blue california
Promise Health Plan

601 Potrero Grande Dr
Monterey Park, CA 91755

January 30, 2023

Subject: **Notification of April 2023 Updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medi-Cal Provider Manual.* The changes listed in the following provider manual sections are effective April 1, 2023.

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

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

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

If you have any questions regarding this notice about the revisions that will be published in the April 2023 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

UPDATES TO THE APRIL 2023
BLUE SHIELD PROMISE HEALTH PLAN MEDI-CAL MANUAL

Section 3: Benefit Plans and Programs

3.2 Managed Long-Term Services and Supports (MLTSS)

3.2.2.2: Bed Hold and Leave of Absence

Added entire section 3.2.2.2, which describes the Bed Hold policy for retaining a bed or room for a resident during the time that the resident is temporarily absent.

3.2.2.3: Continuity of Care

Added entire section 3.2.2.3, which describes the Continuity of Care policy for members residing in an SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care.

Moved Section 7.3 Enhanced Care Management to Section 3.5: Enhanced Care Management below.

3.5 Enhanced Care Management

Deleted and replaced DHCS's list of 6 mandatory ECM "populations of focus," with the following:

ECM Target Populations

The Department of Health Care Services (DHCS) has identified ten (10) mandatory ECM "populations of focus." These populations are listed below:

- Individuals Experiencing Homelessness (eligible as of January 2022)
- Individuals At Risk for Avoidable Hospital or ED Utilization (eligible as of January 2022) Adults with Serious Mental Health and/or Substance Use Disorder Needs (eligible as of January 2022)
- Individuals Transitioning from Incarceration (eligible to be referred in as of January 2022 with full roll out expected January 2024) Adults Living in the Community and At Risk for LTC Institutionalization (eligible as of January 2023)
- Adult Nursing Facility Residents Transitioning to the Community (eligible as of January 2023)
- Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition (eligible as of July 2023)
- Children and Youth Involved in Child Welfare (eligible as of July 2023)
- Individuals with Intellectual or Developmental Disabilities (I/DD) (eligible in conjunction with one or more of the above Populations of Focus as of January 2022)
- Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes (eligible in conjunction with one or more of the above Populations of Focus as of January 2022, eligible as an independent Population of Focus as of January 2024)

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 Members dually eligible for Medicare and Medicaid if they are enrolled in a Blue Shield Promise plan and otherwise meet criteria. To refer a Member to ECM, please contact ECM@blueshieldca.com for a copy of the referral form and additional details regarding eligibility and exclusion criteria.

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 7.9.23.

3.5.1: Authorization Time Frames

Added the following language, regarding timelines to make a determination:

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

Updated language concerning processing time frames for urgent referrals, in boldface type below:

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** determination informing them of the authorization decision for the requested service. Providers and Members will be sent written confirmation of the determination within two (2) calendar days.

Updated language in bullet point, in the Utilization Management Timeliness Standards (Medi-Cal Managed Care-California) chart, regarding deferring a decision on a routine (non-urgent) request, in boldface type below:

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.**

Added the following bullet point, to the Utilization Management Timeliness Standards (Medi-Cal Managed Care-California) chart, regarding timeliness of receiving requested additional information, for both Urgent and Expedited Authorization (Pre- Service) - Extension Needed requests:

Additional information incomplete or not received

- If requested information is not received by the end of the deferral period, Blue Shield Promise will review the request with/based on the information received.

3.5.3: Specialty Referrals

Added the following language to the paragraph regarding referrals to a specialist:

Out of Network requests require prior authorization.

3.6: Community Health Worker Services

Added new section describing the Community Health Worker Benefit, which is defined as preventive health services, provided by a Community Health Worker, to prevent disease, disability, and other health conditions.

3.7: Doula Services

Added new section describing the Doula Services Benefit, which is defined as preventive health services, provided by a Doula, to prevent perinatal complications and improving health outcomes for birthing parents and infants.

Section 6: Grievances, Appeals, and Disputes

6.2: Member Appeals Requests

Added the following language to the section describing the Member Appeals Process:

Appeals filed by the provider on behalf of the member require written consent from the member.

6.3: Independent Medical Review

Replaced 48 hours with 3 business days to indicate the time frame, within which the provider shall provide documents to the IMR organization, when an enrollee has applied for an IMR.

Section 7: Utilization Management

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Deleted CMC from the list of Health Plan/Lines of Business information for Authorization Logs-Approval reporting requirements.

7.1.5: UM Review Process for Appropriateness of Care

Added Pharmacy and Therapeutics (P&T) Committee Approved Criteria to the list of approved guidelines or sources that may be utilized for issuing approvals, denials, or modifications.

7.1.6: Review Criteria

Added the following language describing the review criteria that the plan is required to disclose:

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 procedures or conditions requested, please contact the UM Department at (800) 468-9935. In addition, this information can also be found on blueshieldca.com/promise/providers under *Clinical policies, procedures, and guidelines.*

Deleted the following bullet points from the list of functions and activities that comprise the Blue Shield Promise UM Program:

- Self-Referable Service
- Direct OB/GYB Access Program
- Various Linked Programs
- WIC Program Services
- Medi-Cal Waiver Program Services
- Healthy Families Mental Health
- Healthy Families Seriously Emotionally Disturbed (S.E.D.)

Added the following bullet points from the list of functions and activities that comprise the Blue Shield Promise UM Program:

- Early Periodic Screening, Diagnostic, Treatment (E.P.S.D.T.)
- Comprehensive Perinatal Services Program (C.P.S.P.)

7.2.Complex Case Management Program

7.2.2 Case Management in the Ambulatory Setting

Removed language describing the process to maintain the Case Management Database.

7.5: Authorization and Review Process

7.5.1: Authorization Time Frames

Added Standard request and ***updated*** Urgent Requests, as follows:

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

The requesting provider's office will be contacted by phone or fax **within 24 hours** of determination informing them of the authorization decision for the requested service.

7.5.3: Specialty Referrals

Added the following language:

Out-of-network requests require prior authorization.

7.6.1: Emergency Services

Updated/added language defining an Emergency Medical Conditions, Emergency Services and Care and Emergency Psychiatric Conditions.

7.6.2: Urgent/Emergent Admissions

Added the following language:

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 timeframe, 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 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.

7.7: Authorization Denials, Deferrals, and Modifications

Updated bullet point language, in boldface type, listing provisions describing how the health plan or provider will send authorization information:

- The Member will be sent written confirmation within **2 working days** of the determination.

Updated language in boldface type below, describing what's included within the denial letter to members and providers:

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).

7.8.6: Reconstructive Surgery

Added following bullet point to list of items comprising the definition of Reconstructive surgery:

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).

7.9.3: Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)

Added the following items to list of items that EPSDT screening service shall, at a minimum include:

- Blood Lead Screening
- Adverse Childhood Experiences (ACEs)

Added the following bullet point to list of medical necessity criteria that the requested EPSDT Supplemental Services must meet:

- Necessary transportation services, including medical and non-medical transportation subject to Blue Shield Promise established policies and procedures for obtaining such services.

Added contact information, as follows:

If providers have any care management questions about Behavioral Health Treatment (BHT), they can contact our BHT Program Team at (888) 297-1325, 8:30 a.m. to 5 p.m., Monday through Friday. Providers may also contact Blue Shield Promise with any questions regarding EPSDT or EPSDT Supplemental Services by calling our Provider Services dedicated number at (800) 468-9935 6 a.m. to 6:30 p.m., Monday through Friday.

7.9.8: Sensitive Services

Added following language, concerning outpatient mental health care for children 12 and older:

Outpatient Mental Health Care for children twelve (12) years of age or older, who are mature enough to participate intelligently in the mental health treatment or counseling and is one of the following:

- In danger of causing serious physical or mental harm to self or others without mental health treatment; or
- An alleged victim of incest or child abuse

7.9.10 Mental Health (Medi-Cal Managed Care)

Updated language to indicate that behavioral health services will be delivered by Blue Shield Promise's directly contracted behavioral health network effective 4/1/23.

7.9.11: Vision

Removed language stating that providers must use the Prison Industry Authority (PIA) Optical lab for all glass lens prescriptions.

7.9.14: Long Term Care (LTC)

Deleted and replaced with the following language:

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 a LTC to a general acute care hospital, and then require a return to a 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.

7.9.16: Tuberculosis

Deleted and replaced with the following language about TB Screening:

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 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. Blue Shield Promise UM Case Managers will participate in a supportive role in coordinating, referring, reporting, contacting and the assessment of needs for 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.

7.9.18: Phenylketonuria (PKU)

Added the following language describing Therapeutic Medical Food, as follows:

Medically Necessary Enteral Nutrition Products

"Therapeutic Medical Food" one that is 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.

The enteral nutrition product requested on an authorization must be on the List of Enteral Nutrition Products and the beneficiary must meet the medical criteria for the specific product, see the Medi-Cal Part 2 Pharmacy Provider Manual.

Updated the following bullet points in a list of ways decisions and appeals, regarding enteral nutrition products, can be rendered, in boldface type:

- **For members < 21: within 24 hours of request received within the UM Department with necessary information received to make a medical determination.**
- Expedited requests: within **72 hours** for services that a provider or a Plan determines that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function

7.9.19: Cancer Screening

Added the following language regarding prior authorization not being required for FDA approved 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 not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial.

7.9.23: Community Supports

Added the following bullet points in a list of Community Supports:

- Nursing Facility Transition/Diversion to Assisted Living Facilities (starting 01/2023)
- Community Transition Services/Nursing Facility Transition to a Home (starting 01/2023)

7.10: Delegated UM Reporting Requirements (IPA/Medical Groups Only)

Deleted language concerning the Managed Care Program Data (MCDP) Report.

Section 9: Quality Improvement

Removed all references to the Cal-Medi-Connect (CMC) Program, throughout Section 9, as Blue Shield Promise no longer offers the CMC Program.

9.1.3: Quality Improvement Process

Added the following language, in the paragraph, entitled, "Quality Studies (HEDIS/PIP/PDSA Focused Review Studies)," concerning the providers' requirement to participate in the quality studies process:

All network providers are required to participate in the quality studies process and must provide medical records upon request as part of this process. This includes providing medical records upon request and in the requested timeframes for the purposes of performance reporting and audits for Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS).

9.1.4: Communication of Information

Added the following bullet points to the list of Quality Improvement activities, analyses, and data:

- Comprehensive Perinatal Services Program (CPSP)
- Early Preventive Screening, Diagnostic and Treatment (EPSDT)
- Child Disability and Prevention Program (CHDP)

9.2: Quality of Care Focused Studies

Removed the following bullet point in list of sources used as standards, norms and guidelines for measuring the quality of care:

- HEDIS Medicare performance standards

9.5 Initial Health Assessment *changed to* 9.5 Initial Health Appointment

Updated language describing the features of IHA Health Appointment Services.

Added language to the "Procedures" sub-section, explaining that Blue Shield Promise collaborates with providers to offer transportation assistance to and from an IHA.

Deleted the following item from list of monitoring and oversight actions that Blue Shield Promise will conduct to ensure that newly enrolled members receive an IHA appointment:

e. Any CAP considered critical, if required, is due within 10 business days of the date of the review. A non-critical CAP is due 30 days from the date of the issued CAP report.

9.6 Facility Site Review

Added language explaining that Blue Shield Promise maintains policies and procedures that ensure the FSR Program follows the Department of Health Care Services (DHCS) All Plan Letter 22-017, or most current version.

9.6.1: FSR Evaluation

Updated a list of procedures for FSR Evaluation, in boldface type:

4. 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.
12. Blue Shield Promise **FSR unit may engage a delegated practitioner/provider's** IPA/medical group(s), to offer educational and technical assistance **should a CAP not be submitted within the established timeframes.**
13. 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.
14. Blue Shield Promise follows the DHCS FSR **standards** as written in **DHCS All Plan** Letter **22-017**, or most current version.

9.7 Medical Records

Deleted *and* ***replaced*** Medical Records Policy with the following:

9.7.1: Policy

The onsite or virtual practitioner/provider audit is a comprehensive evaluation of the 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.

Certified Site Reviewers (CSRs) are expected to determine the most appropriate method(s) in each site to ascertain 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.

Reviewers will ensure confidentiality of Protected Health Information (PHI) or Personally Identifiable Information (PII) when conducting a Medical Record Review (MRR).

See DHCS Policy Letter 14-004, Attachment B See DHCS All Plan Letter 22-017, or most current version.

9.7.2: Procedures

Deleted *and* ***replaced*** with the following Procedure items:

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.
3. Initial medical records of a new provider will be reviewed within 90 calendar days of the date the BSC PHP 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 office. BSC PHP personnel are available to assist the practitioner/provider in preparation for the review and forms can be obtained from the BSC PHP provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms.

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 BSC PHP 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.

7. Compliance levels are:

   a. Exempted Pass = 90%

   b. Conditional Pass = 80-89%

   c. Not Pass is below 79%

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.

11. If the CAP is considered non-critical, the provider or designated personnel will have no greater than 120 days from the date the CAP report was provided to complete the corrective action plan and submit it to the Facility Site Review unit at Blue Shield Promise.

14.

   b. Provide educational support and technical assistance if it is not approved as submitted, a member of the FSR team will indicate what is missing or incomplete and will request the missing information from the practitioner's office.

9.8 Access to Care

Added the following language:

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.

9.12: HEDIS Measurements

Updated HEDIS Measurements.

9.13: Credentialing Program

Updated language in the "Scope" section as follows:

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) employed in these practitioner's offices and see 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), psychologists (PhD, PsyD), qualified autism service professionals, audiologists (AU), registered dietitians and nutritionists (RD, RDN), and other practitioners authorized by law to deliver health care services and contracted by Blue Shield Promise on an independent basis.

9.13.1: Credentials Process for Directly Contracted Physicians

Updated the following language about the credentialing process, in boldface type:

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 the California Participating Physician Application (CPPA)and the Council for Affordable Quality Healthcare (CAQH) applications. **A signed and dated statement attesting to all the following need to be included the application process**.

In addition to completing an initial application, the practitioner must provide:

3. A copy of a current malpractice insurance certificate with the practitioner listed as an insured with the minimum required coverage. **For practitioners with federal tort coverage, a copy of the federal tort letter is required.**
4. A current curriculum vitae (CV) **for the previous 5 years as a health professional**. Include month and year with no gaps **or written explanation of any discrepancy or gaps greater than 6 months**.
7. Physician Supervisory Agreement (for Midlevel only **as applicable**).

Upon receipt of a completed application, Blue Shield Promise **for Behavior Health/Mental Health/Substance Abuse practitioners/providers will confirm receipt of application within 7 business days and complete review of application within 60 business days of receipt. 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 documents with signature pages are dated more than three months prior to the receipt of a completed application, the Credentialing Department will contact the applicant for the missing information. Failure to submit the information after the third attempt will be considered a voluntary withdrawal of the application.

9.13.2: Minimum Credentials Criteria

Updated the following credentialing requirements, in boldface type:

1. All applicants will meet the following minimum credentialing requirements
   x. Maintain current and valid malpractice insurance in at least a minimum coverage of $1 million per occurrence and $3 million annual aggregate (Optometrists and audiologists are required to have minimum malpractice coverage of $1 million per occurrence and $2 million annual aggregate). **For practitioners with federal tort coverage, a copy of the federal tort letter is required**.
   z. Be eligible to participate in the Medi-Cal program with no sanctions. The enrollment and screening must be verified through Medi-Cal enrollment site **or the PED approval letter**.

6. 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)**.
7. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialist (CNS) and nurse mid-wives (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.
8. Allied health professionals are required to have successfully completed the professional **degre**e/program required for their requested specialty.

9.13.2: Minimum Credentials Criteria

Updated to the following language in the paragraph entitled "Health Delivery Organizations," in boldface type:

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, freestanding surgical centers, durable medical equipment practitioners, dialysis centers, eating disorder centers, outpatient physical therapy centers, comprehensive outpatient rehabilitation centers, federally qualified health centers, 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:

- In good standing with the state and federal regulatory bodies.
- Current accreditation by a Blue Shield Promise recognized accrediting bodies.
- If the HDO is not accredited, the Blue Shield Promise facility site review, CMS or 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 for CBAS or DME's, $1 million and $2 million.**
- **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.**

9.13.3: Credentials Process for IPA/Medical Groups

Added L.A. Care guidelines to list of guidelines that IPA/medical groups who are delegated for credentialing activities are required to credential and recredential in accordance with.

Updated "Credentialing Systems Controls Oversight" section to comply with NCQA requirements.

11.1: Health Education Program

Added language in boldface type below to explain what education interventions address:

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 the Population Health Management (PHM) Strategy, including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.**

Added the following bullet point to list of goals for the Health Education (HE) Program:

- 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

11.2.1: Member Education

Deleted and replaced language about Health Education Materials, with the following:

A variety of brochures and handouts are available to providers and members at no cost on the Blue Shield Promise website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education-medi-cal. We encourage providers to give them to members at the point of service.

11.3.1: Provider's Responsibility to Health Education

Deleted language stating that Providers are responsible for implementing the Staying Healthy Assessment Tool.

11.4: IPA/Medical Group's Responsibility to Health Education *changed to* 11.5: IPA/Medical Group's Responsibility to Health Education

Deleted *and* ***replaced*** with below, which describes IPA/medical groups' responsibilities to participate in Health Education activities:

IPAs/medical groups are required to comply with the responsibilities outlined in Sections 11.1 through 11.4 and are required to 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.

11.5 Staying Healthy Assessment (SHA) Tool

Removed this section from the manual. DHCS has removed the requirement for this tool.

11.6: Tobacco Cessation Services Cessation Services *changed to* **11.4: Tobacco Cessation Services Cessation Services**

Added language describing Providers' requirement to implement tobacco-cessation interventions.

11.7.3: Wellvolution

Removed the Well-Being Programs (Designed to help generally healthy members achieve their health goals) from the list of programs offered by Wellvolution.

Added the following program to the list of programs offered by Wellvolution:

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. Our program providers include QuitSmart, and EX Program.

Section 12: Provider Services

12.2: Provider Orientations

Updated the following language concerning Provider Orientations, in boldface type:

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 ten (10) business days of placing a provider on active status. **Direct network providers must have completed training before entering provider into PHP network and/or provider directory. Training must have been conducted within the past 12 months of being added to the Medi-Cal network. If the Provider is not available for an in-person orientation, the NPO will be conducted telephonically, WebEx, or via a self-directed online module.**

12.6: Provider Network Additions (IPA/Medical Groups)

Updated the following language, concerning New Provider Orientation, in boldface type:

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.**

12.7.2: Termination Notification Requirements

Updated terminology in this section by deleting "provider" and replacing it with "IPA/medical group."

Updated the following language, concerning Termination Notification Requirements, in boldface and strikethrough type:

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 ~~directly contracted providers~~ shall send written notification for all provider withdrawals and terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the Group is notified and at a

minimum of 60 **calendar** days in advance. 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**.

Added 4. to the Termination Notification Requirements:

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

Updated terminology in this section by deleting "provider" and replacing it with "IPA/medical group."

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

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

Updated, in boldface type, the following item in the list of Culturally and Linguistically Appropriate Services (CLAS) areas that Blue Shield Promise will be responsible to include, to comply with APL22-002:

14. 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.

17.5: Translation of Member-Informing and Health Education Materials

Updated language concerning the responsibility to provide culturally and linguistically appropriate informing materials, in boldface type:

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 Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise will send the Member Handbook and Welcome Packets to LEP 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 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.

Appendices

Appendix 1: IPA Delegation Matrix *changed to* Appendix 1: Delegation of Utilization Management Responsibilities

Added the following new appendices which detail delegated responsibilities for credentialing and claims:

Appendix 2: Delegation of Credentialing Responsibilities

Appendix 3: Delegation of Claims Processing Responsibilities

Removed the following appendices from the manuals and placed these forms on the Provider Portal at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/forms.

- Appendix 2: Request for Release of Mental Health Care Information Form
- Appendix 3: Notification of Extension for Use of Mental Health Care Information Form
- Appendix 6: Health Education Referral Request Form
- Appendix 7: Health Education State Requirements for Providers
- Appendix 8: Request/Refusal for Interpretive Services Form (English)
- Appendix 9: Request/Refusal for Interpretive Services Form (Spanish)
- Appendix 10: Protocol for Requesting Interpretation Services
- Appendix 11: Cultural and Linguistically Appropriate Services Referral Request Form
- Appendix 12: Provider Request to Terminate Patient/Provider Relationship
- Appendix 17: Palliative Care Patient Eligibility Screening Tool Form
- Appendix 18: Palliative Care Program Patient Disenrollment Form

Renumbered the remaining appendices.

Appendix 4: Access to Care Standards

Updated the following cell in Attachment A in boldface type:

Type of Care and Service	Blue Shield Promise Health Plan Standard
PCP (and OB/GYN) Routine or Non-Urgent Care Appointments	Within ten **(10)** business days of the request.

Appendix 16: Delegation Oversight Claims, Compliance, IT Integrity, and Monitoring *changed to* Appendix 9: Delegation Oversight Claims, Compliance, IT System Integrity, Auditing and Monitoring

Deleted the following language:

Claims Oversight Audit Review Process

Audits and Audit Preparation

Blue Shield Promise will perform an annual audit for claims and compliance oversight which include internal controls and IT system security.

Deleted and ***replaced*** the New Network Provider Training Oversight and Monitoring section with the following:

Newly Contracted Provider Training Oversight

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 providers new provider orientation training within ten (10) business days of becoming a participating Medi-Cal provider.

Delegation Oversight performs quarterly and annual audits 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.

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 Newly Contracted Provider Training Attestation, go to the Blue Shield Promise provider website at blueshieldca.com/promise/providers and navigate to the *Forms* section. 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 the completed training.***

The Delegated Entity is also required to submit newly contracted provider annual training materials for review if there have been any updates or changes to the training material. The material must be submitted to the Blue Shield Promise Delegation Oversight Compliance Team by February 1st of the following year to BSCProviderTraining@blueshieldca.com.

As a reminder, the Delegated Entity is responsible for providing access to provider manuals, clinical protocols, evidence-based guidelines, and any other pertinent information to out-of-network providers.

Deleted and ***replaced*** the Compliance Program Oversight and Monitoring section with the following:

Compliance Program Effectiveness Oversight Audit

Delegation Oversight will perform an annual audit of the effectiveness of the Delegated Entity's Compliance Program. The audit includes the assessment of the following:

- Compliance program structure (the effectiveness of your organization's compliance program.
- Risk bearing organization (RBO) and management services organization (MSO) ownership and hours of availability
- Training material and the training your organization conducts on all employees (including temporary and contracted employees)
- Implemented policies and procedures
- FWA reporting
- Monitoring and auditing internal risks
- Organization's internal controls and organization capacity structure.

This audit will be performed either via Blue Shield Promise Delegation Oversight Compliance Team individually on an annual basis or as a shared audit through HICE (Health Industry Collaborative Effort).

The Compliance audit evidence grid will be provided by the Delegation Oversight Auditor prior to the scheduled audit date. The grid should be used as a guide for audit documentation submission guidelines and as well as policy and business rules to assist with understanding the audit history and requirements. To download a copy of the audit grid, go to the Blue Shield Promise provider website at blueshieldca.com/promise/providers and navigate to the *Forms* section. All requested documents from the evidence grid must be submitted to BSCandPHP_DOCPEAudit@blueshieldca.com. For more information on the shared audit process and joining, please visit the HICE website at iceforhealth.org/teamactivities.asp.

Appendix 20: Community Supports Criteria and Exclusion Guide *changed to* **Appendix 11: Community Supports Criteria and Exclusion Guide**

Personal Care & Homemaker Services

Added the following to Exclusion Criteria for LA County services:

Members who are IHSS ineligible can receive up to a 2 month max limit of services.

Added the following new categories that are applicable to services in both Los Angeles and San Diego counties:

- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities (available as of 1/1/2023).
- Community Transition Services/Nursing Facility Transition to a Home (available as of 1/1/2023).