blue california
Promise Health Plan

601 Potrero Grande Dr
Monterey Park, CA 91755

October 14, 2022

Subject: **Notification of January 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 January 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 January 2023 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

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

Section 3: Benefits

3.2.2.1 Accessing LTC Services

Updated language to indicate that Blue Shield Promise LTC case managers conduct telephonic and written clinical review of members in LTC facilities up to every six (6) months.

Section 4: Member Rights and Responsibilities

4.1: Member Rights and Responsibilities

Added language to indicate that Members have a right to file a grievance if they 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 they requested.

Section 6: Grievances, Appeals, and Disputes

6.4.3: Provider Disputes Policy and Procedure

Added the following language about the format to use when submitting an appeal:

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

Section 7: Utilization Management

7.3: Enhanced Care Management

Updated the list of core ECM services, as follows:

- 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

Added language on how to refer a member to ECM, as follows:

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.

Utilization Management Timeliness Standards

Added language to the chart for Routine (Non-urgent) Pre-Service - Extension Needed indicating that a decision will be made 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.**

Removed Post Service – Extension Needed from the chart. This is not a valid type of request. A decision must be made within 30 days of receipt. MCPs must approve, modify, or deny a provider's retrospective request for health care services within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

7.7: Authorization Denials, Deferrals, and Modifications

Added language in boldface type below to comply with APL 22-002 issued by the DHCS:

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).**

7.8.7 Standing Referral

Updated language in the Review and Determination section to align with DHCS regulations:

- Authorizations are only required for services identified on the Prior Authorization List or if the provider is out of network (OON);
- Determination from two (2) business days to three (3) business days; and
- Communication of decision to two (2) business days from determination.

7.9.1.2 Provider Communications

Added language below:

Blue Shield Promise CCS Nurses are responsible for informing the Member's PCP of the Member's CCS eligibility.

7.9.1.5 CCS Age Out and Transition of Care Coordination Program

Updated timeline of when Blue Shield Promise Case Managers will reach out to the Member, as follows:

At 60 days prior to 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.

7.9.2: Child Health and Disability Prevention Program (CHDP)

This section has been ***deleted and replaced*** with the following:

All Members under 21 years of age are to have access to and receive Child Health and Disability Prevention (CHDP) Program services in accordance with state and federal requirements for providing preventive services to children. The CHDP program is designed to ensure that eligible children and youth receive periodic health assessments and have access to ongoing health care.

The CHDP program adopted the American Academy of Pediatrics (AAP), Bright Futures Recommendations for Pediatric Preventive Care. The CHDP periodicity schedule is the Bright Futures/AAP Periodicity Schedule, and the CHDP program Health Assessment Guidelines (HAG) mirror the Bright Futures/AAP guidelines.

The CHDP program includes:

i. Programs providing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening, including preventive health, vision and dental screening, follow-up services and care coordination. (See Section 7.9.3: Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) for details on this program.) CHDP program providers are required to comply with state and federal laws and regulations.

ii. CHDP Gateway which serves as a presumptive eligibility entry point for children, to provide an automated pre-enrollment process, to confer and provide temporary, full-scope Medi-Cal services to CHDP-eligible children and youth for preventive, primary and specialty health care coverage. Eligibility is based on age, household composition and family income, and services are available beginning on the date eligibility is determined.

iii. Responsibility for local administration of Health Care Program for Children in Foster Care (HCPCFC) and the Childhood Lead Poisoning Prevention (CLPP) program.

The following Medi-Cal enrolled providers are eligible to participate in the CHDP program as health assessment providers if they meet CHDP enrollment requirements:

- Physicians
- Independent pediatric nurse practitioners
- Independent family nurse practitioners
- Medical groups that employ physicians who meet the requirements outlined in this section
- Health clinics that employ physicians who meet the requirements outlined in this section
- Laboratory providers

Conditions of Participation for CHDP providers include:

- Participation in the Vaccines For Children (VFC) program. To participate in the VFC program and receive VFC vaccines, a provider must agree to the program's terms and conditions and sign a VFC Provider Enrollment Form. Vaccines for the VFC program are available at no cost to the provider. Medi-Cal reimburses only an administration fee for vaccines provided through the VFC program to individuals younger than 19 years of age.
- Successful completion of a medical record review by the local CHDP program. The medical record review is performed to assess format, documentation, coordination, and continuity of care in order to ensure that children and youth receiving EPSDT/CHDP services are receiving the appropriate level of care.
- Successful completion of a facility site review to ensure each service location is safe and readily accessible to individuals with disabilities.

The provision of CHDP services is accomplished through Blue Shield Promise providers and/or local health department and school-based programs in accordance with L.A. Care's and/or Blue Shield Promise's Memoranda of Understanding (MoU).

Follow-Up on Conditions Identified During CHDP Exams

Blue Shield Promise will arrange for any medically necessary services identified through a health assessment (or episodic exam). Treatment for these conditions is to be initiated within 60 days after identified need. Medical records must contain a justification regarding the member's condition. The Primary Care Physicians will coordinate continued medical care with the CHDP office.

7.9.3: Regional Centers

Moved this section to 7.9.4.

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

Moved this section to 7.9.3 and ***deleted*** *and* ***replaced*** with the following:

All Members under 21 years of age are to have access to and receive Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) services in accordance with state and federal requirements for providing preventive services to children. The provision of EPSDT services is accomplished through Blue Shield Promise Primary Care Physicians (PCPs). EPSDT is a Medicaid benefit for individuals under the age of 21 that provides a comprehensive array of prevention, diagnostic and treatment services. EPSDT benefits are designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting.

The term 'early and periodic screening, diagnostic, and treatment services' means the following items and services:

(1) Screening Services

A. Services are provided:

i. At intervals which meet reasonable standards of medical and dental practice, as determined by the use of the current American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care, including but not limited to screening services, vision services, hearing services, and immunizations, at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions, and

B. Shall at a minimum include:

i. A comprehensive health and developmental history (including assessment of both physical and psychosocial/behavioral, and developmental disorder screening at 9th, 18th and 30th month visits).

ii. A comprehensive unclothed physical exam (including a physical examination, blood pressure before 3 years old for at risk patients, BMI, height and weight and head circumference (from newborn – 24 months), assessment of nutritional status.

iii. Administration of appropriate immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and CDC schedules.

iv. Laboratory tests appropriate to age and sex (including lead blood level assessment appropriate for age and risk factors as well as appropriate reporting and treatment

for abnormal levels, Tuberculosis (TB) risk assessments for all members and a PPD skin test and/or chest x-ray for those considered high-risk, etc.)

v. Health education (including anticipatory guidance).

(2) Vision Services

A. Services are provided:

i. At intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and

ii. At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

B. Shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental Services

A. Services are provided:

i. At intervals which meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health care, and

ii. At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

B. Shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing Services

A. Services are provided:

i. At intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and

ii. At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

B. Shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

Follow-Up on Conditions Identified During EPSDT Exams

For members under the age of 21, the EPSDT benefit also includes providing all medically necessary services, unless carved out of Blue Shield Promise contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate a defect, physical and mental illness, or condition. Treatment for these conditions is to be initiated within 60 days after identified need. Medical records must contain a justification regarding the member's condition. Primary Care Physicians (PCPs) will coordinate continued medical care and referrals to specialists.

EPSDT Supplemental Services (ESS)

EPSDT Supplemental Services (ESS) are any services a state is permitted to cover under Medicaid law that are medically necessary to correct or ameliorate a defect, physical and mental illness, or condition for a Member under the age of 21 if the service or item is not otherwise included in the state's Medi-Cal Plan.

ESS may include, but are not limited to the following:

- Case management services
- Targeted Case Management (TCM) services
- Care coordination services
- Cochlear implants
- Home nursing
- Psychology
- Occupational therapy
- Audiology
- Orthodontics
- DME (in certain instances)
- Hearing aids
- Mental health evaluation and services
- Medical nutrition services assessment and therapy
- Pharmacy
- Physical therapy evolution and services
- Pulse oximeters
- Speech therapy
- Transportation services (including non-emergency medical transportation (NEMT) and non-medical transportation (NMT) to and from medical appointments for the medically necessary EPSDT services.

Requested EPSDT Supplemental Services must meet the following medical necessity criteria:

- The services requested meet specific requirements for orthodontic dental services or 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 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.
- 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.
- Medi-Cal covers all medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This may include 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.

PCPs may contact Blue Shield Promise with any questions regarding EPSDT or EPSDT Supplemental Services.

7.9.6: Comprehensive Perinatal Services Program (CPSP)

Added the following bullet point to the Monitoring section:

- The 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. 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.

7.9.10: Mental Health (Medi-Cal Managed Care)

Role of Primary Care Physicians

Added language in boldface type below:

The Primary Care Physician is responsible for:

- Trauma screenings: **As required by the Department of Health Care Services,** PCPs **must** screen children and adults for Adverse Childhood Experiences (ACEs) which research shows are strongly associated with increased health and social risks.
- 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.

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.**

7.9.15: Alcohol and Drug

Removed the HPCPS billing codes.

8.1: Encounter Data – Medi-Cal

Added contact information for Medi-Cal Encounter Data, as follows:

If you have any other encounter submission related questions, please email EPE@blueshieldca.com.

Added the following language:

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, we 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 at: http://www.dhcs.ca.gov/dataandstats/Pages/QualityMeasurementAndReporting.aspx

COMPLIANCE GUIDELINES

Capitation/Penalties of Performance

Blue Shield Promise will provide an Encounter Performance Summary Report to the IPA/medical group on a regular basis and will use to evaluate the encounter data quality performance. Submission requirements can be found in the Blue Shield Promise Companion Guides.

Encounter submission performance goals as outlined in the Encounter Performance Summary Report are as follows:

Timeliness

Medi-Cal LA: 65% received within 30 days from the date of service
Medi-Cal SD: 65% received within 60 days from the date of service

Accuracy

A compilation of the initial monthly file submission and any subsequently corrected data for the same file name must be 95% accurate. The IPA/medical group is responsible to correct the rejections and re-submit the corrections to Blue Shield Promise within 10 days of the notice received.

Blue Shield Promise imposes a penalty on any Capitated Provider who fails to meet the timeliness and accuracy requirements, per the provider's base agreement, if applicable.

If, by the fifteenth (15th) day following the expiration of the thirty days, the encounter data has not been submitted, Blue Shield Promise shall deduct a monthly capitation as stated in the provider's base agreement, if applicable, for each month the IPA/medical group is late, inaccurate, incomplete, or otherwise non-compliant with the requirements. A corrective action

plan (CAP) will be issued to allow provider to identify steps for correction. If a CAP is not cured for three consecutive months following the issue date, or there is no substantial improvement within this time period, the Blue Shield Promise shall review notice for possible move to termination.

At the request of Blue Shield Promise, the IPA/medical group will need to provide primary source verification data upon request to support encounter data validation activities.

Additionally, when encounter data does not meet the submission requirements each month, the 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.
    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. The Capitated Provider must submit a CAP 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 person responsible for implementing the CAP.
    b. A list of specific actions to be taken to ensure that encounter data meets the submission requirements.
    c. Completion dates for each of the corrective actions.
    d. An accurate and complete encounter data file.
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 be frozen to new enrollment and to capitation deductions in accordance with the terms of the provider agreement. 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.

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

Updated the Mission Statement of the Quality Program, as follows:

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.

Deleted **and** ***replaced*** the Objectives of the Quality Program, with the following:

- Maintain NCQA Health Plan Accreditation for Medi-Cal and Cal MediConnect product lines.
- Maintain Multicultural Healthcare Distinction for Medi-Cal and prepare for transition to NCQA Health Equity Accreditation for Medi-Cal in 2023.
- Meet or exceed minimum performance levels in all DHCS Managed Care Accountability Set measures for Medi-Cal San Diego and Los Angeles.
- Improve physical and mental health outcomes.
- Ensure quality improvement program goals align with the goals and priorities of the Department of Healthcare Services (DHCS).
- Ensure mechanisms are in place to identify and address patient safety issues and foster strong relationships with providers to improve safety within practices and clinics.
- Ensure that mechanisms are in place to support, facilitate and improve continuity and coordination and transitions of care.
- Address all aspects of care; including behavioral health, non-emergency medical transportation, and Long-term Services and Supports (LTSS).
- Ensure adequate clinical resources are in place to administer the quality program, including a full-time Medical Director whose responsibility is direct involvement in the implementation of the QI activities, in accordance with Title 22 CCR Section 53857.
- Ensure members have access to all medically necessary covered services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender/gender identity, marital status, sexual orientation, health status or disability.
- Ensure there is a separation between medical and financial decision making.
- Ensure accessible health care by maintaining an adequate, qualified provider network through regular assessments of the availability of preventive and primary care, and high-volume and high-impact providers.
- Ensure that timely, medically necessary, and appropriate care and services meeting professionally recognized standards of practice are available to members with varying needs and complex conditions.
- Monitor, improve, and measure member and provider satisfaction with all aspects of the delivery system and network.
- Implement initiatives to improve member and provider experience and satisfaction.
- Ensure availability and access to care, clinical services, care coordination, and care management to vulnerable populations, including Cal MediConnect and Seniors and

Persons with Disabilities (SPD). Ensure performance of delegated vendors and providers against Blue Shield Promise standards and requirements.

- Assess and meet the standards for cultural and linguistic needs of our members.
- Ensure languages spoken by at least 5% of our membership are identified and reviewed against the languages spoken by our provider network with the goal of addressing disparities.
- Adhere to national Culturally and Linguistically Appropriate Services (CLAS) standards and NCQA Multicultural Health Care Distinction/ Healthy Equity Accreditation Standards.
- Develop and/or maintain processes to obtain and utilize race, ethnicity, and language data in the development of services and programs.
- Assess and implement process to obtain sexual orientation and gender identity (SOGI) data in the development of Health Equity services and programs while ensuring appropriate privacy protections are in place.
- Implement or improve programs and services that support the elimination of health care disparities in our membership.
- Ensure the provider network is sufficient to meet the language needs and preferences of the membership.

Added language about whom the Quality Program serves:

- 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 providers and any delegated or subcontracted providers.

9.2: Quality of Care Focused Studies

Updated the agencies to which Blue Shield Promise reports quality data to, as follows:

Blue Shield Promise annually reports to regulatory agencies on performance on 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.

9.5 Initial Health Assessment

Deleted *and* ***replaced*** the Policy, Procedure, and Provider Incentives sections to align with current processes. ***Noted*** the following:

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.

9.6 Facility Site Review

Deleted *and* ***replaced*** all of Section 9.6 Facility Site Review and 9.6 subsections with the following:

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 Department of Health Care Services ("DHCS") Policy Letter 14-004, 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). 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, as well as bordering counties. 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/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/quality-improvement.

9.6.1: FSR Evaluation

Policy

The Facility Site Review is a comprehensive evaluation of the PCP office's policies, procedures, and processes at a physical location. The reviews are conducted by a Certified Site Reviewer using the DHCS tools that have been approved by Blue Shield Promise Medical Directors. Blue Shield Promise will utilize the most current DHCS Facility Site Review tool to evaluate readiness and compliance with DHCS requirements. See DHCS Policy Letter 14-004 or most current version.

Procedure

1. An FSR will be conducted by Blue Shield Promise upon receipt of a request from Provider Network Administrators or Credentialing prior to any Primary Care Physician's site being added to the practitioner/provider network.
2. The FSR Coordinator 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.
3. 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.
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 by the FSR coordinator. If Blue Shield Promise is unsuccessful in contacting a recredentialing site, an auto-scheduled

date will be generated in order to complete the review by the required timelines.

5. 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 and the California Department of Health Care Services.
6. 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.
7. 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 score
8. Any CAP considered critical, if required, is due within 10 business days of the date of the review. A non-critical CAP for the rest of the deficiencies will be due 30 days from the date of the issued CAP report.
9. 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.
10. New Practitioners/Providers site locations may request for 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.
11. Practitioners/Providers currently in the network that are issued CAPS and do not complete applicable CAP or CAPS within the established timeframes may be referred to the Credentialing Committee 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.
12. 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 timeframes to offer education and technical assistance.
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, and the provider's members will be appropriately reassigned.

14. Blue Shield Promise follows the DHCS FSR guidelines as written in Policy Letter 14-004, or 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 Policy Letter 14-004 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

Deleted *and* ***replaced*** Section 9.7.1 Policy and 9.7.2 Procedures 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 current DHCS Medical Record Review tool to evaluate compliance with DHCS requirements.

Certified Site Reviewers (CSRs) are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife is labeled "**RN/NP/MD/PA/CNM/LM".**

Reviewers must ensure confidentiality on Protected Health Information (PHI) or Personally Identifiable Information (PII).

See DHCS Policy Letter 14-004, Attachment B or current version APL 20-006.

9.7.2: Procedures

1. Medical records shall be randomly selected using 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) pediatrics preventive criteria will be reviewed. For PCP sites where the OB-GYN providers both specialty and preventive services, based on the age of the patient,

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 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 see 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 Scoring of the medical record review will show The Certified Nurse reviewer will conduct the Medical Record Review in conjunction with the periodic Facility Review utilizing the most current approved Medical Record Review Tool.
3. If an initial Medical Record Review is required, it will be a separate on-site or virtual review from the Facility Review and only medical records will be reviewed. Medical records of a new provider within 90 calendar days of the date the MCP first assigns members to a provider. CSRs may defer review an additional 90 calendar days only 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 Department will arrange an appointment with the individual practitioner/ provider office. Blue Shield Promise personnel are available to assist the practitioner/provider in preparation for the review and forms can be obtained from Blue Shield Promise 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 Blue Shield Promise is unsuccessful in contacting a site, an auto-scheduled date will be generated in order 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. Failure 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 score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.
9. Not Applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed and must be explained in the comment section
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. The Provider or designated personnel will have 45 days from the date of the review to complete the corrective action plan and submit it to the Facility Site Review unit at Blue Shield Promise.
12. The Medical Record Review results will be maintained in the practitioner/ provider's FSR file.
13. The review results are accessed as needed by the Credentialing Department for the practitioner/provider's credentialing file.
14. When the CAP is received the review nurse will review the entire Corrective Action Plan and based on clinical knowledge and the document content will:
    a. Approve the CAP and place it in the practitioner/provider's FSR file and have a closure letter sent to the Practitioner.
    b. If it is not approved as submitted, a member of the FSR team will indicate what is missing or inappropriate and will request the missing information from the practitioner's office.
15. If the practitioner/provider's CAP is not received within the established timeframes, a 2nd request letter may be sent to the practitioner providing additional time to submit evidence.
16. If the practitioner/provider does not furnish the required documentation, a third request may be sent. An unannounced visit may occur or a tandem audit with another contracted health plan may take place.
17. If the CAP is not received per the established timeframe, the Credentialing Committee may be consulted for additional action which may include panel closure to new members, conducting annual review, and/or termination from network.
18. Focused Reviews may be requested at the discretion of the Facility Site Review unit at any time to monitor provider sites between routinely scheduled site review audits.
    a. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to established CAP timelines.

Section 9.7.3 Guidelines ***has been changed*** to 9.7.3 Medical Record Review Categories

9.7.3: Medical Record Review Categories

Added medical record criteria guidelines for format, documentation, coordination of care, pediatric preventive, adult preventive, and OB/CPSP preventive criteria. Noted medical record criteria is subject to change based on the latest DHCS review tools and standards or Blue Shield Promise discretion.

9.12: HEDIS Measurements

Added language about obtaining HEDIS resources:

Blue Shield Promise can assist Providers in improving performance on quality measures. Various tools and resources are available, including 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.

Updated HEDIS measurements to align with 2022 NCQA standards.

Section 10: Pharmacy and Medications

10.1: Pharmaceutical Utilization Management

The reviewing agency for chemotherapy and biologic agents "Thompson Micromedex DRUGDEX" ***was changed to*** "IBM Micromedex DRUGDEX."

Section 11: Health Education

11.2.1: Member Education

Added the following language:

Access to an over-the-phone interpreter service is also available for Members requiring interpretation in other languages.

Ordering Health Education Materials

Noted that Health Education materials are available to members and providers in threshold languages or alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files).

11.7.3 Wellvolution

Added Section 11.7.3 Wellvolution which describes digital and in-person whole health programs.

11.7.3: Departments in Collaboration with Health Education

Moved this section to 11.7.4.

Section 14: Claims

14.1 Claim Submission

F. Claim Filing Limits

Added Roman numeral v. below to list of situations when a claims delay is permitted:

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:

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.

14.2: Claims Processing Overview

G. Emergency Claims

Deleted the following language as it is no longer applicable.

ER level 5 are forwarded and reviewed by a physician. Physician reviewer determines whether or not service meets the requirements of emergency level 5.

14.3: Coordination of Benefits (COB)

Added the following claims procedure when dealing with members who have other health coverage (OHC):

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 remittance advice date.

14.4: Third Party Liability (TPL)

Updated language concerning the right to recover costs of benefits paid for treatment in boldface and strikethrough font below:

If the member receives a related monetary award or settlement from the third-party, third-party insurer, or from uninsured or underinsured motorist coverage, ~~the Plan, the medical group, or the IPA have~~ **DHCS has** the right to recover the cost of benefits paid for treatment of the injury or illness.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

Updated the definition of Materials in Alternative Formats as follows:

"Materials in Alternative Formats" are materials, such as health education materials and information on how to access health plan services, that 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.

Appendices

Appendix 1: IPA Delegation Matrix

Added the following delegated activity to the IPA delegation matrix:

V. Utilization Management System Controls

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting /Due Date	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
V. Utilization Management Systems Controls	☒Yes ☐ No	The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. • All staff titles or roles authorized to modify dates. o Policies and procedures state if no staff are authorized to modify dates under any circumstances. • The circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. o Date modifications. o When the date was modified. o The staff who modified the date. o Why the date was modified. 6. Describe system security controls in place to protect data from unauthorized modification. • Limiting physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware and physical records and files. o "Physical access" does not refer to the organization's building or office location. • Preventing unauthorized access and changes to system data. • Password-protecting electronic systems, including requirements to: o Use strong passwords. o Discourage staff from writing down passwords. o User IDs and passwords unique to each user. o Change passwords when requested by staff or if passwords are compromised. Note: If the organization's policies and procedures state that it follows the	At least annually, monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters	n/a	• Pre-delegation • Annual • Focus	• 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 agreed timeframe.

		National Institute of Standards and Technology guidelines, this is acceptable to describe the process for password-protecting electronic systems. • Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. At a minimum, the description includes: • The method used to monitor compliance with the organization's policies and procedures described in factors 1–6. o If the UM system does not allow date modifications under any circumstances, the description includes the functionality of the system that ensures compliance with established policy. o If the UM system allows date modifications only under specific circumstances established by policy, the description includes the process for monitoring compliance with established policy. o If the organization uses system alerts or flags to identify noncompliance, the description indicates how this process is conducted and monitored. o If the organization conducts auditing, sampling is not an allowable method. ▪ The description specifies the staff roles or department involved in the audit and the audit frequency. • The staff titles or roles responsible for oversight of the monitoring process. • The organization's process for taking actions if it identifies date modifications that do not meet its established policy, including: o A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters. o The staff roles or department responsible for the actions. o The process for documenting and reporting date modifications that do not meet its established policy. • At least annually, the organization demonstrates that it monitors compliance with its delegate UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.				

		2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. 4. Documentation indicates the staff roles or department involved in the audit. 5. The organization uses one of the following methods to audit files, if sampling it utilized: o 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. **The NCQA "8/30 methodology" available at** https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/				

Appendix 4: Access to Care Standards

Deleted *and* ***replaced*** the following cells in Attachment A:

Type of Care and Service	Blue Shield Promise Health Plan Standard
PCP (and OB/GYN) Routine or Non-Urgent Care Appointments	Within fifteen (15) business days of the request.
OB/GYN Specialty Care	Within ten (10) business days of the request.
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within ten (10) business days of the request.
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).

Appendix 14: List of Incidental Procedures for APG Payment Rate

Deleted the following procedure codes:

0290T	Laser inc for pkp/lkp recip
0356T	Insrt drug device for iop

Appendix 15: List of Office-Based Ambulatory Procedures for APG Payment Rate

Added the following procedure codes:

42975	Dise eval slp do brth flx dx
53454	Tprnl balo cntnc dev adjmt

Deleted the following procedure code:

0551T	Tprnl balo cntnc dev adjmt

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

This section has been ***deleted*** and ***replaced*** with the following:

Claims Oversight Audit Review Process

Audits and Audit Preparation

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

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

Blue Shield Promise will provide the Delegated Entity with written results within 30 days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause and remediation within 30 days of receipt of audit results or provide additional supporting documentation within time period provided by Blue Shield Promise.

Regulatory Audit

In the event DMHC requires that Blue Shield Promise conducts additional compliance oversight, Blue Shield Promise will require the Delegated Entity to participate within the regulator-specified time schedules or deadlines and 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 the Delegation Oversight Committee.

Deleted and replaced Paid and Denied Claims Timeliness with the following:

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)) and within 45 working days (CCR, Title 28, Section 1371.35 (a)) from the date of receipt of claim.

Claim processing begins when a claim is first delivered to delegated payor's office. The number of days measured are both calendar and working days. The time limit to make payment applies to all claims, without regard to whether the billing provider is contracted or non-contracted.

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

Updated Interest and Penalty language in boldface type below:

Interest and Penalty: Applies to paid claims, adjustments, and Provider Disputes (CCR Title 28 Section1300.71(i)).

Interest is applicable for contracted and non-contracted providers claims paid later than the **regulatory requirement**. Interest must be paid beginning **on the 46th working day which is** the first day after **the regulatory requirement of the 45th working day through the date the check is mailed.**

Updated **the** Provider Denial definition in boldface type below:

Provider Denial is a denial in which the provider **is liable and not the member**. These are separate from contested claims. A Delegated Entity may deny a claim or portion thereof, by notifying the provider, in writing, that the claim is denied within forty-five (45) working days after the date of receipt. (CCR Title 28 Section 1300.71 (d) and (h)).

New Network Provider Training Oversight and Monitoring

Updated language to include information on when and where to submit evidence of new provider orientation training, as follows:

On a quarterly basis (the 15th day of the month post quarter end), the delegated entity will submit a universe for the prior quarter's Newly Contracted Providers and a signed attestation from each provider demonstrating completion of training. Training and annual updates to materials are due by February 1st each year. Any questions related to this audit can be submitted to BSCProviderTraining@blueshieldca.com.

Compliance Program Oversight and Monitoring

Added language to include reporting requirements:

Please visit the HICE website for an approved evidence grid that is needed for submitting documentation as part of audit as well as policy and business rules to assist with understanding the audit history and requirements.

IT System Integrity Oversight and Monitoring

Added language to include reporting requirements:

Please visit the HICE website for an approved evidence grid that is needed for submitting documentation as part of audit as well as policy and business rules to assist with understanding the audit history and requirements.

Updated Claims Delegate Reporting Instructions section to include instructions on how to submit reports, report naming conventions, submission schedules and sample reports.

Added the following new appendix which details the projected utilization rate, unit cost, and per-member per-month (pmpm) information for each type of service for the Medi-Cal line of business.

Appendix 21: 2023 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 2023 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 2023
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 7/1/23 for calendar year 2023.	
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 2023. The overall pmpm was reconciled to Blue Shield overall capitation paid in the first half of the year 2021 and trended to 2023.	

Attachment 1

Actuarial Cost Model - Blue Shield Promise
Medi-Cal
Center Date: 07/01/2023

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	491.98	1,560.21	57.57 - 70.36
Outpatient Facility	484.18	439.62	15.96 - 19.51
Emergency Room	369.53	454.18	12.59 - 15.38
Long-Term Care	2,203.46	272.93	45.10 - 55.13
Physician Primary Care	2,290.83	76.47	13.14 - 16.06
Physician Specialty	3,218.14	105.99	25.58 - 31.27
FQHC	875.89	55.00	3.61 - 4.42
Other Medical Professional	977.26	155.94	11.43 - 13.97
Mental Health - Outpatient	303.17	108.10	2.46 - 3.00
BHT Services	1,145.12	48.71	4.42 - 4.88
Pharmacy	-	-	- - -
Laboratory and Radiology	857.59	44.55	2.87 - 3.50
Transportation	986.13	78.40	6.12 - 6.76
CBAS	895.47	70.13	4.97 - 5.49
Hospice	550.65	92.04	4.01 - 4.43
MSSP	-	-	- - -
IHSS	-	-	- - -
HCBS Other	20.27	659.84	1.06 - 1.17
All Other	7.39	175.94	0.10 - 0.11
All State-Plan Health Care Services(1) Sub-Total:	15,677.07	$ 178.53	$ 211.00 - $ 255.46
Total Claims/Benefit Cost			**$ 211.00 - $ 255.46**

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