwarded to the Blue Shield Promise 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 available. The case may then be forwarded to the Blue Shield Promise Medical Director for review and determination of any quality-of-care issues. A case review may also include a review of the care provided by a like-peer specialist and/or a review by the Blue Shield Promise Peer Review Committee.

9.1: Quality Improvement Program *(cont'd.)*

9.1.3: Quality Improvement Process *(cont'd.)*

- The Potential Quality Issue (PQI) Referral Form is intended to be used to report potential or suspected deviations from the standard of care that require further review from the health plan to determine justification. To access the form, navigate to Provider Connection portal, click on Forms, scroll to the Reporting Forms section, select the PQI Referral Form and then follow the directions accordingly.
- During the review process, information is obtained from an IPA/medical group or directly from the involved provider. Upon review completion, depending upon the severity of any quality findings identified, follow-up actions may be taken and can include a request for corrective action or an education letter. Patient safety concerns or patterns of poor care can be considered during Blue Shield Promise re-credentialing activities or reviewed in more detail by the Blue Shield Promise Credentialing Committee and may result in termination from the Blue Shield Promise network.
- Contracted 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.

Quality Studies (HEDIS/PIP/PDSA Focused Review Studies)

QI Department staff will perform quality studies, as indicated, based on findings from reviews of the quality-of-care issues, utilization data, pharmacy data, complaints and grievances, satisfaction survey results, medical record audit results, facility site review results, and other clinical indicators. In addition, Blue Shield Promise will participate with collaborative plans and regulatory agencies in state required HEDIS/PIP/PDSA studies. Studies conducted jointly with regulatory agencies will be in accordance with regulatory agency and state requirements. Quality studies conducted independently of regulatory bodies will be in accordance with Blue Shield Promise policies and procedures. 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), within 2 weeks of the request 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), Potential Quality Issues (PQI), and DHCS' validation of Encounter Data.

Credentialing

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

9.1: Quality Improvement Program *(cont'd.)*

9.1.4: Communication of Information

All Quality Improvement activities are presented and reviewed by the Quality Management Committee. Types of activities, analyses, and/or data may include:

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

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

- Correspondence with a provider displaying individual results and a comparison to the provider's group or affiliation, or against the peers in the network.
- Correspondence with the IPA/medical groups showing results and comparisons to the network.
- Announcements and informational communications as needed.
- Online
- Provider Manual updates

9.1: Quality Improvement Program *(cont'd.)*

9.1.4: Communication of Information *(cont'd.)*

Quality Improvement Program Description and Policies and Procedures

The Quality Program Description and its policies and procedures are reviewed at least annually and will be amended to reflect changes in scope and identified needs resulting from new or revised regulatory and/or accreditation requirements, significant changes in membership, provider scope, scope of services, or operational changes occurring during the year. The program description, work plan, and annual evaluation are reviewed and approved by the Quality Management Committee and Board Quality Improvement Committee (BQIC). Quality Improvement policies and procedures are reviewed and approved by the Quality Management Committee.

Annual Work Plan

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

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

Annual Program Evaluation

Blue Shield Promise's Quality Program is reviewed at least annually to assess the overall effectiveness of the program. Findings from the annual Quality Program Evaluation are considered at the time of the Quality Program revision.

The assessment of activities in the Quality Work Plan is conducted to evaluate the success of individual activities in meeting the specific goals and objectives of the Quality Program. The annual review of the Quality Program ensures that the overall program is comprehensive, meets current industry standards, and is effective in continuously improving the quality of health care and services delivered. Identified opportunities are addressed in the following year's program and work plan.

An executive summary is presented to the QMC, QOC, and BQIC for review and action which may include acceptance, clarification, modification, and follow-up as appropriate. An informational summary of the annual evaluation is available to providers.

9.2: Quality of Care-Focused Studies

Policy

The Blue Shield Promise Quality Improvement Department develops quality improvement studies based on data collected through various methods including, but not limited to, encounter data, claims data, complaints and grievances, potential quality issues (PQI), access and availability surveys, and satisfaction surveys. Blue Shield Promise annually reports to regulatory agencies on the performance of Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS) measures and participates with regulatory agencies in the submission of state-mandated performance improvement plans (PIPs) and Plan Do Study Act (PDSA) cycles to test change through rapid-cycle improvement for measures falling below the minimum performance level. Studies conducted in collaboration with other health plans and state-wide collaborative Quality Improvement Projects will be conducted in accordance with regulatory agency requirements. Focused review studies conducted independently of a regulatory agency will be in accordance with the procedures as described herein.

Procedure

1. Focused review studies will include the following design elements:
    - Objective and reason for topic selection
    - Sampling framework and sampling methodology
    - Data collection criteria and analysis methodology
    - Report of data and/or findings
    - Quantitative/Qualitative analysis
    - Barrier analysis
    - Action plans, as appropriate
    - Reassessment, as appropriate
2. The study will be designed to produce accurate, reliable, and meaningful data in accordance with standards of statistical analysis. The study questions will be framed using information from scientific literature, professional organizations, practitioner/provider representatives, regulatory requirements, and outcome-related data. The practice guidelines/ quality indicators used in the study will be specified, whenever possible. The variables to be collected and analyzed will be defined and derived from the practice guideline/quality indicators.

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

9.2: Quality of Care Focused Studies *(cont'd.)*

a. Data may be collected through sampling or may include the entire population that meets the study criteria. The following criteria should be considered in making this decision:
   - The size of the member population eligible for the study.
   - The method of data collection (e.g., administrative data, medical record review, or a hybrid of both, or electronic clinical data systems).
   - The nature of data to be collected.
   - The degree of confidence required for the data.

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

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

9.2: Quality of Care Focused Studies *(cont'd.)*

- Develop clinical practice guidelines through collaboration with plan partners and other collaborative plans.
- Address any practitioner/provider-specific concerns through the peer review process.

d. Implementation schedule
e. Monitoring plan

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

9.3: Clinician and Member Satisfaction Surveys

Clinician Satisfaction Survey

Blue Shield Promise conducts an annual Clinician Satisfaction Survey to assess and improve participating clinicians' satisfaction with Blue Shield Promise's performance. The overall objective of the Clinician Satisfaction Survey is to use the results to improve satisfaction with Blue Shield Promise's performance in utilization management, authorizations and coordination of care, credentialing, translation and interpretation services, contracting, communications, reimbursement, access to care, telehealth, and other key areas. Opportunities are gleaned with each annual survey that allows Blue Shield Promise to demonstrate subsequent improvements in most measured categories. Blue Shield Promise conducts the annual Clinician Satisfaction Survey using a statistically valid random sample of participating primary care physicians, specialists, and behavioral health professionals. The survey is administered using three modalities to maximize responses: U.S. mail, internet, and telephone. The survey is conducted by an independent firm, which is also responsible for following strict quality assurance guidelines. The consultant that performs the Clinician Satisfaction Survey is NCQA-certified and CMS-approved. Results of the annual Clinician Satisfaction Survey are summarized and reported internally to appropriate departments and committees for follow-up and action as well as externally with state regulators.

Member Satisfaction Survey

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

9.4: Clinical Practice Guidelines

Policy

Blue Shield adopts nationally recognized clinical practice guidelines which are reviewed and approved annually through our committees and overseen by our Medical Care Solutions department. Members and providers are educated on these guidelines primarily 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 one or more of the following methods:

- As part of the new Provider Orientation process
- Included in annual Quality Assurance information mailings which are distributed to Providers
- Posted on the Provider website

9.5: Initial Health Appointment (IHA)

Purpose

To establish the patient/doctor relationship and obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status. All newly enrolled members must receive an Initial Health Appointment (IHA) within 120 days of enrollment. See DHCS All Plan Letter 22-030.

Policy

The IHA consists of a comprehensive health history, assessment of health education needs, complete physical assessment, psychosocial/behavioral assessment, screenings, lab tests appropriate to age and gender, TB risk assessments, Advisory Committee on Immunization Practice (ACIP) recommended immunizations, tobacco usage assessment and interventions, unhealthy alcohol and drug use screening and interventions, review of Preventive Services (USPSTF), follow-up, treatments, and referrals (if necessary).

Effective January 1st, 2023, the completion of an Individual Health Education Behavioral Assessment (IHEBA) also known as SHA (Staying Healthy Assessment form) is no longer required at the IHA visit.

As referenced in Title XVII and the United States Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics (AAP) members are entitled to and should receive timely access to an IHA or, alternatively, should have documentation in the member's medical record that a comparable assessment has been performed within the last 12 months.

Documentation

Although there is no specific form(s) for use in conducting and documenting an IHA, complete documentation of this comprehensive health assessment visit is required to be kept in the member's medical record. To assist Blue Shield Promise providers with documentation of the IHA, age-appropriate physical evaluation templates are available on the Blue Shield Promise provider website at: www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms.

Handwritten medical records must be signed, dated, and legible. Legibility means the record-entry is readable by a person other than the writer.

Documentation of an IHA should include (but is not limited to):

1. Past medical history:
    - Prior major illnesses
    - Prior surgeries
    - Prior hospitalizations
    - Current medications
    - Allergies
    - Age-appropriate dietary and feeding status

9.5: Initial Health Appointment (IHA) *(cont'd.)*

2. Identification of Risks
3. Social history
    - Marital and living arrangements
    - Current employment
    - Occupational history
    - Use of drugs and/or alcohol
    - Level of education
    - Sexual history
    - Housing instability
4. Mental status exam
5. Health Education
6. Diagnoses

The Initial Health Appointment (IHA) Services include:

A. Health Assessments for members under 21 years of age in accordance with the AAP/Bright Futures Periodicity Schedule must include, at a minimum:
- Complete health and developmental history.
- Review of organ systems.
- Behavioral/Social/Emotional Screening (annually from newborn to 21 years).
- Developmental disorder screening at 9th, 18th and 30th month visits
- Maternal Depression Screening at 1st, 2nd, 4th, and 6th month visits
- Screen adolescents for depression and suicide risk, making every effort to preserve the confidentiality of the adolescent. Adolescent depression screening begins routinely at 12 years of age.
- Adverse Childhood Experiences Screening (ACEs)
- Risk assessment for high blood pressure starting with newborns, then blood pressure measurements starting at 3 years of age.
- Head circumference from newborn through 24 months; Length/Height and Weight from newborn; BMI starting at 24 months.
- Physical examination, including assessment of physical growth.
- Assessment of nutritional status.
- Hearing and vision screening, as appropriate.
- Oral health risk assessment at 6, 9-, and 12-month visits. Continue with risk assessment at 12-, 18-, 24-, 30-month and 3- and 6-year visits if members do not have an established dental home after 12 months.
- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption and every 3 to 6 months thereafter in the primary care or dental office based on caries risk.

9.5: Initial Health Appointment (IHA) *(cont'd.)*

- If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
- Immunizations as recommended by ACIP and CDC schedules and reported to the California Immunization Registry (CAIR) within 14 calendar days of administration.
- Risk assessment for sudden cardiac arrest and sudden cardiac death from 11 to 21 years.
- Tuberculosis (TB) risk assessments for all members and a PPD skin test and/or chest x-ray for those considered high-risk.
- Tobacco usage assessment (age 11 years and above) and provision of interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.
- HPV Vaccine is recommended by ACIP for girls and boys as young as 9 to 26 years old.
- HIV Screening, as appropriate. Screen adolescents at least once between the age of 15 and 21. Those at increased risk of HIV should be retested annually or more frequently.
- Risk assessment for hepatitis B (HBV) infection from newborn to 21 years of age.
- Hepatitis B screening for adolescents at increased risk of infection
- Hepatitis C screening starting at age 18 years.
- Intimate Partner Violence screening, as appropriate.
- Nutrition Assessment.
- Obesity Screening. Children and adolescents ages 6 and older with a high BMI should be provided with comprehensive, intensive behavioral interventions or referrals for interventions.
- Sexual Activity Assessment and contraceptive care.
- Sexually Transmitted Infection (STI) screening on all sexually active adolescents.
- Cervical Cancer Screening, as appropriate.
- Lab tests appropriate to age and sex, including anemia (Hemoglobin/ Hematocrit) starting at age 9-12 months.
- Diabetes risk assessment.
- Blood lead testing at appropriate intervals as well as appropriate reporting and treatment for abnormal levels.

9.5: Initial Health Appointment (IHA) *(cont'd.)*

- The medical record reflects an assessment of alcohol/drug misuse, using a validated screening tool, for members ages 11 years and older, and the name of the screening tool and the member's score is documented in the medical record. For positive alcohol/drug misuse screening results, the medical record reflects assessment using a validated assessment tool, and documentation that brief misuse counseling has been offered and/or a referral for additional evaluation and treatment.
- Documented referral to the Women, Infants, and Children (WIC) Program for breastfeeding, postpartum women, or parent/guardian of children under the age of 5 years.

B. The IHA Health Appointments for Asymptomatic members 21 years of age and older must include, at a minimum:
   - Complete history and physical examination which includes a review of organ systems that includes inspection of ears, nose, mouth, throat, teeth, and gums.
   - Height, weight, and blood pressure documented.
   - Diabetic screening as part of cardiovascular risk assessment in adults ages 35 to 70 who are overweight or obese.
   - Dyslipidemia screening and calculation of 10-year Cardiovascular Disease (CVD) event risk in adults ages 40 to 75.
   - Hepatitis B and hepatitis C screening for all adults and testing at least once in a lifetime, except when risk factors exist.
   - Mammography screening for breast cancer is completed every 2 years on all women starting at age 40 and continuing through age 74 unless pathology has been demonstrated.
   - Cervical Cancer screen (Pap smear) for women beginning at the age 21-65 or first sexual intercourse and once every 3 years, or for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years.
   - Chlamydia and gonorrhea screen for all sexually active females 24 years or younger and in women 25 years or older who are at high risk for infection (high risk—such as but not limited to, new or multiple sex partners, prior history of STD, not using condoms consistently and correctly).
   - Tuberculosis (TB) risk assessments for all members and a PPD skin test and/or chest x-ray for those considered high-risk.
   - Initial and annual assessment of tobacco use for each member and interventions, including education and counseling for those members using tobacco.
   - The medical record reflects an assessment of alcohol/drug misuse, using a validated screening tool, for members ages 11 years and older, and the name of the screening tool and the member's score is documented in the medical record. For positive alcohol/drug misuse screening results, the medical record reflects assessment using a validated assessment tool, and documentation that brief misuse counseling has been offered and/or a referral for additional evaluation and treatment.

9.5: Initial Health Appointment (IHA) *(cont'd.)*

- Intimate Partner Violence (IPV) Screening and the provision of ongoing support services for anyone who screens positive.
- Depression and suicide risk screening for older adults (65 years and older).
- Screening for anxiety for adults 64 years and younger, including pregnant and postpartum women.
- Adverse Childhood Experiences Screening (ACEs).
- HIV Screening.
- Sexually Transmitted Infection (STI) Screening.
- Health education and anticipatory guidance appropriate to age and health statistics.
- Documented referral to the Women, Infants, and Children (WIC) Program for breastfeeding, postpartum women, or parent/guardian of children under the age of 5 years.
- Colorectal cancer screening performed for all adults at age 45 and concluding at age 75 years, or per current guidelines. Prostate Specific Antigen (PSA) testing for men annually at 45 years of age with high risk and ages 50 – 70 for men with average risk.
- Annual cognitive health assessment using at least one cognitive assessment tool for adults 65 years and older.
- Immunizations administered as recommended by the current ACIP and CDC schedules and reported to California Immunization Registry (CAIR2) within 14 calendar days of immunization.
- Lung cancer screening in adults aged 50 to 80 years who have a 20-pack-a-year smoking history and are currently smoking or have quit within the past 15 years.

Procedure

1. The Member Handbook, distributed at the time of enrollment, contains both basic information about PCP services and specific information describing the importance of the IHA. It encourages members to access this service. Members are specifically directed, in their Blue Shield Promise New Member packet, to contact their PCP's office to schedule an IHA.
2. Blue Shield Promise Provider Relations representatives educate both newly contracted practitioners/providers and contracted practitioners/providers about the 120-day IHA requirements for newly enrolled Medi-Cal members. Blue Shield Promise also uses bulletins and newsletters to reinforce practitioner/provider awareness of the 120-day IHA requirement for newly enrolled members.
3. In collaboration with our providers, Blue Shield Promise conducts outreach to all new members to ensure timely access to the IHA. Members will receive phone calls notifying them of the available service, offering assistance to schedule an IHA, offering transportation assistance to and from an IHA, or encouraging them to call their PCP to make an IHA appointment within 120 days of enrollment.

9.5: Initial Health Appointment (IHA) *(cont'd.)*

Procedure *(cont'd.)*

4. To ensure that newly enrolled Blue Shield Promise members obtain an IHA with their new PCP within 120 days of enrollment, Blue Shield Promise will coordinate with our members and providers as follows:
   a. Blue Shield Promise will make reasonable attempts to contact each new member to schedule the timely IHA.
   b. Blue Shield Promise will notify newly enrolled members of the importance and availability of IHAs through the Member Welcome Letter, member telephonic outreach, member handbook, EOC, and newsletters.
   c. Blue Shield Promise will notify PCPs of the requirement to schedule IHAs for newly enrolled members within 120 days of enrollment through the Blue Shield Promise Provider Manual, provider newsletters, Provider Connection, provider websites and fax blasts.
5. To ensure that newly enrolled Blue Shield Promise members obtain an IHA within 120 days of their enrollment date, PCPs are responsible for the following actions:
   a. Blue Shield Promise PCP offices are required to contact new members by email, letter, and/or telephone to assess the current need for an IHA, and to schedule an IHA for the member within the required 120 days of enrollment, if warranted.
   b. If a comprehensive health assessment has recently been performed elsewhere and all elements of the IHA have been completed within 12 months prior to the member's enrollment date, then the new PCP may be given an exception to the 120-day IHA time frame requirement, provided that the PCP obtains the appropriate previous medical records and documents from the previous PCP and adds them to the member's current medical record.
   c. If a member refuses an IHA, the PCP must document the refusal in the member's medical record. The PCP is responsible for educating the member on the importance of scheduling an IHA appointment within 120 days of enrollment to establish the patient/doctor relationship and obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status, and the PCP's education efforts with the member and the member refusal to schedule an IHA must be recorded in the member's medical record.
6. To ensure that newly enrolled Blue Shield Promise members complete an IHA within 120 days of their enrollment date, Blue Shield Promise will conduct the following monitoring and oversight actions:
   a. Blue Shield Promise will monitor PCP compliance with the requirement to contact new members by email, letter, and/or telephone to assess the current need for an IHA, via randomized medical record reviews conducted on a quarterly basis.
   b. Blue Shield Promise will monitor PCP compliance with the requirement to schedule an IHA for all new members within 120 days of enrollment, via randomized file reviews conducted on a quarterly basis.

9.5: Initial Health Appointment (IHA) *(cont'd.)*

Procedure *(cont'd.)*

c. After completing the medical record review, the Blue Shield Promise nurse auditor will score the PCP medical record according to the approved scoring guidelines. Compliance will fall into the following categories:
   (i) Pass: 90% and above
   (ii) Not Pass: 89% and below
d. Illegible entries on handwritten medical records will be scored as "No", indicating that there was no documentation that the specified criteria was included in the IHA.
e. A Corrective Action Plan (CAP) is required for all PCPs who do not pass the IHA medical record audit.
f. Blue Shield Promise IHA nurse auditors will provide education and resources to PCPs needing assistance with CAP completion.
g. PCPs currently in the network that are issued CAPS and do not complete applicable CAP or CAPS within the established time frames may be referred to Provider Relations for further action, which may include but is not limited to immediate closure of panels to new membership, annual audit and/or termination from the network.
h. Blue Shield Promise and the practitioner's/provider's delegated IPA/medical groups may contact practitioners/providers who do not submit their CAP within the established time frames to offer education and resources for assistance.

7. To ensure that newly enrolled Blue Shield Promise members receive follow-up, further evaluation, or referral in a timely manner, when a significant health problem, requiring further evaluation or referral, is identified during the IHA, or another interaction with the PCP, the PCP is responsible for scheduling an appointment date with the member for follow-up within 60 days.
8. Blue Shield Promise will monitor PCP compliance with the requirement to schedule an appointment date for follow-up within 60 days for a member who was identified during the IHA, or another interaction with the PCP, as having a significant health problem, requiring further evaluation or referral enrollment, via randomized medical record reviews conducted on a quarterly basis.
9. If a new member cancels an IHA or does not show up for the IHA the PCP must make reasonable attempts to contact the member to reschedule the appointment. All PCP outreach to the member must be documented in the member's medical record.
10. Blue Shield Promise will monitor PCP documentation of the PCPs compliance with the requirement for the PCP to make reasonable attempts to contact a new member who has canceled or did not show up for an IHA, via randomized medical record reviews conducted on a quarterly basis.
11. If a member refuses to schedule an IHA, the refusal must be documented by the PCP in the member's medical record. The PCP is responsible for educating the member on the importance of scheduling an IHA within 120 days of enrollment to establish care, and the PCP's education efforts must be recorded in the member's medical record.

9.5: Initial Health Appointment (IHA) *(cont'd.)*

Provider Incentives

Blue Shield Promise is committed to providing supportive services for network providers and has developed an IHA provider incentive program for contracted network providers who perform IHAs for new Medi-Cal enrollees to Blue Shield Promise. The IHA provider incentive program rewards Blue Shield Promise network providers for ensuring that every member who requires an IHA receives the care they need. Eligible providers can receive payouts that will be made for every IHA completion demonstrated in Blue Shield Promise data systems, via encounter data with a date of service within 120 days of the member's enrollment in the Blue Shield Promise Health Plan. If a network primary care physician is interested in participating in the Blue Shield Promise IHA Provider Incentive program, providers are encouraged to contact the Blue Shield Promise Provider Services number to inquire about applying for the incentive program.

9.6: Facility Site Review

Overview

The Facility Site Review (FSR) process is a comprehensive evaluation of Blue Shield Promise primary care physician (PCP) offices and includes a review of the physical site, administration, policies and procedures, medical record keeping practices, as well as other critical areas, to demonstrate contractual requirements are met and maintained. Blue Shield Promise maintains policies and procedures that ensure the FSR Program follows the DHCS All Plan Letter 22-017, or most current version, and Title 22 Regulatory requirements, which are mandatory under Blue Shield Promise's contract with DHCS and LA Care Health Plan (for Los Angeles County).

Certified Site Reviewers (CSRs) are expected to determine the most appropriate method(s) in each site to ascertain the information needed to complete the review. Review criteria shall be reviewed by approved clinical professionals only. CSRs will be, at a minimum, a registered nurse (RN) however, a nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife may also be able to obtain a CSR certification.

Each PCP site will be evaluated at the time of initial credentialing and at least every three (3) years by Blue Shield Promise, a contracted reviewer, or a County Collaborative Health Plan, according to requirements. Blue Shield Promise participates in the Site Review Collaborative in the County where a site(s) is/are located and will accept reviews completed by Certified Site Reviewers from other contracted Health Plans in the same county. Complete facility site review audit tools and standards as well as additional resources are available under the QIP focus areas heading of the Quality Improvement Program page found at the following link:

https://www.blueshieldca.com/en/bsp/providers/programs/quality-improvement

9.6: Facility Site Review *(cont'd.)*

9.6.1: FSR Evaluation

Procedure

1. New providers will be evaluated by the Provider Information and Enrollment (PIE) team to determine whether a valid FSR exists prior to adding a new IPA relationship to the Blue Shield Promise Medi-Cal provider network.
2. If an FSR cannot be validated, the FSR unit will be notified.
3. An FSR will be conducted by Blue Shield Promise upon receipt of a request from the PIE team prior to any Primary Care Physician's site being added to the provider network.
4. The FSR unit will process an FSR for all sites within 60 days of receipt of a request for an FSR or at least 30 days prior to their three-year or annual anniversary date.
5. The FSR will be conducted using the most current review Survey tool as directed by the DHCS and approved by the Blue Shield Promise Medical Directors.
6. Practitioners/Providers for initial credentialing and recredentialing will be contacted a minimum of three (3) times to schedule a mutually agreed-upon date and time to conduct the review. If Blue Shield Promise is unsuccessful in contacting an initial credentialing site, Provider Network Administrators or Credentialing will be notified. If Blue Shield Promise is unsuccessful in contacting a recredentialing site, an auto-scheduled date may be generated to complete the review by the required timelines.
7. The Facility Site Review unit will send a confirmation letter along with a link that contains sample copies of the tools to be used as well as a set of policies and procedures and forms that your office can use to update the office policies and procedures to meet criteria from the Center for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS).
8. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough, and helpful. If a reviewer cannot answer a question, the reviewer will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.
9. After completing the review, the reviewer will score the facility according to the approved scoring guidelines. Compliance will fall into the following categories:
    - Exempted Pass: 90% and above without deficiencies in Critical Elements, Pharmaceutical, or Infection Control sections.
    - Conditional Pass 80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical, or Infection Control sections.
    - Not Pass 79% and below.
    - A Corrective Action Plan (CAP) is required for all sites that have a deficiency in a critical element, Pharmaceutical, or Infection Control sections, regardless of the score.

9.6: Facility Site Review *(cont'd.)*

9.6.1: FSR Evaluation *(cont'd.)*

10. Any CAP considered critical is due within 10 business days of the date of the review. A non-critical CAP for remaining deficiencies will be due 30 days from the date of the issued CAP report.
11. Blue Shield Promise Facility Site Review unit will provide educational and technical support to assist practitioners/providers with the review preparation and applicable CAP completion.
12. New Practitioners/Providers' site locations may request an educational visit. Any non-contractual provider site location that does not receive a passing score on their initial FSR or passes but does not close any applicable CAP(s) per the established timelines, will be required to request a resurvey.
13. Blue Shield Promise Facility Site Review Unit will follow the established CAP timeline for CAP notification and completion as outlined in DHCS APL 22-017, or most current version
14. Providers that do not come into compliance with review criteria and CAP requirements within the established timelines may be removed from the Network. Their members may also be expeditiously reassigned to other Network Providers.
15. Practitioners/providers that score below 80% in the FSR or MRR for two consecutive reviews must score a minimum of 80% for both FSR and MRR in the next review. Sites that don't score a minimum of 80% will be removed from the network for a period of three years, and the provider's members will be appropriately reassigned.
16. Blue Shield Promise follows the DHCS FSR standards as written in DHCS All Plan Letter 22-017, or the most current version.

9.6.2: Facility Site Review Categories

1. Access/Safety
2. Personnel
3. Office Management
4. Clinical Services
    - Pharmaceutical Standards
    - Laboratory Review
    - Radiology Review
5. Preventive Services
6. Infection Control

For FSR Review tools and standards, see DHCS All Plan Letter 22-017 or most current version. The most current version may also be provided to the PCP site prior to the scheduled FSR.

9.7: Medical Records

9.7.1: Policy

The onsite or virtual practitioner/provider audit is a comprehensive evaluation of medical records. Through this process, Blue Shield Promise will identify areas of excellence and deficiencies based on approved criteria. Blue Shield Promise will provide information, suggestions, and recommendations to assist providers in meeting and exceeding standards. All primary care physicians will have a complete medical record review (MRR) at each practice location, conducted in conjunction with the facility site review process.

Blue Shield Promise will utilize the most current version of the DHCS Medical Record Review tool to evaluate compliance with DHCS requirements.

Reviewers will ensure the confidentiality of Protected Health Information (PHI) or Personally Identifiable Information (PII) when conducting a Medical Record Review (MRR).

9.7.2: Procedure

1. Medical records shall be randomly selected using the methodology decided upon by the reviewer. Ten (10) medical records are reviewed for each primary care physician (PCP) site. For sites with only adult or only pediatric patient members, all ten records reviewed will be in only one preventive care criteria. For sites with adult and pediatric members, five (5) adults and five (5) pediatric preventive criteria will be reviewed. For PCP sites where the OB-GYN provides both specialty and preventive services, based on the age of the patient, the reviewer must review either adult or pediatric preventive criteria as well as OB Comprehensive Perinatal Services Program (CPSP) criteria.
    a. PCP sites that document patient care performed by multiple PCPs in the same medical record are considered "shared." The Managed Care Plan (MCP) must consider shared medical records as those that are not identifiable as "separate" records belonging to any specific PCP. Scores calculated on shared medical records apply only to PCPs sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, 20 records for 4-6 PCPs, and 30 records for 7 or more PCPs based on specialty and/or population served.
        i. Example for determining the number of medical records to review:
            1. A site that has three (3) providers, two (2) providers see only adults and share records, and one (1) only sees pediatrics and does not share records, 10 medical records on the two providers who share medical records and 10 medical records on the provider who does not share records will be conducted and scored separately. A total of 20 medical records shall be reviewed for this site. Two (2) scores will be reported for this site.
2. The medical record review looks at member records related to format, documentation, Continuity/Coordination of Care, Pediatric Preventive Care, Adult Preventive Care, and, if applicable, OB/CPSP Preventive Care. Reviews are completed and scored. The Certified Site Reviewer will conduct the Medical Record Review in conjunction with the Facility Site Review utilizing the most current and approved Medical Record Review Tool.

9.7: Medical Records *(cont'd.)*

9.7.2: Procedure *(cont'd.)*

3. Initial medical records of a new provider will be reviewed within 90 calendar days of the date that Blue Shield Promise first assigns members to a provider. CSRs may defer the review an additional 90 calendar days if the new provider does not have enough assigned members to complete a review of the (10) medical records. At the end of six months, if the provider still has fewer than ten assigned member records, the CSR must complete an MRR on the total number of records available and adjust the scoring according to the number of records reviewed.
4. Staff from the FSR unit will schedule an appointment with the individual practitioner/provider's office. Blue Shield Promise personnel are available to assist the practitioner/provider in preparation for the review and forms can be obtained from the Blue Shield Promise provider website at www.blueshieldca.com/content/dam/bsca/en/promise/docs/Facility-Site-Review-Policy-and-Procedures.pdf.
    a. Practitioners/providers for initial credentialing and recredentialing will be contacted a minimum of three (3) times to schedule a mutually agreed-upon date and time to conduct the review. If Blue Shield Promise is unsuccessful in contacting a site, an auto-scheduled date will be generated to complete the review by the required timelines.
    b. The Facility Site Review unit will provide confirmation of a scheduled MRR.
5. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough, and helpful. If a reviewer cannot answer a question, he/she will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.
6. Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for review criteria determinations.
7. Compliance levels are:
    a. Exempted Pass = 90%
    b. Conditional Pass = 80-89%
    c. Not Pass is below 79%
8. The minimum passing score is 80%. A Corrective Action Plan (CAP) is required for a total MRR score below 90%. Also, any section scores of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

9.7: Medical Records *(cont'd.)*

9.7.2: Procedure *(cont'd.)*

9. Not Applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed and will be explained in the comment section.

   Practitioners/providers that score below 80% in the FSR or MRR for two consecutive reviews must score a minimum of 80% for both FSR and MRR in the next review. Sites that don't score a minimum of 80% will be removed from the network for a period of three years, and the provider's members will be appropriately reassigned.

10. Blue Shield Promise Facility Site Review unit will provide educational and technical support to assist practitioners/providers in meeting compliance and completion of any applicable CAPs.
11. Blue Shield Promise Facility Site Review unit will follow the established CAP timeline for CAP notification and completion as outlined in DHCS APL 22-017, or most current version.
12. Providers that do not come into compliance with review criteria and CAP requirements within the established timelines may be removed from the network. Their members may also be expeditiously reassigned to other network providers.

9.7.3: Medical Record Review Categories

Pertinent medical record criteria during Medical Record Review are as follows and is subject to change based on the latest DHCS review tools and standards or Blue Shield Promise discretion:

I. Format Criteria

A. Member identification is on each page.
B. Individual personal biographical information is documented.
C. Emergency "contact" is identified.
D. Medical records are maintained and organized.
E. Members assigned and/or rendering primary care physician (PCP) are identified.
F. Primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.
G. Person or entity providing medical interpretation is identified.
H. Signed Copy of the Notice of Privacy.

II. Documentation Criteria

A. Allergies are prominently noted.
B. Chronic problems and/or significant conditions are listed.
C. Current continuous medications are listed.
D. Appropriate consents are present:
   1) Release of Medical Records
   2) Informed Consent for invasive procedures

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

E. Advance Health Care Directive Information is offered.
F. All entries are signed, dated, and legible. (All documentation must be in English, and Non -English proficient forms must have the English form available on site or in each record.)
G. Errors are corrected according to legal medical documentation standards.

III. Coordination of Care Criteria

A. History of present illness or reason for the visit is documented.
B. Working diagnoses are consistent with findings.
C. Treatment plans are consistent with diagnoses.
D. Instruction for follow-up care is documented.
E. Unresolved/continuing problems are addressed in subsequent visit(s).
F. There is evidence of practitioner review of specialty/consult/referral reports and diagnostic test results.
G. There is evidence of follow-up of specialty consult/referrals made, and results/reports of diagnostic tests, when appropriate.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.

IV. Pediatric Preventive Criteria

A. Initial Health Appointment (IHA) Includes H&P. Effective January 1st, 2023, the completion of an Individual Health Education Behavioral Assessment (IHEBA) also known as a SHA (Staying Healthy Assessment form) will no longer be required at the IHA visit.
   1) Comprehensive History and Physical
   2) Risk Assessment
B. Subsequent Comprehensive Health Assessment.
   1) Comprehensive History and Physical exam completed at an age-appropriate frequency
   2) Risk Assessment
C. Well-child visit.
   1) Alcohol Use Disorder Screening and Behavioral Counseling
   2) Anemia Screening
   3) Anthropometric Measurements
   4) Anticipatory Guidance
   5) Autism Spectrum Disorder Screening
   6) Blood Lead Screening
   7) Blood Pressure Screening
   8) Dental/Oral Health Assessment
      a) Fluoride Supplementation
      b) Fluoride Varnish
   9) Depression Screening

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

a) Suicide-Risk Screening
b) Maternal Depression Screening

10) Developmental Disorder Screening
11) Developmental Surveillance
12) Drug Use Disorder Screening and Behavioral Counseling
13) Dyslipidemia Screening
14) Hearing Screening
15) Hepatitis B Virus Infection Screening
16) Hepatitis C Virus Infection Screening
17) Human Immunodeficiency Virus (HIV) Infection Screening
18) Psychosocial/Behavioral Assessment
19) Sexually Transmitted Infections (STIs) Screening and Counseling
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening
21) Tobacco Use Screening, Prevention, and Cessation Services
22) Tuberculosis Screening
23) Vision Screening

D. Childhood Immunizations.
   1) Given according to Advisory Committee on Immunization Practices (ACIP) guidelines
   2) Vaccine administration documentation
   3) Vaccine Information Statement (VIS) documentation

V. Adult Preventive Criteria

A. Initial Health Appointment (IHA): Includes H&P. Effective January 1st, 2023, the completion of an Individual Health Education Behavioral Assessment (IHEBA) also known as a SHA (Staying Healthy Assessment form) will no longer be required at the IHA visit.
   1) Comprehensive History and Physical
   2) Risk Assessment
B. Periodic Health Evaluation according to the most recent United States Preventive Services Taskforce (USPSTF) Guidelines.
   1) Comprehensive History and Physical Exam completed at an age-appropriate frequency
   2) Risk Assessment
C. Adult Preventive Care Screenings.
   1) Abdominal Aneurysm Screening
   2) Alcohol Use Disorder Screening and Behavioral Counseling
   3) Breast Cancer Screening
   4) Cervical Cancer Screening
   5) Colorectal Cancer Screening
   6) Depression Screening
   7) Diabetic Screening

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

a) Comprehensive Diabetic Care
8) Drug Use Disorder Screening and Behavioral Counseling
9) Dyslipidemia Screening
10) Folic Acid Supplementation
11) Hepatitis B Virus Screening
12) Hepatitis C Virus Screening
13) High Blood Pressure Screening
14) HIV Screening
15) Intimate Partner Violence Screening for Women of Reproductive Age
16) Lung Cancer Screening
17) Obesity Screening and Counseling
18) Osteoporosis Screening
19) Sexually Transmitted Infection (STI) Screening and Counseling
20) Skin Cancer Behavioral Counseling
21) Tobacco Use Screening, Counseling, and Intervention
22) Tuberculosis Screening

D. Adult Immunizations.
1) Given according to ACIP guidelines
2) Vaccine administration documentation
3) Vaccine Information Statement (VIS) documentation

VI. Obstetrician (OB)/Comprehensive Perinatal Services Program (CPSP) Preventive Criteria

A. Initial Comprehensive Prenatal Assessment (ICA).
1) Initial prenatal visit
2) Obstetrical and Medical History
3) Physical Exam
4) Dental Assessment
5) Healthy Weight Gain and Behavioral Counseling
6) Lab tests
a) Bacteriuria Screening
b) Rh Incompatibility Screening
c) Diabetes Screening
d) Hepatitis B Virus Screening
e) Hepatitis C Virus Screening
f) Chlamydia Infection Screening
g) Syphilis Infection Screening
h) Gonorrhea Infection Screening
i) Human Immunodeficiency Virus (HIV) Screening

B. First Trimester Comprehensive Assessment.
1) Individualized Care Plan (ICP)
2) Nutrition Assessment

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

3) Psychosocial Assessment
   a) Maternal Mental Health Screening
   b) Social Needs Assessment
   c) Substance Use Disorder
4) Breast Feeding and other Health Education Assessment
5) Preeclampsia Screening
6) Intimate Partner Violence Screening

C. Second Trimester Comprehensive Assessment.
1) ICP
2) Nutrition Assessment
3) Psychosocial Assessment
   a) Maternal Mental Health Screening
   b) Social Needs Assessment
   c) Substance Use Disorder Assessment
4) Breast Feeding and other Health Education Assessment
5) Preeclampsia Screening
   a) Low Dose of Aspirin
6) Intimate Partner Violence Screening
7) Diabetes Screening

D. Third Trimester Comprehensive Assessment.
1) ICP Update and Follow Up
2) Nutrition Assessment
3) Psychosocial Assessment
   a) Maternal Mental Health Screening
   b) Social Needs Assessment
   c) Substance Use Disorder Assessment
4) Breastfeeding and other Health Education Assessments
5) Preeclampsia Screening
   a) Low Dose of Aspirin
6) Intimate Partner Violence Screening
7) Diabetic Screening
8) Screening for Strep B
9) Screening for Syphilis
10) Tdap Immunization

E. Prenatal care visit periodicity according to most recent American College of Obstetricians and Gynecologists (ACOG) standards.
F. Influenza Vaccine.
G. COVID Vaccine.
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and assessment of Infant Feeding Status.
I. HIV-related services offered.

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

J. AFP/Genetic Screening offered.
K. Family Planning Evaluation.
L. Comprehensive Postpartum Assessment.
   1) ICP
   2) Nutrition Assessment
   3) Psychosocial Assessment
      a) Maternal Mental Health Screening/Postpartum Depression screening
      b) Social Needs Assessment
      c) Substance Use Disorder Assessment
   4) Breastfeeding and other Health Education Assessments
   5) Comprehensive Physical Exam

9.7.4: Physical Accessibility Review Survey (PARS) (FSR Tool Attachment C)

Purpose

To establish Medi-Cal managed care health plan requirements for the implementation of the Facility Site Review (FSR) Tool Attachment C. The DHCS developed the requirements for FSR Attachment C pursuant to Welfare and Institutions (W&I) Code Section 14182(b)(9). The existing site review process, or FSR Tool, detailed in the Medi-Cal Managed Care Division's (MMCD) PL 02-02, remains in effect and will incorporate these requirements for assessing the level of physical accessibility of provider sites, including specialist and ancillary service providers, that serve a high volume of Seniors and Persons with Disabilities (SPDs).

Policy

The physical accessibility review will be conducted for providers servicing the seniors and persons with disabilities (SPD) population which includes PCPs, specialists, and ancillary providers to provide equal and appropriate access to health care treatment and services and network of our providers.

Blue Shield Promise will utilize the most appropriate and current DHCS Physical Accessibility Review Survey (PARS) tools to assess provider sites based on the following categories:

- Attachment C – Primary Care and Specialty Care Providers
- Attachment D – Ancillary Care Providers
- Attachment E – Community-Based Adult Services (CBAS) Providers

Blue Shield Promise has certified clinical and non-clinical personnel to conduct PARS audits.

Procedure

The FSR Attachment C survey is required and may be recertified if there are no structural changes or renovations from the last conducted on-site review date.

1. Accessibility indicators include the following areas:
   A. Parking

9.7: Medical Records *(cont'd.)*

9.7.4: Physical Accessibility Review Survey (PARS) (FSR Tool Attachment C) *(cont'd.)*

Procedure *(cont'd.)*

B. Exterior Building
C. Interior Building
D. Restroom
E. Exam Room
F. Exam Table/Scale

2. Results of Level of Access include:
   A. Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room, and restroom. To meet. Basic Access requirements, all (29) Critical Elements (CE) must be met.
   B. Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.
   C. Medical Equipment Access: PCP site has height adjustable exam table and patient-accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to the level of Basic or Limited Access as appropriate.

Note: The results of PARS/FSR Attachment Care are informational only and unlike Facility Site Review and Medical Records Reviews, results do not require corrective action. Results may be shared with the provider's office and a copy of the results can be provided upon request. If an office chooses to make a change based on PARS results or recommendations, reviewers can return to perform an additional assessment to update health plan results. The results of this survey are included in the provider directory.

9.8: Access to Care

Blue Shield Promise requires its providers to comply with the standards listed in the attachments of Appendix 4: Access to Care Standards.

Compliance with these standards is monitored through member complaints and grievances, Potential Quality Issues ("PQI"), member satisfaction surveys, medical record reviews, disenrollment, PCP transfers, and annual Access Surveys and Studies. Blue Shield Promise will ensure that accurate provider contact lists are generated for all provider types required to be surveyed for the current Measurement Year.

Blue Shield Promise shall ensure that its provider network is sufficient to provide accessibility, availability, and continuity of covered healthcare services established by regulatory and accreditation standards.

9.8: Access to Care *(cont'd.)*

Monitoring Access for Compliance with Standards

Access to care standards is reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis. Provider network adherence to access standards are monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, and after-hours access.
2. Member complaint data – assessment of member complaints related to access to care.
3. Member satisfaction survey – evaluation of members' self-reported satisfaction with appointments and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. The results of the analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.

After Hours Care and Emergencies

Primary and specialty care physicians are required to be available to render emergency care to members 24 hours a day, 7 days a week, either directly or through arrangements for after-hours coverage with an appropriately qualified practitioner/provider. Physicians may provide care in their offices or based on the medical necessity of the case, refer the member to an urgent or emergency care facility. Blue Shield Promise has a nurse on call to arrange for care if a practitioner/provider is unavailable. If a member contacts the Plan about an emergency situation, the Plan will direct the member to an appropriate urgent or emergency care center for immediate assessment and treatment.

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.

Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record.

9.8: Access to Care *(cont'd.)*

3. When the Provider must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of members must be accommodated when scheduling appointments. This includes, but is not limited to, wheelchair-using members and members requiring language translation.
5. A process for member notification of preventive care appointments must be established. This includes but is not limited to immunizations and mammograms.
6. A process must be established for member follow-up in the case of missed appointments for a condition that requires treatment, abnormal diagnostic test results, or the scheduling of procedures that must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any member based on age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental, or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a member's medical (physical or mental) condition or the expectation of the need for frequent or high-cost care. If a PCP chooses to close his/her panel to new members, Blue Shield Promise Health Plan must receive thirty (30) days advance written notice from the Provider.

IPA/medical groups are expected to ensure that each practitioner/provider in their network receives and complies with Appendix 4: Access to Care Standards.

Medi-Cal Laws require organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal manage care enrollee must be comparable to those for Medi-Cal fee-for-service members.

Plan-to-Plan Arrangements

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

9.8.1: Monitoring Process

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

9.8: Access to Care *(cont'd.)*

9.8.1: Monitoring Process *(cont'd.)*

DHCS Timely Access Requirements

As part of DHCS's network adequacy monitoring, DHCS reviews Blue Shield Promise's performance with timely access standards by administering a quarterly Timely Access Survey. The rate of compliance is assessed on a quarterly and annual basis during each Measurement Year and the annual results are posted publicly and included in the Annual Network Certification that is submitted to CMS in accordance with 42 CFR Section 438.207(d).

DHCS uses a third-party vendor to administer their quarterly Timely Access Survey. The Timely Access Survey uses Blue Shield Promise's Medi-Cal Managed Care 274 Provider Network file (274 Provider file) data and a statistical sampling methodology to identify provider locations for the practicing providers surveyed. The survey administrator contacts provider offices, Blue Shield Promise's Member Services lines, and nurse triage lines throughout the year to assess compliance standards. Provider offices are asked to confirm the next available appointments to collect appointment wait times, including accessibility through telehealth services. Provider offices are also asked to respond to questions related to knowledge of patients' rights to translation and interpretation services. Additionally, to validate Blue Shield Promise's 274 Provider file data, provider offices are asked to confirm information including but not limited to: each provider's telephone number, address, office hours, and whether the provider is accepting new patients.

Blue Shield Promise Member Services staff are asked to respond to questions related to translation, interpretation, and telehealth services. DHCS also verifies wait times for the Blue Shield Promise Member Services line and nurse triage line through their Timely Access Survey. DHCS provides the results to Blue Shield Promise each quarter and compiles the quarterly results into an annual result provided to Blue Shield Promise by the second quarter of the subsequent Measurement Year.

Effective January 1, 2025 (MY 2025), timely access MPLs are established for the following categories: appointment wait times, MCP Member Services wait times, Provider knowledge of the interpretation services requirements, and 274 Provider file data quality as outlined in the MPL Chart below.

Minimum Performance Level (MPL) Categories and Thresholds

Timely Access Category	MPL Effective 1/1/2025 to 12/31/2026	MPL Effective 1/1/2027	MPL Effective 1/1/2028
Urgent Adult PCP Appointment	70%	80%	90%
Urgent Pediatric PCP Appointment	70%	80%	90%
Non-Urgent Adult PCP Appointment	70%	80%	90%
Non-Urgent Pediatric PCP Appointment	70%	80%	90%
Urgent Adult Specialist Appointment	70%	80%	90%

Timely Access Category	MPL Effective 1/1/2025 to 12/31/2026	MPL Effective 1/1/2027	MPL Effective 1/1/2028
Urgent Pediatric Specialist Appointment	70%	80%	90%
Non-Urgent Adult Specialist Appointment	70%	80%	90%
Non-Urgent Pediatric Specialist Appointment	70%	80%	90%
Non-Urgent Non-Physician Mental Health Care or SUD Provider Appointment	70%	80%	90%
Urgent Non-Physician Mental Health Care or SUD Provider Appointment	70%	80%	90%
Non-Urgent Non-Physician Mental Health Care or SUD Provider Follow-Up Appointment	70%	80%	90%
Non-Urgent Ancillary Appointment35	70%	80%	90%
274 Provider Data Quality	70%	80%	90%
Member Services Telephone Wait Times that are 10 Minutes or Less	90%		
24/7 Nurse Triage Line[36]	90%		
Providers Demonstrating Awareness of Interpretation Service Requirements	90%		
Provider Participation	90%		

9.8: Access to Care *(cont'd.)*

9.8.2: Subcontracted Network Certification Requirement

The Department of Health Care Services (DHCS) requires Medi-Cal managed care plans to implement a subcontracted annual network certification process effective July 1, 2021. A subcontracted network is a network in which Blue Shield Promise has delegated various functions, including but not limited to; claims, credentialing, financial solvency, and utilization management to entities such as groups, independent provider associations (IPAs), hospitals, and applicable vendors.

The goal of the subcontracted network certification requirement is to ensure managed care plans (MCPs) that delegate the responsibility of providing Medi-Cal covered healthcare services to subcontracted networks meet network adequacy requirements for each subcontracted network. All subcontracted networks will be subject to the same network adequacy standards required of the primary MCP, as outlined in DHCS APL 23-001, which include:

- Mandatory provider types
- Network capacity and ratios
- Network provider types
- Provider to member ratios
- Telehealth
- Time and distance standards
- Timely access to care

9.8: Access to Care *(cont'd.)*

9.8.2: Subcontracted Network Certification Requirement *(cont'd.)*

The below grid outlines the mandatory provider types (MPT):

Ancillary Services
Certified Nurse Midwives (CNM)
Doulas
Federally Qualified Health Centers (FQHC)
Freestanding Birth Centers (FBC)
Hospitals
Indian Health Care Providers (IHCP)
Licensed Midwives (LM)
Long Term Services and Support (LTSS)
Mental Health (non-psychiatry) Outpatient Services (Adult and Pediatric)
Obstetrician/Gynecologist (OB/GYN) Primary Care
Obstetrician/Gynecologist (OB/GYN) Specialty Care
Pharmacies
Primary Care (Adult and Pediatric)
Rural Health Clinics (RHC)
Specialty Care (Adult and Pediatric) Adult and pediatric core specialists: • Cardiology/Interventional Cardiology • Dermatology • Endocrinology • ENT/Otolaryngology • Gastroenterology • General Surgery • Hematology • HIV/AIDS Specialists/Infectious Diseases • Nephrology • Neurology • Oncology • Ophthalmology • Orthopedic Surgery • Physical Medicine and Rehabilitation • Psychiatry • Pulmonology

The full list of network adequacy standards may be found on the DHCS website in Attachment A of APL 23-001.

Subcontracted networks will need to meet network adequacy standards for the scope of services they are contracted to provide. If Blue Shield Promise determines that a subcontracted network will not be certified, we must clearly explain the reason(s) and work with the subcontracted network to ensure that members within the network would otherwise be able to access appropriate care.

Subcontracted network will be assessed on a minimum biannual basis. Upon completing the review of subcontractor assessments, Blue Shield Promise will provide a CAP notification letter to each subcontractor found non-compliant with the subcontracted network certification requirements, outlining the deficiencies and specific issues of noncompliance that the subcontractor must address. Subcontractors must provide an initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action, including policies, and sets forth steps the subcontractor will take to correct the deficiencies identified.

9.8: Access to Care *(cont'd.)*

9.8.2: Subcontracted Network Certification Requirement *(cont'd.)*

Subcontractors have six months to correct all deficiencies during which time must provide Blue Shield Promise with monthly status updates that demonstrate action steps the subcontractors are undertaking to address the CAP. Blue Shield Promise may impose sanctions, or other appropriate enforcement actions, for failure to comply with Network Adequacy All Plan Letter 23-006 and access standards at the end of the six-month CAP period. If monetary sanctions are to be imposed by DHCS, Blue Shield Promise will consider imposing monetary sanctions on subcontractors.

Blue Shield Promise has requirements for delegated entities which address frequency and time frame of reporting of provider data used in the network adequacy indicators with subcontractors. Subcontractors are required to validate their provider network quarterly though established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels etc., outlined in Section 12.7 of this manual.

9.8.3: Advanced Access

Blue Shield Promise 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 Promise 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.

Advanced Access is a way of scheduling appointments that allow patients to seek and receive care from a qualified provider the same day or the next day, as opposed to weeks in the future. Typical physician schedules are fully booked for days or weeks in advance, meaning that when patients call for appointments, they cannot be seen that day or the next day. Consequently, wait times for appointments can be long, and patients may opt to use an emergency department instead or may not show up for their appointment. By contrast, when a physician offers Advanced Access, there is less backlog; and patients needing to be seen are offered an appointment on the day that they call or within 24 hours.

There are many ways to offer Advanced Access and ultimately comply with timely access standards, such as saving a daily block of time for appointments or keeping a few appointments available throughout the day for same-day or next-day appointments.

9.8: Access to Care *(cont'd.)*

9.8.3: Advanced Access *(cont'd.)*

There has been ongoing interest in advanced access as waiting times for routine healthcare have lengthened over time, potentially leading to concerns about negative health outcomes and emergency department overuse. Participating providers, PMGs and IPAs that use an Advanced Access Program contend that it reduces patient wait times, improves continuity of care, and reduces missed appointments.

Conversely, Blue Shield Promise requires participating providers PMGs, and IPAs give written notice to Blue Shield Promise no more than 30 calendar days after a provider stops offering advanced access appointments to ensure compliance with Section 1367.03(d) and Rule 1300.67.2.2(b)(1), (c)(5)(I), (d)(2)(E) and (h)(6)(D) concerning Advanced Access verification requirements.

9.9: Broken/Failed Appointments

9.9.1: Broken/Failed Appointment Follow-up

Policy

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients. DHCS requires that missed/broken appointments must be documented in the medical record on the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours.

Procedure

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

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

9.9: Broken/Failed Appointments *(cont'd.)*

9.9.1: Broken/Failed Appointment Follow-up *(cont'd.)*

Broken/Failed Appointments

Broken appt. date:
Review date:
Follow-up req:
Follow-up ASAP:
New appt. date:
Practitioner/provider signature:
Completed by:

2. At the end of each day the receptionist will determine which patients failed to keep their appointment by:
   a. Checking the appointment schedule and making a list of all failed appointments.
   b. Gathering the pulled charts which were ready for appointments (Charts are pulled the day before scheduled appointments).
3. Use a progress sheet with the latest date or a new progress sheet and stamp the sheet with the "Broken/Failed Appointment" rubber stamp.
4. Attach the progress sheet to the medical record and forward it to the primary care physician.
5. The medical assistant (M.A.) or designated individual will review all charts of those patients who missed an appointment and wait for further orders from the practitioner/provider.
6. The practitioner/provider will review the chart to determine the need for patient recall.
7. The practitioner/provider will complete items 2, 3, and 6 as needed, on the Broken/ Failed Appointment" rubber stamp, using the following guidelines:
   - Item 2 – Write in review data.
   - Item 3 – Enter a checkmark if follow-up action is ordered.
   - Item 4 – Enter a checkmark if the patient is to return to the clinic as soon as possible.
   - Item 6 – Enter signature and title.
8. If the patient needs follow-up, the M.A. or designated individual shall try to contact the patient.
9. One time by phone. If there are no results, a recall postcard or letter will be mailed out to the patient's current address of record. A copy will be filed in the chart.
10. Every attempt to contact the patient, with the date and time of each attempt, must be documented in the progress notes. Only the following staff may document patient recall activities in the medical record: M.D., P.A., N.P., R.N., L.V.N., or M.A.

9.9: Broken/Failed Appointments *(cont'd.)*

9.9.1: Broken/Failed Appointment Follow-up *(cont'd.)*

11. The M.A. completes items 1, 5, and 7 as needed on the broken/failed appointment stamp using the following guidelines:
    - Item 1 – Enter the date of the broken appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 6 – Enter the date, signature, and title of the person doing the recall activity.
12. The broken/ failed appointment will also be documented in the appointment schedule for tracking purposes.
13. The practitioner/provider is responsible for final decisions concerning a broken/ failed appointment follow-up. Patients being followed for reportable conditions shall also be reported to the local health authority.
14. The administrator or office manager is responsible for:
    a. Assuring that all clinic personnel are aware of their responsibilities under this procedure.
    b. Designating, in conjunction with the Medical Director, the persons responsible for implementing this policy.
    c. Periodically monitoring the performance of staff in carrying out their duties.

9.10: Advance Directives

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

9.11: Clinical Telephone Advice

Policy

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

9.11: Clinical Telephone Advice *(cont'd.)*

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

Blue Shield Promise contracts with a certified vendor for a 24-hour Nurse Advice Line.

9.12: HEDIS Measurements

Use of Practitioners/Providers Performance Data

Practitioners and providers will allow Blue Shield Promise to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). Providers are expected to meet or exceed the 50th percentile for all DHCS Managed Care Accountability Set (MCAS). If the contracted provider is a Federally Qualified Health Center (FQHC) enrolled in the Alternative Payment Model (APM) program, the FQHC is expected to meet or exceed the thresholds for minimum performance set forth by the APM program specifications. Blue Shield Promise will also share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your Quality Program Manager.

Blue Shield Promise can assist providers in improving performance on quality measures. Various tools and resources are available, including Clinical Action Registry Report and our HEDIS tip sheets. To obtain these resources and for the most current descriptions and list of HEDIS and MCAS measures, contact your Quality Program Manager.

Refer to Appendix 13: HEDIS Measurements for the list of all HEDIS measurements.

9.13: Credentialing Program

Purpose

To ensure that all network practitioners/providers meet the minimum credentials requirements set forth by Blue Shield Promise and the regulatory agencies including, but not limited to, the NCQA, DHCS, DMHC, CMS, L.A. Care, other regulatory agencies and credentialing mental health parity regulations for participation in the network. At least every three (3) years, the practitioners/providers are required to undergo recredentialing to ensure that they are in compliance with these standards, except for Intermediate Care Facility/Developmentally Disabled (ICF/DD) facilities, which require recredentialing every two (2) years.

9.13: Credentialing Program *(cont'd.)*

Scope

The credentialing program applies to all directly contracted and delegated practitioners, who are affiliated with Blue Shield Promise through their relationship with a contracted IPA/medical group. Blue Shield Promise requires the credentialing of the following independent contracted practitioners: physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), acupuncturists (AC), optometrists (OD), occupational therapists (OT), physical therapy (PT), speech therapists (SP), speech language pathology (SLP), certified orthotists, certified ocularists, dispensing opticians, telemedicine practitioners and mid-level practitioners/providers (PA, NP, CNS and CNM/NMW) and deliver health care services to Blue Shield Promise members. Blue Shield Promise and its delegates may also credential other allied health professionals, such as licensed clinical social worker (LCSW), licensed professional clinical counselor (LPC), licensed marriage and family therapist (LFMT), licensed psychologists (PhD, PsyD), qualified autism service providers or professionals with a license or certification, audiologists (AU), registered dietitians and nutritionists (RD, RDN), Chiropractors (DC), Doulas (DOU) and other practitioners authorized by law to deliver health care services and contracted by Blue Shield Promise on an independent basis.

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

Objectives

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

Credentialing Policies and Procedures

Policies and procedures are reviewed annually and revised as needed to meet the NCQA, DHCS, DMHC, CMS, L.A. Care, state, federal, and mental health parity regulatory agencies' credentialing requirements.

9.13: Credentialing Program *(cont'd.)*

Policies and procedures are reviewed by the Medical Director and submitted to the Credentials Committee and Compliance Department for review and approval.

Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners/providers contracted with Blue Shield Promise. The Medical Director serves as chairman of the Credentials Committee, which is comprised of a multi- specialty panel of practitioners/providers in the Blue Shield Promise network, the Credentialing Manager and any additional physicians as needed, for their professional expertise. However, only physicians have the right to vote in the Credentials Committee Meeting. A minimum of three (3) voting members is considered a quorum. The Credentials Committee meets at least once a month but not less than quarterly. If there is a need, the committee will conduct an ad-hoc meeting.

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

- Review, recommend, and approve/deny initial credentialing, recredentialing, ongoing monitoring activities and inactivation/termination of directly contracted and delegated practitioners/providers for the Blue Shield Promise network.
- Review and approve credentialing policies and procedures and ensure they are in compliance.
- Review and recommend actions for all network practitioners/providers identified with sanction activities from a state licensing agency, Preclusion list, Medi-Cal Suspended and Ineligible list, The System Award for Management (SAM), and The Office of Inspector General (OIG).
- When there is a quality deficiency, appropriate authorities were reported; and
- Fair Hearings are offered and carried out in accordance with the established policies and procedures.

9.13.1: Credentials Process for Directly Contracted Physicians

The Credentials Committee is responsible for making decisions regarding initial credentialing, recredentialing, and changes to credentials, and inactivation of all directly contracted practitioners/providers.

Blue Shield Promise has adopted use of either the California Participating Physician Application (CPPA) or the Council for Affordable Quality Healthcare (CAQH) applications.

Applications include questions/fields regarding the practitioner's race, ethnicity and language, and providing the information is optional. Applications include a statement that the organization does not discriminate or make credentialing decisions based on the applicant's race, ethnicity or language.

9.13: Credentialing Program *(cont'd.)*

9.13.1: Credentials Process for Directly Contracted Physicians *(cont'd.)*

A signed and dated declaration attesting to the following must be included in the application process.

1. Reasons for inability to perform the essential functions as a provider, with or without accommodation.
2. Lack of present chemical dependency or substance abuse, including illegal drugs.
3. History of loss of license and felony convictions.
4. History of loss or limitations of privileges or disciplinary activities.
5. Attestation regarding the correctness and completeness of the application.

In addition to completing an initial application, the practitioner must provide:

1. A copy of his/her current professional license to practice.
2. A copy of a current and valid Drug Enforcement Administration (DEA) certificate (if applicable).
3. A copy of a current malpractice insurance certificate with the practitioner listed as insured with the minimum required coverage. For practitioners with federal tort coverage, a copy of the federal tort letter is required.
4. Work history, which covers the most recent five (5) years as a health professional. Documentation should include month and year for each position with no gaps in employment or include an explanation for any gaps greater than six (6) months. Work history can be documented on the credentialing application or on a curriculum vitae (CV).
5. A copy of the board certificate (if applicable).
6. Medicare number, Medi-Cal number and NPI number.
7. Physician Supervisory Agreement (for Midlevel only as applicable).
8. A copy of the ECFMG certificate (if applicable).

A written explanation regarding any sanction activity, malpractice judgments in the last five (5) years or pending claims, restriction of privileges, etc.

Upon completion of the credentialing verification process, a report summarizing each applicant's credentials is forwarded to the Credentialing Committee Chair or Credentialing Committee for review and action. If the Committee recommends denial, limitation, suspension, or termination of membership based on a medical disciplinary cause or reason, the practitioner shall be entitled to a formal hearing pursuant to the Fair Hearing policy. The Fair Hearing policy does not apply to mid-level practitioners except as required by applicable laws.

The Credentialing Committee's approval date is considered as the final credentialing approval date. Practitioners are notified of the credentialing decision within thirty (30) calendar days.

9.13: Credentialing Program *(cont'd.)*

9.13.1: Credentials Process for Directly Contracted Physicians *(cont'd.)*

The Quality Management Committee receives reports on credentialing activities on a quarterly basis.

The Credentialing Department notifies the Contracting Department or the Promise Provider Relations (PPR) for credentialing activities on a monthly basis. The monthly distribution includes a practitioner/provider listing and practitioner/provider profiles. The Contracting Department and PPR will follow their procedures for executing the contract and adding the practitioner/provider to the network. If a practitioner chooses to opt-out of Medi-Cal due to not meeting Medi-Cal requirements, including Medi-Cal required New Provider Orientation, the provider will have to inform the plan that the practitioner is Opting-Out of Medi-Cal network. When a practitioner meets all Medi-Cal requirements, the practitioner will need to be re-submitted for practitioner to be Opted-back into Medi-Cal network. This does not replace meeting Minimum Credentialing Requirements and completing the Credentialing process.

9.13.2: Minimum Credentials Criteria

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

Credentialing Application and Supporting Documentation - Practitioners are required to submit a completed Promise-approved application (e.g., California Participating Practitioner Application (CPPA) or Council for Affordable Quality Healthcare (CAQH) application) appropriate to their specialty, with the following supporting documentation:

a. A copy of a current and valid medical or professional state licensure, certification or registration, including a Physician's Certificate of Registration while practicing medicine within the constraints of Section 2113 of the California Business and Professions Code
b. A copy of a valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate with a California address, if applicable. If the applicant has not been granted a DEA, is in the process of obtaining a DEA with a California address or in the process of renewal, the applicant will need to provide written documentation allowing another practitioner with a valid DEA certificate to write all prescriptions requiring the covering practitioner name and a DEA number for the prescribing practitioner until applicant has a valid DEA certificate.
c. A copy of a current and valid Conscious Sedation, Oral Sedation, and/or General Anesthesia Permit, if applicable
d. Documentation of education and training completed
e. Board Certification, if applicable.
f. A current curriculum vitae (CV) or documentation of work history for the previous 5 years with written explanation of any discrepancy or gaps greater than six months.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

g. A copy of an Educational Commission for Foreign Medical Graduates (ECFMG) certification, if applicable.
h. Written explanation of any occurrences in the last five (5) years: sanction activity, felony convictions, malpractice judgments or settlements exceeding $300,000, pending malpractice lawsuits, loss of license or limitations of privileges or disciplinary actions, and pending civil, regulatory, and criminal investigations.
i. A copy of a current malpractice liability insurance certificate in the minimum amounts required for the practitioner's respective specialty. Current malpractice insurance with minimum amounts of $1 million per occurrence and $3 million aggregate ($1 million per occurrence and $2 million aggregate for optometrists and audiologists or $1 million per occurrence and $1 million aggregate for behavioral analysts). For practitioners with federal tort coverage, a copy of the federal tort letter is required.
j. Reasons for inability to perform essential functions of the position for which they are submitting the application for participation.
k. Documentation of lack of present illegal drug use
l. Current hospital privilege information, if applicable, or documentation of coverage arrangements (e.g., Hospitalist programs)
    i. Hospital privilege information is not required for practitioners practicing in a specialty that typically does not require admitting privileges (e.g. Allergy & Immunology, Dermatology, Pathology, Radiology, Radiation Oncology, Psychology, Optometry, Dental Surgery, Physical Therapy, Audiology, Chiropractic, Acupuncture, etc.) and in counties where Promise has not established a comprehensive hospital network
    ii. For directly contracted practitioners and practitioners from those IPAs that have a shared-risk contract with Promise, the Credentials Committee may, at its discretion, approve credentialing for practitioners who do not have admitting privileges at hospitals in the Promise network.
m. National Provider Identifier (NPI) Number.
n. Medi-Cal Enrollment, if required by DHCS.
o. Primary Care Physician (PCP) practitioners must receive a minimum passing score on the facility site review and medical record review.
    i. An initial facility site review/medical record review of all PCP offices are required prior to inclusion into the Blue Shield Promise network. This will be a structured visit, in accordance with the QI facility site review and medical record procedures. The FSR must be conducted prior to the initial credentialing decision and every three (3) years thereafter.
p. Requirements applicable to Non-Physician Medical Practitioners (NPMP):
    i. Certified Nurse Midwives (CNM) must be board-certified

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

ii. NPMPs such as Physician Assistants (PA), Nurse Practitioners (NP), clinical nurse specialists (CNS) and Nurse Midwives (NMW), must include a delegation of service agreement or supervising practitioner agreement with a Promise network practitioner
   A. **Exception:** Certified Nurse Midwives (CNM), and Nurse Practitioners that obtain license designation of 103NP or 104NP are exempted from this requirement.
iii. Board Certified Assistant Behavioral Analysts must be board-certified and must include a delegation of service agreement or supervising practitioner agreement completed and signed by a Behavior Analyst Certification Board (BACB) certified supervising physician

q. Current and signed attestation confirming the correctness and completeness of the application.

2. Applicants will meet the following minimum training requirements:
   a. Physicians (MD, DO) must be either:
      i. Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards; or
      ii. Completed the requisite residency or fellowship required by the ABMS or AOA specialty boards; or
      iii. A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969 and had been in practice full time since may be "grandfathered" into Family Practice.
      iv. The physician has completed an International Medical Graduate (IMG) training program and has completed a Canadian or British Isles residency program. (The ABMS formally recognizes Canadian and British medical schools and residencies as equivalent to US training but does not recognize Canadian and British Specialty Boards.)
   b. Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Foot and Ankle Surgery (ABFAS) [formerly American Board of Podiatric Surgery ("ABPS")] or American Board of Podiatric Medicine (ABPM) [formerly American Board of Podiatric Orthopedics and Primary Podiatric Medicine ("ABPOPPM")].
   c. Optometrists (OD) are required to complete a professional degree in Optometry.
   d. Oral Surgeons (DDS, DMD) are required to have completed a professional degree in dentistry or be board certified with the American Board of Oral and Maxillofacial Surgery (ABOMS).
   e. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialist (CNS) and nurse midwives (NMW) must have successfully completed the academic program required for the requested status or required training. For example, a nurse practitioner must have completed a nurse practitioner academic program.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

f. Allied health professionals are required to have successfully completed the professional degree/program required for their requested specialty.
g. Human Immunodeficiency Virus (HIV) specialists must meet at least one of the following four criteria, with annual confirmation:
    i. Credentialed as an "HIV/AIDS Specialist" by the American Academy of HIV Medicine.
    ii. Board certified in the field of HIV medicine by a member board of American Board of Medical Specialties.
    iii. Board certified in the field of infectious diseases and has the following training and experience in the 12 months immediately preceding the practitioner's credentialing / recredentialing application:
        A. Provided continuous and direct medical care to a minimum of 25 patients who are infected with HIV; and
        B. Successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year.
    iv. Satisfies the following training and experience requirements:
        A. In the 24 months, immediately preceding the practitioner's credentialing / recredentialing application, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV; and
        B. In the 12 months immediately preceding the practitioner's credentialing / recredentialing application, has completed at least one of the following:
            a. Board certification or recertification in the field of infectious diseases.
            b. Minimum of 30 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients.
            c. Minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients and passed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Recredentialing

At least every three (3) years, a practitioner/provider must be recredentialed to maintain his/her membership with Blue Shield Promise. Six (6) months prior to the recredentialing due date, the Credentialing Department will email out a recredentialing application to non-CAQH participant practitioner/provider or will retrieve the recredential application from CAQH for CAQH participant practitioner/provider.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

The non-CAQH participant practitioner/provider will be instructed to complete the application with current information, complete an attestation questionnaire, sign, date the appropriate pages, and return it with the supporting documentation as required to the Credentialing Department.

A notification stating that failure to return the recredentialing application by its deadline may be considered a voluntary resignation by the practitioner/provider. Upon receipt of a completed recredentialing application, the Credentialing Department will follow its procedures in processing the application for recredentialing. If the recredentialing application is not received by Blue Shield Promise Credentialing Department by the given time frame, a follow-up for recredentialing will be emailed or phone call made to the practitioner/provider.

A final follow-up email notification will be sent to practitioners/providers who have not returned their applications from the initial mailing. The Provider Information and Enrollment department and the Contracting Department will be notified of the practitioners/providers who are non-responsive to the recredentialing requests and will follow their procedures for appropriate action, including administrative termination for non-compliance.

Credentialing Time Limit

The primary source verifications must be completed within 120 calendar days, along with current and signed attestation confirming the correctness and completeness of the provider's application.

Practitioners/Providers' Rights

Practitioners/Providers shall have the right to:

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

Confidentiality of Credentialing Information

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in secured database within the Credentialing Department. Only authorized personnel have access to credentialing files.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

Practitioners/providers may access their files in accordance with the established policies. All confidential electronic data will be access-controlled through passwords. Access will be assigned based on job responsibility, and on a need-to-know basis. All Credentialing Committee members, guests, and staff involved in the credentialing process sign a confidentiality agreement annually.

Sanctions and Exclusions Review for Initial and Recredentialing

At the time of initial and recredentialing Blue Shield Promise queries the following to determine if there have been any sanctions placed or lifted against a practitioner/provider.

- Appropriate State licensing boards actions including but not limited to accusations, probations, license restrictions, and letter of reprimands.
- National Practitioner Data Bank (NPDB)
- Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE)
- Medi-Cal Suspended and Ineligible Provider List
- System for Award Management (SAM) exclusions
- Preclusion List
- Potential Quality Issues (PQI) review is only required for recredentialing files

Ongoing Monitoring and Interventions

On a monthly basis the Credentialing Department obtains and review sanctions, exclusions, disciplinary action reports and adverse events for all practitioners and HDOs participating in the Promise network.

Monitoring activities include:

- Review sanction and disciplinary action reports from the following sources within thirty (30) calendar days of release:
    - Appropriate State licensing boards actions including but not limited to accusations, probations, license restrictions, and letter of reprimands.
    - Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE)
    - System for Award Management (SAM) exclusions
    - Medi-Cal Suspended and Ineligible Provider List sanctions or exclusions
    - Preclusion List
    - Restricted Provider Database (RPD)
- Review sanction alert service information received within thirty (30) calendar days of alert.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

- All reviewed disciplinary action and sanction alert reports will be saved in an Ongoing Monitoring folder in the Credentialing Department.
- All documentation received about the sanction, practitioner response and supporting documentation will be reported to the Credentials Committee for review and action.
- The Credentialing Committee may, in its sole discretion, refer a practitioner to the Clinical Quality Review Department for further review and investigation.
- The Clinical Quality Department will review complaints and adverse events at least monthly, and in its sole discretion, refer a practitioner to the Credentialing Committee.
- Blue Shield Promise also monitors the practitioner for license, DEA, and malpractice insurance expiration dates.
    - License renewals are verified with the licensing board within thirty (30) days of the expiration date.
    - DEA renewals are verified from the U.S. Drug Enforcement Administration or by an updated copy from the provider. In-scope practitioners who are required to have a DEA license but do not currently prescribe must submit documentation stating that they do not prescribe and provide the name of a covering physician who can prescribe on their behalf. If the practitioner states in writing they do not prescribe controlled substances and that, in their professional judgment, their patients do not require controlled substances, they are not required to have a DEA certificate. However, they must describe their process for handling instances when a patient requires a controlled substance.
    - Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

Possible Actions:
Except for administrative or automatic terminations, if sanction information, complaints or adverse events regarding a practitioner is discovered, Blue Shield Promise must determine if there is evidence of poor quality that could affect the health and safety of its members warranting action for a medical disciplinary cause or reason. Depending on the nature of the adverse event, sanction, recommendations from the Peer Review Committee or other identified incident, the Credentials Committee will implement actions including, but not limited to:

- Denial or rejection of credentialing application
- Restriction or suspension of network participation privileges pending investigation
- Closing the practitioner's panel to new member referrals pending investigation
- Required practitioner participation in continuing education activities
- Implementation of practitioner supervision activities, monitored by the Credentialing Department
- Implementation of a performance improvement plan, monitored by the Credentialing Department
- Termination of network participation

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

Administrative Terminations:
If an existing practitioner is identified on the OIG exclusion report or the Medi-Cal Suspended and Ineligible Provider List, the practitioner shall be administratively terminated from the Promise network and is not entitled to Fair Hearing procedures. Provider Relations, Contracting, Compliance and Special Investigation Unit, Utilization Management (UM) and Claim department will immediately be notified to take appropriate actions.

Practitioner or HDO must, at all times, be in good standing with state and/or federal regulatory bodies. If a practitioner or HDO's license, certificate or registration to practice in California is restricted, suspended, revoked or if the practitioner or HDO is not in good standing with a state and/or federal regulatory body, the practitioner or HDO may be automatically and immediately terminated in accordance with Sections 14043.6 and 14123 of the Welfare and Institutions Code.

Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner/provider is directly contracted with Blue Shield Promise, then the practitioner/provider may be notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome.

If the practitioner/provider is delegated to an IPA/medical group, then the affected IPA/medical group may be notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the IPA/medical group's response, is forwarded to the Credentials Committee for review and action.

Blue Shield Promise will adhere to the California Business and Professional Codes requirements for submitting 805 and 805.01 reports to the Medical Board of California and to the Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner Data Bank and to the State Medical Board.

Health Delivery Organizations
Prior to contracting with, and at least every three (3) years thereafter, Blue Shield Promise will re-evaluate health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, clinical laboratories, hospices, birthing centers, ambulatory surgery centers, freestanding surgical centers, durable medical equipment practitioners, dialysis centers, eating disorder centers, outpatient physical therapy centers, comprehensive outpatient rehabilitation centers, Federally Qualified Health Centers (FQHC), speech pathology clinics, portable x-ray suppliers, wound care centers, infusion therapy practitioner centers, outpatient diabetes self-management training practitioners, inpatient, residential & ambulatory behavioral health/substance abuse centers, telemedicine practitioners and nursing homes to ensure they have appropriate structures and mechanisms in place to render quality care and services. The evaluation process includes confirmation of the following:

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

- In good standing with the state and federal regulatory bodies.
- Current accreditation by Blue Shield Promise recognized accrediting bodies.
- If the HDO is not accredited, the Blue Shield Promise facility site review, CMS or DHHS survey is required.
- NPI number
- Proof of current malpractice liability insurance certificate in the amount of $1 million per occurrence and $3 million annual aggregate; or $1 million per occurrence and $2 million annual aggregate for CBAS or DME providers.
- Ensure collection, validation, and storage of all required application-related documentation, i.e., license provider specific certifications (ex. CLIA) and any sanction information, as determined by State and Federal regulatory bodies.

Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Facilities

ICF/DD Requirements:

A. To meet Blue Shield Promise credentialing requirements, and ICF/DD facility must submit an ICF/DD Attestation under penalty of perjury that the following credentialing requirements are satisfied:
    - Completion of the MCP's specific Provider Training within the last two (2) years
        - **Please note:** For initial credentialing, the MCP-specific provider training needs to be completed within the first 30-days of the provider being contracted with the MCP.
    - Facility Site Audit from State Agency
    - No Change in 5% Ownership Disclosure since the last submission to MCP
    - Possess an active California Department of Public Health ("CDPH") License and Centers for Medicare & Medicaid Services ("CMS") Certification
        - In good standing as a Regional Center Vendor
B. For the initial credentialing, ICF/DD Homes must submit the below items in addition to the ICF/DD Attestation:
    - W-9 Request for Taxpayer Identification Number and Certification
    - MCP Ancillary Facility Network Provider Application
    - Certificates of Insurance (Professional and General Liability)
    - City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)
    - 5% Ownership Disclosure

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

C. Recredentialing is to occur every two (2) years through re-submission of an ICF/DD Attestation. If an ICF/DD facility has a change to any requirement attested to between the recredentialing years, an ICF/DD facility must report that change to their MCPs along with any required documentation, within 90-days of when the change occurred.

Federally Qualified Health Clinic (FQHC) requirements:

A. FQHCs must complete the Blue Shield Promise credentialing process for each location before being added to the provider network.
    - HDO application with attestation and date
    - Health delivery organization state license
    - National Provider Identifier (NPI) number
    - Certificate of insurance: $1m/$3m aggregate
    - Accreditation or Facility Site Review
    - Confirmation of Medi-Cal enrollment
B. Recredentialing is required at least every three (3) years.

Primary Care Physicians

A primary care physician (PCP) is a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, basic case management, acute and chronic conditions, and psychosocial issues.

PCP services will be provided by appropriately trained personnel, typically, although not exclusively:

- General practitioners.
- Providers board certified or board qualified in family practice, internal medicine, or pediatrics; or
- OB/GYN practitioners

PCP Procedure

1. The PCP is responsible for the management and coordination of the patient's complete medical care for covered services. A PCP must be knowledgeable about preventive care and is expected to provide their patients with a periodic evaluation of all body systems. It is expected that a PCP will have the expertise to perform the basic medical services. The PCP provides those services that can be provided appropriately within their skills and refers to specialty care when additional knowledge or skills are required.
2. The PCP will arrange for laboratory tests, x-rays, referral to specialists, hospitalization, or any other covered health care services that are medically necessary.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

3. A referral is required for cases that are difficult to manage and/or when care is beyond the scope of practice for the PCP. All procedures and care for which the PCP has not received training or has had experience will be referred to a specialist.
4. Referrals to participating and non-participating specialists for capitated members are subject to any additional rules imposed by the contracting medical group.
5. The PCP must ensure timely receipt of the specialist's report. If the PCP has not received the specialist's report within 30 days, the PCP should contact the specialist to obtain the report. When appropriate a follow-up appointment with the PCP should be scheduled within 30 days of the specialty care.
6. Medical record documentation should be legible and include reason for the referral to specialty care; written reports from the specialist regarding the findings, treatment, and recommendations; date of return visit or a notation that no-follow up appointment is required. When the patient has been hospitalized, there should be evidence that the PCP is aware of the patient's status and follow-up.
7. Medical record documentation should be legible and include reason for the referral to specialty care; written reports from the specialist regarding the findings, treatment, and recommendations; date of return visit or a notation that no-follow up appointment is required. When the patient has been hospitalized, there should be evidence that the PCP is aware of the patient's status and follow-up.
8. PCPs are also expected to:
    a. Ensure access to care 24 hours a day in the most appropriate setting.
    b. Refer members to specialists and ancillary services as necessary.
    c. Maintain confidentiality of medical records.
    d. Provide preventive health services and health education services.
    e. Comply with Blue Shield of California Promise Health Plan requirements and procedures.
    f. Ensure medical records are available to Blue Shield Promise and other regulatory and oversight agencies.
    g. Forward to Blue Shield Promise, within 24 hours, all member grievances received at the practitioner level through an established and documented grievance process.
    h. Comply with Blue Shield Promise credentialing requirements; and
    i. Ensure adherence to all aspects of office and facility audits.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Additional Requirements

- A practitioner applying for General Practice in the Medi-Cal line of business must meet one of the following requirements:
  - Has completed at least one (1) year of stateside training in primary care medicine (Internal Med or Family Practice) and must complete two years training in the requested specialty program; or
  - Has completed at least one (1) year of specialized training (not in primary care medicine) in the United States and provide two (2) letters of recommendation from other primary care physicians.
- OB/GYN: An OB/GYN requesting to participate as a PCP must meet the following requirements:
  - Have completed at least one (1) year of stateside primary care medicine.
  - If an OB/GYN has completed at least one (1) year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from primary care physicians for the primary care training.
- Age Limitation Exception: General Practice 0-110, Internal Medicine 16-110, Pediatrics 0-21, Family Practice 0-110 and OB/Gyn 13-110.

Non-Physician Medical Practitioners (NPMP)

Non-Physician Medical Practitioners include Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (C.N.S.). Blue Shield Promise must ensure that the applicable NPMP's are under the supervision of a direct-contracted physician. A supervising physician directs the practice of the NPMP's, who act as an agent to the supervising physician. The number of non-physician medical practitioners who may be supervised by a single primary care physician shall be in accordance with applicable professional licensing statutes and regulations.

The use of NPMP's must fall within the individual's scope of practice, as determined by the respective licensing board. The responsibility to comply with regulations of the NPMP's respective licensing board belongs to the supervising physician.

NPMP requiring supervision must have a supervising practitioner agreement, also known as a Collaboration Agreement completed, and signed by both the NPMP and the contracted supervising physician.

Street Medicine NPMP: A supervising physician must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Nurse Practitioners (NP)

Assembly Bill 890 (AB 890) grants nurse practitioners the ability to practice independently, by establishing two categories, 103 NP and 104 NP. A 103 NP has a defined role under physician supervision, while a 104 NP, after fulfilling a three-year supervised "transition to practice," gains full independent practice authority without physician supervision. To practice in an integrated setting, 103 NPs must hold national certification and carry liability insurance. If an NP is interested in solo practice, completion of a three (3) year transition to practice is required.

AB 890 allows 103 NPs and 104 NPs to practice to the full extent of their education and training and allows direct access to health care for millions of Californians who now have coverage but often struggle to find healthcare providers. A nurse practitioner shall verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada." A nurse practitioner shall post a notice in a conspicuous location accessible to the public that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

Certified Nurse-Midwife (CNM)

Senate Bill 1237 (SB 1237) states that certified nurse-midwives who attend cases of low-risk pregnancy and childbirth and provide prenatal, intrapartum, and postpartum care, including family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board, are not required to practice under the supervision of a physician.

SB 1237 authorizes a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-up policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon to provide a patient with specified services. If the nurse-midwife does not have those mutually agreed-upon policies and protocols in place, the bill, except as specified, would requires the patient to be transferred to the care of the physician and surgeon to provide those services, and would authorize the return of the patient to the care of the nurse-midwife after the physician has determined that the condition of circumstance that required, or would require, the transfer is resolved. Hospital privileges are required if the certified nurse-midwife patient's planned place of birth is in the hospital. DEA schedule II and III controlled substances furnished certificate is required if the certified nurse-midwife who is ordering controlled substances ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. Certified nurse-midwives must be certified by the American Midwifery Certification Board.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

SB 1237 requires a certified nurse-midwife to refer all emergencies to a physician and surgeon immediately and authorizes a certified nurse-midwife to provide emergency care until the assistance of a physician and surgeon is obtained. SB 1237 requires a certified nurse-midwife who is not under the supervision of a physician and surgeon to provide oral and written disclosure to a patient and obtain a patient's written consent, as specified. The bill requires a certified nurse-midwife who is authorized to furnish or issue a drug order for a controlled substance to additionally register with the Controlled Substance Utilization Review and Enforcement System (CURES).

Mental Health and Substance Use Disorder Providers

Assembly Bill 2581 requires the following procedures to be put in place for Mental Health/Substance Use Disorder providers, effective January 1, 2023:

Blue Shield Promise will acknowledge receipt and completeness of a Behavior Health/Mental Health/Substance Abuse practitioner/provider application within 7 business days and complete credentialing within 60 days. Blue Shield Promise will obtain and verify the information in accordance with its policies and procedures. If the required supporting documents are missing or the attestation has not been signed within the past 90 days, the Credentialing Department will contact the applicant to provide an updated attestation date. Failure to submit the information after three or more attempts will be considered a voluntary withdrawal of the application.

Street Medicine Providers

Street Medicine is defined as being provided to an individual experiencing unsheltered homelessness in their living environment, in places not intended for human habitation. Mobile units and RVs that go to the individual experiencing unsheltered homelessness in their living environment ("on the street") are considered street medicine as specified in APL 22-023.

Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location do not qualify as street medicine, it is considered mobile medicine, as it requires people experiencing unsheltered homelessness to visit a health care Provider at the Provider's fixed, specified location.

DHCS does not require a street medicine provider to be affiliated with a brick-and-mortar facility and does not prescribe any particular contracting type for MCPs and street medicine providers.

Street Medicine providers may provide medical services in the role of the members assigned primary care physician (PCP) for members experiencing homelessness and must meet eligibility criteria for being a PCP.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Non-Specialty Mental Health Services (NSMHS)

Non-Specialty Mental Health Services Practitioners include Licensed Clinical Social Workers (LCSW), License Professional Counselors (LPCC), License Marriage and Family Therapist (LMFT), Licensed Psychologist, Psychiatric Physician Assistants (PA), Psychiatric Nurse Practitioners (NP), and psychiatrists with practitioner training and licensure requirements.

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

Abortion Provider Protections

Existing law declares another state's law authorizing a civil action against a person or entity that receives or seeks, performs or induces, or aids or abets the performance of an abortion, or who attempts or intends to engage in those actions, to be contrary to the public policy of this state, and prohibits the application of that law to a controversy in state court and the enforcement or satisfaction of a civil judgment received under that law.

Senate Bill 487 Abortion: Provider Protections (SB 487) would specifically include within these provisions, in addition to abortion performers, abortion providers. The bill would also prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care services provider from containing any term that would result in termination or nonrenewal of the contract or otherwise penalize the provider based on a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California. The bill would also prohibit a health care service plan or health insurer from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

SB 487 would also authorize the department, subject to obtaining necessary federal approvals and the availability of federal financial participation under Medi-Cal, to elect to not suspend an individual or entity as a provider in the Medi-Cal program if the revocation, suspension, or loss of the individual or entity's license, certification, or approval authority in another state or the pending disciplinary hearing during which the individual or entity surrendered the license, certification, or approval authority in another state is based solely on conduct that is not deemed to be unprofessional conduct under California law. The bill would also require the department to seek any necessary federal approvals to implement these provisions.

SB 487 would authorize the director, subject to obtaining necessary federal approvals and the availability of federal financial participation under Medi-Cal, to request a waiver under federal law, as permitted, if the provider's suspension from participating in the Medicare or Medicaid program was based solely on conduct that is not deemed to be unprofessional conduct under California law. The bill would also require the department to seek any necessary federal approvals to implement these provisions.

Doula Providers

All doulas must be at least 18 years old, possess an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification, and have completed Health Insurance Portability and Accountability Act training. Additionally, a doula must qualify by meeting either the training or experience pathway, as described below:

Training Pathway:

- Complete a minimum of 16 hours of training in the following areas:
  - Lactation support
  - Childbirth education
  - Foundations on anatomy of pregnancy and childbirth
  - Nonmedical comfort measures, prenatal support, and labor support techniques
  - Developing a community resource list
  - Provide support at a minimum of three births

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Experience Pathway:

- All of the following:
    - At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
    - Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following: Three written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed Provider, a community-based organization, or an enrolled doula. "Enrolled doula" means a doula enrolled either through DHCS or through an MCP.

9.13.4: Credentials Process for IPA/Medical Groups and delegated entities

IPA/medical groups and entities that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non-physician practitioners/providers in accordance with the above Blue Shield Promise policies and procedures, NCQA, DHCS, DMHC, CMS, L.A. Care Health Plan guidelines, and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years. Medi-Cal enrollment is required to participate in the network.

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

1. The Credentialing Delegation Oversight Auditor will conduct pre-delegation evaluations and annual audits in accordance with the Delegated Oversight Policies and Procedures. The audit will include a review of the IPA/medical group's policies and procedures, Credentialing Information Integrity requirement, Credentialing Committee structure and minutes, ongoing monitoring, organizational provider credentialing, sub-delegation oversight activities, quarterly reports, Medi-Cal enrollment verification process, and credential files, as applicable. The Health Industry Collaboration Effort (HICE) standardized audit tools will be used to perform audits. The audit tool can be found on the HICE website under *Approved HICE Documents.* The IPA/medical group will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, at least two (2) weeks prior to the scheduled audit date.
2. Develop a process for documenting information and activities in credentialing files.
    a. Credentialing policies and procedures must clearly describe the process for documenting information and activities in their credentialing files.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

3. Blue Shield Promise will use one of the following methods for the file review:
    a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield Promise auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed for the audit to the IPA/medical group. The Blue Shield Promise auditor will audit the files in the order indicated on the file selection list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files for the non-compliant element.
    b. The NCQA's 5 percent or 50 file review methodology of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the Blue Shield Promise auditor will audit the universe of files rather than a sample.
4. After completion of the initial file review, the auditor will follow the same procedure for the recredential file review, review performance monitoring data and recredentialing timeliness (work history and education/training are not applicable at recredentialing).
5. Delegated Entities must maintain a score of at least 95% for credentialing delegation. If the score is below 95%, a corrective action plan (CAP) is required. A corrective action plan addressing all deficiencies must be submitted to Blue Shield Promise Credentialing Delegation Oversight Department within 30 calendar days of receipt of the notification. After reviewing the CAP, the IPA/medical group will receive a letter noting acceptance of the CAP or any outstanding deficiencies.
6. The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements prior to closing the audit.
7. The delegated credentialing status may be terminated by Blue Shield Promise at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
8. Blue Shield Promise retains the right to approve, suspend and terminate practitioners/providers or sites based on issues with quality of care.
9. Delegated IPA/medical groups are required to submit a quarterly report on practitioners/providers credentialing, recredentialing, termination and suspension activities, and quality improvement activities utilizing the Health Industry Collaboration Effort (HICE) standardized reporting tools found on the HICE website under *Approved HICE Documents*.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

Quarterly reports are due on the following dates:

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

Reports may also include credentialing and recredentialing activity of Organizational Providers if oversight responsibility is delegated.

Reports should be submitted to the designated delegated credentialing mailbox, and/or the Delegation Oversight Auditor assigned to the group.

10. Delegated entities must develop and implement Credentialing Information Integrity (CII) policies and procedures, audits credentialing information for inappropriate documentation and updates and implement corrective actions that address identified integrity issues. (This requirement replaces NCQA's Credentialing System Controls requirements)

A. Protecting the integrity of credentialing information policies and procedures must specify:

1. The scope of credentialing information.
   Policies must describe the protection for each of the following documents:
   - Application and Attestation
   - Credentialing Documents received from primary source or agent
   - Documentation of credentialing activities
     - Verification dates
     - Report dates
     - Credentialing decisions
     - Credentialing decision dates
     - Signature or initials of the verifier or reviewer
   - Credentialing Committee Minutes
   - Documentation of clean file approval, if applicable
   - Credentialing checklist, if used.
2. Staff responsible for performing credentialing activities.
   Policies must include the titles of staff who:
   - Document credentialing activities
   - Staff who are authorized to modify (edit, update, delete) credentialing information or if no staff may modify, then state no staff are authorized to do any updates under any circumstances.
   - Perform the annual oversight of CII functions, to include the annual audit and follow-up, if applicable
3. The process for documenting updates to the credentialing activities.
   Policies must include:

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

- Description of when it is acceptable to update credentialing information (e.g., to update expiring licensures)
- Describes the process staff should follow when making updates to credentialing information, including the following documentation:
  - When (date and time) the information was updated.
  - What information was updated.
  - Why the information was updated
  - Staff who updated the information.

4. Inappropriate documentation and updates.

   Policies specify that the following are inappropriate updates to credentialing information:
   - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
   - Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential).
   - Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
   - Attributing verification or review to an individual who did not perform the activity.
   - Updates to information by unauthorized individuals.
5. Auditing credentialing staff and the process for documenting and reporting identified information integrity issues.
   Policies must include:
   - Description of the Group's audit of credentialing staff documentation and updates.
   - It is not required that the methodology be included, only that an annual audit will be conducted.
   - Process for documenting and reporting inappropriate documentation and updates to:
     - Groups designated individual (s) when identified, and
   - Outline consequences for inappropriate documentation and updates.

B. Information integrity Training

The Delegate annually trains credentialing staff on:

1. Inappropriate documentation and updates related to 9.A.4.
2. Delegates audit of staff, documenting and reporting information integrity issues for 9.A.5.

Evidence: Training materials and evidence that training was completed are both required.

- Trainings inform staff of:
  - The audits of staff documentation and updates to credentialing files
  - Process for documenting and reporting inappropriate documentation and updates to the designated individual(s) or 9.A.5
  - The consequences for inappropriate documentation and updates.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

C. Audit and Analysis

Delegate Annually:

1. Audits for inappropriate documentation and updates to credentialing information.
   - Audit universe is to include a random sample of 5% or maximum of 50 files. If 5% is less than 20 total files, a review of a minimum of 10 initial and 10 recredentialing is required. Universe includes all initial or recredentialing decisions made during the look-back period (12 months).
   - The annual audit must include all items under Inappropriate documentation and updates. 9.A.4
   - The Audit and Analysis report must include the following: Report date, Title of individuals who conducted audit, The auditing period, File universe size, Audit sample size, Audit log showing file identifier and type of credentialing information audited, Findings for each file and rationale, and results (percentages and total inappropriate documentation and updates found)
2. The Delegate conducts a qualitative analysis of inappropriate documentation and updates.
   - The Delegate performs a qualitative analysis for each inappropriate documentation and update found during the audit to determine the cause. The cause is then documented along with staff who performed the qualitative analysis.

D. Improvement Actions

1. Implements corrective actions to address all inappropriate documentation and updates found in 9.C.
2. Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3-6 months after completion of the annual audit in 9.C.

10. The Delegate must develop and implement policies and procedures for ongoing monitoring of practitioners' sanctions, complaints, and quality issues between recredentialing cycles and taking appropriate action against practitioners when it identifies occurrences of poor quality. At a minimum, the IPA/medical group must collect and review the following:
    - Medicare and Medicaid sanctions and exclusion.
    - Sanctions or limitations on licensure.
    - Medi-Cal Suspended and Ineligible Provider List at Initial and Recredentialing, as well as monthly.
    - Collect and review member complaints. Investigate all complaints upon receipt and evaluate the practitioner's history of complaints, if applicable. Evaluate the history of all complaints for all practitioners at least every 6 months; and
    - Monitor Identified adverse events - monthly
    - Updating provider licenses upon expiration

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

11. The Delegate is required to review all Blue Shield Promise practitioners/ providers sanction activities within the 30 calendar days of the report's release by the reporting entity and report the findings to Blue Shield Promise as Blue Shield Promise practitioners/providers are identified that require action to be taken.
12. The IPA/medical group is responsible for providing and assisting in any credentials document needed for investigation and audit which includes but, not limited to specific information related to a provider's training, action related to any sanctions, etc.
13. The IPA/medical group is required to submit copies of originals files for selected practitioners/providers at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audits, by the requested due date.
14. The IPA/medical group is responsible for Identifying Qualified HIV/AIDS Specialist in accordance with CA H&SC §1374.16; DMHC TAG (QM-004), DHCS MMCD All-Plan Letter 01001).
    - The IPA/medical group must develop and implement policy and procedures describing the process that the organization identifies and reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations on an annual basis. The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist and criteria which can be accessed at www.dmhc.ca.gov.
    - Annually, conducts screening of HIV/Aids Specialists to ensure qualifications and criteria of the DMHC are met.
    - Notify department responsible for authorizing standing referrals of its physicians that qualify as HIV/AIDS specialists according to DMHC regulations.
15. The Delegate will be required to sign and abide by the credentialing delegation agreement.
16. If the Delegate subdelegates any credentialing activities the IPA/medical group will be responsible for oversight activities of the subdelegate.
17. The delegation agreement must include the following:
    a. Is mutually agreed upon
    b. Describes the delegated activities and the responsibilities of the Delegate and the Sub-delegated entity. Agreements implemented on or after 7/1/25 must include Credentialing Information Integrity requirements, including Staff Training.
    c. Requires at least quarterly reporting of the sub-delegated entity to the delegate
    d. Describes the process by which the Delegate evaluates the sub-delegated entities' performance.

- The Agreement should include the annual review of the delegate's policies and procedures and review of files, as applicable, and Credentialing Information Integrity (CII) annual audit, annual training and monitoring processes.
- The Agreement has appropriate language regarding safeguarding the information used in the credentialing processes against inappropriate documentation and updates. Required delegation language for credentialing information integrity specifies that the following documentation and updates to credentialing are inappropriate:
  - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
  - Creating documents without performing the required activities.
  - Fraudulently altering existing documents (e.g., credentialing minutes, clean file reports, ongoing monitoring reports).
  - Attributing verification or review to an individual who did not perform the activity.
  - Updates to information by unauthorized individuals

e. Specifies that the Delegate regains the right to approve, suspend and terminate individual practitioners, providers, and sites, even if decision making is delegated.
f. Describes the remedies available to the Delegate if the Sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

18. The Delegate will conduct a pre-delegation evaluation prior to implementing delegation.

19. The Delegate must review delegate's credentialing activities annually to include:

a. Annually reviews its delegate's credentialing policies and procedures.
b. Annually audits credentialing and recredentialing files against NCQA and any other applicable regulatory requirements.
c. Annually evaluates the delegates performance against any NCQA and any other applicable regulatory requirements.
d. Quarterly evaluates regular reports as specified in the delegation agreement.
e. Annually audits the delegates credentialing information integrity Delegates must comply with NCQA requirements.
   - Review evidence that the Delegate reviewed the sub-delegate's Credentialing Information Integrity (CII) and performed annual audit of inappropriate documentation or updates to
     - Application/attestation
     - Credentialing documents received from the source or agent
     - Documentation of completion of credentialing activities to include: verification dates, report dates, credentialing decision dates, signature or initials of the reviewer or verifier, credentialing checklist, if used.
   - The audit and analysis report includes those examples and items outlined under Item 9.C.2.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

- An annual report is required even if no inappropriate documentation or updates are found.
- Delegate must show evidence that the sub-delegate's CII audit was reviewed and evaluated.

f. Implement corrective actions to address inappropriate documentation and inappropriate updates found in 19.e.

- The Delegate must implement corrective actions if there are findings under the annual audit.
- The documentation of corrective actions planned or taken, including time frames to address the findings.
- The documentation includes staff (by title) responsible for actions and the report includes those items identified under 19.D.2.
- The Delegate shows evidence (reports/meeting minutes) and approves the actions plans developed and implemented.

g. Conducts an audit of the effectiveness of the corrective actions (19.f) on the findings for each delegate 3-6 months after completion of the annual audit for 19.e.

- The Delegate must show evidence that the subdelegate audited the effectiveness of the corrective actions within 3-6 months of the annual audit and conducted a qualitative analysis if there were integrity issues found during the follow-up audit. The report includes those items identified under 9.D.2.
- The audit universe includes initial and recredentialing files processed 3-6 months after the annual audit.
- Evidence of the Delegate's review and evaluated findings may include a report, meeting minutes, or other evidence provided and concludes overall effectiveness of corrections implemented.

20. Improvement Actions

For delegation arrangements that have been in effect for more than 12 months, at least once in the past year, the organization identified and followed up on opportunities for improvement, if applicable.

9.13: Credentialing Program *(cont'd.)*

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.

9.13: Credentialing Program *(cont'd.)*

9.13.5: Termination of Practitioners/Providers *(cont'd.)*

- 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.

9.14: Quality Improvement and Health Equity Transformation Program

Blue Shield Promise is committed to the delivery of quality and equitable health care services. To achieve this, Blue Shield Promise has implemented a Quality Improvement and Health Equity Program (QIHETP), also known as Health Equity Advancements Resulting in Transformation, or HEART program that includes at a minimum the standards set forth in 42 Code of Federal Regulations (CFR) sections 438.330 and 438.340, 28 California Code of Regulations (CCR) section 1300.70, and all health equity-related contractual requirements as published by the DHCS and the DMHC.

The scope of Blue Shield Promise's QIHETP includes:

- A formal governance structure
- Integration and promotion of health equity activities
- A continuous quality improvement process
- Staff training
- An opportunity for network Provider participation
- A Network Provider training
- Monitoring and reporting of the QIHETP to all Subcontractors, Downstream Subcontractors, and Network Providers, as well as, to regulatory bodies.

9.14.1: Health Equity Office and QIHETP Structure

Blue Shield Promise Health Equity Office (HEO) champions the holistic drive to eliminate disparities among members and communities served. The HEO structure is designed for maximal integration throughout the health plan to readily implement and prioritize policies, programs, and procedures to address health inequities.

9.14: Quality Improvement and Health Equity Transformation Program *(cont'd.)*

9.14.1: Health Equity Office and QIHETP Structure *(cont'd.)*

The HEO is led by the Chief Health Equity Officer (CHEO) who reports directly to the Blue Shield Promise President and Chief Executive Officer (CEO). This reporting structure ensures that our top leaders and organization align to health equity across the enterprise.

The Blue Shield Promise HEART QIHETP governance structure includes the following at a minimum:

- The HEO develops the QIHETP strategy and drives program development and implementation.
- QIHETP activities are supervised by Blue Shield Promise' Medical Director and the CHEO.
- Blue Shield Promise' Governing Board oversees the QIHETP and actively participates in strategic planning.
- The HEO manages and facilitates the Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Blue Shield Promise' Medical Director, or the Medical Director's designee in collaboration with the Blue Shield Promise CHEO.
- The QIHEC follows internal governance structure policies and procedures to report to the Medi-Cal Committee of the Board, who is responsible for the approval of the QIHETP description, work plan, evaluation, and monitoring performance toward QIHETP goals. The Medi-Cal Committee of the Board reports to the Blue Shield of California Board of Directors via consent agenda.
- The QIHEC includes participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of the QIHETP development and performance review.

If you are interested in joining the QIHEC contact BSPHealthEquity@blueshieldca.com for more information.

9.14.2: Integration and Promotion of Health Equity

Blue Shield Promise' policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to:

- Marketing strategy
- Medical and other health services policies
- Member and provider outreach
- Community Advisory Committee
- Quality Improvement activities, including delivery system reforms
- Grievance and Appeals
- Utilization Management

9.14: Quality Improvement and Health Equity Transformation Program *(cont'd.)*

9.14.3: Continuous Quality Improvement

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

Blue Shield Promise' quality improvement and health equity programs are comprehensive and designed to monitor, evaluate, and improve the quality and equity of care and services delivered to members and providers objectively, systematically, and continuously. Blue Shield Promise is responsible for all quality improvement and health equity functions applicable to our business and members. Quality improvement and health equity are not delegated.

Blue Shield Promise recognizes that quality and health equity are deeply intertwined, and we cannot have a high-quality plan without equity. The HEO and Quality team collaborates to conduct quality improvement and health equity activities in all areas and dimensions of clinical and non-clinical member care and service. Blue Shield Promise annually develops a QIHETP work plan steeped in health equity that outlines quality improvement activities for the year and focuses on reducing health disparities. The plan is reviewed by the CHEO and CMO and submitted to the QIHEC and governance structure for review, comment, and approval.

Blue Shield Promise seeks to meet the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS and meet health disparity reduction targets for specific populations and measures as identified by DHCS. Blue Shield Promise applies the principles of CQI to all aspects of service delivery through analysis, evaluation, and systematic enhancements as related to health equity, including quantitative and qualitative data collection and data-driven decision-making, using up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field, incorporate feedback provided by members, families, and Network Providers in the design, planning, and implementation of its CQI activities, and incorporate other issues identified by Blue Shield Promise, DHCS, DMHC, and/or NCQA.

Blue Shield Promise will ensure the identification, evaluation, and reduction of health disparities by:

- Analyzing data to identify differences in quality of care and utilization, as well assessing as the underlying reasons for variations in the provision of care to its members.
- Developing equity-focused interventions to address the underlying factors of identified health disparities, including Social Drivers of Health (SDOH).

9.14: Quality Improvement and Health Equity Transformation Program *(cont'd.)*

9.14.3: Continuous Quality Improvement *(cont'd.)*

- Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under the 2024 Managed Care Boilerplate Contract Exhibit A, Attachment III, Subsection 2.2.9.A (External Quality Review (EQR) Requirements, Quality Performance Measures).
- Deploying mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient prescription drugs.
- Analyzing multiple data sources (e.g., Encounter data, pharmacy data, utilization data, health outcomes), stratifying by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.
- Deploying mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001 and W&I Code Sections 14197 and 14197.04.
- Deploying mechanisms to continuously monitor, review, evaluate, and improve quality and health equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, behavioral health, and ancillary care services.

As part of the CQI process, Blue Shield Promise disseminates and monitors the use of clinical practice guidelines. The CHEO reviews clinical practice guidelines to assess opportunities to integrate into the QIHETP.

Blue Shield Promise will develop interventions designed to address PHM and Social Drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity. Blue Shield Promise will develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. Blue Shield Promise will deploy a member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services. Blue Shield Promise will ensure that the QIHETP requirements are applied to the delivery of both physical and behavioral health services.

The CHEO also collaborates with Quality department staff as they conduct and participate in Performance Improvement Projects (PIPs), including any PIP required by CMS, in accordance with 42 CFR section 438.330 as directed by DHCS. Blue Shield Promise will participate in statewide collaborative PIP workgroups. Blue Shield Promise complies with the DHCS PIP requirements outlined in APL 19-017 Quality and Performance Improvement Requirements and must use the PIP reporting format as designated therein to request

9.14: Quality Improvement and Health Equity Transformation Program *(cont'd.)*

9.14.3: Continuous Quality Improvement *(cont'd.)*

DHCS' approval of proposed PIPs. PIPs will include measurement of performance using objective quality indicators including: 1) Implementation of equity-focused interventions to achieve improvement in the access to and quality of care, 2) Evaluation of the effectiveness of the interventions based on the performance measures, and 3) Planning and initiation of activities for increasing or sustaining improvement. Blue Shield Promise will report the status of each PIP as requested by DHCS.

Recognizing that addressing disparities requires collaboration, Blue Shield Promise may seek partnerships in intervention planning and implementation. If your practice is interested in partnering in a health disparity initiative, contact BSPHealthEquity@blueshieldca.com.

9.14.4: QIHETP and Covered Services

Blue Shield Promise is responsible for the quality and health equity of all Covered Services. Blue Shield Promise ensures that the QIHETP requirements are applied to the delivery of both physical and behavioral health services.

Blue Shield Promise ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Mental Health and Substance Use Disorder Services, non-specialty Mental Health Services (NSMHS) set forth in W&I Code Section 14189 is Covered Services in accordance with W&I Code Section 14184.402. Blue Shield Promise considers equity in the provision of such services.

9.14.5: Staff Training

The CHEO collaborates with Blue Shield Promise Cultural and Linguistics department staff to implement and maintain annual sensitivity, diversity, communication skills, health equity, and cultural competency training and related trainings (e.g., providing gender affirming care) offered internal Blue Shield Promise employees as well as contracted staff (clinical and non-clinical), as determined by Procedure Section D of Staff Training in this the DHCS 2024 Managed Care Boilerplate Contract Provision: Diversity, Equity, and Inclusion Training. This training will help with the delivery of equitable services to all members engaging with the health plan. The training offered to Blue Shield Promise employees is entitled *Advancing Health Equity: Training to Support Member Interactions.*

9.14: Quality Improvement and Health Equity Transformation Program *(cont'd.)*

9.14.6: Network Provider Participation

Blue Shield Promise ensures Network Providers participate in the QIHETP and regularly update its Network Providers on activities, findings, and recommendations of the QIHEC, QIHETP and Population Needs Assessment (PNA) by way of various committee forums.

If you are interested in joining the QIHEC contact BSPHealthEquity@blueshieldca.com for more information.

9.14.7: Network Provider Training

The CHEO collaborates with Blue Shield Promise staff to ensure that the Network Provider mandatory training includes information on all member rights specified in the DHCS 2024 Managed Care Boilerplate Contract, Exhibit A, Attachment III, Section 5.1 (Member Services), and diversity, equity, and inclusion (DEI) training (sensitivity, diversity, communication skills, and cultural competency training) as specified in the DHCS 2024 Managed Care Boilerplate Contract, Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training) and detailed in APL 24-016 DEI Training Program Requirements. The Network Provider mandatory training is entitled *Advancing Health Equity*.

The HEO at Blue Shield Promise is dedicated to advancing health equity and promoting diversity, equity, and inclusion within the healthcare system. Mandated state training ensures that staff, new subcontractors, downstream subcontractors, and network providers are equipped with the knowledge necessary to be mindful, respectful, and inclusive of members' diverse health beliefs, practices, and cultural and linguistic needs.

This training also addresses social drivers of health and the impacts of disparities on members' healthcare, including but not limited to, seniors and persons with disabilities (SPD) population, members with chronic conditions, members with Specialty Mental Health Service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and Children with special health care needs. The objective is to teach participants an enhanced awareness of diverse imperatives and issues related to improving access and quality of care for Blue Sheild Promise members.

In accordance with APL 24-016, all subcontractors, downstream subcontractors, and network providers serving Blue Shield Promise members complete the training within 90 days of their active date and every 3 years or during times of re-credentialing or contract renewals . Blue Shield Promise will monitor training completion, deficiencies, and record maintenance. A Corrective Action Plan (CAP) may be enforced for subcontractors, downstream subcontractors, and network providers who have not completed their training. Those required to complete the *Advancing Health Equity* course will receive an email notification with a link to register for and complete the course.

All subcontractors, downstream subcontractors, and network providers serving Blue Shield Promise members must complete the training by January 1, 2026. Attendance records will be reviewed and maintained by Blue Shield Promise staff.

9.14: Quality Improvement and Health Equity Transformation Program *(cont'd.)*

9.14.7: Network Provider Training *(cont'd.)*

The APL 24-016 also requires that Blue Shield Promise monitor grievances related to discrimination, enforcing corrective action for individuals with a grievance concerning discrimination filed against them.

The HEO will keep all Subcontractors, Downstream Subcontractors, and Network Providers informed of all health equity related trainings.

If you have any questions regarding the mandatory DEI Training Program Requirements contact BSPHealthEquity@blueshieldca.com.

9.14.8: Monitoring and Reporting

- Blue Shield Promise prepares a QIHETP plan and evaluation report, no less than 12 months apart and submits to the DHCS.
- Blue Shield Promise ensures reporting of accreditation activities, providing copies of reports from independent private accrediting agencies, such as the National Committee for Quality Assurance (NCQA).
- Blue Shield Promise annually tracks and reports on a set of Quality Performance Measures and Health Equity measures as identified by the DHCS.
- Blue Shield Promise will report on all Health Equity and Quality Measure Set (HEQMS) measures as set forth by the DMHC APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024).
- Blue Shield Promise makes the written summary of the QIHEC activities publicly available on the Blue Shield Promise website at least quarterly.
- Blue Shield Promise provides a written summary of QIHEC activities, findings, recommendations, and actions to DHCS upon request.
- Blue Shield Promise makes the QIHETP plan publicly available on its website on an annual basis.

9.15: Reporting of Provider Preventable Conditions

Overview

Provider Preventable Conditions (PPC) consist of health care-acquired conditions (HCAC) when they occur in acute inpatient hospital settings only and other provider-preventable conditions (OPPC) when they occur in any health care settings.

In May of 2017, the DHCS released All Plan Letter 17-009 (APL 17-009), superseding APL-16-011, along with updated guidance for no longer allowing paper submissions of Form 7107 and requiring the submission of Provider Preventable Condition reporting through DHCS's secure online system. The DHCS also re-released encounter and claims data related to PPCs, HCACs, and OPPCs.

Definitions

"***Health care-acquired conditions (HCAC)***" are the same conditions as the hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception that Medi-Cal does not require providers to report deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age. The ICD-10-CM codes for HCACs are available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html.

"Other provider-preventable conditions (OPPC)" are also known as "never events" and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as follows:

- Wrong surgery/invasive procedure
- Surgery/invasive procedure performed on the wrong patient
- Surgery/invasive procedure performed on the wrong body part

Providers must report these three OPPCs when these occur in any health care setting. "Invasive procedure" refers to a surgical procedure.

The data screening and reporting process, which is to be instituted as an ongoing, continual monthly screening process within health plan or medical practice operations, is summarized below.

Welfare and Institutions Code 14131.11, as well Title 42 of the Code of Federal Regulations, Sections 447, 434 and 438, require all Medi-Cal providers to report provider-preventable conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment prescribed to a Medi-Cal patient for which payment would otherwise be available. States are prohibited from permitting payment to providers for treatment of PPCs. PPCs include both the "Health Care Acquired Conditions" (HCACs) defined in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act and "Other Provider Preventable Conditions" (OPPCs).

9.15: Reporting of Provider Preventable Conditions *(cont'd.)*

Reporting PPCs to the DHCS and Blue Shield Promise

DHCS requires providers to report PPCs after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of beneficiary information. Network providers should report PPCs to DHCS using the secure online reporting portal. Providers may email questions about PPCs to the DHCS at PPCHCAC@dhcs.ca.gov.

Instructions for filling out the online DHCS form can be found online at www.dhcs.ca.gov/individuals/Documents/PPC_form_instructions.pdf.

In addition to reporting PPCs to the DHCS, Blue Shield Promise requires network providers to email a copy of the PPCs submitted to the DHCS to Blue Shield Promise using the Blue Shield Promise PPC/HCAC Submission Form. This form is accessible at the Blue Shield Promise Provider Portal at www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms under *Reporting forms*. Please complete this form online, save it, then email it to BSPromisePPCHCAC@blueshieldca.com.

In addition to the form, for all delegated and non-delegated groups, please submit the patient's medical records. Please ensure the email is sent following your organization's secure email method policy and encrypt any emails sent to Blue Shield Promise that contain patient/member protected health information.

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Effective January 1, 2022, the Department of Health Care Services (DHCS) transitioned Medi-Cal pharmacy services from the Medi-Cal managed care plans to a centralized delivery system. This new centralized delivery system is called Medi-Cal Rx. Magellan is DHCS' contracted pharmacy benefit management vendor that will administer Medi-Cal Rx benefits.

Blue Shield Promise Health Plan will continue to provide medical benefits and support services such as provider network, customer care support, and utilization management as well as appeals and grievances for prescription medications that are covered under the medical benefit.

Blue Shield Promise Health Plan is in compliance with all DHCS and Department of Managed Health Care (DMHC) All Plan Letters (APLs) and requirements related to this carve out.

For questions regarding Medi-Cal Rx pharmacy benefits, policies, and procedures, contact the Medi-Cal Rx Customer Service Center at (800) 977-2273 or visit https://medi-calrx.dhcs.ca.gov/home/.

> *Note:* 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.

10.1: Pharmaceutical Utilization Management

This program incorporates utilization management to encourage appropriate and cost-effective use of medications. This will apply to drugs billed through medical or institutional claims. The Blue Shield of California Pharmacy & Therapeutics Committee is the governing body responsible for oversight and approval of policies and procedures pertaining to drug utilization including medication policies that are under the medical benefit to ensure appropriate use consistent with the current medical evidence. To view the Healthcare Professional/Physician Administered Drug Requests (medical benefit drugs) form, go to Blue Shield Promise's Provider Portal at https://www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms and click on *Authorization request forms.*

Review of Medication Requests for Non-FDA Approved Indications

1. In accordance with Section 1367.21 of the California Health and Safety Code, Blue Shield Promise will not limit or exclude coverage for a drug on the basis that the drug prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
    a. The drug is approved by the FDA;

10.1: Pharmaceutical Utilization Management *(cont'd.)*

b. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition, or for the treatment of a chronic and/or seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is covered by Blue Shield Promise; and,
c. The drug has been recognized for treatment of that condition by one of the following:
    - American Hospital Formulary Service Drug Information.
    - Two peer-reviewed articles from major medical journals supporting the proposed off-label use as safe and effective.
    - For chemotherapy and biologic agents:
        - Lexi-Drugs
        - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium for chemotherapy and biologic agents.
        - Elsevier Gold Standard Clinical Pharmacology.

2. It shall be the responsibility of the participating prescriber to submit to Blue Shield Promise documentation supporting compliance with the above-mentioned requirements when requested by the plan.
3. Criteria utilized in the review of a prior authorization request for a non-FDA approved indication will include, at a minimum, the following:
    a. Submission of the required medical information.
    b. Contraindications or previous treatment failures with FDA approved medications that have FDA approved indications for the intended use of the requested medication.
4. Any coverage required by this section shall also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.
5. For purposes of this section, "life-threatening" means either or both of the following:
    a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
    b. Diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
6. For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.
7. The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of Blue Shield Promise.
8. Nothing in this section shall be construed to prohibit the use of a copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

10.2: Specialty Pharmaceuticals

Purpose

To establish clear policy and procedures for prescribing specialty pharmaceuticals covered under the medical benefit and ensuring reliable access to these medications.

Policy

As of July 1, 2003, Blue Shield Promise no longer requires a health care service provider to assume or be at financial risk for any item described as a qualifying specialty pharmaceutical covered under the medical benefit. The health care provider is permitted to assume financial risk for these items after making the request in writing at the time of negotiating an initial contract or renewing a contract with Blue Shield Promise.

The items included in AB 2420 are:

- Injectable chemotherapeutic medications and adjunct injectable pharmaceutical therapies for side effects.
- Injectable medications or blood products used for the treatment of hemophilia, including Hemlibra and Hympavzi.
- Injectable medications related to transplant services.
- Adult vaccines.
- Self-injectable medications.
- Other injectable medication or medication in an implantable dosage form costing more than $250 per dose.

Medical benefit specialty pharmaceuticals prescribed for members associated with a non-risk medical group will require prior authorization review when listed on the Prior Authorization List. These requirements may include step therapy with preferred drugs or biosimilar agents, and place of service. The Blue Shield Promise Pharmacy Department will conduct the prior authorization review utilizing criteria and guidelines approved by the Blue Shield of California Pharmacy & Therapeutics Committee unless the health care provider has been delegated to perform the prior authorization review. To view the Healthcare Professional/Physician Administered Drug Requests (medical benefit drugs) form, go to Blue Shield Promise's Provider Portal at https://www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms and click on *Authorization request forms.*

> *Note:* Covered medical benefit drugs 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 *(cont'd.)*

Procedure

IPA/Medical Groups Not Retaining Specialty Pharmaceutical Risk and Blue Shield Promise Directly Contracted Physicians

1. In situations where the member is assigned to an IPA/medical group or a directly contracted physician, where Blue Shield Promise assumes the risk for providing specialty pharmaceuticals, physicians must obtain a prior authorization approval from the health plan regardless of whether they utilize office stock, refer patient to a home infusion provider, direct the member to an outpatient facility for administration or require the services of a specialty pharmacy vendor.
2. Physicians who plan to prescribe a specialty pharmaceutical will submit a prior authorization request to the Blue Shield Promise Pharmacy Department. Physicians may obtain a prior authorization form by calling Blue Shield Promise. The completed prior authorization form should be faxed to (866) 712-2731. The Blue Shield Promise Pharmacy Department will review the submitted request. All determinations will be based on the Blue Shield Promise prior authorization guidelines, step therapy, site of service requirements and nationally accepted evidence-based guidelines.
3. If additional information is needed to make a final determination, the Blue Shield Promise Pharmacy Department will send a request to the prescribing physician or the primary care physician. Pharmacy personnel will adhere to the HIPAA minimum necessary information requirements. The Blue Shield Promise Pharmacy Department will also notify the patient that the request is pending additional information from the prescribing physician.
4. If the prior authorization request is approved the Blue Shield Promise Pharmacy Department will enter a prior authorization override that permits the processing of the prescription drug claim under the medical benefit.
5. The Blue Shield Promise Pharmacy Department will notify the provider, member, and the specialty pharmacy in writing of the medication approval. Letters of approval will be mailed to the Blue Shield Promise member and a copy will be faxed to the provider. The servicing provider or specialty pharmacy will receive a faxed copy of the approved prior authorization form.
6. If the prior authorization request is modified or denied, the Blue Shield Promise Pharmacy Department will notify the member and the physician in writing.
7. All denials based on insufficient medical necessity will reference the appropriate guidelines utilized when evaluating the prior authorization request. For denials based on treatment of a condition that is not a covered benefit, the denial letter will reference the applicable state or federal regulation.

10.2: Specialty Pharmaceuticals *(cont'd.)*

8. 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.
9. If applicable, the servicing provider or 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.
10. Approval notices for specialty pharmaceuticals will include the specific medication NDC (National Drug Code) and the HCPCS (Health Care Common Procedure Coding System). All claims should be billed utilizing the appropriate NDC code and JW modifier indicator single dose container drug waste as appropriate. A manual HCFA 1500 claim with NDC, HCPCS, and or JW modifier may be subsequently submitted to Blue Shield Promise for reimbursement.

IPA/Medical Group Retaining Specialty Pharmaceutical Risk

If a member is assigned to an IPA/medical group that has elected to keep the financial risk for medical benefit specialty pharmaceuticals, Blue Shield Promise will refer the provider and member to the IPA/medical group for review of the prior authorization request. The IPA/medical group will be expected to conduct the prior authorization review utilizing Blue Shield Promise criteria and guidelines approved by the Blue Shield of California Pharmacy & Therapeutics Committee. Adherence to Blue Shield Promise's medical necessity, site of service and biosimilar first policies is required and will be subject to the delegation audit.

IPA/medical groups are responsible for complying with California Health and Safety Code Section 1367.206(b) and California Insurance Code 10123.201(c)(2) for medically necessary exception requests. IPA/medical groups will approve a medication prior authorization request if:

1. Trial of preferred drugs has been attempted, but caused intolerable side effects, inadequate response achieved, diminished effect, or unable to try due to contraindications.
2. Rationale is submitted by provider that states one of the following:
    a. Preferred drugs are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.

10.2: Specialty Pharmaceuticals *(cont'd.)*

IPA/Medical Group Retaining Specialty Pharmaceutical Risk *(cont'd.)*

b. Preferred drugs are not clinically appropriate because they are expected to do any of the following:

   i. Worsen a comorbid condition.

   ii. Decrease the capacity to perform daily activities.

   iii. Pose a significant barrier to adherence or compliance.

10.3: Reporting

Medi-Cal Pharmacy CALINX claim files are available by the 15th of each month and can be accessed via the Blue Shield Promise Provider Portal. Participating Provider Groups that do not have access to these files should ask their Account Manager to create a user account. Once the account has been created, access instructions and additional information will be sent to the requestor.

10.4: Drug Storage and Dispensing in Provider Offices

Policy

All medications, including vaccines and drug samples, used at provider sites will be stored, handled, and administered according to State Department of Health Services and other state or federal regulations and according to manufacturers' recommendations.

Procedure

1. Each site shall maintain and periodically update a set of internal medication/ pharmacy policies and procedures.
2. All medications shall be stored in their original containers. This does not apply to cleaning or antiseptic solutions that may be poured into other dispensing containers.
3. Germicides, disinfectants, test reagents and household cleaning substances shall be stored separately from medications.
4. All multiple dose containers shall be labeled with the date they are originally opened.
5. All medications and related items including sample drugs shall be routinely checked for expired items.
6. All medications shall be discarded, per Title 22 requirements, when they reach their expiration date.
7. Medications shall be stored in a segregated manner according to their route of administration (i.e., oral, injectable, topical).
8. All medications, needles, and syringes are to be stored in an area only to authorized personnel.

10.4: Drug Storage and Dispensing in Provider Offices *(cont'd.)*

9. Medications shall be stored at temperature levels specified by the manufacturer (i.e., room temperature, refrigerated at 35-45 degrees F or frozen at less than 7 degrees F).
10. Controlled substances (Schedule II or III) are to be stored separately from other medications in a securely locked cabinet. Controlled substances shall be inventoried, logged, and controlled. The physician is responsible for the use, storage, and inventory of all controlled substances.
11. Items other than medications that are stored in a refrigerator are kept in a separate compartment from drugs.
12. Medications that are transferred from the original container into another are classified as "re-packaged." The following information is required on the new container: date of re-packaging, initials of re-packager, manufacturer name, and original lot number.
13. Medications shall be prepared in a designated, clean area of sufficient size as to minimize the potential for medication errors.
14. Drugs for emergency use should be stored in a secure, locked area and a location that is accessible in an emergency.
15. A list of contents and expiration dates should be on the outside of the emergency "box."
16. The contents of the emergency "box" should match the contents list.
17. The use and/or dispensing of sample medications are discouraged. If a provider elects to use and/or dispense sample medications, the following standards must be met:
    a. A physician or pharmacist shall be responsible for the storage, inventory, and dispensing of sample medications.
    b. Only a physician or pharmacist shall dispense sample medications. This cannot be delegated to other office staff.
    c. Sample medications shall be logged when received, including the medication name, quantity, manufacturer name, lot number, and expiration date.
    d. Samples may only be dispensed to the provider's own patients.
    e. Samples may not be sold.
    f. Samples must be stored in a secure manner.
    g. If samples are dispensed, they must meet all labeling requirements.
    h. An appropriate entry is made in the patient's medical chart in a similar manner as if a prescription had been written.
    i. Samples may not be used to satisfy prior authorization requirements for trial and failure of a medication.

10.5: Access to Pharmaceutical Care and Services

Blue Shield Promise will ensure appropriate member access to pharmaceutical care or services billed under medical or institutional claims.

Access to pharmaceutical care or services will be monitored through a variety of methods. The Chief Medical Officer is ultimately responsible for resolving all member issues related to pharmaceutical access.

11.1: Health Education Program

Purpose

The Health Education (HE) Program is committed to improving and maintaining the health and wellness of Blue Shield Promise members through health education, health promotion, skill training, interventions and disease management offered in a culturally sensitive and linguistically appropriate manner. Educational interventions address health categories and topics that align with findings from Blue Shield Promise's Population Needs Assessment, Population Health Strategy and Department of Health Care Services requirements, including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

Goals

- Promote appropriate use of health services.
- Promote health education services.
- Encourage member involvement with their Primary Care Physician (PCP) in the management of his or her personal health.
- Increase member knowledge on preventive health care services and screenings.
- Encourage risk reduction and lifestyle changes to improve health.
- Increase use of preventive services for early detection of disease according to current guidelines for age and gender.
- Increase member's knowledge and skills to enable him or her to cope with chronic disease.
- Increase member's feelings of self-efficacy in managing chronic diseases.
- Increase health equity through targeted member engagement in evidence-based disease management programs that use health education interventions and seek to close care gaps for members that participate in these programs.

11.2: Scope of the Health Education Program

11.2.1: Member Education

The Blue Shield Promise Health Education program is committed to ensuring its member population receives quality health education services that are appropriate to their cultural and linguistic needs. The Health Education program promotes knowledge, skills, and behavior change to increase feelings of self-efficacy so that members can manage chronic disease as well as maintain optimum health for themselves and their families. The following programs are available to Blue Shield Promise members through self-referral and referral from their PCP or internal departments.

Members and providers may obtain more information about these programs and services by calling the HE Department.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.1: Member Education *(cont'd.)*

Health Education Classes

The Blue Shield Promise Health Education (HE) Department or the Blue Shield Promise Utilization Management (UM) Department receives and processes referrals for HE classes and/or other interventions. Blue Shield Promise providers may refer their patients to HE services by completing and submitting the Health Education Referral Form (See www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms) to the HE Department via fax or mail. Once the referral is received, HE will locate a health education class. If no class is available, HE will send written information to the member on the requested topic. For referrals to programs with a cost, the provider may submit their referral using a Treatment Authorization Request (TAR) Form to the UM Department, via fax or mail. The PCP will receive documentation of the final outcome for referrals submitted to the HE or UM Departments.

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, Spanish, 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.

The Blue Shield Promise HE Department works with the Growth and Engagement Department and Quality Improvement Department to coordinate activities for Blue Shield Promise's involvement in community outreach efforts and health screening events.

Health Education Materials

A variety of brochures and handouts are available to providers and members at no cost on the Blue Shield Promise website at www.blueshieldca.com/healtheducationlibrary. We encourage providers to give them to members at the point of service.

All materials selected are culturally sensitive and linguistically appropriate (refer to Section 17: Culturally and Linguistically Appropriate Services (CLAS) for definitions), and do not exceed the 6th grade reading level as required by the Department of Health Care Services (DHCS).

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.1: Member Education *(cont'd.)*

Accessing Health Education Materials

The HE Department has a variety of materials in threshold languages and alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) available to members and providers. Materials in languages other than English are also reviewed for cultural sensitivity and linguistic appropriateness for the target population. Providers may print materials from the Blue Shield Promise library at www.blueshieldca.com/healtheducationlibrary. Providers who are unable to print materials from the library or who want to request materials in non-English, non-Spanish languages or in an alternative format can contact the Blue Shield Promise HE Department at BlueShieldofCAHealthEducation@blueshieldca.com.

Member Resources

The HE Department informs members of available health education services through the Blue Shield Promise member newsletter, provider referrals, the Customer Care phone line, targeted mailings, Blue Shield Promise websites, and community outreach events. The member newsletter is mailed to each member household and includes brief articles on a variety of health topics as well as information on Blue Shield Promise Health Education programs.

Members may call the HE Department to request HE brochures or information on health education classes, and/or other interventions. Access to an over-the-phone interpreter service is available for members requiring interpretation.

Blue Shield Promise Health Plan develops Preventive Health Guidelines for adults and children/adolescents. These guidelines represent a compilation of recommendations from various organizations including the American Academy of Pediatrics, American Academy of Pediatric Dentistry, Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, and National Cancer Institute. Preventive Health Guidelines for Adults and Children/Adolescents are available in English and Spanish on the Blue Shield Promise member website at www.blueshieldca.com/en/bsp/medi-cal-members/health-wellness.

Members may also call Customer Care to request a printed copy of the guidelines. Providers are notified about updates to the guidelines via the Blue Shield Promise Provider Connection website at https://www.blueshieldca.com/en/provider, provider visits, or blast fax. Members are notified about updates to the guidelines via member newsletters.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.2: Mandated Health Education Topics

The following health related topics are mandated by the DHCS:

- Age Specific Anticipatory Guidance *
- Asthma
- Breastfeeding
- Complementary and Alternative Medicine
- Diabetes
- Exercise/Physical Activity
- Family Planning
- HIV/STD Prevention
- Hypertension
- Immunizations
- Injury Prevention (intentional & unintentional)
- Nutrition
- Obesity
- Parenting
- Perinatal
- Substance Abuse
- Tobacco Prevention and Cessation
- Unintended Pregnancy

*Includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.

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

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.2: Mandated Health Education Topics *(cont'd.)*

The mandated health education topics will be provided to all members by the following methods:

- Displaying health education materials in PCP/IPA/medical group office
- Sending health education materials to the member's home
- Providing health education classes
- Providing member newsletters
- Providing outreach activities
- Referring to health education community services
- Providing 24-hour nurse availability
- Providing access to a Health and Wellness portal

11.2.3: Selection of Health Education Materials

Blue Shield Promise is highly committed to the delivery of quality health promotion and educational materials. Health Education materials are chosen to not only address DHCS requirement but to address the needs of the Blue Shield Promise member population. All materials selected are culturally sensitive and linguistically appropriate and meet the 6th grade reading level requirement.

Methods of Testing Reading Levels of Health Education Material

All member health education materials must be reviewed and tested using an approved tool. The Fry Readability Formula is based on the assessment of three 100-word passages from an article. The average number of syllables and average number of sentences per 100 words are plotted on a grade level graph to determine the approximate grade level. The Flesch-Kincaid Grade level is equivalent to the US grade level of education. It shows the required education to be able to understand a text. The Fry Readability Formula and Flesch-Kincaid Grade Level assessments are the commonly used methods to assess the readability of materials distributed by Blue Shield Promise.

Health Education Material Standards

In addition to the reading level methods listed above, standards for health education materials are based on the following:

- Content/style
- Layout/appearance
- Visuals

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.3: Selection of Health Education Materials *(cont'd.)*

- Cultural appropriateness: Represents the member population's ethnic group, practices and behaviors based on their cultural background. Understanding of the members' cultural background is a key factor in providing quality and appropriate delivery of health education.
- Linguistic appropriateness: Represents all appropriate languages based on member population in the provider office. Selection of translation methods plays a critical role. Patient rights mandate that patients receive understandable information on illness, injuries, etc. Proper translation of English language material ensures that these rights are not violated.
- Field testing (if applicable)
- Medical accuracy

Readability and Suitability Checklist

The Readability and Suitability Checklist (RSC) is used to document the reviewed material's reading level, medical accuracy, and cultural and linguistic appropriateness. It also includes a review of the material's content and layout. Materials are re-reviewed every five years or sooner if the material or health guidelines are updated.

Health Education Materials Library

Blue Shield Promise contracts with a health education library vendor that has received DHCS approval of their materials because they meet readability and suitability requirements. Materials from this library are exempt from the RSC review process. An RSC is completed for all other materials that are not part of the vendor library. These materials and their corresponding RSC are kept on file for review for audit purposes.

11.2.4: Provider Education

The Health Education Department coordinates provider education specific to health education. This includes providing access to materials on all state mandated health topics, cultural linguistic requirements, and effective techniques in patient education and communication. This is done via provider in-service education, blast faxes/email, and information posted on the Blue Shield Promise website. Health Education information is also disseminated via provider meetings (i.e., IPA Joint Operations Committees, IPA Forums, and Medical Services Committee meetings), and special mailings.

The Health Education Department also educates providers on the findings from the Population Needs Assessment.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.4: Provider Education *(cont'd.)*

All other operational provider information is the responsibility of the appropriate Blue Shield Promise department. Because provider issues may overlap with health education, the Health Education Department is readily available to assist these areas in the provision of provider educational services.

11.3: Member Education Contractual Requirements

11.3.1: Provider's Responsibility to Health Education

Pursuant to the contractual agreement under the Department of Health Care Services (DHCS), member education must include the following:

- Promotion of preventive services, education, and counseling
- Promotion of appropriate use of Medi-Cal managed care plan services
- Education of the availability of local social healthcare programs

The provider is responsible for providing culturally sensitive and linguistically appropriate health education, prevention, and counseling services to the member population based on their needs (See https://www.blueshieldca.com/en/bsp/providers/programs/health-education-providers). Providers are strongly encouraged to guide their patients to take increased responsibility for their personal health. The Blue Shield Promise HE Department is responsible for providing all state mandated health education materials and associated services to members via contracted providers. Also, 24-hour free interpretation services are available to providers with LEP patients needing interpreter services.

The provider is responsible for promoting breastfeeding to his or her patients. Research shows that breastfeeding brings many benefits to both the infant and mother. These benefits include health, nutritional, immunologic, developmental, economic and environmental.

Additionally, providers should not distribute samples or materials with formula company logos on them to their patients, as per MMCD Policy Letter 98-10. Providers are encouraged to refer Medi-Cal patients to WIC services.

11.3: Member Education Contractual Requirements *(cont'd.)*

11.3.2: Monitoring Provisions of Health Education

The Blue Shield Promise HE Department assesses the effectiveness and quality of health education services offered by providers using the following methods:

- Audits of medical records at provider sites performed by Blue Shield Promise Health Plan or L.A. Care Health Plan.
- Focused review studies conducted by the Quality Management Department, assessing data obtained from various sources (i.e. medical records, encounter data, provider, and member surveys, etc.).

Medical Record Documentation of Health Education Services

Documentation of health education in medical records should include the following:

- Health education relative to the diagnosis and/or presenting problem
- Brochures or other HE information given to the patient
- Patient's understanding of the education provided
- Referral to HE services (i.e., classes, counseling, program, etc.)
- Documentation of interpreter services used by the patient
- Signature and title of all staff providing HE to patient

11.4: Tobacco Cessation Services

Per All Plan Letter (APL) 16-014, providers are required to implement tobacco cessation interventions and a tobacco user identification system into their practices. Providers must:

- Conduct initial and annual assessment of each patient's tobacco use and note this information in patient's medical record
- Offer FDA-approved tobacco cessation medications (for non-pregnant adults)
- Provide counseling using the "5 A's" model or other validated model for treating tobacco use and dependence
- Refer patients to available individual, group, and telephone counseling services
- Offer services for pregnant tobacco users
- Provide interventions to prevent the use of tobacco in children and adolescents

11.4: Tobacco Cessation Services *(cont'd.)*

Recommendations on how to identify tobacco users include:

- Add tobacco use as a vital sign in the chart or Electronic Health Records
- Use International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use
- Place a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco
- Record status on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160)

How to Start the Conversation

Provider: Discuss some of the health problems associated with smoking, for example:

"As your health care provider and someone who cares about you and your health, I'd like to help you quit smoking because it's the best thing you can do for your health and anyone who lives with you."

Tobacco Cessation Medications Available to Medi-Cal Patients

Smoking cessation agents for adults who use tobacco products are covered by the Medi-Cal RX program. Some of these medications may have quantity limits and are subject to change. Currently, none of the tobacco cessation medications require prior authorization. For additional information, please see the Medi-Cal RX Contract Drugs List here: https://medi-calrx.dhcs.ca.gov/home/cdl/. Some of the agents (i.e., patches, lozenges, and gum) are found in the over-the-counter list: https://medi-calrx.dhcs.ca.gov/home/cdl/.

Providers play a key role in the member's journey in quitting smoking. Please work with your patient to find the best option for quitting smoking such as referring them to community resources and/or prescribing them tobacco cessation medication.

To view the policy letter, learn more about the required interventions, find training and patient resources, please visit the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers/programs/tobacco-cessation-medi-cal.

11.5: IPA/Medical Group's Responsibility to Health Education

IPAs/medical groups are required to comply with the responsibilities outlined in Sections 11.1 through 11.4 and participate in health education activities that are required by Blue Shield Promise in order to best support health education goals for members and remain compliant with regulatory requirements.

11.6: Program Resources

11.6.1: Health Education Staff

Health Education and Cultural and Linguistic Senior Manager

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

The Senior Manager is responsible for developing, implementing, managing, and evaluating member education programs and provider education programs related to health education and ensures compliance with NCQA, state, federal and L.A. Care requirements for health education. The Senior Manager ensures that materials and programs are culturally sensitive and linguistically appropriate to the member population under standards created by LA Care Health Plan and the DHCS. The Senior Manager ensures compliance with NCQA, Multicultural Distinction standards and National CLAS standards.

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

- Development, implementation and evaluation of annual Health Education Workplan and Program.
- Development, implementation and evaluation of Policies and Procedures.
- Oversight of development, implementation, and evaluation of health education provider, member, and condition specific programs.
- Oversight of evaluation and distribution of culturally and linguistically appropriate member education materials.
- Meeting the requirements of the DMHC, DHCS, and L.A. Care Health Plan and other regulatory agencies as appropriate.
- Collaborate with L.A. Care Health Plan to meet DHCS requirements.

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

11.6: Program Resources *(cont'd.)*

11.6.1: Health Education Staff *(cont'd.)*

Health Educator

The Health Educator reports to the Health Education and Cultural and Linguistic Senior Manager and the Health Education Manager and works in conjunction with them to implement health education programs appropriate to our member and provider population.

In addition, the Health Educator supports provider relations, community outreach, and quality improvement activities associated with member education, as well as collaborates with outside agencies.

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

11.6.2: Health and Wellness Portal

The health and wellness portal is an online resource available to members. The goal of the portal is to increase members' ability to manage their health by helping them identify their risks via a wellness assessment and connecting them to self-management tools and resources that can help mitigate their risks. Members can also track their health over time on the portal. Some of the tools available on the portal include a health library on topics including physical activity, blood pressure, cholesterol, blood glucose, and nutrition. To access the health and wellness portal, members can log on to their Blue Shield Promise member portal at www.blueshieldca.com and find the Your Wellness Assessment section. Upon selection of this section, members will be automatically redirected to their health and wellness portal.

11.6.3: Wellvolution

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. Members can choose programs ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow. Once the member receives their Blue Shield Promise member ID card, they can go to https://www.wellvolution.com/medi-cal to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs that are personalized and have proven results, at no cost.

11.6: Program Resources *(cont'd.)*

11.6.3: Wellvolution *(cont'd.)*

The following programs are offered through Wellvolution:

Mental & Behavioral 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, a personalized care plan, and more.

Weight Loss Programs – Programs specifically designed to help members make changes that fit their lifestyle and promote a healthy weight. Members could lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 pounds per week.

Disease Prevention Programs - Targeting reduction of risk for type 2 diabetes, such as the Diabetes Prevention Program, and heart disease, prevention programs provide members with a health coach and an individualized plan that meet the unique needs and address several areas of a member's life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.

Chronic Condition Reversal Programs – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from health coaches and a supportive member community. Our high touch reversal programs, incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence.

Tobacco & Vaping Cessation Programs – All programs include a two-month supply of nicotine replacement therapy in the form of the patch, lozenge, or gum at no additional cost to our members.

All Wellvolution programs are 100% covered by Blue Shield Promise and there is no cost to Blue Shield Promise members to enroll in Wellvolution programs.

11.6: Program Resources *(cont'd.)*

11.6.4: Departments in Collaboration with Health Education

Cultural and Linguistic

The Health Education unit collaborates with the Cultural and Linguistic unit to develop and implement training sessions for providers, staff, and IPA/medical groups. These units also work together to ensure proper translation of health education materials into threshold languages and alternative formats. Blue Shield Promise adheres to NCQA Multicultural Distinction Standards and the National CLAS standards. The goal is to support the improvement of CLAS for our members, providers, and employees. For more information, refer to Section 17.

Quality Improvement

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

Customer Service Department

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

Provider Relations Department

The Provider Relations Department works with the Health Education Department in identifying provider needs for health education materials and services.

Growth and Engagement Department

The Health Education Department works with the Growth and Engagement Department to coordinate activities for Blue Shield Promise involvement in community outreach efforts. Additionally, this department works with HE to help identify health education needs of the provider.

Utilization Management

The Health Education Department works with Utilization Management to direct appropriate health education interventions for patients identified through the UM/HE referral process. The HE Department assists the UM Department in educational efforts by identifying and supplying appropriate materials for UM to send to members and supports UM Case Management by assisting with HE interventions for members referred by Case Managers.

Health Equity Office

The Health Equity Office assists the Health Education department to incorporate health equity into strategic planning, program design, and operations.

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

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

The following resources are available to providers and staff:

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

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

12.1: Provider Manual Distribution

Provider manuals are distributed to all new IPA/medical groups and hospitals during Joint Operation Committee meetings and for Blue Shield Promise directly contracted providers within ten (10) business days of placing provider on active status. Blue Shield Promise will request and maintain documented receipt of all provider manuals distributed. Provider manuals are updated quarterly. Updates to the provider manual are made available on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers under *Provider manuals*.

12.2: Provider Orientations

Orientations are conducted by the Provider Services staff to educate new IPA/medical groups, hospitals, ancillary providers, and Blue Shield Promise directly contracted providers on Plan operations and policies and procedures within thirty (30) business days of placing a provider on active status. Direct network providers must have completed training before entering provider into Blue Shield Promise network and/or provider directory. Training must have been conducted within the past 24 months of being added to the Medi-Cal network. If the provider is not available for an in-person orientation, the New Provider Orientation (NPO) will be conducted telephonically, WebEx, or via a self-directed online module.

12.2: Provider Orientations *(cont'd.)*

IPA/Medical Group Responsibilities

Blue Shield Promise's contracted IPA/medical groups are responsible for conducting provider training and orientation for its contracted providers within thirty (30) business days of placing a provider on active status with the IPA/medical group regardless of their effective status with Blue Shield Promise. IPA/medical groups are required to provide evidence of the 30-day training as requested by Blue Shield Promise. When submitting provider to be added to the network, IPA/medical groups must attest to the completion of a 30-day provider orientation training by providing the training date of completion within submitted provider rosters or provider profiles. New Provider Training Attestation forms must also be completed for each individual practitioner and IPA/medical group must be prepared to provide a copy of the New Provider Training Attestation Form to Delegation Oversight.

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

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

12.4: PCP Enrollment Limits

A primary care physician (PCP) may be assigned a maximum of 2,000 members total. When a PCP reaches the enrollment limit, the PCP's panel is closed to new enrollment until the PCP's membership drops below the maximum level. State regulations require Blue Shield Promise to ensure the network meets the following provider to member ratios:

- Primary Care Physician 1:2,000
- Capacity is added to PCP when supervising Mid-Level provider up to a max capacity of 1:5,000

A PCP can limit the growth of their enrollment by requesting to close their panel. When a provider closes their panel, the provider is no longer open for the auto assignment default process or member choice selection. Exceptions may be made for existing members.

Additionally, Blue Shield Promise has the capability of closing a provider's panel to new patients if the member experiences access issues, quality issues, or provider has failed a facility site review. The provider's panel will re-open upon an approved corrective action plan (CAP).

12.5: Mid-Level Medical Practitioners

The use of Mid-Level Practitioners increases primary and specialty care capacity and member access to professional services. Relative to primary care, the number of potential assigned members to a PCP can be increased by 1,000 members for each mid-level practitioner the PCP supervises to a maximum of 5,000 members.

PCPs may supervise up to four (4) mid-level practitioners in any combination according to the following state regulated physician supervisor to mid-level provider ratios:

Nurse Practitioner	1:4
Physician Assistant	1:2
Midwife	1:3

The delegation of specified medical services to mid-level practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the mid-level practitioner.

12.6: Provider Network Additions (IPA/Medical Groups)

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

- Primary Care Physicians
- Specialty Care Physicians
- Hospitals
- Urgent Care Centers
- Federally Qualified Health Clinics (FQHC), FQHC Look-alikes (health centers that provide similar services and meet the same performance requirements as FQHCs but do not directly receive federal funding under the Health Center Program), and Indian Health Clinics

The addition of an IPA/medical group provider requires submission of a provider profile to Blue Shield Promise.

Los Angeles county Primary Care Physicians, Specialty Care Physicians, Hospitals and Urgent Care Center additions need to be submitted to Blue Shield Promise Information & Enrollment Department through the provider portal: https://www.blueshieldca.com/en/provider.

Los Angeles county Federally Qualified Health Clinics additions will need to be sent to the IPA/medical groups assigned provider relations representative.

12.6: Provider Network Additions (IPA/Medical Groups) *(cont'd.)*

San Diego county Primary Care Physicians, Specialty Care Physicians, Hospitals, Urgent Care Center and Federally Qualified Health Clinics additions need to be submitted to Blue Shield Promise Information & Enrollment Department through the provider portal: https://www.blueshieldca.com/en/provider.

Medi-Cal enrollment is required to participate in the network. New Provider Orientation (NPO) training completion is a requirement to add providers to the Medi-Cal network.

See Section 9.13: Credentialing Program for minimum credentialing data requirements.

12.7: Provider Network Changes

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

Providers affiliated with Blue Shield Promise through an IPA/medical group must send notification to the IPA/medical group in accordance with their contractual agreement. Notification of changes should be directed to the Provider Information & Enrollment Department. through the provider portal: https://www.blueshieldca.com/en/provider.

12.7.1: PCP Terminations

IPA/medical groups and/or Blue Shield Promise directly contracted providers shall log onto the provider portal: https://www.blueshieldca.com/en/provider for all provider withdrawals and terminations as soon as the group is notified and at a minimum of 90 days in advance. Blue Shield Promise cannot guarantee that members will remain with the same PCP/IPA/medical group due to member choice.

Blue Shield Promise retains the right to obligate the PCP/IPA/medical group to provide medical services for existing members until the effective date of member transfer. When an IPA/medical group fails to designate an appropriate provider, members will be reassigned as described below:

Blue Shield Promise Directly Contracted Physicians

1. If the terminating PCP practices under a group contract, the members will remain with the group.
2. If the terminating PCP practices under a solo contract, the members will be reassigned within the Blue Shield Promise Provider Network.

IPA/Medical Groups

1. If the terminating PCP practices in a Federally Qualified Health Center (FQHC), clinic, or staff model, the members will remain with the FQHC, clinic, or staff model and will remain with the group.

12.7: Provider Network Changes *(cont'd.)*

12.7.1: PCP Terminations *(cont'd.)*

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

12.7.2: Termination Notification Requirements

Blue Shield Promise recognizes the importance of timely member notification prior to the termination of a regularly seen specialist or specialty group. The IPA/medical groups delegated for this function and/or Blue Shield Promise shall log onto the provider portal: https://www.blueshieldca.com/en/provider as soon as the Group is notified .In accordance with the Department of Health Care Services (DHCS), Blue Shield Promise members are required to receive at least 30 calendar days' prior notice of an upcoming physician termination, including specialist or specialty group termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later, unless directed by DHCS.

The specifics of the requirements are as follows:

1. All Blue Shield Promise contracted IPA/medical groups must notify members seen regularly by a specialist or specialty group whose contract is terminated at least 30 days prior to the effective termination date. The letter to the member must include notification of the specialist or specialty group's termination, the effective date of termination, and the procedures for selecting or assigning another specialist or specialty group. (Please refer to the Continuity of Care Guidelines in Section 7.8.5 for members qualifying for continuity of care.)

12.7: Provider Network Changes *(cont'd.)*

12.7.2: Termination Notification Requirements *(cont'd.)*

2. Contracted IPA/medical groups must have policies that define members seen regularly by a specialist or specialty group and which outline the provider's implementation plan for notifying members of the specialist/specialty group termination, as well as the procedures they may follow to select another specialist. Ways to identify affected members may include but are not limited to:
    - Number of visits within a specified time period such as two or more cardiac follow-up visits within one year.
    - Repeated referrals for the same type of care over a specified time period such as four referrals for the treatment of diabetes over a two-year period.
    - Receipt of periodic preventive care by the same specialist or specialty group such as a woman receiving an annual well woman exam by the same OB-GYN.
3. If the IPA/medical group does not provide Blue Shield Promise affected members with 30 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 30-day advance notice of the termination is given.
4. Member notices must be sent in the members' preferred language within the threshold language requirements for each county, in accordance with APL 21-004. Blue Shield Promise will provide the IPA/Medical Groups with letter templates and enclosures, all translated in the threshold languages. Alternative Format Selection for members with visual Impairments or other disabilities requiring provisions of written materials in alternative formats must also be available upon request, in accordance with APL 22-002.

12.7.3: Blue Shield Promise Oversight

Blue Shield Promise provides appropriate oversight of each of its contracted IPA/medical groups, including, but not limited to:

- Specialist/Specialty Group Termination Policy and procedures as outlined above;
- Review of member notification letter regarding specialist/specialty group terminations. Note: Letters must be Blue Shield Promise approved template letters.

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

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

1. Identify "affected members" regularly seen by a specialist or specialty group;
2. Inform affected members of the specialist/specialty group termination; and

12.7: Provider Network Changes *(cont'd.)*

12.7.3: Blue Shield Promise Oversight *(cont'd.)*

3. Assign or direct affected members to select another specialist or specialty group.

In addition, the IPA/medical group is required to maintain copies of all notification correspondence between the IPA/medical group and affected members.

12.7.4: Office Relocation

IPA/medical groups or Blue Shield Promise directly contracted providers shall log onto the provider portal: https://www.blueshieldca.com/en/provider for all office relocations. The PCP/IPA/medical group is responsible for submitting a coverage plan to Blue Shield Promise, if necessary.

PCP that changes office locations will require a facility site review (FSR). The PCP's panel will be closed to new membership until the new location has successfully completed the FSR review and been enrolled. Once the new site is enrolled and approved, members will be transferred from the existing site to the new site. If the PCP moves outside of the former office's geographic area, Blue Shield Promise will coordinate with the IPA/medical group to reassign the members to a new PCP within Blue Shield Promise's access standard of five (5) miles but no more than ten (10) miles. In transferring members, the provider's location, specialty, and language are taken into consideration. If the IPA/medical group is unable to meet this requirement, members will be transferred to a provider in the geographic area of the former office location.

12.7.5: Provider Leave of Absence or Vacation

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

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

PCPs may change their Blue Shield Promise IPA/medical group affiliation by submitting written notification of the change request to the Provider information & Enrollment that the PCP wishes to change from in accordance with the contractual agreement and with contract regulators.

12.7: Provider Network Changes *(cont'd.)*

12.7.6: Change in a Provider's IPA/Medical Group Affiliation *(cont'd.)*

Blue Shield Promise will process the request in accordance with the member notification policy.

Blue Shield of California
Provider Information & Enrollment
P.O. Box 272854
Chico, CA 95927-2854

12.7.7: Change in a Provider's Panel Status

The IPA/medical group is required to inform the Plan within five (5) business days when either of the following occur:

1. One or more of their providers is not accepting new patients;
2. One or more of their providers previously did not accept new patients and is currently accepting new patients; or
3. If the one or more of their providers was not accepting new patients and is contacted by an enrollee/Plan member or potential enrollee/Plan member seeking to become a new patient, the provider shall direct the enrollee/Plan member or potential enrollee/Plan member to our Member Services Department at (800) 605-2556 (Los Angeles) or (855) 699-5557 (San Diego) TTY 711 for assistance in selecting a new provider. The provider is also to direct the enrollee/potential enrollee to the Department of Managed Care Services (DMHC) to report any provider directory inaccuracy.

Provider Directory Inaccuracies

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

- Submit provider demographic changes on Blue Shield Promise's provider portal, Provider Connection at www.blueshieldca.com/provider
- Complete an Online Interface Form
- Call Blue Shield Promise Member Services at (800) 605-2556 (Los Angeles) or (855) 699-5557 (San Diego)

12.7: Provider Network Changes *(cont'd.)*

12.7.7: Change in a Provider's Panel Status *(cont'd.)*

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

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

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

Documentation shall include the provider's name, location, and a description of the Blue Shield Promise validation, the outcome, and any changes or updates made to the provider directory.

Blue Shield Promise will terminate a provider upon confirming:

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

Online Interface Form

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

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

12.7.8: Network Validation

1. 90 business days Network Validation.

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

12.7: Provider Network Changes *(cont'd.)*

12.7.8: Network Validation *(cont'd.)*

The validations include the following:

a. Provider Notice:

(1) Instructions to review and submit provider changes within 30 business days.

(2) Instructions on how the plan provider can update the information listed in the provider directory using the online interface.

b. Attestation:

(1) Receipt of network validation.

(2) Confirm that the information in the provider directory or directories is current and accurate; or

(3) Update the information required to be in the directory or directories.

2. Plan Provider Attestation Requirement:

Blue Shield Promise requires an attestation from plan providers. If an attestation or an update is not received, Blue Shield Promise shall:

a. Send an attestation reminder if the provider does not attest after 30 business days of the initial outreach notice.
b. If the provider has not attested after 45 business days an intent to suppress notice is sent.
c. If the provider does not attest after 55 business days of the initial outreach notice, the provider is suppressed from the directory.

3. Removing a Plan Provider:

If no response to the provider notice(s) is received, after the required ten (10) business day notice period, the plan provider shall:

a. Be removed from the provider directory by the next required update; or
b. If provider responds within the 10-business day notice period, plan provider will not be removed.

4. Blue Shield Promise's Provider Directory Protocol:

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

12.7: Provider Network Changes *(cont'd.)*

12.7.9: Practice Locations

- 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 an 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 therapists, etc.) shall be limited to eleven (11) in-person practice locations.

12.7.10: 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.

"***Telehealth***" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a member's health care while the member is at an originating site and the provider is at a distant site. Telehealth supports member self-management and caregiver support for members and includes synchronous interactions and asynchronous store and forward transfers.

Policy

Blue Shield Promise Clinics shall adhere to the Department of Health Care Services' (DHCS) policy on covered services offered through Telehealth modalities as outlined in the DHCS Medi-Cal Provider Manual at Medicine: Telehealth. This includes clarification on those covered services which can be provided via Telehealth and the expectations related to documentation for Telehealth.

12.7: Provider Network Changes *(cont'd.)*

12.7.10: Telehealth *(cont'd.)*

Provider Requirements

Providers rendering covered services via a Telehealth modality must be licensed in the State of California and enrolled as a Medi-Cal provider or non-physician medical practitioner affiliated with an enrolled Medi-Cal provider group. If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California, or a border community as outlined in the DHCS Medi-Cal Provider Manual. Providers who do not have a path to enroll in Medi-Cal, please refer to APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.

Each provider providing covered services to a member via a Telehealth modality must also meet the requirements of Business and Professions Code (BPC) Section 2290.5(a)(3), or otherwise be designated by DHCS as able to render Medi-Cal services via Telehealth.

Pursuant to WIC section 14132.725 (b)(2)(A), DHCS will periodically update the covered services and provider types and requirements that may be appropriately delivered through Telehealth.

Reimbursable Services

Existing covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a Telehealth modality only if all of the following criteria are satisfied:

1. The treating provider at the distant site believes the covered services being provided are clinically appropriate to be delivered via Telehealth based upon evidence-based medicine and/or best clinical judgment.
2. The member has provided verbal or written consent.
3. The medical record documentation substantiates that the covered services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service. Providers are not required to:
    a. Document a barrier to an in-person visit for covered services provided via Telehealth (WIC section 14132.72(d)); or
    b. Document the cost effectiveness of Telehealth to be reimbursed for covered services provided via a Telehealth modality.
4. The covered services provided via Telehealth meet all state and federal laws regarding confidentiality of health care information and a member's right to their own medical information.

12.7: Provider Network Changes *(cont'd.)*

12.7.10: Telehealth *(cont'd.)*

Certain types of covered services cannot be appropriately delivered via Telehealth. These include covered services that would otherwise require the in-person presence of the member for any reason, such as those that are performed in an operating room or while the member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/ removal of medical devices. A provider must assess the appropriateness of the Telehealth modality to the member's level of acuity at the time of the service. A provider is not required to be present with the member at the originating site unless determined medically necessary by the provider at the distant site.

All providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a Telehealth modality. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and medical record documentation defined in the DHCS Medi-Cal Provider Manual. Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a member who is not physically present (face-to-face) at the fee for service (FFS) rate.

Effective no sooner than January 1, 2024, all providers furnishing applicable covered services via audio-only synchronous interactions must also offer those same services via video synchronous interactions to preserve member choice. Also, effective no sooner than January 1, 2024, to preserve a member's right to access covered services in-person, a provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:

1. Offer those same services via in-person, face-to-face contact.
2. Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different provider to arrange for that care.

12.7: Provider Network Changes *(cont'd.)*

12.7.10: Telehealth *(cont'd.)*

Member Consent

Providers must inform members prior to the initial delivery of covered services via Telehealth about the use of Telehealth and obtain verbal or written consent from members for the use of Telehealth as an acceptable mode of delivering services.

If a provider, whether at the originating site or distant site, retains a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of covered services and includes the required information below, this is sufficient for documentation of consent. Providers also need to document when a member consents to receive covered services via Telehealth prior to the initial delivery of the services. Consent must be documented in the member's medical record and made available to DHCS upon request.

In addition to documenting consent prior to initial delivery of covered services via Telehealth, providers are also required to explain the following to members:

- The members' right to access covered services delivered via Telehealth in-person.
- That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the member without affecting their ability to access Medi-Cal covered services in the future.
- The availability of non-medical transportation for in-person visits.
- The potential limitations or risks related to receiving covered services through Telehealth as compared to an in-person visit, if applicable.

DHCS has created model member consent language for providers to use, which can be found on the DHCS website.

Establishing New Patients via Telehealth

Members may be established as new patients by providers via Telehealth through the following ways:

1. All providers may establish new patient relationships via synchronous video Telehealth visits.
2. All providers may establish new patient relationships via audio-only synchronous interaction only if one or more of the following criteria applies:
    a. The visit is related to sensitive services, which is defined in Civil Code section 56.06(n) as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Family Code sections 6924 - 6930, and HSC sections 121020 and 124260, obtained by a member at or above the minimum age specified for consenting to the service specified in the section.

12.7: Provider Network Changes *(cont'd.)*

12.7.10: Telehealth *(cont'd.)*

b. The member requests an audio-only modality.

c. The member attests they do not have access to video.

3. Federally Qualified Health Centers (FQHCs), including Tribal FQHCs, and Rural Health Clinics (RHCs) may establish new patient relationships through Rural Health Clinics (RHCs) store and forward modality, as defined in BPC Section 2290.5(a), if the visit meets all of the following conditions:

   a. The member is physically present at a provider's site, or at an intermittent site of the provider, at the time the covered service is performed.

   b. The individual who creates the patient's medical records at the originating site is an employee or subcontractor of the provider, or another person lawfully authorized by the provider to create a patient medical record.

   c. The provider determines that the billing provider is able to meet the applicable standard of care.

   d. A member who receives covered services via Telehealth must otherwise be eligible to receive in-person services from that provider.

12.8: IPA/Medical Group Specialty Network Oversight

See Section 9.8: Access to Care.

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

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

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

12.10: Provider Grievances

See Section 6: Grievances, Appeals, and Disputes, subsection 6.4: Provider Disputes – Claims Processing.

12.11: Provider Directory

The Blue Shield Promise provider directory is updated quarterly. Any member of the public may download a PDF copy of the directory from www.blueshieldca.com/en/bsp/medi-cal-members/find-provider. A searchable directory is also available online.

To request a printed copy of the directory, please contact Blue Shield Promise in writing at:

- Blue Shield of California Promise Health Plan
  Customer Care
  3840 Kilroy Airport Way
  Long Beach, CA 90806-2452.

By phone:

- (800) 605-2556 (Los Angeles) [TTY:711]
- (855) 699-5557 (San Diego) [TTY:711]

Or online:

- www.blueshieldca.com/memberwebapp/bscphp/contact-us-medical

Blue Shield Promise will postmark the printed copy within five (5) business days of the request.

The plan provides a comprehensive provider directory for Medi-Cal members. Directory includes the following provider types:

- Primary Care Physicians (PCPs)
- Specialists
- Hospitals
- Vision providers
- Federally Qualified Health Clinics
- Community Support and Justice Involve Providers
- Doulas
- Enhanced Care Management (ECM)
- Behavioral/Mental Health and Substance Use Disorder Providers
- Long Term Supports and Service Providers
- Gender Affirming Care Providers (GAC)

Online searchable and printed Provider Directory includes the following, at a minimum:

- Provider Group Affiliation
- Which accommodations the Provider's office or facility has provided for individuals with physical disabilities, including offices, exam rooms, and equipment;
- Whether the Provider offers Covered Services via Telehealth

All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted IPA/medical group and/or Blue Shield Promise Provider Information & Enrollment department through the provider portal: https://www.blueshieldca.com/en/provider. Providers may also review their information on the Blue Shield Promise website at www.blueshieldca.com/promise. Blue Shield Promise is committed to ensuring the integrity of the directory.

12.12: Prohibition of Billing Members

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

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

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

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13.1: Introduction

The marketing of managed care services to Medi-Cal beneficiaries is strictly regulated and monitored by Blue Shield Promise Health Plan and the California Department of Health Care Services (DHCS); therefore, Blue Shield Promise and its providers must adhere to all regulatory guidelines.

13.2: Prohibited Conduct

Prohibited conduct includes but is not limited to:

1. False or misleading claims or representations that include, for example:
    a. A specific health plan is recommended or endorsed by any state or county agency.
    b. The state or county recommends that a Medi-Cal beneficiary enroll in a specific health plan.
    c. A Medi-Cal beneficiary will lose their Medi-Cal benefits or other welfare benefits if he/she does not enroll.
    d. Any representation that office staff is an employee(s) of the state or county.
2. The offering or giving of any form of compensation, reward, or loan to induce enrollment.
3. Making use of any list of Medi-Cal beneficiary names or information obtained originally from confidential state or county data sources.
4. Providing confidential beneficiary information or data sources to health plans or other third-party entities for enrollment purposes.
5. Marketing practices that discriminate against members or potential members on the basis of any characteristic protected by federal or state law. Protected characteristics include, without limitation: sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code Section 422.56.
6. Engaging in any Medi-Cal marketing activity on state or county premises or any other location not authorized in Blue Shield Promise's marketing plan or by DHCS.

Blue Shield Promise is responsible for monitoring marketing activities of its providers when such activity relates to Blue Shield Promise and Medi-Cal. Providers must receive approval on all marketing materials containing the Blue Shield Promise Health Plan name and logo prior to use.

In addition to monitoring provider marketing material development, usage, and distribution, Blue Shield Promise shall continuously and closely monitor provider outreach efforts.

13.2: Prohibited Conduct *(cont'd.)*

Primary care physicians (PCPs) may NOT:

1. Coerce, threaten, or intimidate patients into making a particular health plan or provider selection.
2. Influence patients to change health plan membership based on financial gain to the PCP.
3. Tell patients that they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
4. Make any reference to competing health plans (e.g., comparing plans in a positive or negative manner) for purposes of encouraging or influencing a patient to enroll or disenroll from a particular health plan based on the PCP's financial interest.
5. Mail complete enrollment forms to HCO on behalf of patients.
6. Photocopy sample enrollment forms with the health plan and PCP names filled in for distribution to patients or to fill in the health plan and PCP names on blank enrollment forms for patients to sign and mail.
7. Use photocopied blank forms or plain-printed enrollment forms. (Only DHCS-supplied forms will be accepted).
8. Have health plan marketers stationed and enrolling in or outside the PCP office.
9. Allow PCP staff to receive any remuneration for marketing or enrolling beneficiaries.

13.3: Monitoring Provider Marketing Material Development/Usage/ Activity Guidelines

When using the Blue Shield Promise Health Plan name/logo:

1. Providers must submit one (1) set of materials, including a reading level assessment, to Blue Shield Promise for review and approval prior to use through the appropriate Medical Group or Independent Physicians Association (IPA) Administrator or health plan contract administrator:
    a. If materials are general in nature, and if the provider contracts with more than one health plan, only one (1) set must be submitted to a health plan.
    b. If the materials contain the names or logos of more than one health plan, the contracted provider must submit a set of materials to each health plan mentioned for review and approval.
2. Submitted materials must contain final content and be clear and legible. Rough ideas are unacceptable and will not be reviewed.
3. No marketing materials are to be used and/or activities done without prior consent from Blue Shield Promise. This includes general advertising used to reach Medi-Cal beneficiaries, tactical advertising with the Blue Shield Promise Health Plan name and/or logo, and collateral/promotional items such as brochures, pamphlets, pens, etc.
4. The Blue Shield Promise and regulatory review and approval process may take 90 days or more to complete.

14.1: Claim Submission

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

A. Blue Shield Promise requires that providers submit all encounters electronically and encourage providers to submit all claims and receive payments electronically as well, for faster processing and payment, using electronic data interchange (EDI). To enroll in electronic claim submission, providers can use Office Ally or Change Healthcare. To enroll in electronic encounter submission, providers can use FinThrive or Office Ally.

Approved Clearinghouse	Website	Phone Number
Office Ally	https://cms.officeally.com/	(360) 975-7000
Change Healthcare	www.changehealthcare.com	(866) 371-9066
FinThrive (Encounters only)	www.finthrive.com	(800) 390-7459

Paper claims must be submitted using the current versions of UB-04, CMS-1450 and CMS 1500 forms. Paper claims, invoices, and additional information such as medical records, daily summary charges and invoices must be submitted. The primary submission option is to send via SimpliSend. Go to www.blueshieldca.com/en/provider/claims/how-to-submit for instructions.

Paper claims can be mailed to the following address: Blue Shield Promise Health Plan, P.O. Box 272660, Chico, CA 95927-2660

B. Providers must follow the most recently updated Current Procedural Terminology (CPT) coding guidelines, National Drug Code (NDC) for drugs as well as the Healthcare Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, and Department of Health Care Services (DHCS) coding guidelines.

National Drug Code (NDC)

Blue Shield Promise validates National Drug Codes using the sources noted below. Only submit a NDC if required:

- Department of Health Care Services (DHCS) Medi-Cal Rx Approved NDC List
- US Food and Drug Administration (FDA) 240 National Drug Code Directory

Note: Blue Shield Promise requires claims and encounters reporting Physician Administered Drugs (PADs) to include both the Healthcare Common Procedure Coding System (HCPCS) code and a valid National Drug Code (NDC) for Medi-Cal members.

14.1: Claim Submission *(cont'd.)*

Services that include the use of 340B Physician Administered Drugs should be reported accurately with the proper procedure code, National Drug Code, drug unit, and drug quantity to Blue Shield Promise. The "UD" modifier must be included in one of the four available modifier positions (2400 SV101-3, 4, 5 or 6) within the electronic transmission (837).

C. Except as required by DHCS, any Medi-Cal Fee Schedule published on or after the fifteenth (15th) of the month will become effective for dates of service on or after the first (1st) day of the month following the month during which such change was published by DHCS. For example, the Medi-Cal Fee Schedule posted in October will be effective November 1.

D. Blue Shield Promise removes deleted HCPCS and CPT codes from its claims payment system. To ensure timely payment, providers are encouraged to only submit currently valid and recognized CPT and HCPCS codes. For drug codes, the CPT or HCPCS and NDC are required for consideration of payment.

E. Providers must ensure all claims submitted to Blue Shield Promise are complete and accurate. Complete claim means a claim or a portion thereof, if separable, including attachments and supplemental information or documentation which provides "reasonably relevant information" as defined in Title 28 Section 1300.71 Claims Settlement Practices, Section (a)(10), "information necessary to determine payer liability" as defined in Section (a)(11); and:

   1. For emergency services, legible emergency department reports.
   2. All required/mandatory fields in current CMS-1500 form for professional services and UB-04 form for facility services adopted by the National Uniform Billing Committee (NUBC).
   3. All required/mandatory fields in current CMS-1500 adopted by the National Uniform Claim Committee (NUCC).
   4. Any Medi-Cal designated requirements such as Universal Product Number (UPN) for medical supplies or National Drug Codes (NDC) for pharmacy related claims.

Claims submitted electronically must be HIPAA compliant and meet all requirements for EDI transactions.

F. Claim Filing Limits

   1. Medi-Cal claims submissions must meet the following time requirements:
      a. Claims must be submitted within 180 days from the date of service.
      b. Claims submitted beyond 180 days from the date of service will be denied for timely filing unless documentation supporting the reason for delay meets one of the following situations:

14.1: Claim Submission *(cont'd.)*

i. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four (4) months after the month of service.
ii. If a provider has submitted a bill to a liable third party, the provider has one (1) year after the month of service to submit the bill for payment.
iii. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one (1) year to submit the bill after the month in which the services have been rendered.
iv. Blue Shield Promise finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.
v. If the provider has submitted a bill to the Other Health Coverage (OHC), the provider has 90 calendar days from the date of the OHC plan's payment to submit the claim to Blue Shield Promise.

c. Claims received after the 12th month after the month of service will be denied as untimely.

G. Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

1. ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. The ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.
2. Providers that are identified as a participant in the Blue Shield Promise provider network must receive the remittance advices and payments electronically for services provided to Blue Shield Promise members.
3. Blue Shield Promise will automatically enroll Blue Shield Promise providers with the clearinghouse Office Ally for their ERA/835 transactions.
4. If a Blue Shield Promise provider would like to enroll their ERA/835 transactions through a different clearinghouse, please see below for approved clearinghouses (not an inclusive list). Providers will need to send a completed ERA form indicating the clearinghouse selection. If a clearinghouse is not selected, providers will automatically be assigned to Office Ally.

Approved Clearinghouse	Website	Phone Number
Allscripts	www.allscripts.com	(800) 334-8534
Change Healthcare	www.changehealthcare.com	(866) 371-9066
Office Ally	https://cms.officeally.com/	(360) 975-7000
Navicure	www.navicure.com	(770) 342-0800
Trizetto Provider Solutions	www.trizettoprovider.com	(888) 550-5637

14.1: Claim Submission *(cont'd.)*

5. To enroll in ERA/EFT, providers must download the enrollment form from the Blue Shield Promise provider website at https://www.blueshieldca.com/en/bsp/providers and follow these steps:
   a. On the home page, click on *Working with us.*
   b. Scroll to the bottom of the page to the box labeled *Manage electronic claims and encounter*s then click on the link *learn more about electronic claims.*
   c. Scroll down to *Sign up for electronic remittance advice and electronic payments* and click on *Read enrollment instructions.*
   d. Click on *Sign up for ERA* in the box labeled *Electronic Remittance Advice.*
   e. Click on the link *ePayments Provider Authorization Form.* This form also includes the enrollment for electronic funds transfer (EFT).

   Enrollment forms must be faxed to the number listed on the form at (866) 276-8456. For questions regarding the ERA enrollment process, please call the EDI Help Desk at (800) 480-1221.

14.2: Claims Processing Overview

A. Blue Shield Promise makes every effort to ensure claims that are the Blue Shield Promise financial responsibility are paid, denied, or contested within 30 calendar days of receipt. At least 90% of claims that are the Blue Shield Promise financial responsibility to pay are processed within 30 calendar days of receipt, 95% within 45 working days of receipt, or 99% within 90 calendar days of receipt.
   - Receipt dates are based on when Blue Shield Promise receives the claim the first time.

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

C. Reimbursement Rates
   1. To be eligible for payment, the claim must be complete and accurate.
   2. Contracted providers are paid at contracted rate.
   3. Non-contracted providers are paid at Medi-Cal established rates. If there are no Medi-Cal established rates, payment will be made at 15% of billed charges.
   4. Miscellaneous drugs/supplies for non-surgical procedures are reimbursable with HCPC Z7610 when all the following criteria is met, and will be paid at $36.53 per Drug for Miscellaneous Drugs with Revenue Codes 25x or 63x, and $227.60 per Item for Miscellaneous Supplies with Revenue Code 27x:

14.2: Claims Processing Overview *(cont'd.)*

i. The item is billed by hospital outpatient departments, emergency rooms, surgical clinic, or community clinic;
ii. The item being billed does not have a unique billing code/HCPCS code; and
iii. The item is not related to a surgical procedure.

D. Effective through December 31, 2025, interest payments are applied to complete claims that are not paid within 45 working days. Interest is paid for the period of the time that the payment is late.
   1. Blue Shield Promise will pay interest at a rate of 15% per annum beginning with the first calendar day after the 45 working day period for non-emergency services.
   2. Blue Shield Promise will pay interest at a rate greater than $15 or 15% per annum beginning with the first calendar day after the 45 working day period for emergency services.
   3. Blue Shield Promise will automatically include all interest that has accrued in the payment made to the provider, without requiring a request. If Blue Shield Promise fails to comply with this requirement, Blue Shield Promise will pay an additional $10 penalty fee.
   4. Interest payments are not made for claims where additional information is received after the original claim payment or denial, claims denied due to untimely filing and later paid because evidence of timely prior filing to the incorrect payer is submitted, or claim denied due to untimely filing is paid because information about a good cause for the delay is accepted.

E. Effective January 1, 2026, interest payments are applied to complete claims that are not paid within 30 calendar days. Interest is paid for the period of the time that the payment is late.
   5. Effective January 1, 2026, as defined in Assembly Bill (AB) 3275, Blue Shield Promise will pay interest at a rate of 15% per annum beginning with the first calendar day after the 30 calendar day period for both emergency and non-emergency services.
   6. Blue Shield Promise will automatically include all interest that has accrued in the payment made to the provider, when making payment on a claim beyond the 30-calendar day requirement, without requiring a request. If Blue Shield Promise fails to comply with this requirement, Blue Shield Promise will pay the provider the greater of an additional $15 or a fee of 10% of the accrued interest.
   7. Interest payments are not made for claims where additional information is received after the original claim payment or denial, claims denied due to untimely filing and later paid because evidence of timely prior filing to the incorrect payer is submitted, or claim denied due to untimely filing is paid because information about a good cause for the delay is accepted.

14.2: Claims Processing Overview *(cont'd.)*

F. Balance Billing

Providers must not balance bill members for any covered/authorized services. Title 22, Section 51002 of the California Code of Regulations states "a provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service."

G. Overpayment Recovery

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

If a provider contests Blue Shield Promise's overpayment request within 30 working days, the Plan will treat the challenge as a Provider Dispute.

H. Emergency Claims

Emergency claims are paid without prior authorization.

I. Family Planning and Sensitive Services Claims

Claims for family planning and sensitive services (such as abortion, sexually transmitted diseases, HIV testing, and counseling) do not require authorizations. Claims for sterilization services must be submitted with completed and signed DHCS Consent Form (PM 330 Form). Claims submitted without the form will be rejected and not be paid. Claims will be paid upon receipt of completed and signed PM 330 Form.

Claims submitted for services related to rape and/or sexual assault are excluded from any cost sharing (pursuant to AB 2843). Blue Shield Promise is prohibited from requiring that a police report be filed, for charges to be brought against the assailant, or for an assailant to be convicted; to provide the covered services.

J. Inpatient Hospital Claims – Emergency Admission

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

14.2: Claims Processing Overview *(cont'd.)*

K. Inpatient Hospital Claims – Elective Admission

All elective inpatient admissions require prior authorization. Prior authorization, bed type and days billed versus pre-certification are verified for inpatient claims. Claims are paid according to authorized level of care. Lack of prior authorization will result in payment denials.

L. Inpatient Hospital Claims – Readmissions

Blue Shield Promise does not allow separate reimbursement for inpatient claims that have been identified as a readmission to the same hospital within 30 days of discharge for the same, similar, or related condition unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Blue Shield Promise views repeat, non-separately reimbursable, and planned readmissions as part of a single episode of care, for which only one DRG (Diagnosis Related Group)/Per diem payment is issued. Both the initial admission and the subsequent readmission are considered fully covered by the payment made for the first admission.

The following readmissions are excluded from 30-day readmission review:

1. Transfers from out-of-network to in-network facilities.
2. Transfers of patients to receive care not available at the first facility.
3. Readmissions that are planned for repetitive or staged treatments, such as cancer, chemotherapy, or staged surgical procedures.
4. Admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, and Inpatient Rehabilitation Facilities.
5. Obstetrical readmissions.
6. Readmissions greater than 30 days from the date of discharge from first admission.
7. Readmission claims billed with discharge status code 07, indicating member left against medical advice.

M. Outpatient and Other Claims

1. Ambulatory services, outpatient surgeries, ancillary, and specialty services require prior authorization. Claims for these services without prior authorization will result in payment denials.
2. Some services are established as no prior authorization required.
3. For Annual Cognitive Health Assessment claims, providers must complete the following steps in order to receive payment:
    - Complete the Dementia Care Aware training prior to the assessment. Blue Shield Promise will check the DHCS list of providers who have completed the training.

14.2: Claims Processing Overview *(cont'd.)*

- Denied claims may be submitted to Provider Dispute Resolution, with dated proof that training was completed prior to the assessment.

- Meet all contracted provider billing requirements.
- Attach Medical Record updates to the claim. The updates must contain:
  - The screening tool(s) used, including one or more of the cognitive assessment tools required by All Plan Letter (APL) 22-025;
  - Verification that the screening results were reviewed by the provider;
  - The results of the screening, along with the provider's interpretation of them;
  - A summary of the details that were discussed with the member and/or their authorized representative; and
  - A description of appropriate actions taken in response to the results of the assessment.

4. Public Provider Ground Emergency Medical Transportation (PP-GEMT) Program is effective January 1, 2023. Refer to https://www.dhcs.ca.gov/provgovpart/Pages/PPGEMTIGT.aspx webpage for published guidance regarding program background and eligibility criteria.
   - The PP-GEMT add-on is applicable to public providers of ground emergency medical transportation, as defined in Welfare and Institutions (W&I) Code section 14105.945(a)(1).
   - Eligible public providers will be identified and reimbursed appropriately.

N. Alternate Payment Methodology (APM) Program
Federally Qualified Health Centers (FQHCs) participating in Alternate Payment Methodology (APM) program must conform with the Department of Health Care Services (DHSC) FQHC APM Program Guide for Claims Data.

O. Incidental Procedures
Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services for which provider is reimbursed pursuant to the APG payment rate. Incidental procedure services and supplies are considered included in Ambulatory Patient Groups (APG) rates. A list of incidental procedures is provided in Appendix 6.

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

The Plan audits claims for billing accuracy, allowable charges, medical necessity, Hospital Acquired Conditions and Never Events to ensure consistency with currently accepted standards in the industry.

14.2: Claims Processing Overview *(cont'd.)*

These standards include but are not limited to those defined by Optum reference manuals and followed by other commercial payors, as well as the UB 04 Billing Manual guidelines and the National Uniform Billing Committee guidelines. The program encompasses Plan claims for all lines of business and all facilities.

Categories of charges that are subject to review and payment denial include but are not limited to those charges that are mutually agreed to in Plan's contracts (e.g., Disallowed Charges); those charges that are determined to be not medically necessary; those for which there is no substantiating documentation; and those considered to be unbundling of another global charge, such as room and board charges or other facility room charges. Precedence for denial of such charges has been established by Optum resource manuals, and other commercial payors, as well as the Uniform Bill (UB 04) Billing Manual guidelines and definitions.

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

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

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

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

14.3: Coordination of Benefits (COB)

Medi-Cal is considered a payer of last resort. Other coverage should be billed as the primary. When billing Plan, submit the primary payer's explanation of benefits (EOB) or remittance advice (RA) with the claim.

Prior to delivering services to members, providers must review the Medi-Cal eligibility record for the presence of Other Health Coverage (OHC). If the member has OHC, providers must compare the OHC code (found in Appendix A on the DHCS website at (https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-010AttA.pdf) to the requested service. If the requested service is covered by the OHC, providers are to instruct the member to seek the service from the OHC carrier. As stated in Title 42 U.S. Code Section 1396a(a)(25)(D), regardless of presence of OHC, providers should not refuse a covered Medi-Cal service to a Medi-Cal member and should proceed as follows:

1. If a member has OHC, provider should consider OHC plan as the member's primary health plan.
2. If the member has OHC, the provider shall submit a claim for Covered Services provided to the member to the OHC prior to submitting the claim to Blue Shield Promise.
3. Blue Shield Promise shall remain the secondary health plan and payer of last resort for Medi-Cal eligible members.
4. If a member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the provider should bill the primary health plan for the medical, other care or treatment benefits. Blue Shield Promise Medi-Cal members will be considered the secondary health plan and payer of last resort.
5. A provider shall submit the claim for covered services along with the OHC plan's remittance advice to Blue Shield Promise within 90 calendar days from the OHC plan's payment date.

Providers may access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295 or the Medi-Cal Online Eligibility Portal. Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.

14.4: Third-Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan, the member's designated medical group, or Independent Practice Association (IPA) will provide the necessary treatment according to plan benefits.

If the member receives a related monetary award or settlement from the third-party, third-party insurer, or from uninsured or underinsured motorist coverage, DHCS has the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

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

14.5: Claims Status Inquiry

Providers may verify receipt of claims within 15 days of submission to Blue Shield Promise by calling (800) 468-9935 ext. 3, by checking Blue Shield Promise's provider portal at https://www.blueshieldca.com/en/provider, or by submitting an EDI 276 claim inquiry request. Please allow for the appropriate processing timeframes when obtaining claim status. To enroll and setup EDI 276/277 claim inquiries, please contact your clearinghouse or software vendor. If available, claim status transactions may be integrated into your practice management system.

14.6: Delegation Oversight Claims

Please see Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training requirements for Blue Shield Promise's Delegated Entity/Specialty Health Plans.

14.7: Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) Requirement for Personal Care and Home Health Care Services Providers

In accordance with federal and state laws, Blue Shield Promise is required to implement electronic visit verification (EVV) for all Medi-Cal personal care services (PCS) and home health care services (HHCS) providers that are delivered during in-home visits by the provider. This includes, but is not limited to, PCS and HHCS that are delivered during in-home visits by a provider, PCS and HHCS delivered as a part of Community-Based Adult Services (CBAS) Emergency Remote Services (ERS), Community Supports – personal care and homemaker services, respite services, day habilitation programs and all other HHCS programs covered.

Electronic Visit Verification (EVV) is a telephone and computer-based solution that electronically verifies when in-home service visits occur.

Providers rendering in-home service visits are required to be registered and trained in an approved EVV system, while also submitting the following required six (6) data elements for each in-home visit:

1. The type of service performed.
2. The individual receiving the service.
3. The date of the service.
4. The location of service delivery.
5. The individual providing the service.
6. The time the service begins and ends.

Failure to meet these requirements will result in providers being considered out of compliance. As a result, DHCS may take disciplinary action(s) to address the non-compliant provider, per W & I §14043.51.

To learn how to register and take the training through the state-sponsored EVV system, Sandata Technologies, LLC (Sandata), view the DHCS Quick Reference Guide at https://www.dhcs.ca.gov/provgovpart/Documents/Step-By-Step-Onboarding-Process-Quick-Reference-Guide.pdf.

Information about the state-sponsored EVV can be found on DHCS's website at https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx. This link also provides details about Provider Types and Codes that are subject to EVV requirements.

15.1: Financial Analysis

The Corporate Financial Accounting & Reporting Department is responsible for the accurate financial reporting of capitation and claims expense transactions.

The Provider Solvency Department is responsible for monitoring the financial solvency of IPAs, Medical Groups, Hospitals, and Health Plans having a risk arrangement with Blue Shield Promise.

The Managed Care Finance Department is responsible for data generation and timely payment of capitation.

On a monthly basis, IPAs, medical groups, hospitals, and health plans having a risk arrangement with Blue Shield Promise must estimate and document the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other actuarial firm certified methodology and calculation.

IPAs, medical groups, hospitals, and health plans having a risk arrangement with Blue Shield Promise shall comply with Solvency Regulations and maintain at all times:

- A positive working capital (Current Assets - Related Party Receivables - Current Liabilities).
- A positive tangible net equity as defined in CCR Title 28, § 1300.76(c).
- A cash-to-claims ratio as defined in CCR Title 28, § 1300.75.4(f).
- A claims timeliness requirement as defined in CCR Title 28, § 1300.75.4.2.

Financial Reporting Requirements

The information identified below must be submitted by the requested due date to the following email address:

- ProviderSolvency@blueshieldca.com

15.1: Financial Analysis *(cont'd.)*

Frequency	Period	Due Date	DMHC Filing	Financial Statements Required
Quarterly (applicable only for entities serving L.A. Care members)	Quarter End	45 days after quarter end	Yes	Yes Unaudited
Annually	Fiscal Year End	150 days after the fiscal year close	Yes	Yes Audited by an Independent Certified Public Accounting Firm

The following details the information requested:

Department of Managed Health Care (DMHC) Filing

DMHC submission should include:

- Confirmation
- Financial Information
  - Balance Sheet
  - Income Statement
  - Statement of Net Worth
  - Statement of Cash Flows
- Grading Criteria
  - Tangible Net Equity
  - Working Capital
  - Cash to Claims Ratio
  - Incurred but Not Reported Claims (IBNR)
- Certification

15.1: Financial Analysis *(cont'd.)*

DMHC Filing Schedules should include:

- Schedule A – Cash and Cash Equivalents
- Schedule B – Receivables
- Schedule C – Incurred But Not Reported Claims Methodology
- Schedule D – Risk Pool and Other Incentive Revenues
- Schedule E – Administration and Other Expenses
- Schedule F – Enrollment Details
- Schedule G – Claims Inventory (Count)
- Schedule H – Mergers, Acquisitions, or Discontinued Operations
- Schedule I – Required Tangible Net Equity Calculation
- Schedule J – Notes to Financials

Quarterly Financial Statements Submission should include (Applicable only for entities serving L.A. Care members):

- Balance Sheet
- Income Statement (Quarterly and Year-to-Date)
- Statement of Cash Flows

Annual Financial Statements should include:

- Audited Annual Financial Statements

Corrective Action Plans

Failure to comply with the Solvency Regulations, L.A. Care financial solvency contractual obligations, and submission of DMHC filing and financial statements timely to BSCPHP may require entities to submit a corrective action plan to correct any financial solvency deficiencies.

15.2: Capitation Payments

The Managed Care Finance Department is responsible for sending the monthly capitation payments to its contracted IPAs/capitated hospitals/medical groups. Capitation payments are made no later than the 10th of each month for Medi-Cal San Diego and no later than the 13th of the following month for Medi-Cal Los Angeles or within 10 days from receipt of revenue from DHCS or L.A. Care.

Eligibility and Capitation reports are posted on a secured site (Secure File Transfer Protocol (SFTP) server) or sent via secure email. These reports are available to the IPAs/capitated hospitals/medical groups no later than the 10th of each month. Each IPA/capitated hospital/medical group is responsible for coordinating with Blue Shield Promise on how to access the SFTP server. For security measures, only two individuals per IPA/capitated hospital/medical group are issued a username and password to access this site. Any changes to the IPA/medical group's contact person will require a new password or PGP key. IPAs/capitated hospitals/medical groups must request and fill out a new PGP Key Form and submit the form to their assigned Provider Relations Representative.

15.3: Medical Loss Ratio Requirements for Subcontractors and Downstream Contractors

Blue Shield Promise complies with the Department of Health Care Services (DHCS) All Plan Letter (APL) 24-018 Medical Loss Ratio (MLR) Requirements for Subcontractors and Downstream Subcontractors.

Blue Shield Promise utilizes the materiality threshold established by the Department of Health Care Services (DHCS) in accordance with 42 CFR 438.8 for determining if a Subcontractor or Downstream Subcontractor is subject to reporting and remittance requirements.

Subcontractors and Downstream Subcontractors that fall below the annual threshold dollar will not be subject to reporting for the given MLR reporting year, except as required by DHCS on a case-by-case basis.

Commencing with the CY 2023 MLR Reporting year, and until modified by DHCS, applicable Subcontractors that receive $30,000,000 or more in Medi-Cal capitation annually, from a single upstream entity, as payment for services provided in a single county or rating region, for which they assume risk and are not directly providing will be subject to MLR Reporting, remittance, attestation and additional supporting documentation requirements.

Subcontractors are required to update their Policies and Procedures annually.

The due dates for the Annual Medi-Cal Medical Loss Ratio Annual reports will be communicated by Blue Shield Promise upon receipt from the Department of Health Care Services (DHCS.)

All reports should be returned to ProviderSolvency@blueshieldca.com or as otherwise directed by Blue Shield Promise.

Section 16: Regulatory, Compliance and Anti-Fraud

16.1: Anti-Fraud Policy and Program

State and federal agencies have increased investigations based on health care fraud and abuse laws and enforcement against providers and enrollees who violate these laws. State and federal authorities have, in recent times, prosecuted numerous healthcare providers for various fraudulent practices and also mandated health care service plans to establish anti-fraud programs.

Following this mandate and resultant industry trends, Blue Shield Promise has developed an aggressive Compliance and Anti-Fraud Program that includes voluntary disclosure to appropriate agencies of alleged cases of fraud and abuse. Provider cooperation is essential for the success of anti-fraud and abuse efforts and as a provider of health care services to Blue Shield Promise Health Plan members, we would like to draw your attention to this program and request your cooperation.

Health care fraud includes, but is not limited to, knowingly making, or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, member, employee, supplier, or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud.

Healthcare fraud refers to the act of intentionally deceiving or misleading a healthcare provider, insurer, or government healthcare program for financial gain.

Potential fraud refers to the possibility or likelihood of fraudulent activities occurring in a particular situation or context. It indicates the presence of conditions or factors that could enable fraudulent behavior to take place, even if fraud has not yet been detected or proven. Potential fraud may involve suspicious activities, irregularities, or vulnerabilities that could be exploited by individuals seeking to commit fraud for personal gain or advantage.

All reported allegations deemed potential fraud, upon initial review, will be reported to regulatory agencies.

There are two ways in which providers can cooperate in Blue Shield Promise's anti-fraud and abuse efforts:

1. Review practices related to services to Blue Shield Promise members to ensure that:
    a. Fee-for-service bills, if any, accurately describe the actual services performed and duplicate billing is avoided.
    b. Fee-for-service bills are not generated for capitated services.
    c. Members are not billed for covered services except for applicable co- payments.
    d. Co-payments, when applicable, are collected.
    e. Encounter data is reported accurately.

16.1: Anti-Fraud Policy and Program *(cont'd.)*

f. Providers participate in Blue Shield Promise Health Plan utilization reviews to detect and review underutilization in a capitated environment.

g. Blue Shield Promise Health Plan is informed about renewals and changes to all licenses and other credentials.

h. Diagnoses and medical necessity are stated accurately, and accurate medical records are maintained.

i. Full cooperation is demonstrated in transferring members to Plan hospitals when medically appropriate.

j. Any marketing efforts for enrollment as Blue Shield Promise members are within legal limits.

k. Full cooperation is demonstrated with Special Investigations Unit (SIU) audits.

2. Report any fraud and abuse or suspicious activity that may come to your attention to the Special Investigation Unit Hotline at (855) 296-9092 or Promisestopfraud@blueshieldca.com, anonymously. Such instances include:

   a. Any illegal or improper solicitations or offers made to you by Blue Shield Promise employees.

   b. Any illegal or improper solicitations or offers made to you regarding services to Blue Shield Promise members by other providers.

   c. Any attempts by patients to use a Medi-Cal card or Blue Shield Promise identity cards belonging to another.

If the matter relates to Medi-Cal services, providers may also call the State of California, Department of Health Services Medi-Cal Fraud Hotline at (800) 822-6222, email fraud@dhcs.ca.gov, or go to www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

16.2: False Claims Act

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

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

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

16.2: False Claims Act *(cont'd.)*

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

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

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

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

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

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

16.3: Confidentiality of Substance Use Disorder Patient Records

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

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

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

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

16.3: Confidentiality of Substance Use Disorder Patient Records *(cont'd.)*

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

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or

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

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

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

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

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

16.4: Health Information and Data Record Sharing with Blue Shield Promise

Providers shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, compliance milestones, and other program policy and procedure requirements, and additional state and federal regulations as applicable, and as updated and amended from time to time. Such program requirements and State law, implementing regulations and regulatory guidance shall govern the sharing of electronic health record data. Blue Shield Promise is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Providers shall participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield Promise within the timelines set forth in the State requirements as they may be amended from time to time. For informational purposes, the required timelines are currently in effect unless otherwise stated, and apply to the providers below:

- General acute care hospitals, as defined by Section 1250. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Provider and physician organizations and medical groups. as defined by Section 127500.2. (Fewer than 25 physicians, and nonprofit clinics with fewer than 10 providers, the compliance date is 1/31/26.)
- Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
- Acute psychiatric hospitals, as defined by Section 1250. (Fewer than 100 beds and state-run acute psychiatric hospitals, the compliance date is 1/31/26.)
- Emergency medical services, as defined by Section 1797.72.

16.5: Sensitive Health Information

Sensitive Health Information

Under California's existing Reproductive Privacy Act and the Confidentiality of Medical Information Act (CMIA), individuals have a fundamental right to privacy regarding their reproductive/medical decisions. Unauthorized disclosure of medical information is generally prohibited. California Assembly Bill 352 (AB 352) introduced significant changes to how Health Insurance Companies, Managed Health Care Organizations and their downstream/related entities are required to handle sensitive health information, including but not limited to reproductive health, abortion, and transgender services.

AB 352 expands the previously existing privacy requirements, specifying that on or before July 1, 2024, electronic health record (EHR) systems that store such information are required to adhere to additional provisions regarding medical information related to gender-affirming care, abortion and abortion-related services, and contraception ("sensitive services.").

Specifically, EHR systems that collect and store data on behalf of providers and other organizations are required to:

- Ensure limited user access to all medical information, such that, specific medical information related to sensitive services is only accessible to the parties that are authorized to access that specific information.
- Prevent disclosure, access, transfer, transmission, or processing of sensitive services medical information to any person or entities outside of California.
- Segregate and differentiate any medical information related to sensitive services in a patient's record.
- Automatically disable access to any segregated medical information related to sensitive services by individuals and entities in any other state.

By law, Blue Shield Promise and providers must comply with these requirements. As such, Blue Shield Promise expects that providers have systems and processes in place to address data sharing/disclosure requirements.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

Purpose

The purpose of Culturally and Linguistically Appropriate Services (CLAS) is to ensure that members receive effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language, at every medical and non-medical encounter. Language assistance services, including oral interpretation, will be provided free of charge, be accurate and timely, and protect the privacy and independent decision-making ability of the member with LEP. Interpretation can take place in-person, through a telephonic interpreter, or via internet or video remote interpreting (VRI) services. However, MCPs are prohibited from using audio remote or VRI services that do not comply with federal quality standards, or relying on unqualified bilingual/multilingual staff, interpreters, or translators. MCPs should not solely rely on telephone language lines for interpreter services. Rather, telephonic interpreter services should supplement face-to-face interpreter services, which are a more effective means of communication. MCPs that provide a qualified interpreter for a member with LEP through audio remote interpreting services must provide real-time audio over a dedicated high-speed, wide bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses in communication; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the remote interpreting services. To create a comprehensive overview of key points of contact in medical and non-medical care settings, you can categorize the information In medical care settings (telephone advice and urgent care transactions, and outpatient encounters with health care providers) and non-medical settings (e.g., Member services, orientations, and appointment scheduling). This structured approach will help individuals navigate their healthcare options effectively, ensuring that they have access to all necessary services and support.

Procedure

Blue Shield Promise has adopted a CLAS Policy which is consistent with the National Standards for CLAS. Contracts between Blue Shield Promise and IPA/medical groups, providers, hospitals, and ancillary providers include a provision requiring them to participate in and comply with the performance standards, policies, procedures, and programs established from time to time by the local initiative, and Plan with respect to cultural and linguistic services including without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to the local initiative, and Plan. IPA/medical groups will educate and communicate cultural and linguistic requirements, policies, procedures, and programs to their contracted providers on an ongoing basis.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

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

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 shares 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.

CLAS areas that Blue Shield Promise Health Plan will be responsible for include:

1. Hiring a cultural and linguistic specialist responsible for CLAS.
2. Developing policies and procedures on CLAS related topics and requirements and ensuring access to members' CLAS data is protected and only accessible by approved parties.
3. Sharing eligible individual member data on language needs with providers.
4. Sharing 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 www.census.gov/quickfacts/fact/table/CA/PST045221
5. Identifying members with Limited English Proficiency (LEP) and communicating information to IPA/medical groups.
6. Providing information on language patterns of Blue Shield Promise members.
7. Sharing providers' race and/or ethnicity upon member's request.
8. Updating language capability of physicians and clinic staff in the provider directory.
9. Informing members of their rights to: Interpreting services at no cost; not use family members, including minors, or friends for interpreting; request an interpreter during discussions of medical information and explanations of plans of care; receive translated subscriber materials in threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files); and file a complaint or grievance if their cultural and/or linguistic needs are not met.
10. Contracting, coordinating, and covering the cost of face-to-face and American Sign Language (ASL) interpreting services requested by IPA/medical groups, providers, and members.
11. Contracting, coordinating, and covering the cost of 24-hour/7-day telephonic interpreting services when requested by IPA/medical groups, providers, and members.
12. Developing protocol on how IPA/medical groups, providers, and clinic staff can access to free interpreting services through Blue Shield Promise.
13. Developing and distributing resources, tools, and materials to IPA/medical groups (e.g., signs, language ID cards, etc.).

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS *(cont'd.)*

14. Assessing and monitoring the effectiveness of linguistic services.
15. Contracting with a qualified translation company to translate written enrollment and member informing materials in the threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) including the Evidence of Coverage (EOC) booklet, Provider Directory, Marketing Materials, Form Letters (denial letters, complaint and grievance materials, medical care reminders, and other legal documents). Then sharing these translated materials with the IPA/medical groups.
16. Conducting or subcontracting with qualified agencies or qualified facilitators to provide cultural competency, sensitivity, health equity, diversity, and inclusion training courses for health plan staff, IPA/medical groups, providers, clinic staff and downstream subcontractors staff at key points of contact with members.
17. Conducting an annual analysis on the Blue Shield Promise's provider network capacity and members' needs. When gaps and/or barriers are identified, develop, and implement improvement opportunities to meet member needs.
18. Working with the QI Department to address CLAS related grievances presented by members and IPA/medical groups and explore opportunities for improvement.
19. Communicating and disseminating CLAS information and requirements, and cultural competency training opportunities to IPA/medical groups and providers on an ongoing basis.
20. Monitoring and overseeing CLAS programs and compliance with IPA/medical groups.
21. Maintaining a committee that oversees Health Equity Accreditation and CLAS oversight and approve related documentation. Blue Shield Promise members will serve as active committee members.

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS *(cont'd.)*

CLAS areas that IPA/medical groups will be responsible for include:

1. Designating a person responsible for CLAS and including responsibilities in job description. CLAS function is reflected in the organizational chart.
2. Identifying member language on monthly eligibility list sent to providers.
3. Updating Provider Directory to include language capability of providers and clinic staff.
4. Distributing signs to contracted providers on the availability of free interpreter services for members with LEP and ensuring signs are posted at key points of contact.
5. Having appropriate telephone numbers and protocol to access interpreting services through the IPA/medical group or Health Plan.
6. Ensuring access to free interpreting services to members with LEP and hard-of-hearing or deaf members on a 24-hour/7-day basis.
7. Educating and informing providers and clinic staff on how to access interpreting services.
8. Providing and/or promoting cultural competency, sensitivity, Health Equity, diversity, and inclusion training to providers, clinic staff, and downstream subcontractors staff at key points of contact with members.
9. Making member-informing materials available to members with LEP in the threshold languages and ensuring quality translation and cultural and linguistic appropriateness of materials. Informing providers and clinic staff what alternative format materials (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) are available at Blue Shield Promise and how to get them.
10. Having procedures for handling CLAS-related complaints made at the clinic and IPA/medical group sites and logging grievances with CLAS-related issues.
11. Educating providers and clinic staff on the need to maintain a language capability form, certification of language proficiency or interpreting training, or similar documentation on file for bilingual staff, and staff providing interpreting services to members.
12. Educating providers and staff on the process, and availability of CLAS Community resources/agencies. A list of resources/agencies must be kept on file and can be obtained from Blue Shield Promise.
13. Including CLAS related questions in "Provider Satisfaction Survey" and analyzing these results to identify patterns of CLAS related problems for corrective action (optional).
14. Having written policies and procedures covering the above subjects.
15. Documenting all education of CLAS information and its dissemination to contracted providers, as well as retaining copies of agendas, sign-in sheets, handouts/materials from provider cultural competency trainings attended.
16. Translating the Notice of Action (NOA) and Notice of Appeal Resolution (NAR), including the clinical rationale, into the member's preferred language.

17.2: Identification of Members with Limited English Proficiency (LEP)

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

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

"Threshold Languages" are primary languages spoken by limited English proficiency (LEP) population groups meeting a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiaries, whichever is lower. The Department of Health Care Services (DHCS) designates threshold languages in each county. Languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county.

The following threshold languages have been identified by DHCS for Los Angeles County: Arabic, Armenian, English, Chinese (Cantonese and Mandarin), Farsi, Cambodian, Korean, Russian, Spanish, Tagalog, and Vietnamese.

For San Diego County, the threshold languages are Arabic, Chinese, English, Farsi, Spanish, Russian, Tagalog, and Vietnamese.

"Materials in Alternative Formats" are materials, such as health education materials and information on how to access health plan services, which are available in the following formats: audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files. All member-informing materials can be made available in alternative formats.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and IPA/medical groups will assess their member population's language preference distributions to determine special needs and develop appropriate plans and services.
2. Blue Shield Promise will provide a monthly new member eligibility list to IPA/medical groups and providers, which will include the primary language spoken by each member. IPA/medical groups and providers may use the eligibility list as a tool to track their members with LEP.
3. Blue Shield Promise and subcontractors will ensure members are routinely given opportunities to declare their need for culturally and linguistically appropriate services (e.g., when making an appointment, during Initial Health Assessment, on arrival, and in the exam room, etc.). Providers and clinic staff should record each member's primary language in their medical chart.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.3: Access to Free Interpretation Services

It is the responsibility of Blue Shield Promise and subcontractors to provide access to interpreter services, 24 hours a day, seven days a week, at no cost, to members with LEP and hard-of-hearing members when they access health care services.

To comply with the Americans with Disabilities Act, Blue Shield Promise and its Subcontractors must ensure that all hard-of-hearing members or with a speech disability will have access to free interpretation services whether through a video remote interpreting (VRI) service, an on-site appearance, or through other methods that ensure communication, including assistive listening. If VRI services are used, the service must provide real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy blurry, or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers and, the participating individual's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI. Blue Shield Promise will make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination based on disability.

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

An adult not qualified as an interpreter or a minor child accompanying an LEP member may be used only in the following situations:

- As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the members of the public and a qualified interpreter is not immediately available
- If the LEP member specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement are documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

17.3: Access to Free Interpretation Services *(cont'd.)*

Bilingual/multilingual staff may be used to communicate directly with members with LEP only when they have demonstrated that they meet all of the qualifications of a qualified bilingual/multilingual interpreter. If, after being notified of the availability of free interpreters, the member elects to have a family member or friend serve as an interpreter, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality.

Providers **MUST** document the request or refusal of language interpreting services by a member with LEP, hard-of-hearing, or deaf member in the member's medical record. This will be monitored during facility site reviews and medical records review audits.

Providers and clinic staff shall follow Blue Shield Promise protocol for requesting interpreting services to access telephonic, or face-to-face interpreting services for members with LEP, American Sign Language, hard-of-hearing, or deaf members.

Providers and bilingual staff providing interpreting services **MUST** maintain an "Employee Language Skill Self-Assessment" form, certification of language proficiency or interpreting training on file.

Bilingual staff providing medical interpreting services are encouraged to take a language proficiency test by a qualified agency (e.g., Language Line) to determine if the candidate is qualified for medical interpreting. It is recommended that Bilingual staff who rate a 1=Novice or 2=Low Intermediate based on a scale of 1-5 on a language proficiency test use a telephonic or face-to-face interpreter for communicating with members. This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.

17.3.1: Posting of Signs at Key Medical and Non-Medical Points of Contact

Signs informing members of their right to request free interpreting services should be clearly posted at each provider office (i.e., reception area, waiting room, exam room). Blue Shield Promise and IPA/medical groups are responsible for ongoing distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural and Linguistic Department.

17.3.2: Proficiency of Interpreters

Blue Shield Promise and its subcontractors will ensure that members with limited English proficiency (LEP), hard-of-hearing, or deaf members have equal access to healthcare services through the provision of high-quality interpreting and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the member's spoken language 24 hours a day, seven (7) days per week. This includes American Sign Language (ASL) interpreting services.

17.3: Access to Free Interpretation Services *(cont'd.)*

17.3.2: Proficiency of Interpreters *(cont'd.)*

In order to be considered a qualified interpreter for a member with LEP, the interpreter must:

- Demonstrate a proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages.
- Be able to interpret effectively, accurately, and impartially to and from such language and English (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary or terms without changes, omissions, or additional and while preserving the tone, sentiment, and emotional level of the original oral statement; and
- Adhere to generally accepted interpreter ethics principles, including client confidentiality.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and its subcontractors will use the 24-hour/7-day over-the- phone interpreting service as a supplement to in-person interpretation. Subcontractors may rely on Blue Shield Promise to access interpreting services by following the interpreting services protocol. (Please refer to Section 17.2.)
2. Documentation of linguistic competency of individuals providing interpreting services at Blue Shield Promise or the IPA/medical group must be on file. Documents may include:
    a. Written or oral assessment of bi-lingual skills.
    b. Documentation of years served as interpreter.
    c. Successful completion of appropriate training programs.
    d. Confidentiality agreement or verification of confidentiality clause in contract signed by interpreter through agency.
    e. Other relevant documents signifying interpreter capability (e.g., out of state certificate or license).
3. All interpreter services vendors who perform interpreting duties must sign a confidentiality agreement with Blue Shield Promise and its subcontractors.
4. Blue Shield Promise will retain reports of all monitoring systems for interpreting services. Monitoring can include a record of performance measures (i.e., written and/or oral testing of bilingual skills, attendance of relevant training programs and number of years interpreting, etc.); log of 24-hour telephonic interpreting services; analysis of grievances and complaint logs regarding communication or language problems; and interpreting service satisfaction questions included in the annual member satisfaction survey.

17.3: Access to Free Interpretation Services *(cont'd.)*

17.3.2: Proficiency of Interpreters *(cont'd.)*

5. IPA/medical groups should document interpreting services utilization and maintain on file. Documentation may include a log of 24-hour telephonic interpreting services and/or number of over-the-phone and face-to-face interpreting services requests received from contracted providers.
6. Blue Shield Promise and its IPA/medical groups may subcontract with interpreting services agencies to determine the qualifications of its interpreters used at provider sites.
7. Blue Shield Promise and its subcontractors will provide and/or promote opportunities for ongoing cultural competency and cultural diversity trainings to providers and staff.
8. Providers, staff, and downstream subcontractor's staff at key points of contact with members are strongly encouraged to attend cultural awareness/ competency, sensitivity, diversity, equity, and inclusion (DEI) training programs that are offered through L.A. Care, Blue Shield Promise Health Plan, IPA/medical groups, or other cultural awareness/competency training agencies.
9. Providers, staff, and downstream subcontractor's staff at key points of contact with members are strongly encouraged to attend cultural awareness/ competency, sensitivity, diversity, equity, and inclusion (DEI) training programs that are offered through L.A. Care, Blue Shield Promise Health Plan, IPA/medical groups, or other cultural awareness/competency training agencies.
10. Blue Shield Promise and its subcontractors will retain copies, if available, of training curriculum, documentation of attendance, and schedule of training dates.
11. Blue Shield Promise and its subcontractors will retain copies, if available, of training curriculum, documentation of attendance, and schedule of training dates.
12. Blue Shield Promise and its subcontractors will keep a list of cultural resource materials used during a training program
13. Beginning January 2025, all contracted providers will be required to complete training on advancing health equity and will cover a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. This training will meet mandated requirements and will be reviewed annually to determine if there are any updated mandates. Once the training is finalized, a link to access the training will be provided to you.

17.3: Access to Free Interpretation Services *(cont'd.)*

17.3.2: Proficiency of Interpreters *(cont'd.)*

Definitions:

***"Interpreter"* –** is a person who renders a message spoken in one language into one or more languages. ***"Qualified interpreter"* –** Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages); be able to interpret effectively, accurately, and impartially to and from such language(s) and English (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement; and adhere to generally accepted interpreter ethics principles, including client confidentiality.

17.4: Cultural Competency and Health Equity Training

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, diversity, equity 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.

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.

The Blue Shield Promise Health Equity Office (HEO) collaborates with the Cultural and Linguistics department to implement and maintain the mandatory diversity, equity, and inclusion (DEI) training program and requirements as set forth by the DHCS All Plan Letter (APL) 24-016.

The HEO at Blue Shield Promise is dedicated to advancing health equity and promoting diversity, equity, and inclusion within the healthcare system. Mandated state training ensures that staff, new subcontractors, downstream subcontractors, and network providers are equipped with the knowledge necessary to be mindful, respectful, and inclusive of members' diverse health beliefs, practices, and cultural and linguistic needs.

17.4: Cultural Competency and Health Equity Training *(cont'd.)*

This training also addresses social drivers of health and the impacts of disparities on members' healthcare, including but not limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with Specialty Mental Health Service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and children with special health care needs. The objective is to teach participants an enhanced awareness of diverse imperatives and issues related to improving access and quality of care for Blue Shield Promise members.

In accordance with APL 24-016, all subcontractors, downstream subcontractors, and network providers serving Blue Shield Promise members complete the training within 90 days of their active date and every 3 years or during times of re-credentialing or contract renewals . Blue Shield Promise will monitor training completion, deficiencies, and record maintenance. A Corrective Action Plan (CAP) may be enforced for subcontractors, downstream subcontractors, and network providers who have not completed their training. Those required to complete the *Advancing Health Equity* course will receive an email notification with a link to register for and complete the course.

All subcontractors, downstream subcontractors, and network providers serving Blue Shield Promise members must complete the training by January 1, 2026. Attendance records will be reviewed and maintained by Blue Shield Promise staff.

The APL 24-016 also requires that Blue Shield Promise monitor grievances related to discrimination, enforcing corrective action for individuals with a grievance concerning discrimination filed against them.

The HEO will keep all subcontractors, downstream subcontractors, and network providers informed of all health equity related trainings.

If you have any questions regarding the mandatory DEI Training Program Requirements, then contact BSPHealthEquity@blueshieldca.com.

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 Cultural Awareness and Linguistics Program webpage at www.blueshieldca.com/en/bsp/providers/programs/cultural-linguistics.

17.4: Cultural Competency and Health Equity Training *(cont'd.)*

Update Your Provider Directory Information

Easily and securely update your information on Blue Shield Promise's provider portal, Provider Connection at www.blueshieldca.com/provider. If you have not already registered for an account on Provider Connection, click on *Log In/Register* at the top right of the screen and follow the prompts to set up your new account. Once you have created an account, you can share your race, ethnicity, and language information with us by navigating to the *Provider & Practitioner Profiles* section under the *Account Management* heading at the top. This information helps us understand and support our members' specific needs and preference within our network and is displayed on our *Find a Doctor* webpage. See Section 12 for details on how to review and update your provider directory information.

Definitions:

"Culture" is a dynamic and evolving process comprised of a group's learned patterns of behavior, values, norms, and practices.

"Cultural competency" is an increased working knowledge of how behaviors, values, norms, practices, attitudes and beliefs of disease, preventative practices and treatment affect medical and non-medical encounters.

"Organizational cultural competency" is the ability of an organization to adapt to diversity and actively apply knowledge of culture and linguistic issues in serving our diverse membership for improved access and health outcomes.

Transgender, Gender Diverse, Intersex (TGI) Cultural Competency Training (APL 24-017 Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements)

Blue Shield Promise subcontractors, downstream subcontractors and all staff who are in direct contact with, including staff with oral and/or written contact, with members in the delivery of care or Member Services must complete evidence-based cultural competency training for the purposes of providing trans-inclusive health care for individuals who identify as TGI, every two years or more often if needed as per APL 24-017. New staff, whose job duties include oral or written contact with members must complete the training within 45 days of their hire date and every two years thereafter. Additionally, if a member files a grievance against staff for failing to provide trans-inclusive health care and the grievance is found in the member's favor, the staff must complete the training before they have direct contact with members again and within 45 days.

Trans-inclusive health care is defined in H&S section 1367.043(d)(3) as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

17.4: Cultural Competency and Health Equity Training *(cont'd.)*

Those required to complete the TGI course will receive an email notification with a link to complete the course. Completion records will be reviewed and maintained by Blue Shield Promise staff.

The APL 24-017 also requires that Blue Shield Promise monitor grievances related to trans-inclusive healthcare, enforcing corrective action for individuals with a grievance for failing to provide trans-inclusive healthcare.

17.5: Translation of Member-Informing and Health Education Materials

Written informing documents provide essential information to members about access and usage of services. It is the responsibility of Blue Shield Promise and the IPA/medical group to provide culturally and linguistically appropriate informing materials to members in the threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) determined by the Department of Health Care Services (DHCS) and at a 6th grade reading level or below. Blue Shield Promise will provide appropriate auxiliary aids and services for members with disabilities and companions with disabilities. Blue Shield Promise will give primary consideration to the individual's request of a particular auxiliary aid or services.

Blue Shield Promise will provide the Notice of Availability in a conspicuously visible font size no less than 12-point font in English and the top 18 non-English languages.

Blue Shield Promise will provide translated written member information, using a qualified translator, in the required concentration and threshold languages outlined in the Notice of Availability to communicate with its diverse membership who are culturally and linguistically sensitive and appropriate including complying with ADA requirements such as meeting requirements for members with visual disabilities, including Seniors and Persons with Disabilities (SPD).

If a member requested to receive translated written information in either traditional or simplified Chinese, we will provide written information in the member's preferred characters. However, if the member has not indicated a preference for simplified or traditional Chinese characters, we must provide translations in simplified Chinese characters. Only upon member request, Blue Shield Promise will be required to provide translated written information in traditional Chinese characters.

Translated written materials will be accurate, timely, and designed to protect the privacy and independent decision-making ability of the members with LEP.

17.5: Translation of Member-Informing and Health Education Materials *(cont'd.)*

Member informing materials include documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to:

- Member Handbook (also called the *Evidence of Coverage*, or EOC)
- Welcome packets
- Provider directory
- Access and availability of linguistic services
- Marketing Information
- Member surveys
- Member Newsletters
- Preventive Health Reminders (e.g., appointments and immunization reminders, initial health examination notices and prenatal follow-up);
- Grievance and fair hearing process
- Form letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits, including clinical rationale.
- Form letters, notices of action, any notices related to grievances, actions, and appeals, including grievance and appeal acknowledgement and resolution letters, or other documents regarding access and use of plan services and also member clinical information
- Health Risk Assessment
- Notices advising persons with LEP of free language assistance

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise will send the Member Handbook and Welcome Packets to members with LEP in the threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) determined by monthly enrollment information. A tracking system will include documenting materials sent out to members in the different languages, alternative formats, types of materials, and volume.
2. Blue Shield Promise and its IPA/medical groups will have common letters (i.e., denials letter, informed consent, etc.) available in the language(s) that is commonly encountered based on Health Plan and IPA/medical group membership; or a system to provide members the opportunity to receive these documents in their preferred languages. Blue Shield Promise will forward to the IPA/medical group translated member-informing materials and available health education materials.

17.5: Translation of Member-Informing and Health Education Materials *(cont'd.)*

3. A Qualified Translator has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original written statement; and adheres to generally accepted translator ethics principles, including client confidentiality.
4. Blue Shield Promise and its IPA/medical groups will use, at a minimum, the following translation process to ensure quality translation of written member informing materials and health education materials:
    a. The document needing translation will be submitted to the Qualified Translator for translation.

The following three steps are done when translating a source document into the target language: translation, editing, and proofreading. Each step is performed by a different linguist. Once the translation is complete, the requesting department will receive an email from the vendor containing the translation. If machine translation is used when the underlying text is critical to the rights, benefits, or meaningful access of an individual with LEP, when accuracy is essential, or when the source documents or materials contain complex, non-literal or technical language, the translation will be reviewed by a qualified human translator.

Definitions:
"Auxiliary Aids and Services" are services, including attendant services, or devices that enable handicapped persons, including those with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the Commission for Auxiliary Aids and Services.

"***Written Translation***" is translation performed by a qualified translator, of written content in paper or electronic form into or from languages other than English; and written notice of availability of language assistance services.

"***Qualified Translator***" is a translator who has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original written statement; and adheres to generally accepted translator ethics principles, including client confidentiality.

"***Machine Translation***" is an automated translation, without the assistance of or review by a qualified human translator, that is text-based and provides instant translations between various languages, sometimes with an option for audio input or output.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.6: CLAS Related Grievances

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to individuals with LEP that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of an individual with LEP.

Therefore, a Blue Shield Promise Health Plan Medi-Cal member has the right to file a grievance if their cultural and/or linguistic needs are not met.

Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office. (See Section 6: Grievances, Appeals, and Disputes.) CLAS related grievances presented to Blue Shield Promise Health Plan will be processed as follows:

1. The Grievance Unit receives member and provider grievances and determines if the case has a CLAS related issue.
2. Blue Shield Promise's Grievance Department will resolve the issue with the member whenever possible.
3. If a member or provider grievance is classified or coded to have cultural and/or linguistic issues, the case will be forwarded to the Cultural and Linguistic Department.
4. The Cultural and Linguistic (C&L) specialist will investigate, follow-up, and resolve the issue with the provider and/or office staff involved with the case.
5. The Cultural and Linguistic specialist may collaborate with the Grievance, Utilization Management, Quality Management, and Provider Network Operations (PNO) Departments, when necessary.
6. A copy of the actions taken will be kept on file with the Grievance Department, PNO, and Cultural and Linguistic Departments.
7. The Cultural and Linguistic specialist will keep statistics of CLAS related grievances for trends, and statistical information will be reviewed by the CLAS manager.

17.7: Referrals to Culturally Appropriate Community Resources and Services

1. Blue Shield Promise provides members and providers direct access to an online search tool for community resources that includes culturally appropriate services: https://blueshieldpromise.findhelp.com/. Users can search for a variety of social services including resources for food, housing, and education, in their preferred language and within their zip code.
2. Alternatively, Blue Shield Promise will facilitate referrals for culturally appropriate services via the Cultural and Linguistically Appropriate Services referral form found on https://www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms. Providers should complete the form and fax it to the fax number provided on the form. Blue Shield Promise has a closed loop system in place to monitor those members being referred to CLAS Community Resources and Services via the referral form. Once the member is referred, the provider will be informed of the member's participation to the program to encourage further follow-up.
3. Providers should document all referrals in the member's medical chart and maintain all information provided in the member's medical record.

17.8: IPA/Medical Group Monitoring and Reporting Requirements

Based on contract requirements, medical groups are required to comply with the following responsibilities and participate in Cultural and Linguistics activities required by Blue Shield Promise. In accordance with our monitoring process, an attestation must be completed and the IPA/medical group must provide the requested documentation. Medical groups must maintain documentation of the completed activities and make them available upon request.

The Blue Shield Promise CLAS department will monitor the following:

A. Cultural and Linguistic Activities

- Medical groups maintain a current provider roster.
- Medical groups have a process in place for accessing and recording member language.
- Medical groups maintain request or refusal forms of interpreting services in threshold languages available for distribution to providers.
- Medical groups maintain a list of all written member informing materials.
- The Non-Discrimination Notice and Notice of Availability must be included in all member mailings.
- Medical groups referred members to Culturally and Linguistically Appropriate Services (CLAS).

17.8: IPA/Medical Group Monitoring and Reporting Requirements
(cont'd.)

B. Interpreting Services

- Medical groups use Blue Shield Promise's interpreting Services or its vendor for members and hard-of-hearing or deaf members during and after business hours at no cost.
- Medical groups maintain the current "Protocol for How to Access Interpreting Services" or current vendor contracts.

  ACTION REQUIRED:

  1. Medical Groups distributed the "Protocol on How to Access Interpreting Services" to providers by October 31.
  2. To meet this requirement, medical groups must submit evidence of the "Protocol on How to Access Interpreting Services" fact sheet distribution to BlueShieldofCAHealthEducation@blueshieldca.com by October 31, 2025.

     Documentation should include but is not limited to:

     - Agenda & sign in sheet for provider training/meeting/in-services
     - Blast fax confirmation
     - Copy of e-mail sent

C. Provider and Staff Education

- Medical Groups distributed the Blue Shield Promise "Provider Responsibilities" summary sheet to providers by October 31.

  ACTION REQUIRED:

  1. Medical Groups educated providers on C&L state requirements by October 31, 2025.
  2. To meet this requirement, medical groups must submit evidence of the "Provider Responsibilities " summary sheet distribution to BlueShieldofCAHealthEducation@blueshieldca.com by October 31, 2025. Documentation should include but is not limited to:

     - Blast fax confirmation
     - Copy of e-mail sent
     - Provider newsletter article

17.8: IPA/Medical Group Monitoring and Reporting Requirements *(cont'd.)*

D. Cultural and Linguistic Referral Quarterly Report *(Refer to the follow-up email):*

ACTION REQUIRED:

1. Medical Groups submitted the C&L Referral reports to BlueShieldofCAHealthEducation@blueshieldca.com by the 10th of January, April, July, and October.
    - ***Note***: For our records, medical groups must send us a "No data to report" email or a report with a "zero" data although there is no data to report on a quarterly basis.

If you are unable to complete any of the aforementioned activities, please call the Blue Shield Promise Cultural and Linguistic Department at (562)580-6077 or send an email to BlueShieldofCAHealthEducation@blueshieldca.com. We will be happy to assist you and provide you with a personal overview session.

17.9: Online Resources

Language Assistance Resources (Translation and Interpretation)

Providing services that support diverse languages is one way that Blue Shield Promise is addressing some of the barriers to accessible health care. We provide documents and telephonic support in a variety of languages to improve access to healthcare services for our shared members. Additionally, we provide language assistance resources that are available for easy download on our website such as a multilingual sign for your office and member forms that are already translated into the member's desired threshold language.

Please visit our Cultural awareness and linguistics program webpage at www.blueshieldca.com/en/bsp/providers/programs/cultural-linguistics to download a copy of the interpretation services poster.

To request interpreter services, written language translation, or our provider notice of availability of language assistance services, please call our Provider Customer Service at (800) 468-9935 or visit our Language Assistance Resources webpage at https://www.blueshieldca.com/en/bsp/medi-cal-members/plan-documents/language-help-interpreter-services.

17.9: Online Resources *(cont'd.)*

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 the Blue Shield Promise homepage at www.blueshieldca.com/en/bsp to select their desired threshold language. The following are additional multilingual resources found on the Blue Shield Promise website:

- Members can request confidential information using multilingual request forms on our Confidential Communication Request webpage at www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/confidential-communications.
- Our downloadable Grievance Form includes an attached notice of the availability of language assistance services translated into 17 languages. Find the form at

  www.blueshieldca.com/en/bsp/medi-cal-members/your-medi-cal-program/appeals-and-grievance-process
- Blue Shield Promise is committed to complying with state and federal civil rights laws regarding requirements. We offer language assistance services at no additional cost so our members can get the language or format that is most accessible for them. Providers can access our Nondiscrimination and Notice of Availability at www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/nondiscrimination-and-language-assistance-notice.
- Download a copy of the Notice of Availability sign at www.blueshieldca.com/en/bsp/providers/programs/cultural-linguistics.

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Appendices

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Appendix 1: Delegation of Utilization Management Responsibilities

This participating Independent Physician Association/Medical Group Delegation of Utilization Management Responsibilities agreement is made and entered into on <<Date>> by and between BLUE SHIELD OF CALIFORNIA/BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN, a California corporation ("PLAN"), and <<Contract Entity Name>> ("Group").

NOTE: The Division of Financial Responsibility (DOFR) indicates financial risk only and is not to be used to determine delegated responsibilities.

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
I. UM Program & Policies and Procedures	Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible Special Needs Plan (DSNP) Yes No	Develop, implement, and submit to Plan the UM Program outlining structure, accountability, scope, adoption of criteria, processes and other regulatory and NCQA components of UM function.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** • UM Program • UM Program Evaluation • UM Workplan **Quarterly/Semi-Annual:** UM Report Updates (Coalition/HICE Report)	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's contract (i.e., CAP deduction from monthly capitation)
II. Outpatient specialty referrals/prior authorizations Routine/Urgent Pre-service and retrospective review that result	Medi-Cal Yes No Medicare Yes No Commercial Yes No	• Conduct review utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage • Adhere to regulatory turnaround time standards for decision	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a	**Included in section III reporting**: **Monthly: Medi-Cal:** Turnaround Time report, Medi-Cal: Maternity	Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's contract (i.e., CAP deduction from monthly

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
in an approval modification, or denial of services	Dual Eligible Special Needs Plan (DSNP) Yes No	making • Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM determinations are tracked/ monitored through UM Committee	substantive evaluation through review and analysis of performance reporting	Delivery Admission Report Medi-Cal: Complete Denial Modification Files Quarterly: Commercial: Turnaround Time Report Medicare: ODAG Report, Medicare: Part C Report UM HICE Work Plan Report: Annual & Semi-Annual Medicare /Commercial UM Updates (Coalition/HICE Report)		capitation)

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
				Annual & Quarterly: Medi-Cal: UM Updates (Coalition/HICE Report)		
III. Outpatient/ ambulatory procedure referrals – Professional component Routine/Urgent Pre-service and retrospective review that result in an approval, modification, or denial of services	Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible Special Needs Plan (DSNP) Yes No	Conduct review utilizing Plan approved evidence- based UM criteria and Blue Shield Promise Evidence of Coverage Adhere to regulatory turnaround time standards for UM decision making Use Blue Shield Promise-approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM determinations are tracked/monitored through UM Committee Contact Plan within 24 hours for tracking number for facility portion of referral **(Shared Risk only)**	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly: Medi-Cal:** Turnaround Time report Medi-Cal: Maternity Delivery Admission Report Medi-Cal: Complete Denial Modification Files Quarterly: Commercial: Turnaround Time Report Medicare: ODAG Report, Medicare: Part C Report UM HICE Work Plan Report: Annual & Semi-	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's contract (i.e., CAP deduction from monthly capitation)

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
				Annual Medicare /Commercial UM Updates (Coalition/HICE Report) Annual & Quarterly: Medi-CalUM Updates (Coalition/HICE)		
IV. A. (Shared Risk) Inpatient hospitalizations (includes acute care, Long Term Acute Care Hosp. (LTACH), and acute rehab); Skilled Nursing Facility (SNF). Routine/Urgent	☐ **Shared responsibility** Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible	• Forward and coordinate all requests involving inpatient services to Plan UM Dept • Conduct review Utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage • Conduct UM review for inpatient and lower level of care services except for urgent/emergent out-of-	• Conduct UM review for urgent/emergent out-of-area inpatient admissions • Forward information pertaining to the concurrent review to the delegate, if available • Monitor and oversee delegated functions • Establish, publish, and distribute performance	• Not applicable if not delegated **Quarterly: Medi-Cal** UM Report Updates (Coalition/ HICE Report	• Not applicable • Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Not applicable • Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's contract (i.e., CAP deduction from monthly capitation)

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
Pre-service, retrospective, and concurrent review that result in an approval, modification, or denial of services	Special Needs Plan (DSNP) Yes No ☐ **Delegated responsibility** Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible Special Needs Plan (DSNP) Yes No ☐N/A IPA/MG has no responsibility under this section	area admissions • Adhere to regulatory turnaround time standards for UM decision making • Use Blue Shield Promise approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) • Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider • Report any acute stay over 6 days to Blue Shield Promise for coordination of care UM determinations are tracked/monitored through UM Committee	standards and guidelines to the IPA/MG Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting			

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
IV. B. (Full Risk/ Global) Inpatient hospitalizations (includes acute care, Long Term Acute Care Hosp. (LTACH), and acute rehab); Skilled Nursing Facility (SNF). Routine/ Urgent Pre-service, retrospective, and concurrent review that result in an approval, modification, or denial of services	Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible Special Needs Plan (DSNP) Yes No ☐ N/A IPA/MG has no responsibility under this section	• Conduct review Utilizing Plan approved evidence-based UM criteria and Plan Evidence of Coverage • Adhere to regulatory turnaround time standards for UM decision making • Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) • Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider. UM determinations are tracked/monitored through UM Committee	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**UM HICE Work Plan Report:** **Annual & Semi-Annual:** Medicare/Commercial: UM Updates (Coalition/HICE Report) **Annual & Quarterly:** **Medi-Cal:** UM Updates (Coalition/ HICE Report)	• Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's contract (i.e., CAP deduction from monthly capitation)

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
V. Linked Services **(Medi-Cal ONLY)**	Medi-Cal ONLY Yes No Dual Eligible Specialty Needs Plan (DSNP) Yes No	Identify the following and report number of cases to Blue Shield Promise: • DOT for TB • ESRD • Waiver Programs (home care, HIV/AIDS, etc.) • Transplants • Transgender Services • Mental Health • Drug/Alcohol • Hospice • Custodial (Long Term Care) Identify the need for Long-Term Services and Supports (LTSS) and refer to: • CBAS • IHSS • MSSP • LTC	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting Review and coordinate all LTSS services	**Monthly Logs:** Not Applicable .	• Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) for elements of non-compliance Sanction per • IPA's contract (i.e., CAP deduction from monthly capitation) Termination of delegation if CAP objectives are not achieved within agreed timeframe.
VI. A. Complex Case Management	N/A IPA/Medical Group has no responsibility under this section.	Identify and refer members for Complex Case Management Coordinate member care with the Plan	Provide complex case management services to members meeting Plan criteria.	Not applicable	Not Applicable	Not Applicable

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
	Please refer to this manual for instructions on referring to Blue Shield Promise Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible Special Needs Plan (DSNP) Yes No					
VI. B. Basic Case Management	Medi-Cal Yes No Medicare Yes No Commercial Yes No	Provide basic case management to members not eligible for Plan Complex Case Management and Disease Management Programs.	• Provide assistance to delegate when needed • Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and	Not applicable	• Pre-delegation review • Annual due-diligence audit Quarterly/	• Request Corrective Action Plan(s) for elements of non-compliance • Sanctions per IPA's delegation agreement (i.e.,

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
	Dual Eligible Special Needs Plan (DSNP) Yes No		guidelines to the IPA/MG Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting		focus audits	CAP deduction from monthly capitation • Blue Shield Promise may conduct discretionary review to re-measure former areas of non-compliance Termination of delegation if CAP objectives are not achieved within agreed timeframe.
VII. Member Communication	Medi-Cal Yes No Medicare Yes No Commercial Yes No	• Ensure member communications adhere to all regulatory standards • Obtain approval for all Member Communications from Plan prior to distribution to members	• Ongoing evaluation of Member • Communication according to regulatory standards Provide regulatory updates to the delegate as they become available	**Ongoing**	• Pre-delegation review • Annual due-diligence audit Quarterly/ focus audit	

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
	Dual Eligible Special Needs Plan (DSNP) Yes No					
VIII. Member Appeals/ Grievances	N/A IPA/MG has no responsibility under this section	Evidence of communication stating requests for appeals are forwarded to Plan upon receipt or per Blue Shield Promise guidelines	Review and resolve all appeals and grievances within established timeframes	Not applicable	Not applicable	Not applicable
IX. Evaluation of New Technology	Medi-Cal Yes No Medicare Yes No Commercial Yes No Dual Eligible Special Needs Plan (DSNP) Yes No	Not applicable	Plan evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health procedures	Not applicable	Not applicable	Not applicable

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via the SFTP or UM SharePoint site to the UMDO dept	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities

Delegated Responsibility: Utilization Management /Information Integrity – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting / Due Date submitted via the SFTP or UM SharePoint site to the UMDO Dept**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
The organization has policies and procedures describing its information integrity specific to UM denial notification dates that: **Element A:** 1. Describe the Scope of UM Information for each of the following types: • UM Requests from members or their authorized representatives. • UM request receipt date.	UMDO ensures that the integrity of UM information is maintained, and any issues are promptly identified and addressed by following detailed performance review of policies and procedures and addressed by: • At least annually, Blue Shield monitors delegate's information integrity	**Annual Reporting** • Information integrity procedural changes • Integrity reports of inappropriate documentation and updates to UM request receipt dates and UM	• Pre-delegation • Annual • Focus • Annually review delegates policies and procedures for – UM 12 • Annually review delegate's information	• Request Corrective Action Plan(s) for elements of non-compliance • Sanctions per Group's delegation agreement (*e.g.*, deduction from Capitation • Health Plan may conduct discretionary review to re-measure former areas of non-compliance • Termination of delegation if CAP objectives are not achieved within

• Appropriate practitioner review. • Use of board-certified consultants. • Clinical information collected and reviewed. • UM decision. • UM decision notification date. • UM denial notice. 2. The staff/titles responsible for completing UM activities. • Responsible for documenting completion of UM activities. • Authorized to modify (edit, update, delete) UM information • Responsible for oversight of UM information integrity functions 3. The process for documenting updates to UM information • Specify when updates to existing UM information is appropriate • Describe the organization's process for documenting the following when updates are made to UM information: • When (e.g., date and time) the information was updated • What information was updated. • Why the information was updated. • Staff who updated the information.	policies and procedures for Elements A, C, D and E. • At least annually, Blue shield monitors delegates on their auditing and reporting specific to UM inappropriate documentation and updates to UM denial receipt and notifications dates as well as conducting a qualitative analysis to determine the cause of each instance of inappropriate documentation identified in the audit. • Annual review of reporting methodology that includes a random sample of 5% or 50 files, and the delegate must provide a completed audit report even if no inappropriate documentation is found. • Annual review of delegates staff training on inappropriate documentation and updates as well as the process for documenting and reporting information integrity issues. • Improvement Actions: ensure corrective actions are implemented to	denial decision notification dates. • Review of Correction Action Plans to address inappropriate documentation • Review of qualitative analysis of each instance of inappropriate documentation • UM staff training on Information Integrity documentation The organization must provide a completed audit report even if no inappropriate documentation and updates were found. **3-6 months after completion of annual audit** • Report 3-6 months after completion of annual audit with correction actions to review effectiveness of corrective actions.	integrity report for inappropriate documentation and updates to UM request receipt dates and UM denial decision notification dates. • Annual review of delegates qualitative analysis of each instance of inappropriate documentation and update identified in the audit to determine the cause. • Annually review of corrective actions to address inappropriate documentation and updates found in element D. • Annual review of the organization UM staff training on inappropriate documentation	agreed timeframe.

4. Inappropriate documentation and updates. • Falsifying UM dates (e.g., receipt date, UM decision date, notification date). • Creating documents without performing the required activities. • Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices). • Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review). • Updates to information by unauthorized individuals 5.The organization audits UM staff and the process for documenting and reporting identified information integrity issues. • Specify that the organization audits UM staff documentation and updates. The organization does not have to include the audit methodology but must indicate that an annual audit is performed. • Describe the process for documenting and reporting inappropriate documentation and updates to: The organization's designated individual(s) when identified,	address all inappropriate documentation and updates found in the audit and ensure the effectiveness of these correction actions is audited withing 3-6 months. • The organization demonstrates that it monitors compliance with its delegate UM denial information integrity, as described in Elements A, C, D and E,		and updates. • Review 3-6 months after completion of annual audit with correction actions to review effectiveness of corrective actions.	

• Specify consequences for inappropriate documentation and updates. **Element C:** Information Integrity Training The organization annually trains UM staff on: 1. Inappropriate documentation and updates (Element A factor 4) 2. Organization audits of staff, documenting, and reporting information Integrity issues (Element A and factor 5) **Element D:** Audit and Analysis-Denial Information The organization annually: 1. Audits for inappropriate documentation and updates to UM denial receipt and notification dates. The organization defines the dates of receipt and notification for UM denial determinations resulting from medical necessity review, consistent with the requirements in UM 5. The audit universe includes files for UM denial decisions (based on the denial decision notification date) made during the look-back period. The organization randomly samples and audits 5% or 50files, whichever is less, from the file universe. The organization may choose to audit more UM denial files than NCQA requires.				

The organization provides an auditing and analysis report that includes: • The report date. • The title of individuals who conducted the audit. • The 5% or 50 files auditing methodology. • Auditing period. • File audit universe size (described in the paragraph above). • Audit sample size. The audit log • The file identifier (case number). • The type of dates audited (i.e., receipt date, notification date). • Findings for each file. A rationale for inappropriate documentation or inappropriate updates. • The number or percentage and total number or percentage of inappropriate findings by date type. The organization must provide a completed audit report even if no inappropriate documentation and updates were found. 2. Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates.				

• Also includes titles of UM staff involved in the qualitative analysis • The cause of each finding **Element E-** Improvement Actions-Denial Information. The organization must implement: 1. Corrective actions to address all inappropriate documentation and updates found in Element D 2. Conducts an audit of the effectiveness of corrective actions (Factor1) on the findings 3-6 months after completion of annual audit in Element D				

Plan will share Member experience and Clinical Performance data with Practitioners and Providers when requested. Requests should be submitted via email to your delegation coordinator.

The Plan and Group agree to accept the terms of the above.

Blue Shield of California			<<Contract Entity Name>>	
("Plan")			("Group")	
By:			By:	
Name:			Name:	
Title:			Title:	
Date:			Date:	

Blue Shield of California Promise Health Plan Participating IPA/Medical Group Delegation of Credentialing Responsibilities

This Participating Independent Physician Association / Medical Group Delegation of Credentialing Responsibilities Agreement ("**Agreement**") is made and entered into **on <<Date>>** by and between **BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN,** a California corporation ("**PLAN**"), and **<<Contract Entity Name>>** ("**Medical Group**").

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
Credentialing and Recredentialing Policy and Procedures	X Yes No	Develop, implement, and submit to Plan the Credentialing Program/Policy and procedures outlining a well-defined credentialing process for evaluating and selecting licensed practitioners to provide care to its members that comply with the Plan, NCQA, state and federal components of credentialing. Policies and procedures must include and comply with all NCQA Credentialing Information Integrity requirements, effective July 1, 2025.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity	• Pre-delegation review • Annual due-diligence audit •	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
II. Credentialing Committee	X Yes No	Designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that the Credentialing Committee that: • Includes representation from participating network providers to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds or the Group's criteria for participation in the network, gives thoughtful consideration to credentialing information and documents discussions about credentialing in meeting minutes. • Ensures that files that meet established criteria are reviewed and approved by the designated medical director or designated qualified physician, or all files are submitted to the Credentialing Committee for review.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement) • Termination of Credentialing delegation if CAP objectives are not achieved

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
III. Credentialing and Recredentialing Primary Source Verifications	X Yes No	Verifies credentialing information through approved primary sources for all elements below, as applicable. Verifications must be completed within one hundred eighty (120) calendar days of the credentialing decision. • A current and valid license to practice • A valid DEA or CDS certificate, as applicable • Education and training; (Initial Cred Only) • Board certification Status • Work history – Minimum of most recent five years as a health professional (Initial Cred Only) • A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the provider • Hospital admitting privileges in good standing, or coverage arrangements • Verifies Sanction Information: State sanctions, restrictions on licensure, limitation on scope of practice, Medicare and Medicaid/Medi-Cal sanctions and exclusions • Includes Quality Improvement	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly:** via the Health Industry Collaborative Effort (HICE) Reports	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement Termination of delegation if CAP objectives are not achieved

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		activities and member complaints in the recredentialing decision making process.				
III. Credentialing and Recredentialing Application and Attestation	X Yes No	**Credentialing Application and Attestation - Credentialing and Recredentialing** Practitioner's application for membership includes a current and signed attestation regarding the following signed within one hundred eighty (180) calendar days of the credentialing decision: • Reasons for inability to perform the essential functions of the position • Lack of present illegal drug use • History of loss of license and felony convictions • History of loss or limitations of privileges or disciplinary actions • Includes Race, ethnicity and language. The attestation must include a statement that the Provider will not discriminate based on these categories. • Current malpractice insurance coverage (Copy of malpractice	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly:** via the Health Industry Collaborative Effort (HICE) Reports	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement Termination of delegation if CAP objectives are not achieved

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		insurance required for CMS and Medi-Cal) • Current and signed attestation confirming the correctness and completeness of the application				
IV. Recredentialing Cycle Length	X Yes No	Recredentials participating practitioners/ providers within thirty-six (36) months of their prior approval date.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly:** via the Health Industry Collaborative Effort (HICE) Reports	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement Termination of delegation if CAP objectives are not achieved
V. Ongoing Monitoring and Interventions	X Yes No	The Group develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly:**	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		practitioners when it identifies occurrences of poor quality. The Group implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions and exclusion. 2. Collecting and reviewing sanctions and limitations on licensure and expiration on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implements appropriate interventions when it identifies findings related to items 1–4 and report findings to the next Credentialing Committee or other designated peer-review body	guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	via the Health Industry Collaborative Effort (HICE) Reports		IPA's delegation agreement • Termination of delegation if CAP objectives are not achieved
VI. Notification to Authorities and Practitioner Appeal Rights	X Yes No	If the Group takes action against a practitioner for quality reasons it reports the action to the appropriate authorities and offers the practitioner a formal appeal process. The Group has policies and procedures that address the following:	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the	**Annually:** - CR Program - CR Program Evaluation - CR Activity	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		• The range of actions available to the group • Making the appeal process known to practitioners • Policy must state that the Group cannot have an attorney, if the practitioner does not have attorney representation. [CA Business & Professions Code 809.3(c)]	IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting			agreement (i.e., CAP deduction from monthly capitation)
VII. Assessment of Organizational Providers	Yes No	The Group has policies and procedures for assessing a health care delivery provider that specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited. • Policy includes at least the following medical providers in its assessment: Hospital, Home Health Agencies and Free-Standing surgical Centers • Policy includes behavioral health care facilities providing mental healthcare	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly:** via the Health Industry Collaborative Effort (HICE) Reports	• Pre-delegation review • Annual due-diligence audit Quarterly/Semi-annual review of credentialing activity	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement Termination of Credentialing delegation if CAP objectives are not achieved.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		or substance abuse services in the following settings: Inpatient, Residential and Ambulatory. • Policy includes CMS/DHCS providers and suppliers as applicable. • Performs an initial assessment and reassessment at least every thirty-six (36) months thereafter.				
VIII. A. Delegation Oversight Written Agreement	X Yes No	If the Group delegates any Credentialing functions the written delegation agreement/document includes the following: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the Group and the delegated entity that includes detailed language of specific credentialing activities. Agreements implemented on or after 7/1/25 must include Credentialing Information Integrity requirements, including Staff Training. 3. Requires at least quarterly reporting by the delegated entity to the Group that specifies what information is reported regarding activities delegated, how and to	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) Sanctions per IPA's delegation agreement

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		whom information is reported. 4. Describes the process by which the Group evaluates the delegated entity's performance. • The Agreement should include the annual review of the delegate's policies and procedures and review of files, as applicable, and Credentialing Information Integrity (CII) annual audit and monitoring processes. • Agreement has appropriate language regarding safeguarding the information used in the credentialing processes against inappropriate documentation and updates. Required delegation language for credentialing information integrity specifies that the following documentation and updates to credentialing are inappropriate: - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date,				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		ongoing monitoring dates). - Creating documents without performing the required activities. - Fraudulently altering existing documents (e.g., credentialing minutes, clean file reports, ongoing monitoring reports). - Attributing verification or review to an individual who did not perform the activity. - Updates to information by unauthorized individuals 5. Specifies the Group retains the right to approve, suspend and terminate individual practitioners, providers, and sites, even if the Group delegates decision making. 6. Describes the remedies available to the Group if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
VIII. A.1 Delegation Oversight Written Agreement	X Yes No	Delegation agreement requires delegate/subdelegate to adhere to CMS regulations.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from) monthly capitation
VIII.B Pre-Delegation Assessment	X Yes No	Oversight will be completed annually For new delegation agreements, the Group evaluates the delegate's capacity to meet NCQA/delegated functions requirements prior to delegation.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Pre-contractually** - CR Program - CR Program Evaluation - CR Activity	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
VIII.C. Review of Delegated Credentialing Activities	X Yes No	**Review of Delegate Credentialing Activities (oversight will be completed annually) according to NCQA and other regulatory requirements as applicable.** For delegation arrangements in effect for twelve (12) months or longer, the Group: 1. Annually reviews its delegates credentialing policy and procedures. 2. Annually audits credentialing and re-credentialing files against regulatory standards. 3. Annually evaluates delegate performance against all standards for delegated activities. 4. Quarterly (Medi-Cal) evaluates regular reports, as specified. **5.** Annually audits the delegates Credentialing Information Integrity (CII). **Note: IPA/Medical Group must comply with all aspects of this factor and NCQA requirements.** • Review evidence that the Delegate reviewed the sub-delegate's Credentialing Information Integrity (CII) and	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly** : via the Health Industry Collaborative Effort via (HICE) Reports	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		performed annual audit of inappropriate documentation or updates to: • Application/attestation • Credentialing documents received from the source or agent • Documentation of completion of credentialing activities to include: - verification dates - report dates - credentialing decision dates - signature or initials of the reviewer or verifier - credentialing checklist, if used. • The Group uses one of the following methods to audit files: - NCQA 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the Group				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		audits the universe of files rather than a sample. 6. Implement corrective actions to address inappropriate documentation and inappropriate updates found in item 5. 7. Measure the effectiveness of action audits. • Conducts an audit of effectiveness of the corrective actions in item 6 on the finds for each delegate 3-6 months after completion of the annual audit for item 5. **Opportunities for Improvement** Identify and followed-up on opportunities for improvement, if applicable.				

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
IX. Identification of HIV/AIDS Specialist (DMHC/ DHCS Requirement)	X Yes No	1. Establish a written process describing how it identifies and reconfirms that appropriately qualified physicians meet the definition of an HIV/AIDS specialist as established by DMHC. 2. On an annual basis, identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations. 3. Notifies the appropriate referral department of qualified practitioners	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)
X. Credentialing UM Medical Directors and UM Physician Reviewers (L.A. Care and Health Plan	X Yes No	Group credentials Utilization Management Medical Directors and all administrative physician reviewers responsible for making medical decisions.	• Monitor and oversee delegated function • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation	• Pre-delegation review • Annual due-diligence audit or Attestation	• Request Corrective Action Plan(s) (CAPs)

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
XI. Mid-Level Supervisor or Delegated Serves Agreements	X Yes No	Group ensures that there is a signed Supervisory Agreement or Delegated Services Agreement between the Physician Assistants, Nurse Practitioners, Nurse Mid-Wives with the Supervising Physician at initial and re-credentialing.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation	• Pre-delegation review • Annual due-diligence audit or Attestation	• Request Corrective Action Plan(s) (CAPs)
XII. Medi-Cal Enrollment Verification	X Yes No	Establish policy and procedures to verify Medi-Cal Enrollment, validate and document that Group providers are appropriately enrolled in Medi-Cal.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation	• Pre-delegation review • Annual due-diligence audit or Attestation	• Request Corrective Action Plan(s) (CAPs)

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
XIII. Mental Health and Substance Use Disorder Providers	X Yes No	Assembly Bill 2581 requires the following procedures be put in place for Mental Health/Substance Use Disorder providers, effective January 1, 2023: • All Mental Health/Substance Use Disorder providers, upon receipt of a completed application, will receive an application received letter within seven days to verify receipt and inform the applicant whether the application is complete. • All complete Mental Health/Substance Use Disorder provider applications for credentialing will be completed within sixty days.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation Reports	• Pre-delegation review • Annual due-diligence audit or Attestation	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) •
XIV. Nondiscriminatio n - Abortion Provider Protections	X Yes No	Senate Bill 487 (SB 487) Nondiscrimination - Abortion Provider Protections. Establish written policy and procedures- describing that the organization is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through	**Annually:** - CR Program - CR Program Evaluation Reports	• Pre-delegation review • Annual due-diligence audit or Attestation •	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.	review and analysis of performance reporting			capitation)

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
Credentialing Information Integrity (Applies to paper and electronic processes) **Delegates must comply with the following standards according to NCQA requirements.** The Delegate has Credentialing Information Integrity (CII) policies and procedures, audits credentialing information and updates and implements corrective actions that address identified information	• At least annually, monitors delegate's Credentialing Information Integrity reports from Group or assessment by Blue Shield. • At least annually, Group demonstrates that it monitors compliance with its Credentialing Information Integrity policies and procedures.	Annual reporting: • Credentialing Information integrity procedural changes • Credentialing Integrity reports of inappropriate documentation and updates • Review of Correction Action Plans to	• Pre-delegation • Annual • Focus • Annually review delegate's Credentialing Information Integrity (CII) policies and procedures, audits of credentialing	• Request Corrective Action Plan(s) for elements of non-compliance. • Sanctions per Group's delegation agreement (*e.g.*, deduction from Capitation • Health Plan may conduct discretionary review to re-measure former areas of non-compliance • Termination of delegation if CAP objectives are not

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
integrity issues. A. The Group has credentialing information integrity policies and procedures that specify: 1. Scope of credentialing information: • Group's policies must describe the protection of each of the following documents: • Application and Attestation • Credentialing Documents received from primary source or agent • Documentation of credentialing activities o Verification dates o Report dates o Credentialing decisions o Credentialing decision dates o Signature or initials of the verifier or reviewer • Credentialing Committee Minutes • Documentation of clean file approval, if		address inappropriate documentation • Review of qualitative analysis of each instance of inappropriate documentation • Staff training on Credentialing Information Integrity documentation	information and updates and implementation of corrective actions that address identified information integrity issues.	achieved within agreed timeframe.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
applicable • Credentialing checklist, if used. 2. Staff Responsible for performing credentialing activities • Group's policies must include the titles of staff who: - Document credentialing activities - Staff authorized to modify (edit, update, delete) credentialing information or if no staff may modify, then state no staff are authorized to do any updates under any circumstances. - Perform the annual oversight of CII functions, to include the annual audit and follow-up, if applicable.				

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
3. Process for documenting updates to credentialing information: • Group's policies must include: • Description of when it is acceptable to update credentialing information (e.g., to update expiring licensures) • Describe the process staff should follow when making updates to credentialing information including the following documentation: o When (date and time) the information was updated. o What information was updated. o Why the information was updated. o Staff who updated the information. **4.** Inappropriate documentation and updates • The Group's policies specify that the following are inappropriate updates to				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
credentialing information: ○ Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates). ○ Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as new credential). ○ Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports). ○ Attributing verification or review to an individual who did not perform the activity. ○ Updates to information by unauthorized individuals. **5. Auditing, documenting, and reporting information integrity issues** • Group's policies must				

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
include: - Describe Group's audit of CR staff documentation and updates. - It is not required that methodology be included, only that an annual audit will be conducted. - Process for documenting and reporting inappropriate documentation and updates to: - Group's designated individual (s) when identified, and - Outline consequences for inappropriate documentation and updates. B. Information Integrity Training The Group trains credentialing staff on: 1. Inappropriate documentation and updates related to Element A, factor 4. 2. P Group's audits of staff, documenting and reporting				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
information integrity issues for Element A, factor 5. C. Audit and Analysis 1. Group annually audits for inappropriate documentation and updates to credentialing information. • Evidence that an annual audit (CII) was conducted for the bullets under Element A, factor 4. • Audit universe is to include a random sample of 5% or maximum of 50 files. If 5% is less than 20 total files, it is required to do a minimum of 10 initial and 10 recredentialing. Universe to include all initial or recredentialing decisions made during the look-back period (12 months). • Audit and Analysis report must include: report date, title of individuals who conducted audit, the auditing period, file				

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
universe size, audit sample size, audit log showing file identifier and type of credentialing information audited, findings for each file and rationale, and results (percentages and total inappropriate documentation and updates found) **2.** Conducts a qualitative analysis of inappropriate documentation and updates. • The Group performs a qualitative analysis for each inappropriate documentation and update found during the audit to determine the cause. The cause is then documented along with staff who performed the qualitative analysis. D. Improvement Actions **1.** Implements corrective actions to address all inappropriate documentation and updates found in Element C.				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
• The Group documents corrective actions it has taken or plans to take, dates of action for all credentialing information found to be inappropriate, including title of staff responsible for implementing the corrective measures. ○ Stating annual training as the corrective action may not be the only action. ○ Example: The PO's credentialing manager shared the annual audit report/analysis results with proposed actions with the PO's leadership and determined appropriate action and time framed for completion of all corrective actions. **2.** Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3-6 months after completion of the annual audit in Element C.				

Delegated Responsibility: Credentialing Information Integrity Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
• The Group conducts an audit 3-6 months after the annual audit to determine if the corrective action measures taken were effective. File universe should be those with credentialing or recredentialing decisions made within the preceding 3-6 months.				

Appendix 2: Delegation of Credentialing Responsibilities

Blue Shield of California Promise Health Plan will share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your delegation coordinator.

The Plan and Medical Group agree to accept the terms of the above.

Blue Shield of California Promise Health Plan			<<Contract Entity Name>>	
("Plan")			("Medical Group")	
By:			By:	
Name:			Name:	
Title:			Title:	
Date:			Date:	

Appendix 3: Delegation of Claims Processing Responsibilities

Blue Shield of California Promise Health Plan Participating IPA/Medical Group/Limited or Restricted Knox Keene Plan

Delegation of Claims Processing Responsibilities

This Participating Independent Physician Association / Medical Group/ Limited or Restricted Knox Keene Plan Delegation of Claims Processing Agreement ("**Agreement**") is made and entered into **on <<Date>>** by and between **BLUE SHIELD OF CALIFORNIA/BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN,** a California corporation ("**PLAN**"), and **<<Contract Entity Name>>** ("**Medical Group**").

Delegated Claims Activity	Delegated	Delegated Entity Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via dedicated email address or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for oversight of delegated function	Corrective Action if Delegated Entity Fails to Meet Responsibilities
I. Claims Processing End to End	MCL ☒Yes ☐ No MCR ☒Yes ☐ No Commercial ☒Yes ☐ No	• Annual, follow-up and monitoring audit participation to demonstrate compliance with end-to-end claims processing requirements as outlined by CMS, DMHC, DHCS, DOI and Blue Shield /Blue Shield Promise contracts. • Submission annually updated/reviewed/approved policies and procedures • Evidence of sub-delegated oversight • Universes and audit material as requested • Completed HICE	• Monitor and oversee delegated functions	See Appendix 8 under Claims Delegate Reporting Instructions	• Pre-delegation review • Annual Oversight audit to include any necessary follow-up audits, CAPs and/or monitoring processes.	• Request Corrective Action Plan(s) (CAPs) • Sanctions per delegated entity delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Claims delegation if CAP objectives are not achieved.

Appendix 3: Delegation of Claims Processing Responsibilities

Delegated Claims Activity	Delegated	Delegated Entity Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via dedicated email address or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for oversight of delegated function	Corrective Action if Delegated Entity Fails to Meet Responsibilities
I. Claims Processing End to End *(cont'd.)*		Questionnaire – to be updated annually • Attestations as required by line of business • Other activities and material to demonstrate compliance with claims processing regulations, i.e. contracted provider rate sheet to validate pricing, sweep universes as required to identify other claims with similar error(s), etc.				
II. Required Claims Compliance Reporting	MCL ☒Yes ☐ No MCR ☒Yes ☐ No Commercial ☒Yes ☐ No	• Monthly Timeliness Reports • Quarterly Timeliness Reports • ODAG – Medicare only • Claims Settlement Practices Report – Quarterly Survey Certification (Commercial and Medi-Cal) • Quarterly Provider Dispute Reports (All lines of business)	• Monitor and oversee delegated reports • Provide the delegated entity a evaluation of submitted reports • Include Principal Officer signature on quarterly report at the level of the definition per requirement as described in California	• See Appendix 8 under Claims Delegate Reporting Instructions and due dates • **Monthly Timeliness Reports by the 15th day of the following month:** Monthly timeliness reports as outlined in the Claims Delegation Oversight Reporting Instruction Manual	• Conduct monthly and quarterly review of claims delegation oversight reporting	• Request Corrective Action Plan(s) (CAPs) if no submission, incomplete reports or consistently late • Report demonstrates non-compliance

Delegated Claims Activity	Delegated	Delegated Entity Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via dedicated email address or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for oversight of delegated function	Corrective Action if Delegated Entity Fails to Meet Responsibilities
II. Required Claims Compliance Reporting *(cont'd.)*		• Annual Principal Officer Form	regulations 28 CCR 1300.45(o):	• **Quarterly Timeliness Reports by the last day of the month following Quarter End:** Quarterly timeliness reports as outlined in the Claims Delegation Oversight Reporting Instruction Manual • **ODAG:** Due dates are outlined in the Claims Delegation Oversight Reporting Instruction Manual • **Quarterly Claims Settlement Practices Report Survey Certification:** Quarterly certification document as outlined in the Claims Delegation Oversight Reporting Instruction Manual • **Quarterly Provider Dispute Reports (All lines of business):** Quarterly Provider		

Appendix 3: Delegation of Claims Processing Responsibilities

Delegated Claims Activity	Delegated	Delegated Entity Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via dedicated email address or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for oversight of delegated function	Corrective Action if Delegated Entity Fails to Meet Responsibilities
II. Required Claims Compliance Reporting *(cont'd.)*				Dispute Reports as outlined in the Claims Delegation Oversight Reporting Instruction Manual • **Annual Principal Officer Form:** Due by the end of September each year as outlined in the Claims Delegation Oversight Reporting Instruction Manual		
III. Sub Delegate Oversight	MCL ☒Yes ☐ No MCR ☒Yes ☐ No Commercial ☒Yes ☐ No	• Delegated Entity that is a Limited/Restricted Knox Keene or Specialty Health Plan, that has contractually sub-delegated any claims related functions, they must demonstrate their annual oversight and monitoring process. o Audit preparation	• Evaluate the delegated entity's oversight by reviewing P&Ps and audit documentation including reports and CAPs	• See Appendix 8 under Claims Delegate Reporting Instructions and due dates • The reporting would be for the delegated entity who is a Limited/Restricted Knox Keene or Specialty Health Plan not the sub delegate whose information would be included with the delegated entity report		• The delegated entity who is a Limited/Restricted Knox Keene or Specialty Health Plan would need to demonstrate oversight of sub delegates CAP

Delegated Claims Activity	Delegated	Delegated Entity Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via dedicated email address or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for oversight of delegated function	Corrective Action if Delegated Entity Fails to Meet Responsibilities
		would include submission of policies and procedures along with audit results and any supporting documentation and CAPs.				

The Plan and Medical Group agree to accept the terms of the above.

Blue Shield of California Promise Health Plan			<<Contract Entity Name>>	
("Plan")			("Medical Group")	
By:			By:	
Name:			Name:	
Title:			Title:	
Date:			Date:	

Appendix 3: Delegation of Claims Processing Responsibilities

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BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Access to Care Standards

ATTACHMENT A

Type of Care and Service	Blue Shield Promise Health Plan Standard
Emergency Services	Immediately, 24 hours a day, 7 days a week.
PCP Urgent Care Services without prior authorization	Within forty-eight (48) hours of the request.
PCP (and OB/GYN) Urgent Care with prior authorization (including referrals made by a physician to another physician)	Within ninety-six (96) hours of the request.
PCP (and OB/GYN) Routine or Non-Urgent Care Appointments	Within ten (10) business days of the request.
Specialist Urgent Care without prior authorization	Within forty-eight (48) hours of the request.
Specialist Urgent Care with prior authorization	Within ninety-six (96) hours of the request.
Specialist Routine or Non-Urgent Care	Within fifteen (15) business days of the request.
OB/GYN Specialty Care	Within ten (10) business days of the request.
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).
Behavioral Health Urgent Care Visits	Within forty-eight (48) hours of the request.
Behavioral Health Non-life-threatening emergency	Within six (6) hours of the request.
Routine or Non-Urgent Care Appointment for Ancillary Services	Within fifteen (15) business days of the request.

Appendix 4: Access to Care Standards

Type of Care and Service	Blue Shield Promise Health Plan Standard
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within ten (10) business days of the request.
After Hours Care	24 hours/day; 7 day/week availability
Initial Health Assessment for a New members (under eighteen (18) months of age)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when a member becomes eligible).
Initial Health Assessment for a New members (over eighteen (18) months of age)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when a member becomes eligible) or within periodicity timelines established by the American Academy of Pediatrics (AAP).
Maternity Care Appointments for First Prenatal Care	Within ten (10) business days of the request.
Office Wait Time to be Seen by Physician (for a scheduled appointment)	Should not exceed thirty (30) minutes from the appointment time. All PCPs are required to monitor waiting times and adhere to this standard.
After-Hour Instruction for Life-Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911 or go to the nearest emergency room."
Physician Response Time to After-Hour Phone Message, Calls and/or Pages	Within thirty (30) minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for members.

The DHCS timely access survey assesses providers for the following appointment types and standards.

Provider Type	Appointment Type	Timely Access Standard
PCP/Specialist	Urgent Care appointment, no prior authorization	48 hours
PCP/Specialist	Urgent Care appointment, requiring prior authorization	96 hours
Non-Physician Mental Health Care	Urgent Care appointment, no	48 hours

Provider Type	Appointment Type	Timely Access Standard
or Substance Use Disorder (SUD) Provider	Prior Authorization	
Dental (carve out)	Urgent Care appointment	72 hours
PCP (includes OB-GYN acting as PCP)	Non-urgent appointment	10 business days
Specialist (including OB- GYN specialty care)	Non-urgent appointment	15 business days
Non-Physician Mental Health Care or SUD Provider	Non-urgent appointment	10 business days
Non-Physician Mental Health Care or SUD Provider	Non-urgent follow-up appointment	10 business days
Ancillary	Non-urgent appointment for the diagnosis or treatment of injury, illness, or other health condition	15 business days
Dental	Non-urgent appointment	36 business days
Dental	Preventive Care appointment	40 business days

Telephone Wait Times	Timely Access Standard
Member Services Line	10 minutes or less
24/7 Nurse Triage Line	Response/Call provided within 30 minutes

Provider Interpretation Services	Timely Access Standard
Providers must demonstrate their awareness that Members are entitled to receive 24/7 interpretation services	N/A

Appendix 4: Access to Care Standards

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Long Term Services and Support Access to Care Standards

ATTACHMENT B

Provider Type	Timely Access Standard by County Size			
	Rural	Small	Medium	Dense
Skilled Nursing Facility	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Subacute Care Facility	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request

Appendix 5: Reimbursement for Ambulatory Surgery Center Services

Reimbursement for ambulatory surgery center (ASC) services is based on the ASC's contractual agreement in effect at the time services are rendered. To receive payment, ASCs must properly identify services provided by submitting a completed UB 04 (or successor), or other HIPAA-compliant claim form and include all applicable codes (Revenue, CPT/HCPCS, modifiers) for each service. Revenue Codes should be appropriate for the bill type.

Plan periodically reviews, and makes appropriate updates to, procedure listings based on industry standards. Updated listings are provided electronically and available upon request.

In calculating allowed amounts, Plan may round the figure to the nearest whole dollar.

I. Outpatient Surgical Services Reimbursed at APG Payment Rate

The Plan has implemented a payment system for outpatient surgical services that classifies ambulatory procedures into related groups. The groups are based on the relative resource needs (costs) for that group of procedures. The core of this payment system is the CPT-specific coding. ASCs must bill with appropriate revenue codes, CPT/HCPCS codes and modifiers in order to receive applicable payment. Plan reimburses ASCs for outpatient surgical services using the APG Payment Schedule.

In the event your listing contains groupers not included in your payment schedule, reimbursement will be issued at the applicable rate for ungrouped surgical procedures. If you have not received the fee schedule CD, contact your Plan Network Manager, who will provide you with a copy.

Appendix 5: Reimbursement for Ambulatory Surgery Center Services

A. Example of Reimbursement Calculation

SURGICAL SERVICES APG PAYMENT SCHEDULE CALCULATION EXAMPLE		
Formula	ASC Payment = (APG Grouper (corresponding APG Weight)) x (APG Payment Rate)	
Example Assumptions	• Revenue code billed is 0360 • CPT code billed is 10021 • CPT code 10021 is assigned to Grouper 001 • Grouper 001 has a **weight** of **0.2000** • Hospital's negotiated value of **APG at 1.0000** (APG Payment Rate) is **$1,000**	
Total Case Rate Payment = 0.2000 x $1,000 = (The case rate payment may be rounded to the nearest whole dollar.)		**$200**

Appendix 6: List of Incidental Procedures for APG Payment Rate

CPT	Description
10004	Fna bx w/o img gdn ea addl
10006	Fna bx w/us gdn ea addl
10008	Fna bx w/fluor gdn ea addl
10010	Fna bx w/ct gdn ea addl
10012	Fna bx w/mr gdn ea addl
10036	Perq dev soft tiss add imag
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11103	Tangntl bx skin ea sep/addl
11105	Punch bx skin ea sep/ addl
11107	Incal bx skn ea sep/addl
15772	Grfg autol fat lipo ea addl
15774	Each additional 25cc
15777	Acellular derm matrix implt
15853	Removal Sutr/Stapl Xreq Anes
15854	Removal Sutr&Stapl Xreq Anes
19030	Injection for breast x-ray
19082	Bx breast add Lesion strtctc
19084	Bx breast add Lesion US imag
19086	BX breast add lesion MR imag
19281	Perq device breast 1st imag
19282	Perq device breast ea imag
19283	Perq dev breast 1st strtctc
19284	Perq dev breast add strtctc
19285	Perq dev breast 1st US imag
19286	Perq dev breast add US imag
19287	Perq dev breast 1st mr guide
19288	Perq dev breast add mr guide
20501	Inject sinus tract for x-ray
20700	Prep and insert drug deliv dev
20701	Removal (deep)
20702	Prep and insert drug deliv dev
20703	Removal (intramedullary)
20704	Prep and insert drug deliv dev
20705	Removal (intra-articular)
20932	Osteoart algrft w/surf & bl
20933	Hemicrt intrclry algrft prtl
20934	Intercalary algrft compl
20985	Cptr-asst dir ms px
21116	Injection, jaw joint x-ray
22552	Addl neck spine fusion
22853	Insj Biomechanical Device
22854	Insj Biomechanical Device
22859	Insj Biomechanical Device
22868	Insj Stablj Dev W/dcmprn

CPT	Description
22870	Insj Stablj Dev w/o Dcmprn
23350	Injection for shoulder x-ray
24220	Injection for elbow x-ray
25246	Injection for wrist x-ray
27093	Injection for hip x-ray
27095	Injection for hip x-ray
27369	Njx Cntrst kne arthg/ct/mri
27648	Injection for ankle x-ray
31627	Navigational bronchoscopy
31649	Bronchial valve remov init
31651	Bronchial valve remov addl
32506	Wedge resect of lung add-on
32507	Wedge resect of lung diag
33508	Endoscopic vein harvest
33866	Aortic hemiarch graft
35572	Harvest femoropopliteal vein
36000	Place needle in vein
36005	Injection ext venography
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36013	Place catheter in artery
36014	Place catheter in artery
36015	Place catheter in artery
36100	Establish access to artery
36140	Establish access to artery
36160	Establish access to aorta
36200	Place catheter in aorta
36215	Place catheter in artery
36216	Place catheter in artery
36217	Place catheter in artery
36218	Place catheter in artery
36245	Place catheter in artery
36246	Place catheter in artery
36247	Place catheter in artery
36248	Place catheter in artery
36251	Ins cath ren art 1st unilat
36252	Ins cath ren art 1st bilat
36253	Ins cath ren art 2nd+ unilat
36254	Ins cath ren art 2nd+ bilat
36299	Vessel injection procedure
36400	Bl draw < 3 yrs fem/jugular
36405	Bl draw < 3 yrs scalp vein
36406	Bl draw < 3 yrs other vein
36410	Non-routine bl draw > 3 yrs
36416	Capillary blood draw

Appendix 6: List of Incidental Procedures for APG Payment Rate

CPT	Description
36474	Endovenous Mchnchem add-on
36481	Insertion of catheter, vein
36500	Insertion of catheter, vein
36510	Insertion of catheter, vein
36591	Draw blood off venous device
36592	Collect blood from picc
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
37247	Trluml Balo Angiop Addl Art
37249	Trluml Balo Angiop Addl Vein
37252	Intravasc us noncoronary 1st
37253	Intravasc us noncoronary addl
38200	Injection for spleen x-ray
38790	Inject for lymphatic x-ray
38792	Identify sentinel node
38794	Access thoracic lymph duct
38900	Io map of sent lymph node
42550	Injection for salivary x-ray
44701	Intraop colon lavage add-on
47001	Needle biopsy, liver add-on
49327	Lap ins device for rt
49400	Air injection into abdomen
49412	Ins device for rt guide open
49424	Assess cyst, contrast inject
49427	Injection, abdominal shunt
50606	Endoluminal bx urtr rnl plvs
50684	Injection for ureter x-ray
50690	Injection for ureter x-ray
50705	Ureteral embolization/occl
50706	Balloon dialate urtrl strix
51600	Injection for bladder x-ray
51605	Preparation for bladder xray
51610	Injection for bladder x-ray
51701	Insert bladder catheter
51702	Insert temp bladder cath
54230	Prepare penis study
55300	Prepare, sperm duct x-ray
58340	Catheter for hysterography
61781	Scan proc cranial intra
61782	Scan proc cranial extra
61783	Scan proc spinal
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
64634	Destroy c/th facet jnt addl

CPT	Description
64636	Destroy l/s facet jnt addl
64643	Chemodenerv 1 extrem 1 - 4 ea
64645	Chemodenerv 1 extrem 5/> ea
66990	Ophthalmic endoscope add-on
68850	Injection for tear sac x-ray
69990	Microsurgery add-on
78808	Iv inj ra drug dx study
92973	Percut coronary thrombectomy
92974	Cath place, cardio brachytx
93462	L hrt cath trnsptl puncture
93463	Drug admin & hemodynmic meas
93561	Cardiac output measurement
93562	Cardiac output measurement
93563	Inject congenital card cath
93564	Inject hrt congntl art/grft
93565	Inject l ventr/atrial angio
93566	Inject r ventr/atrial angio
93567	Inject suprvlv aortography
93568	Inject pulm art hrt cath
93569	NJX CTH SLCT P-ART ANGRP UNI
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93573	NJX CATH SLCT P-ART ANGRP BI
93574	NJX CATH SLCT PULM VN ANGRPH
93575	NJX CATH SLCT P ANGRPH MAPCA
95940	Ionm in operating room 15 min
95941	Ionm remote/>1 pt per hour
96904	Whole body photography
96934	Rcm celulr subcelulr img skn
96935	Rcm celulr subcelulr img skn
96936	Rcm celulr subcelulr img skn
0042T	Ct perfusion w/contrast, cbf
0054T	Bone surgery using computer
0055T	Bone surgery using computer
0095T	Each additional interspace
0098T	Each additional interspace
0198T	Ocular blood flow measure
0348T	Rsa spine exam
0349T	Rsa upper extr exam
0350T	Rsa lower extr exam
0397T	Ercp w/optical endomicroscpy
0437T	Impltj Synth Rnfcmt Abdl Wal
0439T	Myocrd Contrast Prfuj Echo
0444T	1st Plmt Drug Elut OC Ins

Appendix 6: List of Incidental Procedures for APG Payment Rate

CPT	Description
0445T	Sbsqt plmt Drug Elut OC Ins
0466T	Insj ch wal respir eltrd/ra
0513T	Esw integ wnd hlg ea addl
0523T	Ntrapx c ffr w/3d funcil map
0602T	Transdermal GFR Measurements
0603T	Transdermal GFR Monitoring
0604T	Rem Oct Rta Dev Stup&Edu
0605T	Rem Oct Rta Tech Sprt Min 8
0615T	Eye Mvmt alys w/o Calbrj I&R
0777T	R-t prs sensing edrl gdn sys
A4337	Incontinent rectal insert
A4435	1 pc ost pch drain hgh output
A4555	Ca tx e-stim electr/transduc
A4650	Implant radiation dosimeter
A7027	Combination oral/nasal mask
A9575	Inj gadoterate meglumi 0.1ml
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C1822	Gen, neuro, hf, rechg bat
C5272	Low cost skin substitute app
C5274	Low cost skin substitute app
C5276	Low cost skin substitute app
C5278	Low cost skin substitute app
C9143	Cocaine hcl nasal (numbrino)
C9144	Inj, bupivacaine (posimir)
C9254	Inj, lacosamide
C9359	Porous purifi colgn matrx bone vd filler
C9363	Skin sub,(meshd wound matrx)
C9364	Porcine implnt (permacol)
C9756	Fluorescence lymph map w/icg
E0766	Elec stim cancer treatment
G0316	Prolong inpt eval add15 m
G2211	Complex e/m visit add on
G2212	Prolong outpt/office visit
G2213	Initiat med assist tx in er
L8604	Inject bulk agent,dextranomer acid,1ml
Q4100	Skin substitute, NOS
Q4101	Apligraf skin sub
Q4102	Oasis wound matrix skin sub
Q4103	Oasis burn matrix skin sub
Q4104	Integra BMWD skin sub
Q4105	Integra DRT skin sub
Q4106	Dermagraft skin sub

CPT	Description
Q4107	Graftjacket skin sub
Q4108	Integra matrix skin sub
Q4110	Primatrix skin sub
Q4111	Gammagraft skin sub
Q4112	Cymetra allograft
Q4113	Graftjacket express allograf
Q4114	Integra flowable wound matri
Q4115	Alloskin skin sub
Q4116	Alloderm skin sub
S9433	Medical food oral 100% nutr

Appendix 6: List of Incidental Procedures for APG Payment Rate

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Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12011	Repair superficial wound(s)

CPT	Description
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20560	Needle insert w/o inj 1 or 2 mscl
20561	Needle insert w/o inj 3 or more
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst

Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
20615	Treatment of bone cyst
20950	Fluid pressure, muscle
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast
29010	Application of body cast

CPT	Description
29015	Application of body cast
29035	Application of body cast
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast

Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
29740	Wedging of cast
29750	Wedging of clubfoot cast
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31242	Nasal/Sinus Ablation
31243	Nasal/Sinus Cryoablation
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
42975	Dise eval slp do brth flx dx
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
44705	Prepare fecal microbiota
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)

CPT	Description
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure
51100	Drain bladder by needle
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
52284	Cysto Cath Sten Male
53454	Tprnl balo cntnc dev adjmt
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing

Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
58580	Transcervical ablation uterine fibroid
59020	Fetal contract stress test
59025	Fetal non-stress test
59050	Fetal monitor w/report
59051	Fetal monitor/interpret only
59200	Insert cervical dilator
59412	Antepartum manipulation
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital
64445	N block inj, sciatic, sng
64454	Inj Aa&/Strd Gen Nrv Brnch w/img
64455	N block inj, plantar digit
64596	Insj/rplcmnt perq eltrd
64611	Chemodenerv saliv glands
64615	Chemodenerv musc migraine
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle laryny EMG
64624	Dest neurolytic agt gen nrv w/img
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes

CPT	Description
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rprt
0379T	Vis field assmnt tech suppt
0419T	Dstrj Neurofibroma Xtnsv
0420T	Dstrj Neurofibroma Xtnsv
0474T	Insj aqueous drg dev io rsvr
0529T	Interrog dev eval iims ip
0530T	Removal complete iims
0563T	Evac meibomian glnd heat bilat
0566T	Autol cell impt adps tiss njx implt knee uni
0588T	Rev or remvl isdns post tib nrv

Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	DESCRIPTION
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol
C8929	Transthoracic Echo, w or w/o contrst followd with

CPT	DESCRIPTION
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

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Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training

Definitions

"*Delegated Entity/Specialty Health Plan*" describes any party (Medical Group, IPA, Restricted/Limited Knox Keene Plan etc., or for example Vendor for Vision Care) who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately. Blue Shield Promise is dedicated to ensuring that claim functions assigned to Delegated Entities are processed in accordance with regulatory requirements and contractual provisions. Blue Shield Promise monitors Delegated Entities' monthly and quarterly claims processing timeliness via the Delegated Entity's/Specialty Health Plan's submission of the monthly/quarterly timeliness report. Additionally, Blue Shield Promise monitors the Delegated Entity's/Specialty Health Plan's provider dispute resolution (PDR) process via submission of the quarterly Medi-Cal Provider Dispute Report. Both report templates are available from the Delegation Oversight Claims Team or located on the Health Industry Collaborative Effort (HICE) website under *Approved HICE Documents*.

Audits and Audit Preparation

Blue Shield Promise and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield Promise's audit, Blue Shield Promise will send a written notification 60 days prior to the audit that includes the documents the Delegated Entity/Specialty Health Plan is required to provide along with the scope of the audit and due dates of when the material needs to be submitted. The documentation includes providing claims universes for each category. An industry standard questionnaire will need to be completed that will provide detailed information about your claims processing operations and internal controls. Also provided is a cover sheet that is **required to be completed and attached to each claim sample**. Note that the claim sample must include the following from the contract with the provider: the first and last page (signature) of the contract and the rate sheet from the contract or claims system screen shots identifying the claims payment methodology for specific sample selected. All documentation is required to be submitted with the sample claim as noted on the cover sheet.

If the Delegated Entity/Specialty Health Plan chooses not to submit the rate sheet specific to the claim, the Delegated Entity / Specialty Health Plan is required to demonstrate the payment methodology per claim in the audit webinar or submit claims system screen shots demonstrating how the claim was paid per contract or policy and procedure.

Audits and Audit Preparation *(cont'd.)*

If the required documentation is not submitted and the Delegated Entity/Specialty Health Plan refuses to submit or review during the audit webinar, the audit will be closed as non-compliant (failed). The Delegated Entity/Specialty Health Plan will be reported to Blue Shield Promise Contracting/Network Management for refusal to comply with audit requirements as outlined in provider contract and/or this manual.

Blue Shield Promise will perform an annual audit for Claims and Newly Contracted Provider Training Material oversight. On a quarterly and/or monthly basis Blue Shield Promise also conducts audits of Newly Contracted Providers Training timeliness. Based upon contract with Delegated Entity/Specialty Health Plan audit may be monthly or quarterly. Specific to the type of the audit, Blue Shield Promise will provide a notification of the oversight audit scheduled to be conducted that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's/Specialty Health Plan's organization.

For a Blue Shield Promise Contracted Delegated Entity that is a Limited/Restricted Knox Keene or Specialty Health Plan, that has contractually sub-delegated any functions, they must demonstrate their annual oversight and monitoring process. Audit preparation would include submission of policies and procedures along with audit results and any supporting documentation and CAPs.

Blue Shield Promise will require a walk through (including responses to the audit assessment) and demonstration of the Delegated Entity's/Specialty Health Plan's operations.

Specific to claims, the walk through 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 Policies and Procedures (P&P) noted in the industry standard (HICE) questionnaire. P&Ps are also 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.

Audits and Audit Preparation *(cont'd.)*

If required claims documentation is not received, the audit is incomplete and will be closed as non-compliant due to audit preparedness not being met. A corrective action plan (CAP) noting the root cause for non-submission of documents is required by the Delegated Entity/Specialty Health Plan along with a remediation plan. A follow up audit will be scheduled. The Delegated Entity/Specialty Health Plan will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents related to audit preparedness. Electronic submission of all data is required.

Blue Shield Promise will provide the Delegated Entity/Specialty Health Plan with written audit results within 30 calendar days from the scheduled audit date, including an itemization of any deficiencies and whether or not the Delegated Entity/Specialty Health Plan must prepare and submit a formal, written corrective action plan (to be on BSCPHP template provided by the auditor) 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.

Regulatory Audit

In the event Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) requires that Blue Shield Promise conducts additional compliance oversight, Blue Shield Promise will require the Delegated Entity/Specialty Health Plan to participate within the regulator-specified time schedules or deadlines. Blue Shield Promise requires the Delegated Entity/Specialty Health Plan to provide the material in the format requested in the timeframe as stipulated by the regulators. Refusal to do so and/or late submission of documents will result in an escalation to Blue Shield Promise Contracting/Network Management.

Paid and Denied Claims Timeliness: Verify that all claims are finalized within 30 calendar days at 90% and 99% at 90 calendar days (Title 19 Social Security Act 1902 (37 from the date of receipt of claim.

Beginning January 1, 2026, per DMHC APL 25-007/AB 3275, if a complete claim is not reimbursed within 30 calendar days after receipt, interest accrues at a rate of 15 percent per year beginning with the first calendar day after the 30-calendar-day period. Additionally, Delegated Entities must continue to automatically include all accrued interest when making payment on a claim beyond the 30-calendar day requirement. Delegated Entities who fail to meet the interest requirements shall also pay the claimant the greater of either an additional fifteen dollars ($15) or ten percent (10%) of the accrued interest on the claim. The requirements for interest and penalty apply to all claims, including claims for emergency services and care.

Claim processing begins when a claim is first delivered to the delegated payor's office. The number of days measured are calendar days. The time limit to make payment applies to <u>all</u> claims, without regard to whether the billing provider is contracted or non-contracted.

Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training

Date Stamping

Delegated Entities/Specialty Health Plans must date stamp all paper claims, including facsimiles, with the date the claim was received. The stamp should identify the specific Delegated Entity/Specialty Health Plan. 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 claims system.

This would also apply to Electronic Data Interchange (EDI) claims.

Acknowledgement of Receipt

The Delegated Entity/Specialty Health Plan 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 date of receipt for electronic submission claims should be either the date the claim became available to the Delegated Entity/Specialty Health Plan 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/Specialty Health Plan/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 reasonable and customary rates and/or appropriate Medi-Cal fee schedule for services rendered to non-contracted providers, (3) applying appropriate contract rates fee schedules (including TRI Rate for Network/Contracted Providers) as demonstrated by submitted documentation or shared via audit webinar 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.

Interest and Penalty: Applies to paid claims, adjustments, and Provider Disputes (CCR Title 28 Section1300.71(i)).

Payment Accuracy *(cont'd.)*

Interest is applicable for contracted and non-contracted provider claims paid later than the regulatory requirement. Beginning January 1, 2026 per DMHC APL 25-007/AB 3275 interest accrues at a rate of 15 percent per year beginning with the first calendar day after the 30-calendar-day period through the day the check is mailed and/or electronic payment is issued.

Beginning January 1, 2026, per DMHC APL 25-007/AB 3275, Delegated Entities who fail to meet the interest requirements shall also pay the claimant the greater of either an additional fifteen dollars ($15) or ten percent (10%) of the accrued interest on the claim in accordance with sections 1371(a)(4) and 1371.35(b)The requirements for interest and penalty apply to all claims, including claims for emergency services and care.

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

If the interest amount is less than $2.00, the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included. (CCR Title 28 Section 1300.71 (a)(b)).

Adjustments: Claims where additional monies are being paid on a previously paid or zero paid claim. (CCR Title 28 1300.71 (d)).

Contested Claim: A contested claim is defined as a claim or portion thereof that is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims must be adjudicated within 30 calendar days of the received date to be considered compliant. (CCR Title 28 Sections 1300.71 (d) and (h)).

Beginning January 1, 2026, per DMHC APL 25-007/AB 3275, Delegated Entities must contest or deny a claim, or portion of a claim, as soon as practicable but no later than 30 calendar days after receipt of the claim. Delegated Entities/Specialty Plans must notify the claimant, in writing, that the claim is contested or denied.

The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim. Delegated Entity/Specialty Plans may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

Payment Accuracy *(cont'd.)*

If a claim or portion thereof is contested on the basis that the Delegated Entity/Specialty Health Plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information

Delegated Entity/Specialty Health Plan 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 should follow the below requirements.

(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 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.

Note: As defined by CCR Title 28, Section 1300.71(a)(9)- (12) DMHC clarification regarding the determination of financial responsibility between the Delegate and the Health Plan is not related to Medical Necessity per the below requirements.

(9) "Health Maintenance Organization" or "HMO" means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).

(10) "Reasonably relevant information" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

Payment Accuracy *(cont'd.)*

(11) "Information necessary to determine payer liability" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(12) "Plan" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization.

Provider Denial: Provider Denial is a denial in which the provider is liable and not the member. These are separate from contested claims. A Delegated Entity/Specialty Health Plan may deny a claim or portion thereof, by notifying the provider, in writing, that the claim is denied within thirty (30) calendar days after the date of receipt. (CCR Title 28 Section 1300.71 (d) and (h)).

Timely Filing: The Department of Managed Health Care enacted regulations related to claims settlement and dispute resolution practices of health plans and their delegated IPA/medical groups ("AB 1455 Regulations"). Among other things, the AB 1455 Regulations provide timely filing limitations for Medi-Cal claims depending on the provider's status. Timeframes for filing claims for contracted and non-contracted providers are as follows (CCR Title 28 Section 1300.71(b)(1)):

- Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
- Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed.

AB 1324: (Health and Safety Code Section 1371.8; CCR Section 1300.71 (a)(8)(T)). Blue Shield Promise validates that Delegated Entities pay incurred services if the specific service was pre-authorized or referred, even if the member is later found to be ineligible for any reason, when the provider of service relied on the authorization or referral in good faith and validated the eligibility of the member prior to service being rendered. If the Delegated Entity/Specialty Health Plan has an approved authorization and service has not been rendered, the Delegated Entity/Specialty Health Plan needs to formally rescind the authorization by sending a notice to the authorized rendering provider and to the member.

Direct Referral – if the service does not require a physical/paper/electronic referral, AB 1324 does not affect these services.

Payment Accuracy *(cont'd.)*

Accurate and Clear Written Explanation (Specific to Denying, Adjusting and Contesting Claims): The Evidence of Benefit (EOB)/Evidence of Payment (EOP)/Remittance Advice (RA) must contain data that is the same as what was submitted on the claim: the member financial liability (if applicable), same denied date as indicated in claim system, denial rights, the reason why the claim was denied, contested or adjusted and must include where to file a provider dispute including Provider Dispute timely filing requirements to be within 365 days from the last claim action.

The EOB/EOP/RA should include procedures for obtaining dispute forms, instructions for filing the dispute, and a mailing address. For Non-Contracted providers, the Delegated Entity/Specialty Health Plan needs to provide payment methodology. (Title 28 1300.71.38(d) Time Period for Submission) (Title 28 1300.71.38(b) Notice to Provider of Dispute Resolution Mechanism.)

Evidence of Payment (EOP)/Remittance Advice (RA): Each Delegated Entities needs to include the following information in their EOP/RA

- Delegated Entities needs to include if the payment was for TRI Rate by using DHCS CARC 172
- 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 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 Promise Health Plan within 60 working days from the Date of Determination." This appeal would only be for Medical Necessity *de novo* review.

Payment Accuracy *(cont'd.)*

Provider Dispute Resolution (PDR): Section 1300.71.38 CCR, Title 28. The Delegated Entity/Specialty Health Plan shall establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. Time Period for Resolution and Written Determination requires that a Delegated Entity/Specialty Health Plan must resolve each provider dispute within 45 working days after the date of receipt of the provider dispute. Provider Disputes must be in writing and include the following:

a. Provider Name.

b. Provider Identification Number.

c. Provider Contact Information.

d. Clearly identify the disputed item.

e. Date of Service (DOS).

f. A clear explanation of basis for provider's reason that the payment, request for overpayment return, request for additional information, contest, denial, or adjustment is correct.

g. Effective January 1, 2026, consistent with DMHC APL 25-007/AB 3275, interest and penalty, if applicable, are due on all claim payments that are not reimbursed within 30 calendar days after the date of receipt of a complete claim, including payments resulting from provider disputes.

Misdirected/Forwarded Claims: Regulations require the Delegated Entity/Specialty Health Plan to forward misdirected claims to the responsible payor within ten (10) working days of receipt. Blue Shield Promise requires that Delegated Entities forward these claims directly to the financially responsible entity, if known, otherwise deny to the provider with a remit message informing the provider the delegate is not financially responsible for processing of the claim. The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office boxes, or designated claims processor or to the plan's contracted Delegated Entity/Specialty Health Plan for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim. If a Management Service Organization (MSO) that manages several Delegated Entities receives a claim from one of their post office boxes, and it loads the claim into the wrong Delegated Entity/Specialty Health Plan'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/Specialty Health Plan's claim system.

(Title 28 Section 1300.71(a)(8)(B) & Section 1300.71(b)(3)).

Payment Accuracy *(cont'd.)*

Family Planning/State Supported Services: Members have the right to access family planning services through any family planning provider without prior authorization. Health Plan shall inform its members in writing of their right to access any qualified family planning provider without prior authorization in its Member Services Guide. Health Plan shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the provider network and members shall be informed of the availability of these services. Minors do not need parental consent to access these services. (WIC Section 14105.181).

a. 90% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities, within 30 calendar days of the date of receipt and 99% of all clean claims from practitioners within 90 calendar days from the date of receipt. (Title 42 Section 447.75).
b. DHCS requires Blue Shield Promise and their Delegated Entities to reimburse non-contracting Family Planning providers at no less than the appropriate Medi-Cal Fee-For-Service (FFS) rate. This requirement supersedes APLs 10-003 and 10-014, resulting in paying non-contracted providers the appropriate Medi-Cal fee schedule base rate plus any applicable Center for Medicare and Medicaid Services approved directed payments as outlined in federal regulation (i.e., 2016 Final Rule and Title 42, Code of Federal Regulations section 438.6(c)) - not the augmented rates in APL 10-003 and 10-014, e.g. DHCS has retired APLs 10-003 and 10-014.

Check Clearing: Blue Shield Promise accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. Blue Shield Promise follows the audit process as described in the DMHC Financial Examiner Guide and will confirm the date the check or electronic transfer was cleared from the Delegated Entity's/Specialty Health Plan's bank account during the audit process. Blue Shield Promise requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield Promise requires the Delegated Entity/Specialty Health Plan to submit a check cashing attestation to be completed by each provider. This attestation can be requested from your assigned claims delegation oversight auditor.

Corrective Action (CAP)/Follow Up Audits: Blue Shield Promise performs, at a minimum, an annual claims and PDR audit. A follow-up audit will be scheduled by the assigned auditor if the Delegated Entity/Specialty Health Plan fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, Blue Shield Promise will require the Delegated Entity/Specialty Health Plan to submit a remediation plan (Excel worksheet), which will include a due date assigned by the auditor. Based upon Blue Shield Promise's tracking of remediation plan additional monitoring and/or remediation (follow up), Blue Shield Promise will perform validation audits and may escalate the Delegated Entity/Specialty Health Plan to the Delegation Oversight Committee.

Payment Accuracy *(cont'd.)*

This would include on-site visits, scheduled meetings, focal audits, and remediation project plan oversight.

Blue Shield Promise's corrective action plan requires a Delegated Entity/Specialty Health Plan to submit by the date indicated (30 calendar days) from audit result letter. Blue Shield Promise will review and provide a response to corrective action plan. If the Delegated Entity/Specialty Health Plan remains non-compliant after two CAPs have been submitted and/or **no response** to CAP has been submitted, the Delegated Entity will be escalated to the Delegation Oversight Committee (DOC).

For those Delegated Entities that are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield Promise by the date provided by the Blue Shield Promise and DMHC auditors. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other deficiencies/and or enforcement actions.

Claims Oversight Monitoring

Delegated Entity/Specialty Health Plan shall implement controls to ensure claims processes are monitored for integrity and security to protect claims from being altered by unauthorized personnel.

- Delegated Entity/Specialty Health Plan shall not allow the same person or departments to have the ability to pay claims and enter or update providers, vendors and/or eligibility.
- Delegated Entity/Specialty Health Plan shall maintain a disaster recovery plan and provide it during the scheduled audit. The disaster recovery plan shall be reviewed and updated annually.

Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training

Newly Contracted Provider Training Oversight Audit

To operate in full compliance with the DHCS and L.A. Care Contract requirements and all applicable federal and state regulations, Delegated Entities are required to provide all newly contracted network providers new provider orientation training which must start within ten (10) working days and be completed within 30 working days of becoming an active participating Medi-Cal provider. When a Delegated Entity/Specialty Health Plan has a provider with an existing Medi-Cal contract, but who is not participating in Blue Shield Promise Network, the Delegated Entity/Specialty Health Plan can submit evidence of Newly Contracted Provider Training. Upon the provider becoming a participant in Blue Shield Promise Network, an attestation of completion of such training is allowed as far back as 1 year from Blue Shield Promise Network effective date.

Training can be conducted online or in person with records of attendance being maintained to validate training conducted on the following topics:

- Education on Covered Services,
- Policies and procedures for clinical protocols governing Prior Authorization and Utilization Management and carved out service.
- Training must educate Network Providers on member access, including compliance with appointment waiting time standards and ensuring telephone, translation and language access is available for members during hours of operation.
- Training must also include education on secure methods for sharing information between contractors, network providers, subcontractors, downstream subcontractors, members, and other healthcare professionals. This includes training on ensuring providers have accurate contact information for the member and all network providers involved in the member's care.
- Delegated Entity/Specialty Health Plan must also provide training on how to refer and coordinate care for members who need access to Excluded Services.

New and Biennial training also includes the following:

- All member rights specified in DHCS Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment III, Section 5.1 (Member Services).
- Diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in DHCS Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training).

Delegation Oversight performs quarterly and annual audits (to separately include new providers and biennial training) for this requirement according to established audit timeframes to validate that all new providers were trained on Medi-Cal Managed Care services, policies, procedures, and any modifications to your existing training material.

Newly Contracted Provider Training Oversight Audit *(cont'd.)*

Annual audits are conducted on the review of Delegated Entities training materials and/or the Delegated Entity's website that contains the training materials. The annual material must be submitted to the Blue Shield Promise Delegation Oversight Compliance Team by February 1st of the following year to BSCProviderTraining@blueshieldca.com

Evidence of training must be demonstrated in the form of a universe report and signed training attestation from each trained provider and submitted to the Blue Shield Promise Delegation Oversight Compliance Team. To download a copy of the Delegation Oversight Newly Contracted Provider Training Attestation form, go to the Blue Shield Promise provider website at Blue Shield Promise Provider Portal under *Delegation oversight forms*. The reports are due every quarter by the 15th day of the month following quarter end to the following dedicated email address BSCProviderTraining@blueshieldca.com. ***Providers will not be uploaded into the Blue Shield's provider directory for members to access or approval for any authorized services until your organization provides evidence that the provider has completed the training.***

Delegation Oversight performs monthly review audits on Specialized Health Plans requiring submission of monthly universe reports and signed attestations by the 15th of the following month to the dedicated email address BSCProviderTraining@blueshieldca.com. Blue Shield Promise Delegation Oversight Compliance team will review attestations, and universe content against what is in the Specialized Health Plan website provider directory.

As a reminder, the Delegated Entity/Specialty Health Plan is responsible for providing 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. Requiring an out of network provider to call a Delegated Entity/Specialty Health Plan in order to request the aforementioned information and/or documentation would be an automatic deficiency for unrestricted access.

Corrective Action Plan (CAP) Process

- If the Delegated Entity/Specialty Health Plan is found non-compliant in the following areas, a CAP will be requested:
    - A newly contracted provider was not trained,
    - Newly contracted provider training was provided untimely,
    - Annual training/updates not provided, incomplete or inaccurate
    - All required elements were not included in the training,
    - Non submission of training material, report, and signed BSCPHP attestation(s),
    - Inaccurate information contained within the training material, and

Newly Contracted Provider Training Oversight Audit *(cont'd.)*

Corrective Action Plan (CAP) Process *(cont'd.)*

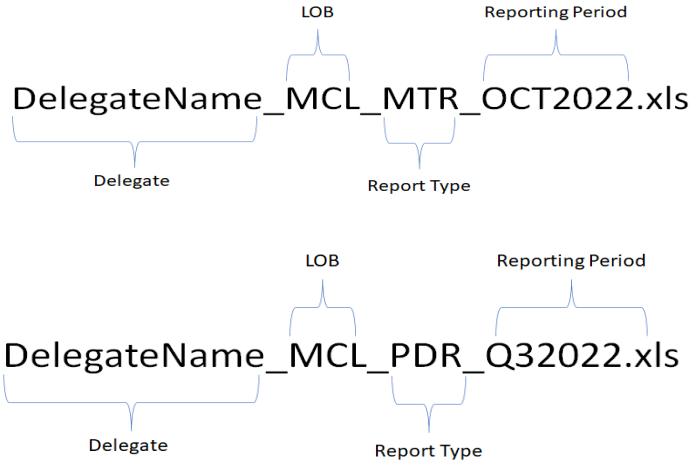
- Evidence-Based Practice Guidelines (specific to the Delegated Entity/Specialty Health Plan) & Clinical Protocols (specific to the Delegated Entity/Specialty Health Plan) are not available for out-of-network providers.
- Unable to provide evidence that a newly contracted provider was trained:
  - The Delegated Entity and Specialty Health Plan will be required to provide evidence of the completion of the training within 30 calendar days of the audit result notice.

Blue Shield Promise's corrective action plan requires a Delegated Entity/Specialty Health Plan to submit by the date indicated (10 Business Days) from audit result letter. Blue Shield Promise will review and provide a response to corrective action plan. If the CAP is not accepted, the Delegated Entity/Specialty Health Plan has five (5) business days to submit a second CAP response. If the delegated entity remains non-compliant after two CAPs have been submitted and/or no response to CAP, the Delegated Entity/Specialty Health Plan will be escalated to the Delegation Oversight Committee (DOC).

Note: Related to the Newly Contracted Provider Training audit no preliminary audit results will be provided. The auditor will provide the final overall audit results of met or not met.

Claims Delegate Reporting Instructions

Report Submission	
Submit Reports To:	ClaimsDelegateReport@blueshieldca.com
Report Template:	Submit results using the BSC Promise report template.
Report Format:	If submitting an Adobe PDF in order to satisfy the Designated Principal Officer signature requirements, please also submit the report on the original Excel template.

Report Naming Convention	
	
Delegate	The Delegated Entity/Specialty Health Plan's name or an acronym which represents the group.
LOB	COMM (Commercial) MCR (Medicare) MCL (Medi-Cal)
Report Type	DECD (Disclosure of Emerging Claim Deficiencies MTR (Monthly Timeliness Reporting) PDR (Provider Dispute Resolution) POF (Principal Officer Form)
Reporting Period	Identify the period being reported on e.g., OCT2022, Q32022, etc.

Designated Principal Officer	
Who Can Sign:	Results for the quarter must be attested to and signed by a Designated Principal Officer, not a signature via snipping tool or typing name on document. A physical signature or computer-generated signature (must be DocuSign to include date and time) from the designated principal officer is mandatory. The person attesting to the accuracy and completeness of the report must be an executive of the organization, Vice President level of above.

Claims Delegate Reporting Instructions *(cont'd.)*

Reports

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

1. Disclosure of Emerging Claim Deficiencies

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

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

Line of Business (LOB)	Due Date	Report Location
Medi-Cal	Claims Settlement Practice reports are submitted quarterly. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 30th • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year.	Blue Shield Promise Provider Portal under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

Reports *(cont'd.)*

2. Monthly Timeliness Report (Medi-Cal)

Claims must be processed within 30 calendar days and 45 working days.

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

Line of Business (LOB)	Due Date	Report Location
Medi-Cal	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 30th • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • October report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	Blue Shield Promise Provider Portal under *Delegation oversight forms*

Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training

Claims Delegate Reporting Instructions *(cont'd.)*

Reports *(cont'd.)*

3. Provider Dispute Resolution Report (Commercial and Medi-Cal)

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

Line of Business (LOB)	Due Date	Report Location
Medi-Cal	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 30th • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	Blue Shield Promise Provider Portal under *Delegation oversight forms*

4. Principal Officer Form

The Principal Officer is the president, vice-president, secretary, treasurer, or chairperson of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions. Title 28 CCR 1300.45(o).

Line of Business (LOB)	Due Date	Report Location
All LOBs	Reports are due by the end of September each year (annually). Also, Delegated Entity/Specialty Health Plan **must** submit updated Principal Officer(s) form to Blue Shield Promise when changes occur	Blue Shield Promise Provider Portal under *Delegation oversight forms*

Appendix 9: DHCS Community Supports Categories and Definitions

Housing Transition Navigation Services (HTNS)

Description: Housing Transition Navigation Services (HTNS) assist Members with finding, applying for, and obtaining housing.

Housing Deposits

Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.

Housing Tenancy and Sustaining Services (HTSS)

Description: Housing Tenancy and Sustaining Services (HTSS) help a Member maintain safe and stable tenancy once housing is secured.

Day Habilitation Programs

Description: Day Habilitation Programs are designed to assist a Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.

Recuperative Care (Medical Respite)

Description: Recuperative Care, also referred to as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition). A stay in a Recuperative Care setting allows an individual to recover from an injury or illness while also obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing. It is for individuals who have medical needs significant enough to result in emergency department (ED) visits, hospital admissions, or other institutional care.

Short-Term Post-Hospitalization Housing

Description: Short-Term Post-Hospitalization Housing provides Members who are exiting an institution and experiencing or at risk of homelessness with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting the institution. This would include recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facilities, or nursing facilities.

Appendix 9: DHCS Community Supports Categories and Definitions

Transitional Rent

Description: Transitional Rent is the newest addition to the suite of Community Supports to support Members experiencing or at risk of homelessness covered under Medi-Cal. Transitional Rent provides up to six months of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

Respite Services

Description: Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Assisted Living Facility (ALF) Transitions

Description: Assisted Living Facility Transitions (formerly known as "Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities") is designed to assist individuals with living in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent nursing facility admissions for Members living in the community. This Community Support is intended for Members with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. For the purposes of this service definition, the term assisted living facility (ALF) includes a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF).

Community or Home Transition Services

Description: Community or Home Transition Services (formerly known as "Community Transition Services/Nursing Facility Transition to a Home") helps individuals to live in the community and avoid further institutionalization in a nursing facility. Community or Home Transition Services support Members in transitioning from a licensed nursing facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household.

Personal Care & Homemaker Services

Description: Personal Care Services and Homemaker Services (PCHS) can be provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services as similarly provided by the In-Home Supportive Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Environmental Accessibility Adaptations (Home Modifications)

Description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Medically Tailored Meals (MTMs)/Medically Supportive Food (MSF)

Description: Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs.

Sobering Centers

Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Asthma Remediation

Description: Asthma Remediation can prevent acute asthma episodes that could result in the need for emergency services and hospitalization. The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a Member, or to enable a Member to function in the home with reduced likelihood of experiencing acute asthma episodes.

Appendix 9: DHCS Community Supports Categories and Definitions

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Community Supports Services and Eligibility Criteria and Restrictions/Limitations Guide
Blue Shield of California Promise Health Plan

This guide provides information for both General (Section A) and Service-Specific (Section B) criteria for Community Supports (CS) under CalAIM, in accordance with the Department of Health Care Services (DHCS) Community Supports Policy Guide Volume 1 and Volume 2 – April 2025 and the DHCS Community Supports: Select Service Definition Updates Memo – February 2025.

A. GENERAL CRITERIA AND EXCLUSIONS

General Criteria for Community Supports (CS) Referrals:
□ Active Medi-Cal with Blue Shield Promise at the time of request for referral. □ Documentation of member's written or verbal consent for the CS referral.
General Exclusions:
□ Member is receiving a similar program and a referral for CS would be duplication of services. □ Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

B. SERVICE-SPECIFIC CRITIERA AND EXCLUSIONS

Housing Transition Navigation Services (HTNS)

Description/Overview: Housing Transition Navigation Services (HTNS) assist Members with finding, applying for, and obtaining housing. The services provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan. As such, a Member may only require a subset of the following activities.

HTNS activities include:

1. Conducting a housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and preferences, potential housing transition strengths and barriers, and identification of housing retention strengths and barriers.
2. Developing a housing support plan based upon the housing assessment.
3. Assisting in searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process. Such service can be subcontracted out to retain any needed specialized skillset.
6. Identifying and securing available resources to assist with attaining housing—such as Transitional Rent, HUD Housing Choice Voucher, and other state and local assistance programs—and matching available resources to Members.
7. Identifying and securing resources including but not limited to Housing Deposits, to cover expenses such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
8. Providing education to the Member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
9. Landlord education and engagement.
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the Member with landlords.
12. Assisting in, arranging for, and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility.

Eligibility (Population Subset):

(1) Individuals who meet the following social and clinical risk factor requirements:
   a) Social Risk Factor Requirement: Experiencing or at risk of homelessness.
   b) Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors:
      (i) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
      (ii) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
      (iii) One or more serious chronic physical health conditions;
      (iv) One or more physical, intellectual, or developmental disabilities; or
      (v) Individuals who are pregnant up through 12-months postpartum.

OR

(2) Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.

OR

(3) Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

Restrictions/Limitations:

- Services do not include the provision of Room and Board or payment of rental assistance.
- Services are not subject to the Room and Board global cap.
- Actions to be taken under HTNS must be identified as reasonable and necessary in the Member's housing support plan. Service duration can be as long as necessary and there is no limit on how many times an eligible Member may be authorized for this service.
- While it is appropriate and optimal for Members to receive HTNS prior to Housing Deposits and/or Transitional Rent, it is not a prerequisite.

Housing Deposits

Description/Overview: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household. The services and goods provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan. As such, a Member may only require a subset of these services/goods.

Housing Deposits include:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and payment in utility arrears.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality standards, or other habitability standards, as applicable, where those costs are not the responsibility of the landlord under

applicable law.
5. Application fees to cover the cost of the lease application.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal.

Eligibility (Population Subset)

(1) Individuals who meet the following social and clinical risk factor requirements:
   a) Social Risk Factor Requirement: Experiencing or at risk of homelessness.
   b) Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors:
      (i) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
      (ii) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
      (iii) One or more serious chronic physical health conditions;
      (iv) One or more physical, intellectual, or developmental disabilities; or
      (v) Individuals who are pregnant up through 12-months postpartum.

OR

(2) Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Deposits.

OR

(3) Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

Restrictions/Limitations:

- Services do not include the provision of Room and Board or payment of rental assistance.
- Services are not subject to the Room and Board global cap.
- Housing Deposits are available once per demonstration period. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. MCPs are expected to make a good faith effort to review information available to them to determine if a Member has already received Housing Deposits once within the demonstration period.
- DHCS is no longer requiring a Member to receive the Community Supports HTNS as a condition of receiving Housing Deposits. However, as has always been required, and in alignment with Transitional Rent, all Members who receive Housing Deposits are required to have a housing support plan. All services and goods related to Housing Deposits must be identified as reasonable and necessary in the Member's housing support plan. See Section V.B for additional information about the housing support plan requirements.

Housing Tenancy and Sustaining Services (HTSS)

Description/Overview: Housing Tenancy and Sustaining Services (HTSS) help a Member maintain safe and stable tenancy once housing is secured. The services provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan. As such, a Member may only require a subset of the following activities.

HTSS activities include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Providing education and training for the Member on the role, rights, and responsibilities of the tenant and landlord.
3. Providing education for the Member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
4. Coaching on developing and maintaining key relationships with landlords/property managers and/or neighbors with a goal of fostering successful tenancy.
5. Coordinating with the landlord and care/case management provider, which can be the Member's ECM Provider or non-Medi-Cal housing supportive services providers such as a CoC program case manager, to address identified issues that could impact housing stability.
6. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.
7. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
8. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain any needed specialized skillset.
9. Assistance with the annual housing recertification process.
10. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
11. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
12. Health and safety visits, including to ensure the unit remains safe and habitable.
13. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
14. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

Eligibility (Population Subset):

(1) Individuals who meet the following social and clinical risk factor requirements:
- a) Social Risk Factor Requirement: Experiencing or at risk of homelessness.
- b) Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors:
  - (i) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
  - (ii) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
  - (iii) One or more serious chronic physical health conditions;
  - (iv) One or more physical, intellectual, or developmental disabilities; or
  - (v) Individuals who are pregnant up through 12-months postpartum.

OR

(2) Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTSS.

OR

(3) Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness,

institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

Restrictions/Limitations:

- Services do not include the provision of Room and Board.
- Services are not subject to the Room and Board global cap.
- These services must be identified as reasonable and necessary in the Member's housing support plan. Service duration can be as long as necessary. There is no limit on how many times an eligible Member may be authorized for HTSS.
- Many individuals will have also received HTNS (at a minimum, the associated tenant screening, housing assessment, and housing support plan) before this service, but it is not a prerequisite for eligibility.

Day Habilitation Programs

Description/Overview: Day Habilitation Programs are designed to assist a Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The service is provided in a Member's home or an out-of-home, non-facility setting. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving ECM or other Community Supports, Day Habilitation Programs can provide a physical location for the provision of Day Habilitation services. When possible, ECM and the other Community Supports should be provided by the same entity that is providing Day Habilitation to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

Day Habilitation Program services include, but are not limited to, training on:

1. The use of public transportation.
2. Personal skills development in conflict resolution.
3. Community participation.
4. Developing and maintaining interpersonal relationships.
5. Daily living skills (cooking, cleaning, shopping, money management).
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Day Habilitation Programs may include assistance with, but not limited to, the following:

1. Selecting and moving into a home.
2. Locating and choosing suitable housemates.
3. Locating household furnishings.
4. Settling disputes with landlords.
5. Managing personal financial affairs.
6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants.
7. Dealing with and responding appropriately to governmental agencies and personnel.
8. Asserting civil and statutory rights through self-advocacy.
9. Building and maintaining interpersonal relationships, including a circle of support.
10. Coordinating with the MCP to link the Member to any Community Supports services and/or ECM.
11. Providing a referral to non-Community Supports housing resources if the Member does not meet the eligibility criteria for HTNS, Housing Deposits, HTSS, or Transitional Rent.
12. Assisting with income and benefits advocacy including General Assistance/ General Relief and SSI if the Member is not receiving these services through Community Supports or ECM.
13. Coordinating with the MCP to link the Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or ECM.

Eligibility (Population Subset): (1) Experiencing homelessness. OR (2) Exited homelessness and entered housing in the last 24 months. OR (3) At risk of homelessness or institutionalization whose housing stability could be improved through participation in a Day Habilitation Program.
Restrictions/Limitations: • Program services are available for as long as necessary. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.

Recuperative Care (Medical Respite)
Description/Overview: Recuperative Care, also referred to as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition). A stay in a Recuperative Care setting allows an individual to recover from an injury or illness while also obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing. It is for individuals who have medical needs significant enough to result in emergency department (ED) visits, hospital admissions, or other institutional care. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include: 1. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs) to the extent permitted by licensure (see below). 2. Coordination of transportation to post-discharge appointments. 3. Connection to any other ongoing services an individual may require, including mental health and substance use disorder services. 4. Support in accessing benefits and housing. 5. Gaining stability with case management relationships and programs.
Eligibility (Population Subset): Members are eligible for Recuperative Care if they meet both of the following criteria: (1) Individuals requiring recovery in order to heal from an injury or illness. AND (2) Experiencing or at risk of homelessness.

Restrictions/Limitations:

- Recuperative Care is an allowable Community Supports service if it is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions.
- Recuperative Care cannot exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six-month global cap on Room and Board services.
- Facility operators and their employed staff providing Recuperative Care that are not licensed as Community Care Facilities may not directly assist Members with ADLs or IADLs. For Members requiring ADL/IADL support in these facilities, MCPs may coordinate the concurrent delivery of Personal Care and Homemaker Services or contract with a licensed third-party provider to furnish these services.

Short-Term Post-Hospitalization Housing
Description/Overview: Short-Term Post-Hospitalization Housing provides Members who are exiting an institution and experiencing or at risk of homelessness with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting the institution. This would include recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facilities, or nursing facilities. To be eligible, an individual must have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing. The Short-Term Post-Hospitalization Housing setting must provide Members with ongoing supports necessary for recuperation and recovery, such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, receiving case management, and beginning to access other housing supports such as HTNS. Short-Term Post-Hospitalization Housing settings may include a private or shared interim housing setting, where residents receive the services described above.
Eligibility (Population Subset): Members are eligible for Short-Term Post-Hospitalization Housing if they meet all of the following criteria: (1) Individuals who are exiting an institution, which includes recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facility, or nursing facility AND (2) Experiencing or at risk of homelessness. AND (3) Meet one of the following criteria: a) Are receiving ECM; b) Have one or more serious chronic conditions; c) Have serious mental illness; or d) Are at risk of institutionalization or requiring residential services as a result of a substance use disorder. AND

(4) Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing

Restrictions/Limitations:

- Short-Term Post-Hospitalization Housing cannot exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six-month global cap on Room and Board services.

Transitional Rent
Description/Overview: Transitional Rent is the newest addition to the suite of Community Supports to support Members experiencing or at risk of homelessness covered under Medi-Cal. Transitional Rent provides up to six months of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria, as described further below. The policies governing Transitional Rent, as set forth in the following sections, are driven by three key objectives: (1) Ensure a connection to long-term housing supports, such as rental subsidies, for Members receiving Transitional Rent to provide a pathway to housing stability and prevent a return to homelessness. (2) Use the temporary housing stability afforded by Transitional Rent as an opportunity to help Members connect to needed health care services. (3) Minimize administrative barriers (without compromising program integrity), so that Members experiencing or at risk of homelessness can readily access Transitional Rent. For Members with significant behavioral health needs, achieving these aims necessitates strong partnerships between MCPs and county behavioral health agencies. The policies set forth below are also designed to support the development and success of such partnerships.
Eligibility (Population Subset): Members are eligible for Transitional Rent if they meet all of the following criteria: (1) Clinical Risk Factor Requirement: Must have one of more of the following qualifying clinical risk factors: a) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS); b) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS); c) One or more serious chronic physical health conditions; d) One or more physical, intellectual, or developmental disabilities; or e) Individuals who are pregnant up through 12-months postpartum. AND (2) Social Risk Factor Requirement: Experiencing or at risk of homelessness. AND (3) Individual must meet one of the following requirements: a) Transitioning Population Requirement: Must be included within one of the following transitioning populations; (i) Transitioning out of an institutional or congregate residential setting: Individuals transitioning out of an institutional or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment facility, an inpatient or residential mental health

facility, or nursing facility.
(ii) Transitioning out of a carceral setting: Individuals transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities.
(iii) Transitioning out of interim housing: Individuals transitioning out of transitional housing, rapid rehousing, a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing, whether funded or administered by HUD, or at the State or local level.
(iv) Transitioning out of recuperative care or short-term post-hospitalization housing: Individuals transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by Medi-Cal managed care, or another source.
(v) Transitioning out of foster care: Individuals having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.

OR

b) Experiencing unsheltered homelessness: Individuals or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

OR

c) Eligible for Full-Service Partnership (FSP): FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

Additional Details on Eligibility Criterion #3 above:

- For Transitioning Populations (i)-(iv) above: A Member must receive authorization for Transitional Rent within six months (i.e., within 182 days) of the transition event (e.g., date of discharge, date of release). For six months from the date of authorization, the Member may use the Transitional Rent benefit without a redetermination of eligibility.
- For Transitioning Population (v) above (Transitioning of Foster Care): Members transitioning out of foster care on or after their 18th birthday are eligible to receive Transitional Rent, assuming satisfaction of the other eligibility requirements, until their 26th birthday and may be authorized at any time during this window. For six months from the date of authorization, the Member may use the Transitional Rent benefit without a redetermination of eligibility.
- For individuals experiencing unsheltered homelessness: Members experiencing unsheltered homelessness, assuming satisfaction of the clinical risk factor eligibility requirement, may be authorized at any time. For six months from the date of authorization, the Member may use the Transitional Rent benefit without a redetermination of eligibility.
- For individuals who are FSP-eligible: Members eligible for FSP, assuming satisfaction of the social risk factor eligibility requirement (experiencing or at risk of homelessness), may be authorized at any time. For six months from the date of authorization, the Member may use the Transitional Rent benefit without a redetermination of eligibility

Restrictions/Limitations:

- Short-Term Post-Hospitalization Housing cannot exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six-month global cap on Room and Board services.

Respite Services
Description/Overview: Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Respite Services can include any of the following: 1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. 2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals. 3. Services that attend to the Member's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them. Home Respite Services are provided to the Member in his or her own home or another location being used as the home. Facility Respite Services are provided in an approved out-of-home location. Respite should be made available when it is useful and necessary to maintain a person in their own home and to pre-empt caregiver burnout to avoid institutional services for which the Medi-Cal MCP is responsible.
Eligibility (Population Subset): • Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. • Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program, and Members with Complex Care Needs.
Restrictions/Limitations: • In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care. • Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal MCP authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit. • This service is only to avoid placements for which the Medi-Cal MCP would be responsible. • Respite services cannot be provided virtually, or via telehealth.
Assisted Living Facility (ALF) Transitions
Description/Overview: Assisted Living Facility Transitions (formerly known as "Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities") is designed to assist individuals with living in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent nursing facility admissions for Members living in the community. This Community Support is intended for Members with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. For the purposes of this service definition, the term assisted living facility (ALF) includes a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF). This service includes two components, as follows:

Time-limited transition services and expenses to enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF. The transitional period will vary in length and services provided based on a Member's unique circumstances. Allowable expenses are those necessary to enable a person to establish ALF residence (except room and board), including, but not limited to:

a. Assessing the Member's housing needs and presenting options.
b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the ALF, so the Member can be safely and stably housed.
c. Assisting in securing an ALF residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
d. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
e. Communicating with facility administration and coordinating the move.
f. Establishing procedures and contacts to retain housing at the ALF.

Ongoing assisted living services are provided to Members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, as long as the Member can maintain residency in the ALF. These services include:

a. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
b. Meal preparation
c. Transportation
d. Medication administration and oversight
e. Companion services
f. Therapeutic social and recreational programming provided in a home-like environment
g. 24-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security
h. Care coordination services to screen for eligibility and support enrollment of Members in Enhanced Care Management (ECM) and other Community Supports

MCPs may not limit their offering of this service to only component 1 (time-limited transition services and expenses) or component 2 (ongoing assisted living services) and must offer both to the extent that they are appropriate for the Member. However, individual Members may require only one or only the other component (e.g., Members already in the ALF will require only component 2 since they are not transitioning; Members enrolled in a waiver program that covers similar wraparound services may require only component 1).

Eligibility (Population Subset):

Members residing in a nursing facility who:

1. Have resided 60+ days in a nursing facility and
2. Are willing to live in an assisted living setting as an alternative to a nursing facility; and
3. Are able to reside safely in an ALF.

Members residing in the Community who:

1. Are interested in remaining in the community; and
2. Are willing and able to reside safely in an ALF; and
3. Meet the minimum criteria to receive nursing facility LOC services14 and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.

Restrictions/Limitations:

- Room and board expenses are not included in this service. Members may receive assistance with room and board from other sources at the same time as receiving this service. Additional details on how Members can obtain assistance for payment of room and board when residing in an ALF can be found at https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx.

Community or Home Transition Services

Description/Overview: Community or Home Transition Services (formerly known as "Community Transition Services/Nursing Facility Transition to a Home") helps individuals to live in the community and avoid further institutionalization in a nursing facility.

Community or Home Transition Services support Members in transitioning from a licensed nursing facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household.

This service includes two components, as follows:

1. Time-limited transition services and expenses to enable a Member to transition from a licensed facility to a private residence or public subsidized housing. Each transitional period will vary in length and services provided based on a Member's unique circumstances. Includes services such as:
   a. Assessing the Member's housing needs and presenting options.
   b. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
   c. Communicating with the landlord (if applicable) and coordinating the move.
   d. Establishing procedures and contacts to retain housing.
   e. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
   f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.
2. Non-recurring set-up expenses are those necessary to enable a Member to establish a basic household that does not constitute room and board and include:
   a. Security deposits required to obtain a lease on an apartment or home. Security deposits should be in alignment with AB-12, 25 enacted in 2024;
   b. Set-up fees for utilities or service access and up to six months' payment in utility arrears, as necessary to secure the unit;
   c. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, and necessary repairs to meet Housing Choice Voucher program quality standards where those costs are not the responsibility of the landlord under applicable law;
   d. Air conditioner or heater;
   e. Adaptive aids designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, bedside commode, shower chair, traction, or non-skid strips, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal (e.g., State Plan, HCBS waiver, etc.).

MCPs may not limit their offering of this service to only component 1 or component 2 and must offer both to the extent that they are applicable to each Member

Eligibility (Population Subset):

Members who:

1. Are currently receiving medically necessary nursing facility Level of Care (LOC) services and in lieu of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
2. Have lived 60+ days in a nursing home and/or Recuperative Care setting; and
3. Are interested in moving back to the community; and
4. Are able to reside safely in the community with appropriate and cost-effective supports and services.

A Member can be eligible for both the California Community Transitions (CCT) program, Home & Community Based Alternatives (HCBA) Waiver, and/or the Multipurpose Senior Services Program (MSSP) and this Community Support; however, they cannot receive both at the same time. MCPs are encouraged to assist Members with enrollment in eligible and available waiver programs, as appropriate.

Restrictions/Limitations:

- Community Transition Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500.00. The transitional coordination cost is excluded from this total lifetime maximum. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence or public subsidized housing through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, without which the Member would be unable to move to the private residence or public subsidized housing and would then require continued or re-institutionalization.

A Member can be eligible for relevant waiver/demonstration programs (e.g., CCT, Home & Community Based Alternatives, etc.) and this Community Support; however, they cannot receive both at the same time if activities provided under each program are duplicative. MCPs are encouraged to assist Members with enrollment in eligible and available waiver/demonstration programs, as appropriate.

Personal Care and Homemaker Services (PCHS)

Description/Overview: Personal Care Services and Homemaker Services (PCHS) can be provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

Includes services as similarly provided by the In-Home Supportive Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

PCHS aid individuals who could otherwise not remain in their homes.

The PCHS Community Support can be utilized:

- During the IHSS application process, including during any waiting period after a referral has been made. PCHS may be authorized prior to, and up until, IHSS services are in place.
- In addition to any approved county IHSS hours when additional support is required, including when IHSS benefits are exhausted.

- For Members who are ineligible for IHSS, PCHS can be put in place to help prevent a short-term stay in a skilled nursing facility (not to exceed 60 days). In order to receive short term PCHS, Members are not required to apply for IHSS, but the authorization request should include information about the need for short term stay in a skilled nursing facility in the absence of PCHS being available.

Eligibility (Population Subset):

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services

Restrictions/Limitations:

- This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.
- If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview: Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab bars to assist Members in accessing the home
- Doorway widening for Members who require a wheelchair
- Stair lifts
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed)

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as a Community Support, the MCP must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice to show the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

The MCP must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the MCP determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
   A. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;
   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and
   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.
2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
3. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset):
Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations:

- If another State Plan service such as Durable Medical Equipment (DME), is available and would accomplish the same goals of independence and avoid institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the MCP must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

Medically Tailored Meals (MTMs)/Medically Supportive Food (MSF)

Description/Overview: Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs.

Medically Tailored Meals and Groceries: MTMs and Medically Tailored Groceries (MTGs) are covered by this service, defined as follows:

a. MTMs: Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive

health conditions.
b. MTG: Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

The provision of MTMs/MTGs must include an individual assessment of the Member's nutrition-sensitive condition and nutritional needs conducted or supervised by Registered Dietitian Nutritionist (RDN) to inform the development of a nutritional plan and connection to the appropriate MTM or MTG services.

The design of each of the MTM/MTG services (e.g., uncontrolled diabetes meal plan, congestive heart failure grocery plan) must be tailored by an RDN or other appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage, or reverse the targeted nutrition-sensitive health condition(s).

The MTM and/or MTG assistance provided (singularly or in a combination of meals and groceries) must meet at least two-thirds of the daily nutrient and energy needs of an average individual, as estimated by the RDN/clinician overseeing the design of the MTM/MTG services. "Medically tailored" interventions must be provided in specified quantities to constitute the majority of the Member's diet over the course of the intervention to have the intended impact on health outcomes. MTM/MTG must not contain ultra-processed foods nor foods with excessive sugar or salt

Medically Supportive Food (MSF): MSFs are packages of foods that adhere to national nutrition guidelines to prevent, manage, or reverse nutrition-sensitive conditions of referred Members. Unlike MTM or MTG, MSF is intended to supplement, rather than replace, all or most of the Member's diet. The design or selection of foods or food options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician. RDNs do not need to oversee the assembly of each grocery box or produce prescription, but, for example, should provide or review the nutrition parameters of the types of foods to be included or approved for the food packages for the targeted conditions. Though MSF food packages do not need to meet minimum nutrient and energy requirements, MSF Community Supports Providers should design food packages to support participants to meet minimum recommendations for fruit, vegetable, or other targeted daily servings for nutrients. MSF must not contain ultra-processed foods nor foods with excessive sugar or salt.

Terms within the category of MSF are defined as follows:
1. Medically Supportive Groceries: Preselected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients to whom they are prescribed.
2. Produce Prescriptions: Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.
3. Healthy Food Vouchers: Vouchers used to procure pre-selected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients, via retail settings such as grocery stores or farmers' markets.
4. Food Pharmacy: A model that specifically combines MSF and nutrition supports to remove barriers to healthy eating and build the knowledge and skills of participants to cook and eat foods appropriate for their nutrition-sensitive conditions. Food pharmacies are often housed within (or managed by) a health care setting, providing a patient cohort with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific chronic or serious health condition(s) that follow the federal Dietary Guidelines for Americans and meet recommendations for the targeted health condition(s). The food is typically paired with peer supports, nutrition education, counseling, and/or culinary classes to build cooking and healthy eating skills and habits.

MCPs must require and oversee that their MTM/MSF Providers produce MTM/MSF meal and food packages that follow national nutrition guidelines and that are appropriate for the nutrition-sensitive conditions identified by the MCP for MTM/MSF services. MTM/MTG and MSF service packages must be tailored or designed at the service level for the identified target chronic or serious health conditions (e.g., MSFs recommended and tailored for Members with chronic heart failure, or the Dietary Approaches to Stop Hypertension (DASH) diet for Members with hypertension who may

benefit from a low sodium diet). Meals, groceries, produce prescriptions, or nutritional intervention packages do not need to be individually customized for each Member, but must be appropriate based on evidence-based guidelines for the targeted nutrition-sensitive health conditions(s) for which the MTM/MSF service is intended to improve. MCPs and their MTM/MSF Community Support Providers must consider the cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) of each individual Member when determining the appropriate MTM/MSF intervention for the Member.

Nutrition Education: Health coaching, counseling, classes, behavioral supports, and tools, including equipment and materials, that are based on a Member's health conditions and needs. DHCS strongly encourages, but does not require, MCPs to work with their Community Supports Providers to offer behavioral, cooking, and/or nutrition education as part of this service alongside the MTM/MSF services offered. Nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support.

- Any nutrition education offered must adhere to nationally-established, evidence-based nutrition guidelines and be vetted by an RDN or other appropriate clinician. The education must be appropriate to the Member's chronic or serious health condition and the MTM/MSF intervention the Member is receiving. Nutrition education can be provided in an individual or group setting. Nutrition education classes do not need to be delivered by an RDN. The organization delivering nutrition education may be the same as the organization providing the MTM/MSF but is not required to be the same organization. An MCP may choose to provide nutrition education directly.
- Nutrition education provided as part of this service does not supplant other Medi-Cal services. MCPs are encouraged to identify and refer Members who are receiving MTM/MSF Community Support services to other Medi-Cal covered services for which they may be eligible such as Medical Nutrition Therapy and Diabetes Self-Management Education.

Eligibility (Population Subset):

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

Restrictions/Limitations:

- Service covers up to two (2) meals and/or meal packages per day using a combination of MTMs and MSF interventions.
- MTM/MSF can be authorized for up to 12 weeks and may be reauthorized thereafter if medically necessary. MCPs and their MTM/MSF providers are encouraged to check in with Members who are receiving this Community Supports at a more frequent cadence to assess whether Members are obtaining and eating the foods/meals provided through this Community Support, and whether any changes need to be made to improve the effectiveness of the MTM/MSF.
- Meals, food, payments, and nutrition services that are eligible for or reimbursed by alternate programs for the Member cannot be funded or counted by MCPs as an MTM/MSF Community Support.

Since MTM/MSF services are delivered as part of the Member's clinical care to address or mitigate nutritional needs from a chronic or serious health condition, they are not covered to respond solely to food insecurities. Given the coexistence of food and nutrition insecurity in populations afflicted by chronic and other serious health conditions, DHCS encourages screening and facilitating access to additional resources (e.g., SNAP, WIC, local food pantries) to combat food insecurity and enhance physical and mental well-being. DHCS considers food assistance benefit programs such as SNAP or WIC not to be duplicative of MTM/MSF services because both benefits are designed to mitigate food insecurity for a household, while MTM/MSF services are provided to the authorized Member as part of a clinical care plan to address their specific, eligible chronic or serious health condition(s).

Sobering Centers
Description/Overview: Sobering Centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are experiencing homelessness or those with unstable living situations, with a safe, supportive environment to become sober. Sobering Centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and, for those experiencing homelessness, care support services. • When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged. • The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate. • This service requires partnerships with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering Centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care. • The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.
Eligibility (Population Subset): Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.
Restrictions/Limitations: • This service is covered for a duration of less than 24 hours.

Asthma Remediation
Description/Overview: Asthma Remediation can prevent acute asthma episodes that could result in the need for emergency services and hospitalization. The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a Member, or to enable a Member to function in the home with reduced likelihood of experiencing acute asthma episodes. Asthma Remediation should supplement the Asthma Preventive Services (APS) Medi-Cal State Plan service. APS covers clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments that identify physical modifications to a home or supplies that would reduce the likelihood of acute asthma episodes. Effective January 1, 2026: Removal of In-Home Environmental Trigger Assessments and Asthma Self-Management Education from the Asthma Remediation Community Support DHCS launched the APS benefit in July 2022, six months after the Asthma Remediation Community Support. The CalAIM Special Terms and Conditions require that Community Supports must supplement and not supplant services received by the Medi-Cal Member through other State, local, or federally funded programs. To implement this requirement, DHCS is updating Asthma Remediation Community Support effective January 1, 2026: asthma self-management education and in-home environmental trigger assessments must be covered by MCPs under the APS benefit and will no longer be covered under this Community Support.

DHCS is providing a phase-out period for asthma self-management education and in-home environmental trigger assessments from the Asthma Remediation Community Support to allow Community Supports Providers that are not currently enrolled with the Medi-Cal program to enroll and seek reimbursement under APS. Throughout 2025, MCPs may still cover asthma self-management education and in-home environmental trigger assessments under the Asthma Remediation Community Support as long as the Member meets eligibility criteria as outlined below. Supplies and physical modifications for Asthma Remediation covered under this Community Support include, but are not limited to:

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) mechanical filtered vacuums
- Integrated Pest Management (IPM) services
- De-humidifiers
- Mechanical air filters/air cleaners
- Other moisture-controlling interventions
- Minor mold removal and remediation services
- Ventilation improvements
- Asthma-friendly cleaning products and supplies
- Other interventions identified to be medically appropriate for the management and treatment of asthma

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver. Services provided to a Member need not be carried out at the same time but may be spread over time, subject to lifetime maximums.

Eligibility (Population Subset):

- Members with a completed in-home environmental trigger assessment within the last 12 months through the Asthma Preventive Services benefit that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the Member. Effective January 1, 2026, MCPs must cover in-home environmental trigger assessments through the APS benefit, as described above.
- When authorizing physical modifications and supplies for Asthma Remediation as a Community Support, MCPs must receive and document that an assessment is completed, as outlined above. An in-home trigger assessment within the last 12 months, assuming no change in the Member's residence, provided under the APSs benefit suffices as a medical appropriateness determination for Asthma Remediation. No further documentation of medical appropriateness is required for the MCP to authorize Asthma Remediation.
- From January 1, 2025 to December 31, 2025 only, if the Member is receiving the in-home environmental trigger assessment or asthma self-management education through the Asthma Remediation Community Support, they must:
    - Have poorly controlled asthma (defined as an emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months, or a score of 19 or lower on the Asthma Control Test), or otherwise have a recommendation from a licensed health care provider (e.g., physician, nurse practitioner, or physician assistant) that the service will likely avoid asthma-related hospitalizations, emergency department visits, and/or other high-cost services.

Restrictions/Limitations:

- If another State Plan service beyond the APS, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan service should be accessed first.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- Asthma Remediation home modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the MCP must provide the owner and Member with written documentation that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers, high-efficiency particulate air (HEPA) filtered vacuum, de-humidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

Appendix 11: 2026 Actuarial Cost Model

Development of Actuarial Cost Model	
Actuarial Cost Model discloses the projected utilization rate, unit cost, and per-member per-month (pmpm) information for each type of service for Medicaid lines of business. These assumptions were developed based on actuarial projections and supplemented with Blue Shield Promise actual experience. The actual experience for each medical group will deviate from these tables. Models were developed to reflect the costs for calendar year 2026 and are inclusive of services that the IPA/Group and/or Blue Shield of California Promise Health Plan bear responsibility for. Blue Shield Promise is providing the following Actuarial Cost Model:	
Attachment 1:	Medi-Cal 2026
Source of Data	
The fee-for-service claim experience data is extracted from Blue Shield Promise Health Plan's claims database. It reflects the overall claims experience incurred for each market segment and is trended to the center date 7/1/26 for calendar year 2026.	
Actuarial Methodology	
The projected utilization rates were developed based on actual encounters for each type of service. The projected unit cost and allowed pmpm costs were developed based on actual fee-for-service incurred claims adjusted for contract scope. Appropriate trend factors were used to estimate claims for calendar year 2026. The overall pmpm was reconciled to Blue Shield Promise overall capitation paid in the years 2023 and 2024 and trended to 2026.	

Appendix 11: 2026 Actuarial Cost Model

Attachment 1

Actuarial Cost Model - Blue Shield Promise
Medi-Cal
Center Date: 07/01/2026

Service Category	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
All State-Plan Health Care Services(1)			
Inpatient Hospital	487.82	1,659.44	60.71 - 74.20
Outpatient Facility	772.33	234.57	13.59 - 16.61
Emergency Room	473.58	455.30	16.17 - 19.77
Long-Term Care	2,021.32	363.44	55.10 - 67.34
Physician Primary Care	2,256.98	81.50	13.80 - 16.86
Physician Specialty	2,706.58	196.50	39.89 - 48.75
FQHC	1,561.18	44.49	5.21 - 6.37
Other Medical Professional	1,039.29	179.96	14.03 - 17.14
Mental Health - Outpatient	332.96	136.90	3.42 - 4.18
BHT Services	1,522.25	60.81	7.33 - 8.10
Laboratory and Radiology	1,998.46	30.39	4.55 - 5.57
Transportation	1,827.45	78.59	11.37 - 12.57
CBAS	349.83	102.86	2.85 - 3.15
Hospice	209.79	305.76	5.08 - 5.61
Community Supports	100.01	161.49	1.28 - 1.41
ECM Community-Based Provider	278.68	99.88	2.20 - 2.44
HCBS Other	18.56	367.16	0.54 - 0.60
All Other	7.13	390.90	0.22 - 0.24
All State-Plan Health Care Services(1) Sub-Total:	17,964.20	189.79	$ 257.33 - $ 310.91
Total Claims/Benefit Cost			**$ 257.33 - $ 310.91**

"Disclaimers:

The information presented herein regarding cost and utilization is provided by way of example only and is based broadly on historical data in Blue Shield Promise's possession. It is not a statement of fact or opinion of what will actually occur and is not offered as an accurate predictor of the experience of any specific IPA/medical group. It is not intended to reflect the actual cost or utilization incurred by any specific IPA/medical group, does not predict the actual costs to any specific group or patient mix, and has not been risk adjusted in any way. Each IPA/medical group recognizes that its actual utilization and unit costs will likely differ from the examples given and could be higher or lower. Each IPA/medical group should not rely on this information in evaluating its own financial risk, but, rather, should review its own patient mix, utilization, and cost information as well as other available information, consult with its own financial and actuarial advisors in evaluating the information contained herein, and make its own independent business judgment in deciding to enter into the financial risk arrangements under the Agreement based on its own independent assessment."

Appendix 11: 2026 Actuarial Cost Model

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Appendix 12: Utilization Management Timeliness Standards

Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request.	Within 5 working days of receipt of all information reasonably necessary to render a decision.	Practitioner: Within 24 hours of the decision. Member: None Specified.	Practitioner: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.

Appendix 12: Utilization Management Timeliness Standards

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

Appendix 12: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the original date of receipt. **Additional information incomplete or not received** • If requested information is not received by the end of the deferral period, then Blue Shield Promise will review the request with the information originally received, decision must be made within 5 working days from the end of the deferral period, not to exceed 28 calendar days from the original date of receipt.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Practitioner: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

Appendix 12: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Expedited Authorization (Pre- Service) • Requests where provider indicates or the provider group / Health Plan determines that the standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Within 72 hours of receipt of the request.	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 3 calendar days (72 hours) of receipt of the request. Member: Within 3 calendar days (72 hours) of receipt of the request. .

Appendix 12: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the provider group / Health Plan determines that the standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • Additional clinical information required.	Additional clinical information required: Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour time frame, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. • Note: The time limit may be extended by up to 14 calendar days if the member requests an extension, or if the provider group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the member's interest. **Additional information received** If requested information is received, decision must be made within 72 hours of receipt of information. **Additional information incomplete or not received** If requested information is not received by the end of the deferral period, then Blue Shield Promise will review the request with the information originally received, decision must be made within 72 hours from the end of the deferral period.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension Member: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension Practitioner: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension Member: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension .
Concurrent review of treatment regimen already	Within 5 working days or less, consistent with urgency of member's medical condition.	Practitioner: Within 24 hours of making the decision.	Practitioner: Within 2 working days of making the decision.

Appendix 12: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
in place (i.e., inpatient, ongoing/ ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	**Note:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb or other major bodily function, or the normal time frame for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. **CA H&SC 1367.01 (h)(2)**	Member: None specified.	Member: Within 2 working days of making the decision.
Urgent Concurrent review of treatment regimen already in place (i.e., inpatient, on-going/ ambulatory services). **Optional:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 72 hours of receipt of the request.	Practitioner: Within 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions).	Member & Practitioner: Within 3 calendar days (72 hours) of receipt of the request.
Post-Service/ Retrospective	Within 30 calendar days from receipt or request.	Member & Practitioner:	Member & Practitioner: Within 30 calendar days of

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Review- All necessary information received at time of request (decision and notification are required within 30 calendar days from request).		None specified.	receipt of the request.
Hospice Urgent Inpatient Care	**Within 24 hours of receipt of request.**	Practitioner: Within 24 hours of making the decision. Member: None Specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

Appendix 12: Utilization Management Timeliness Standards

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HEDIS Measurements

Measure	Description	Criteria
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Blue Shield Promise will audit the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.	Dispensed prescription for an antibiotic medication on or 3 days after the episode date (i.e., the service date with the diagnosis of acute bronchitis/bronchiolitis). members diagnosed with acute bronchitis/bronchiolitis should not receive antibiotics.
Asthma Medication Ratio (AMR)	Blue Shield Promise will audit members that are 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	The member must have a ratio of controller medications to total asthma medications of at least 0.50.
Breast Cancer Screening (BCS-E)	Blue Shield Promise will audit members that are aged 40–74 years of age who had a mammogram to screen for breast cancer during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	The member must have at least one (1) bilateral mammogram screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
Cervical Cancer Screening (CCS-E)	Blue Shield Promise will audit members that are 21-64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer.	Members who were screened for cervical cancer screening using either of the following criteria: • Members 21-64 years of age who had cervical cytology performed within the past 3 years. • Members 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 30-64 years of age who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years.

Appendix 13: HEDIS Guidelines

Measure	Description	Criteria
Chlamydia Screening (CHL)	Blue Shield Promise will audit the percentage of members 16- 24 years of age who are recommended for routine chlamydia screening who had at least one test for chlamydia in the measurement year.	The member must have at least one (1) chlamydia test performed during the measurement year.
Colorectal Cancer Screening (COL-E)	Blue Shield Promise will audit the percentage of percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.	One or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test during the measurement year. • Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year. • Colonoscopy during the measurement year or the 9 years prior to the measurement year. • CT colonography during the measurement year or the 4 years prior to the measurement year. • Stool DNA (sDNA) with FIT test during the measurement year or the 2 years prior to the measurement year.
Appropriate Testing for Pharyngitis (CWP)	Blue Shield Promise will audit the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.	A group A streptococcus test in the seven-day period from three days prior to the Episode Date (i.e., when the member was diagnosed with pharyngitis) through three days after the Episode Date.
Pharmacotherapy Management of COPD Exacerbation (PCE)	Blue Shield Promise will audit the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.	Two Rates are reported: 1. Dispensed prescription for systemic corticosteroid (Systemic Corticosteroid Medications List) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.

Measure	Description	Criteria
		2. Dispensed prescription for bronchodilator on or 30 days after the episode date.
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Blue Shield Promise will audit the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	At least 135 days of treatment with beta-blockers (Beta-Blocker Medications List) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval. Assess for active prescriptions and include days supply that fall within the 180-day measurement interval. For members who were on beta-blockers prior to admission and those who have dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval.
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Blue Shield Promise will audit the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.	The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.
Cardiac Rehabilitation	Blue Shield Promise will audit the percentage of members 18 years and older, who attended cardiac	Initiation: At least 2 sessions of cardiac

Measure	Description	Criteria
(CRE)	rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement. Four rates are reported: • Initiation. The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event. • Engagement 1. The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event. • Engagement 2. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. • Achievement. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.	rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 30 days after the Episode Date (31 total days) (on the same or different dates of service). Engagement 1: At least 12 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 90 days after the Episode Date (91 total days) (on the same or different dates of service). Engagement 2: At least 24 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service). Achievement: At least 36 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service). Note: Count multiple cardiac rehabilitation sessions on the same date of service as multiple sessions. For example, if a member has two different codes for cardiac rehabilitation on the same date of service (or one code

Measure	Description	Criteria
		billed as two units), count this as two sessions of cardiac rehabilitation.
Childhood Immunization Status (CIS-E)	Blue Shield Promise will audit the percentage of children 2 years of age who had DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and flu vaccines by their second birthday.	The member must have the following immunizations by their second birthday: • 4 diphtheria, tetanus, and acellular pertussis (DtaP) • 4 pneumococcal conjugate (PCV) • 3 polio (IPV) • 3 Haemophilus influenza type B (HiB) • 3 Hepatitis B (HepB) • 1 measles, mumps, and rubella (MMR) • 1 chicken pox (VZV) • 1 hepatitis A (HepA) • 2 or 3 rotaviruses (RV) • 2 influenzas (flu)
Lead Screening in Children (LSC)	Blue Shield Promise will audit the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	At least one lead capillary or venous blood test on or before the child's second birthday.
Controlling Blood Pressure (CBP)	Blue Shield Promise will audit members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. Note: The most recent BP reading during the measurement year on or after the second diagnosis of hypertension is used.	Members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD)	Blue Shield Promise will audit members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: • Glycemic Status (<8.0%). • Glycemic Status (>9.0%).	Glycemic Status <8.0%: The most recent HbA1c or GMI (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review. Glycemic Status >9.0%: The most recent HbA1c or GMI (performed during the measurement year) is >9.0% as identified by laboratory

Appendix 13: HEDIS Guidelines

Measure	Description	Criteria
		data or medical record review.
Blood Pressure Control for Patients With Diabetes (BPD)	Blue Shield Promise will audit members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	The most recent BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.
Eye Exam for Patients With Diabetes (EED)	Blue Shield Promise will audit members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	Screening or monitoring for diabetic retinal disease who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
Kidney Health Evaluation for Patients With Diabetes (KED)	Blue Shield Promise will audit the percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	Members who received both an eGFR and a uACR during the measurement year on the same or different dates of service: • At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set). • At least one uACR was identified by both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates four or less days apart. For example, if the service date for the

Measure	Description	Criteria
		quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
Statin Therapy for Patients With Diabetes (SPD)	Blue Shield Promise will audit the percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who met the following criteria. Two rates are reported: 1. Received Statin Therapy. Members who have dispensed at least one statin medication of any intensity during the measurement year. 2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	Rate 1 - Received Statin Therapy: The number of members who had at least one dispensing event for a high-intensity, moderate-intensity, or low-intensity statin medication during the measurement year. Rate 2 – Statin Adherence 80%: The number of members who achieved a proportion of days covered of at least 80% during the treatment period.
Depression Screening and Follow-Up for Adolescents and Adults (DSF)	Blue Shield Promise will audit the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	The member must have had the following: • Depression Screening: The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-up on Positive Screen: The percentage of members who received follow-up care within 30 days of screening positive for depression
Immunizations for Adolescents (IMA)	Blue Shield Promise will audit members that are 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Members must have the following immunizations completed by their 13th birthday: • At least one meningococcal vaccine (MCV) on or between the member's 11th and 13th birthday • At least one tetanus,

Appendix 13: HEDIS Guidelines

Measure	Description	Criteria
		diphtheria toxoids, and acellular pertussis (Tdap) vaccine on or between the member's 10th and 13th birthday • At least two HPV vaccines with different dates of service on or between the member's 9th and 13th birthday • There must be at least 146 days between the first and second dose of the HPV vaccine. • OR at least 3 HPV vaccines with different dates of service on or between the member's 9th and 13th birthday
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Blue Shield Promise will audit the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within 300-day (10-month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: *1. Initiation Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *2. Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	Initiation Phase: Members who had a follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date (i.e., the earliest prescription dispensing date for an ADHD medication). Continuation and Maintenance Phase: Numerator compliant for rate 1 (Initiation Phase) and at least two follow-up visits on different dates of service with any practitioner, from 31-300 days after the IPSD.
Follow-Up After Hospitalization for Mental Illness (FUH)	Blue Shield Promise will audit the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after	30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge. 7-Day Follow-Up: A follow-

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

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Measure	Description	Criteria
		substance use disorder within 7 days after an episode of substance use disorder. Do not include visits that occur on the date of the denominator episode.
Follow-Up After Emergency Department Visits for Alcohol and Other Drug Abuse or Dependence (FUA)	Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. 7-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
Pharmacotherapy for Opioid Use Disorder (POD)	Blue Shield Promise will audit the percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 or more days among members aged 16 and older with a diagnosis of OUD and a new OUD pharmacotherapy event.	New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in the treatment of 8 or more consecutive days.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Blue Shield Promise will audit the percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	A glucose test or an HbA1c test performed during the measurement year.
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Blue Shield Promise will audit the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: 1. The percentage of children and adolescents on antipsychotics who received blood glucose testing. 2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.	• Blood Glucose: Members who received at least one test for blood glucose or HbA1c during the measurement year. • Cholesterol: Members who received at least one test for LDL-C or cholesterol during the measurement

Measure	Description	Criteria

	3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	year.
		• Blood Glucose and Cholesterol: Members who received both of the following during the measurement year on the same or different dates of service.
		  • At least one test for blood glucose or HbA1c
		  • At least one test for LDL-C or cholesterol

Use of Imaging Studies for Low Back Pain (LBP)	Blue Shield Promise will audit the percentage of members 18-75 years of age who had a primary diagnosis of low back pain and did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	An imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD.
Appropriate Treatment for Upper Respiratory Infection (URI)	Blue Shield Promise will audit the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.	Dispensed prescription for an antibiotic medication on or 3 days after the Episode Date (i.e., date of service with a diagnosis of URI).
Depression Remission or Response for Adolescents and Adults (DRR)	Blue Shield Promise will audit the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120-240 days (4–8 months) of the elevated score.	• Depression Follow-Up (Follow-Up PHQ-9): The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score. • Depression Remission. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score (PHQ-9 score of <5). • Depression Response. The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score (most recent PHQ-9 total score at least 50% lower than the PHQ-9 score associated with the index episode start date).

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Measure	Description	Criteria
Developmental Screening in the First Three Years of Life (DEV)	Blue Shield Promise will audit the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	A developmental screening (CPT 96110) in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.
Adults Access to Preventive/ Ambulatory Health Services (AAP)	Blue Shield Promise will audit the percentage of members 20 years and older who had an ambulatory or preventive care visit.	One or more ambulatory or preventive care visits during the measurement year.
Prenatal and Postpartum Care (PPC)	Blue Shield Promise will audit the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Women are assessed for the timeliness of prenatal care and postpartum care.	Timeliness of prenatal care: The member must have had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with a PCP or an OB/GYN. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal visit occurred and evidence of one of the following: • Documentation of pregnancy or referencing pregnancy. • A basic physical obstetrical examination that includes auscultation for fetal heart tone or pelvic exam with obstetric observations or measurement of fundus height. • Evidence that a prenatal care procedure was performed. Postpartum Care: The member must have had a postpartum visit or Pap test on or between 7 and 84 days after delivery.
Well-Child Visits in the First 30 Months of Life (W30)	Blue Shield Promise will audit the percentage of members who had the following number of well-child visits with a PCP during the last 15 months.	1. Well-Child Visits in the First 15 Months: Six or more well-child visits on different dates of service on or

Measure	Description	Criteria
	1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits. Note: Telehealth visits are no longer acceptable.	before the 15-month birthday. 2. Well-Child Visits for Age 15 Months-30 Months: Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
Child and Adolescent Well-Care Visit (WCV)	Blue Shield Promise will audit the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Note: Telehealth visits are no longer acceptable.	One or more well-care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	Blue Shield Promise will audit members that are 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and physical activity.
	
	*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
		Members that have had an outpatient visit with a PCP or OB/ GYN during the measurement year with the following documented:
		• Documentation of BMI Percentile, Height, and Weight
		• Counseling for nutrition
		  • Discussion of current nutrition behaviors
		  • A checklist indicating nutrition was addressed.
		  • Counseling or referral for nutrition education
		  • Anticipatory guidance for nutrition
		  • Weight or obesity counseling

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Measure	Description	Criteria

		• Counseling for physical activity
		  • Discussion of current physical activity behaviors
		  • A checklist indicating physical activity was addressed.
		  • Counseling or referral for physical activity.
		  • Anticipatory guidance specific to the child's physical activity
		  • Weight or obesity counseling

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	The number of members who achieved a proportion of at least 80% for their antipsychotic medications during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total (APP)	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Documentation of psychosocial care or residential behavioral health treatment in the 121-day period from 90 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.
Initiation and Engagement of Substance Use Disorder – Engagement of SUD Treatment – Total (IET)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Initiation of SUD treatment within 14 days of the SUD Episode Date. Engagement of SUD Treatment comprises of one of the following: • SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration on the day after the initiation encounter through 34

Measure	Description	Criteria
		days after the initiation event. • Long-acting SUD medication • Engagement visits and engagement medication treatment event.
Topical Fluoride for Children (TFL-CH)	The percentage of enrolled children ages 1 through 4 who received at least two fluoride varnish applications as: 1) dental or oral health services, 2) dental services, and 3) oral health services within the measurement year.	Two or more fluoride varnish applications during the measurement year, on different dates of service.
Postpartum Depression Screening and Follow Up (PDS-E)	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Numerator 1 - Depression Screening: A documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the date of delivery. Numerator 2 - Follow-Up on Positive Screen: Received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health

Measure	Description	Criteria
		encounter, including assessment, therapy, collaborative care, or medication management. • A dispensed antidepressant medication. OR • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. *Note*: For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.
Prenatal Depression Screening and Follow Up (PND-E)	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Numerator 1 - Depression Screening: A documented result for depression screening, using an age-appropriate standardized screening instrument, performed during pregnancy. Numerator 2 – Follow-Up on Positive Screen: Follow-up care on or up to 30 days after the date of the first positive screen. Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.

Measure	Description	Criteria
		• A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. • A dispensed antidepressant medication. OR • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. *Note*: For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.
Prenatal Immunization Status (PRS-E)	The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.	Numerator 1 - Immunization Status: Influenza • Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, or • Deliveries where members had

Measure	Description	Criteria
		anaphylaxis due to the influenza vaccine on or before the delivery date. Numerator 2- Immunization Status: Tdap • Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or • Deliveries where members had anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine on or before the delivery date, OR encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. Numerator 3 - Immunization Status: Combination Deliveries that met criteria for both numerator 1 and numerator 2.
Low-Risk Cesarean Delivery (LRCD)	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Patients with cesarean births.
Adult Immunization Status (AIS-E)	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, pneumococcal, and hepatitis B.	Numerator 1—Immunization Status: Influenza • Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, or • Members with anaphylaxis due to the influenza vaccine any time before or during the measurement period. Numerator 2—Immunizations Status: Td/Tdap

Measure	Description	Criteria
		• Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period, or • Members with a history of at least one of the following contraindications any time before or during the measurement period: – Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine. – Encephalitis due to the diphtheria, tetanus, or pertussis vaccine. Numerator 3— Members who received two doses of the herpes zoster recombinant vaccine or members with anaphylaxis due to the zoster vaccine Numerator 4— Members who received at least one dose of an adult pneumococcal vaccine on or after their 19th birthday, before or during the measurement period, or or members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period. Numerator 5 – Members who received Hepatitis B

Measure	Description	Criteria
		vaccine in one of the following ways: - At least 3 doses of the childhood hepatitis B vaccines with different dates of service on or before their 19th birthday, or - Hepatitis B vaccine on or after their 19th birthday, before or during the measurement period, including either at least two doses of the recommended two-dose adult hepatitis B vaccine administered at least 28 days apart; or at least three doses of any other recommended adult hepatitis B vaccine administered on different days of service. - Members who had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test, with a positive result any time before or during the measurement period. Any one of these meet criteria: 1) a test with a result great than 10 mIU/mL, or 2) a test with a finding of immunity - Members with a history of hepatitis B illness any time before or during the measurement period. Members with anaphylaxis due to the hepatitis B vaccine
Enrollment by Product Line (ENP)	Blue Shield Promise will audit the total number of members enrolled in the product line, stratified by age and gender.	
Frequency of Selected Procedures (FSP)	This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.	

Measure	Description	Criteria
Plan All-Cause Readmission (PCR)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.
Language Diversity of Membership (LDM)	Blue Shield Promise will audit an unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.	
Race/Ethnicity Diversity of Membership (RDM)	Blue Shield Promise will audit an unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.	
Number of Outpatient ED Visits per 1,000 Long Stay Resident Days (HFS)	Number of unplanned hospitalizations (including observation stays) for long-stay residents per 1,000 long-stay resident days. For this measure, long-stay resident days are all days after the resident's 100th cumulative day in the nursing home. Lower percentages are better.	
Skilled Nursing Facility Healthcare -Associated Infections (HAIs) Requiring Hospitalization (SNF HAI)	The rate of HAIs that are acquired during SNF care and result in hospitalization.	
Potentially Preventable 30-day Post-Discharge Readmission (PPR)	Readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable.	

Appendix 13: HEDIS Guidelines

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Appendix 14: Delegation Requirements for Compliance Program and IT System Security Integrity

Delegation Oversight Compliance Program and IT System Security Monitoring and Review

The Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) require that Blue Shield Promise conducts compliance oversight and monitoring of our contracted delegated entities and specialty health plans. To comply with these requirements, Blue Shield Promise's Delegation Oversight will conduct scheduled reviews of our contracted delegated entities, specialty health plans, third-party MSOs, and IPAs (collectively, "Entities") to ensure compliance with all regulatory requirements for these programs.

The Compliance Program oversight reviews will be performed annually and biannually for IT System Security. Specific to the type of review, Delegation Oversight will communicate to the entity being reviewed, via email, a compliance program or IT security systems review notice 60 days prior to the confirmed review date. The notification will include the scope of the review, documentation submission guidelines and due dates of when the documentation must be submitted.

If the requested documentation is not received, the review will be considered incomplete and will be closed as non-compliant due to audit preparedness not being met. The Entities will be required to provide a corrective action plan (CAP) noting the root cause for the non-submission of the requested documents along with a remediation plan. The Entities will also be escalated to the Blue Shield Promise Delegation Oversight Committee for being non-compliant.

For any Blue Shield Promise Contracted Delegated Entity that is a Limited/Restricted Knox Keene or Specialty Health Plan, that has contractually sub-delegated any functions, they must demonstrate their annual oversight and monitoring processes. This will include submission of implemented policies and procedures along with evidence to support the oversight and monitoring by way of an audit results, with full disclosure of the results and CAPs.

Blue Shield Promise's Delegation Oversight team will provide the entities with the written results from the monitoring within 30 business days from the first date of the review. The results will include an itemization of all reviewed program elements that were met and not met.

While a entities may contract with an MSO/IPA to manage certain functions on its behalf, the entity that holds the contract with Blue Shield Promise is responsible for the performance and compliance of the MSO/IPA. This includes all deficiencies captured during these monitoring activities.

Specific to the IT Security Systems reviews, Blue Shield Promise may conduct a walk-through of the entities operations to ensure the remediation was effective and compliant.

Appendix 14: Delegation Requirements for Compliance Program and IT System Security Integrity

Delegation Oversight Compliance Program and IT Systems Security Monitoring and Review *(cont'd.)*

Regulatory Audits

In the event of a regulatory audit, Blue Shield Promise will require the entities to participate within the regulator-specified time schedules or deadlines. Blue Shield Promise requires the entities to provide the material in the format requested in the timeframe as stipulated by the regulators. Refusal to do so will result in an escalation to Blue Shield Promise Contracting/Network Management.

Compliance Program Monitoring and Annual Review

Blue Shield Promise's Delegation Oversight Team will perform, at a minimum, an annual review on contracted entities implemented Compliance Program. The purpose of this review is to ensure that monitoring activities meet requirements and to confirm that the processes and activities related to Fraud, Waste, and Abuse comply with the standards set forth by CMS, DMHC, DHCS, OIG, DOI, and Blue Shield Promise Health Plan contractual agreements. The annual assessment will encompass (but not be limited to) the review of the following:

- Compliance Program Structure for the entire Organization
- Compliance/Code of Conduct and Fraud, Waste and Abuse Training
- Internal Controls to ensure there are no internal conflicts of interests
- Implemented Compliance Program policies and procedures
- Fraud, Waste and Abuse (FWA) Monitoring, Auditing and Reporting
- Database checks through DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS)
- (If applicable) Evidence of provider organization or limited Knox Keene oversight of sub-contractors (delegated)
    - Demonstrate oversight of all offshore and onshore sub-delegates (monitoring and annual audits) and approved and implemented policy and procedure for offshore sub-delegation

A Compliance Program review evidence submission guideline grid will be provided prior to the review and should be used as a guide for document submission guidelines as well as policy and business rules to assist with understanding the compliance element and program requirements. All requested documents from the evidence grid must be submitted to bscandphp_docpemonitoring@blueshieldca.com.

Compliance Program Monitoring and Annual Review *(cont'd)*

Corrective Action Plan (CAP) Process (if applicable)

Any deficiencies that were identified will require the entities to provide a written corrective action plan (on the Blue Shield Promise CAP template provided by the auditor), for each deficiency listed on the CAP template within 30 business days of receipt of audit results. If not, the CAP review will be closed as non-compliant, and the entities will be escalated to the Delegation Oversight Committee for being non-compliant.

The remediation plan must include the following:

- The root cause of the deficiency
- A detailed remediation plan
- A target date for completion/implementation
- Responsible person(s) for implementation and ensuring continued compliance

If the CAP is not accepted, the entities will have fifteen (15) business days to submit a second CAP response. After two (2) noncompliant CAP submissions and/or Delegation Oversight has not received a response to the CAP request, the entities will be escalated to the Delegation Oversight Committee (DOC) for recommendations.

Note: No preliminary results will be provided. The final overall review results notice will either have a met or not met score.

A follow-up review will be conducted to ensure all agreed upon remediation plans have been implemented and are effective. The review may be conducted remotely, via on-site visits, scheduled meetings, and focal audits.

IT System Security Integrity Oversight and Monitoring

This monitoring activity is designed to perform oversight of delegated entities to ensure data is secure and cannot be manipulated or breached, and that the entities has a process in place to address any fraudulent activities. Blue Shield Promise is contractually required by state and federal agencies and NCQA to conduct oversight of Delegated Entities IT systems and Disaster Recovery Plan/Strategy.

Delegation Oversight will perform an IT system security and integrity review to ensure policy and procedures regarding system changes and security of data are maintained and the entities have an effective process on security incidents and contingency plans for responding to an emergency or other occurrences that affect protection of Protective Health Information (PHI).

IT System Security Integrity Oversight and Monitoring *(cont'd.)*

The scheduled reviews are conducted on a biennial basis with possible quarterly monitoring activities. An evidence submission guideline grid will be provided prior to the review and should be used as a guide for document submission as well as policy and business rules to assist with understanding each monitored element. Entities must submit documentation/evidence up to fifteen (15) business days of the request to BSCDOITSecurityAudit@blueshieldca.com.

The assessment will encompass (but not be limited to) the review of the following:

- Operational effectiveness
- Access to programs and data access rights, role based
- Access to programs and data access control mechanisms and password complexity
- Program changes/standard change management
- Computer operations (backup, recovery, and resumption)
- HIPAA compliance and HIPAA technical safeguards
- Program changes including audit trails to identify data changes
- Access to programs and data access rights – internal controls and segregation of duty
- Access to IT privileged functions – monitoring of internal fraud and unauthorized overrides within IT system/applications
- Implemented controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud

Entities shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

- Entities 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.
- Entities shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times.
- Entities shall maintain a compliance program, and the program is independent of fiscal and administrative management. Entities shall provide a copy to Blue Shield Promise
- Entities shall ensure personnel have appropriate access to data, consistent with their job requirements.
- Entities shall ensure that any and all changes made to data contained in entities; databases are logged and audited.
- Entities shall maintain a disaster recovery plan and ensure that it is reviewed and/or updated annually. Entities shall provide a copy to Blue Shield Promise.

Blue Shield Promise recommends the following IT Security Certification, HITRUST Risk-based r2 level certification. Secondarily, Blue Shield Promise will accept SOC 2 Type I & II certification.

IT System Security Integrity Oversight and Monitoring *(cont'd.)*

Corrective Action Plan (CAP) Process (if applicable)

- If deficiencies are identified, a Corrective Action Plan (CAP) is required.
- Submission of CAP response from entities must be within 30 calendar days of the audit result letter.
- If the CAP is not accepted, the entities will have fifteen (15) business days to submit a second CAP response. After two (2) noncompliant CAP submissions and/or Delegation Oversight has not received a response to the CAP request, the entities will be escalated to the Delegation Oversight Committee (DOC) for recommendations.
- If the entities cannot effectively remediate the deficiency within a determined timeline, a Risk Acceptance Form (RAF) will be required and must be completed and submitted monthly until the deficiency is fully remediated and validated by Blue Shield Promise Health.
- If the entities fails Risk Acceptance monitoring or remediation validation the entities will be escalated to the Delegation Oversight Committee.
- If the entities refuse to allow Blue Shield Promise to perform the IT System Integrity Review. The entities will be referred to Network Management, Contracting and escalated to the Delegation Oversight Committee.

Appendix 14: Delegation Requirements for Compliance Program and IT System Security Integrity

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