Medi-Cal Provider Manual

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Welcome

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

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

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

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

Blue Shield of California Promise Health Plan

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

Medi-Cal

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

Section 1: Introduction

Regulatory Agencies

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

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

Regulatory Requirements for Network Providers

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

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

Mission

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

Section 2: Mission Statement

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3.1: Covered Benefits

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

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

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

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

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

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

MLTSS programs include:

3.2.1: Community-Based Adult Services (CBAS)

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

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

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

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

3.2.1.1: Accessing CBAS

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

3.2.1.2: CBAS Emergency Remote Service (ERS)

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

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

1. Short-term: members may receive ERS for an emergency occurrence for up to three consecutive months. CBAS providers and Blue Shield Promise will coordinate to ensure duration of ERS is appropriate during the member's current authorized period and, as necessary, for reauthorization into a new period;
2. Beyond Three Consecutive Months: ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. CBAS providers and Blue Shield Promise will coordinate on requests for authorization of ERS that exceed three consecutive months. Participants may need and/or be appropriate for ERS beyond three months.

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

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

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

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

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

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

3.2.2: Long-Term Care (LTC)

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

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

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

3.2.2.1: Accessing LTC Services

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

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

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

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

3.2.2.2: Bed Hold and Leave of Absence

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

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

The following requirements shall be met:

1. Acute hospitalization for the beneficiary shall be ordered by the attending physician.
2. The facility shall hold a bed vacant during the entire bed hold period except when notified, in writing by the attending physician that the patient requires more than seven days of hospitalization. If so notified, the facility is no longer required to hold the bed available and shall not bill Medi-Cal for any remaining days of bed hold.
3. The day of departure shall be counted as one day of bed hold and the day of return shall be counted as one day of inpatient care.
4. Bed hold shall be terminated and payment shall not be made on the day of death of the beneficiary.
5. Facility claims shall identify the inclusive dates of bed hold.
6. The beneficiary's records maintained in the facility shall show the name and address of the acute care hospital to which the beneficiary has been admitted.

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

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

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

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

Leave of absence may be approved for:

- A visit with relatives or friends.
- Participation by developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries in an organized summer camp for developmentally disabled persons.

All of the following requirements shall be met:

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

The facility shall hold the bed vacant during leave.

- The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.

- Leave shall be terminated on the day of the death of the patient. Leave shall be terminated if the patient is admitted as an inpatient to any other facility, or if the patient exceeds the approved period of leave of absence and is determined to be absent without leave.

- Failure to return from leave of absence within the approved period shall not invalidate an approved treatment authorization request. There shall be no requirement to file a new treatment authorization request if the patient fails to return from leave within the approved period.

- The patient's records maintained in the skilled nursing facility, intermediate care facility, intermediate care facility for the developmentally disabled, intermediate care facility for the developmentally disabled habilitative, or intermediate care facility for the developmentally disabled-nursing shall show the address of the intended leave destination and the inclusive dates of leave.

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

3.2.2.3: Continuity of Care

Effective January 1, 2023, and through July 1, 2023, for members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, Blue Shield Promise will automatically provide 12 months of continuity of care for the SNF placement. Automatic continuity of care means that if the member is currently residing in a SNF, they do not have to request continuity of care to continue to reside in that SNF. While members must meet medical necessity criteria for SNF services, continuity of care must be automatically applied.

Following their initial 12-month automatic continuity of care period, members may request an additional 12 months of continuity of care, following the process established by APL 18-008, Continuity of Care for Medi-Cal members Who Transition into Medi-Cal Managed Care, or any superseding APL.

A member newly enrolling into Blue Shield Promise and are residing in a SNF after June 30, 2023, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 18-008, or any superseding APL. MCPs must notify the member or their authorized representative and furnish a copy of the notification to the SNF in which the member resides, of the member's right to request continuity of care, consistent with APL 18-008, or any superseding APL.

3.2.2.4: Long-Term Services and Supports Liaison

- Blue Shield Promise will identify an individual or set of individuals as part of their Provider Relations or related functions to serve as the liaison for LTSS Providers
- Blue Shield Promise Liaisons are trained on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, Provider resolutions policies and procedures, and care management, coordination and transition policies.
- Blue Shield Promise LTSS liaisons will assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support members' needs.
- LTSS liaisons do not have to be clinical licensed professionals, they may be fulfilled with non-licensed staff. Blue Shield Promise will identify these individuals and disseminate their contact information to relevant Network Providers, including SNFs that are within Network.

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

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

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

3.3: Long-Term Services and Supports (LTSS)

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

LTSS programs include:

3.3.1: In-Home Supportive Services (IHSS)

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

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

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

3.3.1: In-Home Supportive Services (IHSS)*(cont'd.)*

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

3.3.1.1: Accessing IHSS

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

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

Physicians may refer members to the appropriate IHSS hotline based on the member's county of residence; Los Angeles County IHSS Application Hotline at (888) 944-4477, San Diego County at (800) 339-4661, Blue Shield Promise Social Services Department at (877) 221-0208, or by completing and submitting the Blue Shield Promise Social Services Referral Form which can be accessed on the Blue Shield Promise provider website in the *Forms* section. Physicians will also need to complete the required IHSS forms and provide members with other documentation to support their need for IHSS.

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

3.3.2: Multipurpose Senior Services Program (MSSP)

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

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

3.3.2.1: Accessing MSSP Services

A physician who believes a member might benefit from MSSP services can refer the member directly to the MSSP site serving the member's area or can refer to the Blue Shield Promise Social Services Department at (877) 221-0208 or by completing and submitting the Blue Shield Promise Social Services Referral Form.

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

San Diego County MSSP site:
Aging & Independence Services

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

3.4: Home-Based Palliative Care Program

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

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

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

Member Eligibility

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

- Advanced medical conditions such as congestive heart failure, chronic obstructive pulmonary disease, liver disease, and advanced cancer.
- Children with serious medical conditions.
- The member has started to need visits to the emergency department and hospitalizations.

Member Referral

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

- Blue Shield runs a monthly report to identify members that may qualify for palliative care services. The report algorithm is aligned with the general and disease-specific eligibility criteria.
- Blue Shield Promise members can self-refer to the Program by contacting Blue Shield Promise Customer Care at (800) 605-2556.
- PCPs and Specialists can refer members for a full Palliative Care Program Evaluation by completing the Palliative Care Patient Eligibility Screening Tool form. The form can be found on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers in the *Forms* section, then *Other patient care forms*. Submit the completed form to Blue Shield Promise by fax at (323) 889-2109 or secure email at bscphp_palliativecare@blueshieldca.com.

The monthly report, all Program-related calls, and physician referrals are transferred to a designated Blue Shield RN Clinical Program Manager.

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

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

Evaluation of Eligibility and Enrollment

Upon receiving a palliative care referral, Blue Shield Promise will review to confirm member eligibility for the benefit. A Blue Shield Promise contracted palliative care provider will outreach to the member to offer palliative care services. Upon the members acceptance to participate in the palliative care program, the palliative care agency will initiate the start of services and coordinate with Blue Shield Promise as appropriate.

Member Disenrollment

To ensure Blue Shield Promise has an accurate list of members enrolled in the Program, providers must notify Blue Shield Promise within 15 business days of a member's disenrollment from the Program. The provider will send an email notification to bscphp_palliativecare@blueshieldca.com, notifying Blue Shield of the reason for disenrollment as well as the effective disenrollment date. A member may be disenrolled for several reasons, including member's condition improving, member declining services or member enrolling in hospice services.

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

3.4.2: Covered Services

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

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

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

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

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

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

3.5: Enhanced Care Management

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

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

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

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

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

ECM Target Populations

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

January 2022

- Adults and their Families Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (formerly "High Utilizers")
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Individuals Transitioning from Incarceration (post release services)
- Adults with Intellectual or Developmental Disabilities (I/DD)[1]
- Pregnant or Postpartum Adults[2]

January 2023

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

July 2023

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

January 2024

- Pregnant and Postpartum Individuals (Adults & Youth) At Risk for Adverse Perinatal Outcomes
- Individuals Transitioning from Incarceration (pre-release services)

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

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

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

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

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

For more information regarding eligibility or to refer a member to ECM, please contact ECM@blueshieldca.com.

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.

Submission of Encounter Data for Enhanced Care Management

Providers of Enhanced Care Management (ECM) services must submit encounters on the CareConnect platform in order to be reimbursed for such services. To access CareConnect, log in to Provider Connect, then click *Guidelines & Resources*, then scroll down to *Patient Care Resources* then click on the *Enhanced Care Management (ECM)* blue box.

To submit an encounter, navigate to the member record and open the contact log. Ensure that required fields are completed and select the appropriate HCPC from the available options.

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

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

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

Section 3.6: Community Health Worker

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

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

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

Section 3.6: Community Health Worker *(cont'd.)*

CHW Provider Requirements and Qualifications

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

Supervising providers (the organizations employing or otherwise overseeing the CHWs with which Blue Shield Promise contracts, as described below) are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising providers must maintain evidence of this experience.
CHWs must demonstrate, and supervising providers must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the supervising provider:

- **Certificate Pathway**: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
    - **CHW Certificate**: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the supervising provider. 6 Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services.
    - **Violence Prevention Professional Certificate**: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. 7,8 A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

Section 3.6: Community Health Worker *(cont'd.)*

- **Work Experience Pathway**: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the supervising provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Blue Shield Promise member. CHWs must complete a minimum of six hours of additional relevant training annually. The supervising provider must maintain evidence of this training. Supervising providers may provide and/or require additional training, as identified by the supervising provider.

Supervising Provider Requirements and Qualifications

A Supervising provider is the organization employing or otherwise overseeing the CHW, with which Blue Shield Promise contracts. The supervising provider ensures that CHWs meet the qualifications listed below, oversees CHWs and the services delivered to Blue Shield Promise members, and submits claims for services provided by CHWs. The supervising provider must be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

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

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

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

Section 3.6: Community Health Worker *(cont'd.)*

Member Eligibility Criteria for CHW Services

CHW services require a written recommendation submitted to Blue Shield Promise. Written recommendations will be sent to Blue Shield Promise Social Service Department via fax at (844) 742-1152 by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Claims and Billing

Please note that while a recommendation for CHWs services is required to be submitted to Blue Shield Promise, Blue Shield Promise does not require prior authorization for CHW services as preventive services for the first 12 units in a 12-month period. For members that need additional CHW units, the recommending provider must submit a Treatment Authorization Request (TAR).

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

Provider Referrals

The recommending licensed provider must ensure that a Blue Shield Promise member meets eligibility criteria before recommending CHW services. CHW services are considered medically necessary for Blue Shield Promise members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

Section 3.6: Community Health Worker *(cont'd.)*

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

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department (ED) within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

Documentation Requirements

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

Section 3.6: Community Health Worker *(cont'd.)*

Prior Authorization

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

Plan of Care

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

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

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

3.7: Doula Services

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

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

Description of Doula Services

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

Doulas are not licensed or clinical providers, and they do not require supervision.

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

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

Doula Qualifications

All doulas must be at least 18 years old, possess an adult/infant CPR certification, and have completed basic HIPAA training.

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

Training Pathway:

- Complete a minimum of 16 hours of training in the following areas:
  - Lactation support
  - Childbirth education
  - Foundations on anatomy of pregnancy and childbirth
  - Nonmedical comfort measures, prenatal support, and labor support techniques
  - Developing a community resource list
- Provide support at a minimum of three births

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

Experience Pathway:

- Or all of the following:
  - At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
- Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization, or an enrolled doula.

Doulas must complete three hours of continuing education in maternal, perinatal and/or infant care every three years. Doulas shall maintain evidence of completed training to be made available to DHCS upon request.

Covered Services

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

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

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

An initial recommendation for doula services includes the following authorizations:

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

The extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation.

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

Documentation Requirements

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

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

The initial recommendation can be provided through the following methods:

- Written recommendation in member's record.
- Standing order for doula services by MCP, physician group, or other group by a licensed provider.
- Standard form signed by a physician or other licensed practitioner that a member can provide to the doula.

A second recommendation is required for additional visits during the postpartum period. A recommendation for additional visits during the postpartum period cannot be established by standing order. The additional recommendation authorizes nine or fewer additional postpartum visits.

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

Member Eligibility Criteria for Doula Services

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

Place of Service

There are no Place of Service restrictions for doula services.

Billing Codes and Doula Transaction Log Submission

Doulas should refer to DHCS Medi-Cal Provider Manual for Doula Services for specific billing codes to be used for each covered services and should refer to the Blue Shield Promise Doula Resource Guide for instructions on how to complete the Doula Transaction Log for reimbursement.

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

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

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

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

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

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

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

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

3.8: Annual Cognitive Health Assessment

In accordance with APL 22-025, Blue Shield Promise provides coverage for annual cognitive health assessments for members who are 65 years of age or older and who do not have Medicare coverage.

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

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

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

Providers must use at least one of the required cognitive assessment tools:

- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog
- Eight-item Informant Interview to Differentiate Aging and Dementia
- Short Informant Questionnaire on Cognitive Decline in the Elderly

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

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

Please refer to Section 14.2 for additional claims impacts.

4.1: Member Rights and Responsibilities

Purpose

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

Policy

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

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

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

Member Rights and Responsibilities

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

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

You have the right to be treated well.

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

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

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

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

You have the right to get a range of services.

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

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

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

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

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

What are your responsibilities as a health care member?

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

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

We want you to understand your health plan.

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

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5.1: Eligibility

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

5.2: Member Enrollment

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

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

5.3: Member Health Plan Selection

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

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

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

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

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

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

5.4: Coverage

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

5.5: Newborn Coverage

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

5.6: Change of Primary Care Physician

5.6.1: Member Initiated Change

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

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

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

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

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

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

5.6.2: Primary Care Physician Initiated Change

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

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

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

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

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

5.7: Eligibility List

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

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

5.8: Eligibility Verification

Member eligibility should be verified from the Eligibility Roster at each visit. Should you have any questions about a member's eligibility, please call the Blue Shield Promise Provider Customer Service at (800) 468-9935.

Eligibility Status (Class) Codes

01 = Eligible Member - Capitation paid

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

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

00 = Member Voluntarily Disenrolled - No Capitation paid

99 = Disenrolled Member - No Capitation paid

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

5.9: Identification Cards

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

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

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

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

5.10: Disenrollment

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

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

5.11: Plan Initiated Disenrollment

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

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

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

Reasonable efforts should be made to:

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

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

5.12: Transportation

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

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

5.12: Transportation *(cont'd.)*

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

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

Related Travel Expenses

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

5.13: Translation Services/California Relay Services

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

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

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6.1: Member Grievances

Purpose

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

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

Procedure

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

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

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

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

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

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

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

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

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

Expedited Grievance

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

6.2: Member Appeals Requests

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

Providers and IPA/medical groups are required to provide medical records, authorizations and/or responses within 3 calendar days of the request for non-urgent cases in order to resolve the issue within the regulatory timelines.

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

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

Examples of Appeals are:

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

Appeals can be:

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

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

Standard – Resolved in 30 calendar days.

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

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

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

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

6.2.1: Expedited Appeal

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

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

6.2.1: Expedited Appeal *(cont'd.)*

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

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

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

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

6.3: Independent Medical Review

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

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

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

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

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

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

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

Independent Medical Review for Experimental/Investigational Procedures

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

Members That Qualify to Request the Experimental & Investigational Review Process

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

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

   "Seriously debilitating" Is defined as diseases or conditions that cause major irreversible morbidity, i.e., there is an imminent and serious threat to the health of the member including severe pain, the potential loss of limb, or major bodily function.
2. The member's physician certifies that the member has a condition, as defined in Criteria 1 (above), for which standard therapies have not been effective in improving the condition of the member, or for which standard therapies would not be medically appropriate for the member, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to Criteria 3 (below); and
3. Either (a) the member's physician, who is under contract with or employed by Blue Shield Promise, has recommended a drug , device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies; or (b) the member, or member's physician who is a licensed board-certified or board- eligible physician qualified to practice in the area of practice appropriate to treat the member 's condition, has requested a therapy that, based on two (2) document s which meet the definition of " medical and scientific evidence" as defined by Health and Safety Code 1370.4 subsection d, is more likely to be more beneficial for the member than any available standard therapy; and

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

4. The member has been denied coverage by Blue Shield Promise for a drug, device, procedure, or other therapy recommended or requested.
5. The specific drug, device, procedure, or other therapy recommended would be a covered service, except for a Blue Shield Promise determination that the therapy is experimental or investigational.

Criteria Determining Experimental/Investigational Status

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

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

6.4: Provider Disputes – Claims Processing

Purpose

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

6.4.1: Provider Questions, Concerns, and Disputes

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

All provider payment related issues should be directed to the Provider Dispute Resolution (PDR) Department in writing. Examples of a payment related dispute are non-payment or underpayment of claims by IPA/medical groups. All payment disputes are entered in the PDR database, investigated and a response will be provided in writing within the regulatory timeframe.

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

6.4.1: Provider Questions, Concerns, and Disputes *(cont'd.)*

Disputes are acknowledged within 15 working days and a resolution letter will be sent within 45 working days. Payment can take up to 5 days after the closure of the case.

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

6.4.2: Reconsiderations

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

6.4.3: Provider Disputes Policy and Procedure

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

All written, formal disputes will be responded to in writing. Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within fifteen working days of receiving the written dispute.

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

6.4.4: First Level Dispute

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

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

6.4.4: First Level Dispute *(cont'd.)*

1. The Provider shall be notified of receipt of written dispute within 15 working days and a final determination will be made within 45 working days from the date that Blue Shield Promise received the dispute.
2. All records shall be evaluated by the appropriate Plan personnel who will render a decision. The Blue Shield Promise Provider Dispute Department shall send a written determination letter outlining its conclusions with background information within 45 working days of receipt of the dispute. Language in the letter will include any available next steps the provider can take with the dispute.

6.4.5: Second Level Dispute - L.A. County

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

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

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

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

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

6.4.6: Second Level Dispute - All Other Counties

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

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

7.1: Utilization Management Program

Mission Statement

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

Purpose

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

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

Goals

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

7.1.1: Physician, Member, and Provider Responsibilities

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

Additional activities and responsibilities include:

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

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

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

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

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Weekly Reporting Requirements Authorization Logs-Approval/Denial Data File Requirements for IPA/Medical Groups Only

Approval/denial data files ("Authorization Logs") must be delivered via secure email or SFTP (Secure File Transfer Protocol) file to Blue Shield Promise. To initiate the delivery of authorization logs by means of a SFTP or to obtain the Blue Shield Promise standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com.

Authorization logs must be sent, at minimum, on a weekly basis in order to ensure timely data processing. IPA/medical group approvals, denials and partial denials should be delivered together on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing such as an Excel spreadsheet or delimited fixed width file. Any data file which does not comply with the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield Promise, and returned to the IPA/medical group for correction and resubmission.

Only shared-risk services for which the IPA/medical group is delegated to perform UM and Blue Shield Promise is responsible for claim adjudication are required on the data file.

Incomplete or inaccurate information may negatively impact claim processing. Please help expedite the processing of authorization/denial files by providing the following required information for each record submitted:

- Subscriber ID Number
- Patient Last Name
- Patient First Name
- Patient Date of Birth (mm/dd/yyyy)
- Health Plan/Line of Business (Medi-Cal, Medicare Advantage or Commercial)
- Request Type (Inpatient, Service or Medication)

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

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

- Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility)
- Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.)
- First date of service or Admit date (mm/dd/yyyy)
- Last date of service or Discharge date (mm/dd/yyyy)
- Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable
- Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 9 additional codes, if applicable
- Units: Number of procedures, treatments, days, sessions, or visits
- Servicing Provider Name
- Servicing Provider NPI (National Provider Identifier)
- Facility Name (if applicable)
- Facility NPI (if applicable)
- Requesting Provider Name
- Requesting Provider NPI
- Authorization or Decision Reference Number
- Blue Shield Promise IPA/medical group Identification Number (i.e., IPxxxxxxxxxx) – (It is highly recommended to include your Blue Shield Promise PIN (Provider Identification Number) # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Promise Provider Relations representative.)
- Receipt Request Date (date provider requested authorization from IPA/medical group)
- Decision (Approved, denied, partially denied or void)
- Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.)
- Decision Date (mm/dd/yyyy)
- Discharge Diagnosis (if applicable)
- Discharge Status (i.e., To Home, SNF, if applicable)

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

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

Monthly Reporting Requirements

The following monthly reports are due to Blue Shield Promise by the 15th of the month following the month in which services were rendered or denials made:

Second Opinion Tracking Log – Include all authorizations, modifications, and denial information for second opinion requests. The log must include the reason the second opinion was requested.

Linked Services Log – Include member name, PCP name, diagnosis, and intervention.

ESRD Log – Include authorization number and category; member name, DOB, member ID; PCP, ICD10, CPT and description; requesting provider; referred provider and specialty; place of service and quantity; request type and date, decision, and decision date.

Organ Transplant Log – Include member name, diagnosis, review plan, date case opened and/or closed, monthly updates, and level.

7.1.3: Organization of Health Care Delivery Services

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

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

7.1.4: Medical Services Committee Structure and Membership

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

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

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

Meetings

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

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

Confidentiality

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

Reports

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

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

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

7.1.5: UM Review Process for Appropriateness of Care

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

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

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

Medi-Cal
Pharmacy and Therapeutics (P&T) Committee Approved Criteria
Medi-Cal Guidelines
MCG (Milliman Care Guidelines) 25th Edition
NCCN (National Comprehensive Cancer Network)
Blue Shield Promise Health Plan *Evidence of Coverage* (EOC)
Other nationally accredited resources and professional medical associations (e.g., American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP), The American College of Obstetricians and Gynecologists (ACOG))
Blue Shield Promise Medical policy, as applicable

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

Reviewer Availability

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

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

7.1.6: Review Criteria

The UM Department uses nationally recognized evidenced based review criteria, i.e., MCG 25th Edition, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, Comprehensive Perinatal Service Program Guidelines, and Title 22. A review of criterion is updated on an ongoing basis.

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

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

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

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

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

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

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

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

7.2: Complex Case Management Program

Mission Statement

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

Purpose

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

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

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

7.2.1: The Role of the Case Manager

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

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

- No longer meets medical necessity for the benefit
- Terminates from the plan
- Expires
- Refuses further case management services

7.2.2: Case Management in the Ambulatory Setting

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

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

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

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

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

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

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

- Fractured wrist with surgical repair = suture/wound care, dressings or not, equipment needs, caregiver with instruction, PT/OT needs
- Depression = mental health care
- Fractured leg with cast = PT, crutch, transportation
- Abdominal wound = home health, dressings, and teaching/caregiver
- Absorption/digestive problems = nasogastric/gastrostomy tube and related
- Supplies, liquid nutritional product, instructions to caregiver, monitoring by physician, (Gastroenterologist vs. PCP)
- Major musculoskeletal abnormalities = durable medical equipment and supplies, OT/PT/Speech, caretaker issues/respite, educational needs, incontinent supplies, ADL adaptations
- High-risk OB with symptoms = fetal monitoring, complete bed rest at home, IV therapy

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

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

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

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

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

- CCS
- WIC
- Regional Center
- Alcohol and substance abuse program
- Mental Health
- HIV/AIDs programs
- Waiver program
- Dental services
- Genetically Handicapped Disability Program
- Vision care
- Home Health
- Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP), Early Intervention/Early Start/Developmental Disabilities Services (EI/EI/DDS)
- Organ Transplant benefits for recipient and Living Donor including Organ transplant evaluation

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

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

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

Inpatient review is conducted by licensed clinicians who are responsible for the daily utilization review of acute hospital, skilled nursing, psychiatric, and rehabilitation inpatient stays. UM Clinicians interface with the in-house physicians, facility case managers/social services, discharge planners, and the Chief Medical Officer to assure continuity of care in the most appropriate setting. Immediately upon notification of admission they begin the process of case assessment and the coordination of discharge planning with the focus of medical necessity. Additional functions are as follows:

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

7.3. Primary Care Physician Scope of Care

Primary Care Physicians (PCPs) must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for members less than 21 years of age required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

All preventive health visits for all members less than 21 years of age at times specified by the most recent AAP Bright Futures periodicity schedule and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. The PCP must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

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

Office/Clinic

Allergy:

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

Assessments:

- Annual cognitive health assessments for eligible members 65 years of age or older to identify signs of Alzheimer's disease or related dementias
- Developmental screening
- Screening for depression
- Screening for substance abuse

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

Cardiology:

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

Dermatology:

- Common hair problems including fungal infections, ingrown hairs, virializing causes of hirsutism, or alopecia as a result of scarring or endocrine effects
- Common nail problems including trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails
- Counsel members regarding removal of cosmetic (non-covered) lesions
- Dermal injuries including minor burns, lacerations, and treatment of bites and stings
- Diagnose and treat common hair and nail problems and dermal injuries
- Diagnose and treat common rashes including Contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, seborrheic dermatitis, and tinea versicolor
- Diagnose and treat irritated seborrheic keratosis
- Identify suspicious moles
- Manage mild stasis ulcers
- Screen for basal or squamous cell carcinomas
- Treat acne (acute and recurrent)
- Treat actinic keratosis excluding face with liquid nitrogen or Efudex
- Treat irritated skin tags < 5
- Treat warts with topical suspensions, electrocautery, liquid nitrogen

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

Endocrinology:

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

Gastroenterology:

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

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

General Surgery:

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

Gynecology:

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

Hematology:

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

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

Immunizations:

- Immunizations

Infectious Disease:

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

Initial Health Appointment:

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

Nephrology:

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

Neurology:

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

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

Ophthalmology:

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

Orthopedics:

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

Otolaryngology:

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

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

Podiatry:

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

Pulmonology:

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

Rheumatology:

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

Urology/Nephrology:

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

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

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

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

Vascular:

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

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

7.4: Authorization and Review Process

7.4.1: Authorization Time Frames

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

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

Emergency Care Request: Requires no prior authorization

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

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

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

7.4.1: Authorization Time Frames *(cont'd.)*

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

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

Refer to Appendix 13: Utilization Management Timeliness Standards for the standards for each type of request.

7.4.2: Authorization Validity

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

7.4.3: Specialty Referrals

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

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

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

7.4.3: Specialty Referrals *(cont'd.)*

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

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

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

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

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

7.4.4: Ancillary Referrals

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

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

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

7.4.5: Outpatient Services

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

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

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

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

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

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

7.4.6: Elective Admission Requests

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

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

7.4.6: Elective Admission Requests *(cont'd.)*

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

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

7.5: Emergency Services and Admission Review

7.5.1: Emergency Services

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

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

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

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

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

Life Threatening or Disabling Emergency

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

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

Business Hours

The Blue Shield Promise UM Department is available via telephone from 8:00 a.m. to 5:00 p.m., Monday through Friday. In a 911 situation, if a member is transported to an ED, the ED physician shall contact the member's PCP (printed on the member's enrollment card) as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care. If the PCP intends to refer the member to an ED, the PCP must call the ED to authorize the treatment. The physician's name, date, and time of the authorization will be documented in the ED medical record. If the member seeks treatment at an ED without prior approval from the PCP, the ED will triage the member and call the PCP for approval to treat the member. It is the responsibility of the PCP to grant the authorization for treatment under these circumstances.

After Business Hours

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

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

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

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

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

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

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

7.5.2: Urgent/Emergent Admissions

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

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

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

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

PCP Notification

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

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

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

Plan Notification

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

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

7.5.3: Concurrent Review

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

Clinical information may be obtained from the admitting physician, the hospital electronic medical record, or the hospital Utilization Review (UR) Nurse. The Blue Shield Promise UM Clinician established medical necessity using evidence based clinical guidelines and provides the determination for the request within regulatory turnaround times. If the member remains an inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized are variable and are based on the medical necessity for each day of the member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the UM Clinician and the CMO.

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

7.5.4: Discharge Planning

The purpose of discharge planning is to identify, evaluate and coordinate the discharge planning needs of Blue Shield Promise members when hospitalized. Discharge planning will begin on the day of admission for unscheduled inpatient stays. The review process will include chart review, data collection, and review of the care plan by the attending physician and other members of the healthcare team. Discharge planning is required for all members transferring from one setting, or level of care, to another and includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care settings.

For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process. All prior authorizations required for the member's discharge are processed within time frames consistent with the urgency of the member's condition, not to exceed five (5) working days for routine authorizations, or 72 hours for expedited authorizations.

The goal of the discharge planning process is to follow the members through the continuum of levels of care until the member is safely discharged to their previous level of care. This approach is performed to ensure continuity of care and optimum outcomes for Blue Shield Promise members.

Providers are required to notify the Blue Shield Promise UM Clinician of member discharge within 24 hours of the discharge. The PCP of record is sent a discharge notification letter within 24 hours of notification. This may be done by one of the following mechanisms:

- Dictated hospital summary note from the Attending Physician.
- Phone call from the Attending Physician.
- Phone call from the Blue Shield Promise UM Case Manager.
- Inpatient Hospital Notification letter sent by the UM Clinician.

Ensure each member is evaluated for all care settings appropriate to the member's condition, needs, preferences and circumstances. Members are not discharged to a setting that does not meet their medical and/or mental health needs.

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

7.5.5: Retrospective Review

Blue Shield Promise reserves the right to perform a retrospective review of care provided to a member for any reason. There may also be times during the process of concurrent review (especially telephonic) that the UM Clinician did not receive sufficient information based on criteria (MCG Guidelines). When this occurs, the case will be pended for a full medical record review by the CMO.

All retrospective review referrals are to be turned around within 30 working days of obtaining all necessary information. Notification of retrospective review denials will be in writing to the member and the provider.

When a retrospective UM review indicates that there has been an inappropriate provision of care, the case will be referred to the Quality Management Department for further investigative review and follow-up.

7.6: Authorization Denials, Deferrals, and Modifications

A denial, deferral, and/or modification of a treatment authorization request may occur so that more information can be obtained, or a recommendation of alternative care may be made during the authorization process. Other than when the member is not eligible, only physicians will make denial of service determinations. The signature of the Chief Medical Officer (CMO) or the reviewing physician is required on the denied referral request authorization form.

At the request of the Primary Care Physician (PCP), providing physician, member or member representative, such decisions may be referred for reconsideration or appeal for additional review and determination.

Blue Shield Promise or the delegated IPA/medical group will send written notification of an authorization request denial, deferral, and/or modification to the member, the member's PCP, and/or Attending Physicians according to the provisions below:

- The PCP and/or the requesting provider will be sent a written or electronic confirmation within two (2) working days of the determination.
- The communication to the provider shall include the name and telephone number of the health care professional responsible. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
- The member will be sent written confirmation within 2 working days of the determination.
- For concurrent care within 72 hours of the request, electronic or written.

7.6: Authorization Denials, Deferrals, and Modifications *(cont'd.)*

- Denial of services rationale includes a reference to the specific clinical guideline that was used to make the determination. Providers and members can request a copy of the specific criteria set used.
- The disclosure shall be accompanied by the following notice: "The guidelines that were used by Blue Shield Promise for your case are used by the Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need."
- Criteria/guidelines, specific to the care being delivered or requested, will be made available upon request to the provider or member via phone to the UM Department at (800) 468-9935, via fax to the UM Department at (800) 889-6577, or request via mail to UM Department at Blue Shield Promise Health Plan, 601 Potrero Grande Drive, Monterey Park, CA 91755.

The written notification shall include the following elements:

- The notice to the member will inform the member that they may file an appeal concerning the determination using the appeal process (as prescribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process.
- How to initiate an expedited appeal at the time they are notified of the denial.
- The member's right to, and method for obtaining, a State Fair Hearing.
- The member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel or another spokesperson.
- The name and address of the entity making the determination.
- The State's toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Corporation's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the member's satisfaction.

Included within the denial letter to members and providers are the specific reason(s) for the denial in clear and concise language, including reference to the provision, guidelines, protocol, or other similar criterion on which the denial determination and, if possible, alternative treatments or care. The reason(s) for the denial must be translated into the member's preferred language or alternative format (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files).

No authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reasons including, but not limited to subsequent rescissions, cancellations, or modification of the member's contract or when the Plan did not make an accurate determination of the member's eligibility.

7.7: Referrals

7.7.1: Second Opinion

The member, the PCP, or a participating health professional that is treating an enrollee may on occasion request a second opinion prior to surgery to evaluate treatment options, assist with a diagnosis, or validate the need for specific procedures. The CMO will evaluate the medical necessity of an authorization referral request that is submitted formally for a second opinion consultation. An expert panel list is maintained and utilized for second opinion consultation referrals consisting of a board-certified specialist in each area of medicine.

Second opinions **when medically necessary** will be done by an "appropriately qualified healthcare professional" not previously involved in the member's treatment plan.

"Appropriately qualified health care professional" is defined as a Primary Care Physician or specialist acting within his or her scope of practice, and with a clinical background including training and expertise related to the condition associated with the second opinion request.

Second opinion referral requests will be processed within a standard time frame based on the status of the request. When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function or timeliness that would be detrimental to the member's ability to regain maximum function, the second opinion determination shall be rendered as followed:

- **Urgent** - Within 72 hours
- **Routine** - Within 5 working days

Reasons for a second opinion shall include, but not limited to, the following:

- If the member questions the reasonableness or necessity of a recommended surgical procedure.
- If the member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including (but not limited to) a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.

7.7: Referrals *(cont'd.)*

7.7.1: Second Opinion *(cont'd.)*

- If the member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- If the member was not approved for an organ transplant program.

7.7.2: Self-Referable Services (Medi-Cal)

Blue Shield Promise Medi-Cal members have freedom of choice in obtaining certain specified services such as family planning, HIV testing, and care for sexually transmitted diseases (STDs). These services are self-referable both in-network and out-of- network. If the member chooses to self-refer to any willing provider, including out-of-network providers, these services will be covered without pre-authorization.

The following list includes services that, when performed by the PCP, will be covered without prior authorization.

Description
Abortion Services
Family Planning
HIV Testing
Sensitive Services for Minors (12 yrs. of age and older if sexually active)
Sexually Transmitted Diseases (STDs) Treatment

Blue Shield Promise maintains a list of preferred providers for highly specialized tertiary level care. All reasonable attempts will be made to route non-network care to these providers when applicable.

In most cases, payment for self-referable out-of-network services will be limited to the Medi-Cal fee schedule. As necessary, please refer to the State published document (MMCD Letter No. 94-13) on family planning and STDs. A copy of the document will be furnished to Blue Shield Promise providers upon request.

7.7: Referrals *(cont'd.)*

7.7.3: Direct OB/GYN Access

Blue Shield Promise members have the option to seek obstetrical and gynecological (OB/GYN) physician visits directly from an obstetrician and gynecologist or directly from a family practice physician providing obstetrical and gynecological services without prior approval from another physician, another provider, or the health care plan on an unlimited basis, as defined under the evidence of coverage in the Member Handbook.

Blue Shield Promise's policy is to use contracted/participating providers, as well as medical necessity utilization protocols for any OB/GYN services rendered to a member by a participating physician. The OB/GYN will be required to communicate to the member's PCP all pertinent medical information that has occurred from such an encounter in order to maintain the continuity of care for that member. An outline of the required provisions is as followed:

1. Referrals must be made to Blue Shield Promise contracted OB/GYN physicians only.
2. Routine and preventive health care services including breast exams, mammograms, and pap tests.
3. Payment for the level of the consultation/follow-up that is indicated on the claim shall be established from the documentation sent along with the claim to substantiate the medical necessity for payment at that level.
4. Any recommended treatments, procedures or surgeries will require prior authorization.
5. Any OB/GYN who is also a PCP will be able to self-refer directly for OB services. Further treatments, procedures, or surgeries will require prior authorization from the Blue Shield Promise UM Department.
6. Any OB/GYN who is a PCP will provide all GYN services, other than prior authorized surgeries and procedures included under the capitated primary care services payment agreement contract.

As of July 2019, California law (AB 2193) requires that licensed health care practitioners providing prenatal or postpartum care for a patient must ensure the patient is offered a screening, or is appropriately screened, for any type of mental health conditions that may be occurring. In accordance with the law, Blue Shield Promise requires all participating network practitioners, as well as delegated entities that contract with individual practitioners, to comply with the requirement included in Article 6, Section 123640 (September 2018) of California's Health and Safety Code, following approval of the Assembly Bill 2193 (AB 2193) approved in September 2018.

7.7: Referrals *(cont'd.)*

7.7.3: Direct OB/GYN Access *(cont'd.)*

Blue Shield Promise has developed a Maternal Mental Health Program to assist participating practitioners and delegated entities in implementing the requirement. In compliance with SB 1207, this Maternal Mental Health Program is consistent with sound clinical principles and processes, and includes quality measures that encourage screening, diagnosis treatment and referral.

Providers may visit the Blue Shield Promise provider website Maternal Mental Health Services Program link at blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/maternal-mental-heath-program to view information on required frequency of maternal mental health screenings, approved screening tools, and the appropriate codes to submit with encounters data once the screening has occurred. Providers may also reference Section 7.8.7 to view information on the required Comprehensive Perinatal Services Program (CPSP) in addition to required obstetric provider care for all pregnant and postpartum Blue Shield Promise members.

7.7.4: Independent Medical Review

The independent medical review (IMR) is an expansion of the appeal process. Refer to Section 6.3: Independent Medical Review.

7.7.5: Continuity of Care

Blue Shield Promise will ensure that a member with the following conditions can request to remain with a terminated/non-contracted provider until a safe transfer to a Plan provider can be made, and it is consistent with good medical practice.

1. Acute Condition
2. Serious Chronic Condition
3. Pregnancy: defined as the three trimesters of pregnancy and the immediate postpartum period, including maternity mental health. Completion of covered services shall be provided for the duration of the pregnancy, the completion of covered services shall not exceed 12 months. The postpartum period begins immediately after childbirth and extends for 12 months.
4. Terminal Illness
5. The care of a newborn child between birth and age 36 months
6. Performance of a surgery or other procedure that is authorized by the plan
7. OON Specialty Mental Health Services (SMHS) provider where member's mental health condition has stabilized and member no longer qualifies for SMHS Services.

7.7: Referrals *(cont'd.)*

7.7.5: Continuity of Care *(cont'd.)*

Definitions

"Acute condition" Is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

"Continuity of care" Is ensuring that a member's care is appropriately managed as the member moves through the health care delivery system, follow up care is provided, and the member's medical records and history follows the member from provider to provider.

1. Acknowledgment of the Continuity of Care request will be made within the timeframes specified below, advising the member that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. Notification to the member will be using the member's known preference of communication or by notifying the member using one of these methods in the following order: telephone call, text message, email, and then notice by mail:

   • For non-urgent requests, within seven (7) calendar days of the decision.

   • For urgent requests, within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three (3) calendar days of the decision.
2. Continuity of care considerations will be made in accordance with the urgency of the member's condition at the time of such a request.
3. Continuity of care considerations are applicable only to those circumstances when the member has an acute or serious chronic condition, high risk or late term pregnancy, terminal illness, care of a newborn up to 36 months, and/or performance of a surgery or other procedure that is authorized by the plan. Continuity of care is provided through the postpartum period for members in their second or third trimester of pregnancy.
4. If it is a non-contracted provider and there is no agreement between the Plan and the provider, then the Plan/IPA/medical group shall pay the provider similar rates as those paid to similar providers for similar services within a similar geographical region.
5. If the provider does not accept the payment rate, then the Plan/IPA/medical group is not obligated to continue care with the provider.
6. The provider shall be bound to the Plan's contractual requirements for quality assurance, utilization review and credentialing.
7. The Plan will monitor the care provided by requiring the provider to submit ongoing treatment plans, progress notes and other appropriate medical record information.
8. The Plan will coordinate the exchange of the member's medical record information from the non-contracted/terminated provider to the Plan provider when the member's condition allows for such a transition.
9. Members may file requests with the Plan/IPA/medical group for continuity of care when they are SPD (Seniors & Persons with Disabilities) members, newly enrolled converting from Medi-Cal Fee for Service via telephone, facsimile, or by mail.

7.7: Referrals *(cont'd.)*

7.7.5: Continuity of Care *(cont'd.)*

"Delegated" Defers responsibility for the activity as defined by contractual agreement.

"Serious chronic condition" Is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

1. Persists without full cure or worsens over an extended period of time.
2. Requires ongoing treatment to maintain remission or prevent deterioration.

"Terminated provider" Is a provider/physician whose contract to provide services to Plan members is terminated or not renewed by the Plan or one of the Plan's contracting provider groups.

1. If the provider was contracted with the Plan/IPA/medical group and the contract was terminated, the fee will be based on the contractual agreement prior to the termination.
2. The time frame for members undergoing continued care with a terminated or non-contracted provider is up to 12 months. This time frame may be extended in order for the member's care to be transferred safely.

7.7.6: Reconstructive Surgery

Reconstructive surgery, as defined below, is a covered benefit for Blue Shield Promise members; however, coverage for cosmetic surgery as defined is excluded.

Definitions

"Reconstructive surgery" Is defined as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, tumors, infections, trauma, or disease to do either of the following:

1. Improve function.
2. Create a normal appearance, to the extent possible.
3. In the case of transgender members, gender dysphoria is treated as a "developmental abnormality" for purposes of the reconstructive statute and "normal" appearance is to be determined by referencing the gender with which the member identifies. (See UM Policy 10.2.28 Transgender Services.)

"Cosmetic surgery" Is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

A procedure might be considered either cosmetic or medical depending on the reason for it (e.g., breast reduction surgery for pain).

7.7: Referrals *(cont'd.)*

7.7.6: Reconstructive Surgery *(cont'd.)*

Requests for reconstructive surgery for members to correct a condition which has resulted in a functional defect or has resulted from injury or surgery and has produced a major effect on the member's appearance will generally require review by the Chief Medical Officer (CMO) or a physician reviewer.

Submitted documentation of medical necessity should include all of the following:

1. Brief medical history
2. Condition being corrected
3. Date of injury (if applicable)
4. Symptoms
5. Length of time symptoms were present
6. Previous treatment attempted
7. Applicable operative reports
8. Applicable photographs

Physician Reviewer Evaluation

The reviewing physician may forward the case to a Blue Shield Promise specialty advisor for evaluation and determination.

7.7.7: Standing Referral

Blue Shield Promise members that require ongoing extended access to specialty care for chronic, disabling, life-threatening or degenerative conditions will qualify for the standing referral policy. The policy applies to those circumstances where the coordination of the specialty care for such a condition has become the principal care for the member.

A request for a standing referral to a specialist may be initiated by the member, the PCP, or the Specialty Care Physician (SCP), when the member has a chronic, disabling, life threatening or degenerative condition requiring extended access for continued treatment and care, and it has been deemed necessary by Blue Shield Promise.

Provisions for Requesting a Standing Referral

1. Request is made by the member's PCP, SCP, or the member.
2. Request is to be made to a Blue Shield Promise Contracted Specialist.
3. Request will be reviewed and agreed to between the PCP and SCP and submitted to the Plan or delegated medical group.

7.7: Referrals *(cont'd.)*

7.7.7: Standing Referral *(cont'd.)*

Standing referral requests will include:

1. Member diagnosis.
2. Required treatment.
3. Requested frequency and time period.
4. Relevant medical records.

Provisions for Requesting Extended Access to a Specialist

1. Request is made by the member's PCP or Specialist.
2. Request is related to a life threatening or degenerative condition, or there are disabling factors involved in the request.
3. Request will be reviewed and agreed to by both the PCP and Specialist and submitted to the plan or delegated Medical Group.
4. Requesting PCP or Specialist will indicate the health care services the Specialist will be managing and detail those that will be managed by the PCP.

Review and Determination

1. Authorizations are only required for services identified on the Prior Authorization List or if the provider is out of network (OON).
2. Requests are reviewed by the CMO or medical director designee.
3. Determination will be provided within three (3) business days of receiving all necessary records and information.
4. Communication of the determination to the member and involved practitioners will be provided within two (2) business days of the determination.
5. Approvals shall include:
    a. Number of visits approved.
    b. Time period for which the approval will be made.
    c. Extension request process.
    d. Standard reporting required from the Specialist to the PCP and /or the Plan delegated group physician reviewer.
    e. Process for requesting further referrals, if needed.
    f. Clause specifying: "… member eligibility is to be determined at the time services are provided…"

Specialist Communication Guidelines to Primary Care Physician

1. Specialists will provide information to the PCP on the progress and or any significant changes in the member's condition.
2. PCP will maintain all communicated information in the member's medical record.

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

7.8.1: California Children's Services (CCS)

California Children's Services (CCS) is a Medi-Cal benefit provided by the County. Blue Shield Promise coordinates the benefits for eligible members. The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified and paneled providers. The program's goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for children. Members identified with CCS-eligible conditions are referred to the County CCS program immediately upon identification.

When a member is identified as meeting the criteria for the CCS Program, the member/ member's family or designee is notified in writing and informed they will be contacted by a Blue Shield Promise employee to discuss the CCS Program. For newly enrolled members, or existing Medi-Cal beneficiaries transitioning to Blue Shield Promise, Blue Shield Promise maintains a process by which a CCS-eligible child or youth may maintain access to CCS providers and receive assistance in coordination with the new PCP. For children/youth with an established relationship with an out-of-network provider and are requesting continuity of care, Blue Shield Promise will follow the health plan benefits eligibility guidelines based on Department of Health Care Services (DHCS) requirements.

7.8.1.1 CCS Provider Training

The CCS Program maintains mechanisms to ensure that all contracted providers are informed of and adhere to the following:

- CCS program eligibility requirements
- The need to identify potentially eligible children
- How to refer to the CCS program

For all new providers and IPAs, program training will be presented in the New Provider Training material as well as upon request of a provider or IPA. Training opportunities can also be identified during the annual delegation oversight audits. At a minimum, training will occur at least annually in the form of provider updates emails, newsletters, or e-broadcasts via the Blue Shield Provider Connection website. Blue Shield Promise maintains a process to review Blue Shield Promise provider's qualifications for CCS provider panel participation and encourages those qualified to become paneled. Blue Shield Promise also maintains access to a list of those facilities designated with CCS approval, including hospitals and Special Care Centers.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.1.2 Provider Communications

Blue Shield Promise is responsible for ensuring the provider network is aware of members eligible for or receiving services through the CCS program. Blue Shield Promise shall be responsible for generating and distributing to its IPAs, a report of members identified as being eligible or authorized to receive CCS services received from CCS. Blue Shield Promise will send these reports to its delegated IPAs and contracted providers on a monthly basis. Blue Shield Promise and its delegated IPAs and contracted providers will work with the local CCS office to ensure the member is receiving appropriate medical care and that coordination of care is documented in the member's medical record and/or its delegated IPAs will undertake regular activities, such as review of encounter data necessary to identify members with potential CCS conditions and ensure appropriate referrals to CCS. Blue Shield Promise CCS Nurses are responsible for informing the member's PCP of the member's CCS eligibility.

7.8.1.3 CCS Program Referrals

Initial referrals of members with CCS-eligible conditions are made to the local CCS program by telephone, same-day, or fax. Followed by receipt of supporting medical records, to allow for eligibility determination by the local CCS program. Blue Shield Promise providers are responsible for continuing to provide all medically necessary covered services to the member until CCS eligibility is confirmed.

Once eligibility for the CCS program is established for a member, Blue Shield Promise providers shall continue to provide all medically necessary covered services that are not authorized by CCS. Blue Shield Promise shall ensure the exchange of medical record information, coordination of services and joint case management between the PCP, the CCS specialty providers, and the local CCS program.

If the local CCS program does not approve eligibility, Blue Shield Promise remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, Blue Shield Promise remains responsible for obtaining and paying for the services provided.

Blue Shield Promise's contracted physicians or IPA Health Services staff shall assist in the coordination of care between PCP's, CCS Specialty providers, and the local CCS program. All members who are referred to CCS or confirmed to have a CCS-eligible condition shall be managed by Case Management. The CCS program authorizes payments to Blue Shield Promise network physicians who currently are members of the CCS panel and to other providers who provided covered CCS to the member during the CCS eligibility determination period who are determined to meet the CCS standards for paneling. Blue Shield Promise shall submit information to the CCS program on all providers who have provided services to a member thought to have a CCS-eligible condition.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.1.3 CCS Program Referrals *(cont'd.)*

Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by Blue Shield Promise or a network physician shall be allowed until the next working day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

7.8.1.4 CCS Care Management

The CCS Program will be responsible for case management of all identified CCS-eligible members and authorizes medically necessary care. When a member meets criteria for the CCS Program, the member/member's family or designee is contacted telephonically by a Blue Shield Promise employee to discuss their condition and enroll them in the CCS Care Management Program. The CCS Program will be responsible for case management of all identified CCS-eligible members and authorizes medically necessary care.

The Blue Shield Promise UM Department can serve as a link between Blue Shield Promise PCPs, providers, and specialists as appropriate and the CCS Program. This will be done by appropriately identifying and channeling all potential/applicable referrals to CCS in accordance with the specified program standards.

7.8.1.5 CCS Age Out and Transition of Care Coordination Program

Blue Shield Promise maintains a care coordination program to assist CCS-eligible members nearing the age of 21 years or who are transitioning out of CCS due to the completion of CCS services. The age-out program begins once a member reaches 17 years of age and remains on the CCS report as CCS-eligible members will receive communication informing them of the available services in assisting the member/member's family or designee in planning toward the upcoming transition to an adult care provider.

CCS Case Managers are available to assist the family in identifying appropriate options available to the member, such as specialty services, specialty hospitals, medications, durable medical equipment, etc. For unmet social needs, members/member's families may be referred to a PHP Social Worker for assistance. 60 days prior to the member's 21st birthday, members/member's families or their designee will receive a call from the Blue Shield Promise Case Manager to ensure the care planning is in process or completed. If the assistance is needed, the Blue Shield Promise Case Manager will assist in locating an appropriate specialist as well as addressing any other needs.

For complex care needs requiring specialty services not currently available in-network, the Blue Shield Promise Case Manager will collaborate with the CCS Case Manager, treating specialist or SCC (Special Care Center) and the Blue Shield Promise Provider Network team to locate an appropriate provider.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.1.6 CCS Continuity of Care

For newly enrolled members or existing Medi-Cal beneficiaries transitioning to Blue Shield Promise, Blue Shield Promise maintains a process by which a CCS-eligible child or youth may maintain access to CCS providers and receive assistance in coordination with the new PCP. For children/youth that has an existing relationship with an out-of-network provider and is requesting continuity of care, Blue Shield Promise will follow the health plan responsibilities identified in the DHCS regulatory requirements.

7.8.2: Child Health and Disability Prevention Program (CHDP)

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 purpose of the CHDP program is to provide all members under 21 years of age complete health assessments for the early detection and prevention of disease and disability for low-income children and youth in accordance with state and federal requirements, to ensure the identification and referral of members for treatment, and to establish effective linkages, care coordination and non-duplication of services for members who are already receiving services from local health department, Local Education Agencies (LEA) such as school districts, county offices of education, charter schools, community colleges, and university campuses, or community-based organizations.

The provision of CHDP services is accomplished through Blue Shield Promise providers and/or local health department and/or Local Education Agencies in accordance with Blue Shield Promise or L.A. Care's Memoranda of Understanding (MOU). For more information on screening and diagnostic services for children, visit the Child Health and Disability Prevention Program (CHDP) website. All members under 21 years of age are to receive an Initial Health Appointment within 120 days of enrollment. An Initial Health Appointment (IHA) consists of a comprehensive health history and physical examination and includes an age-appropriate health education behavioral assessment.

Comprehensive Health History and Physical Examination

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

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

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

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

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

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

*According to periodicity schedules

Tests are to include the following:

- Tuberculin tests
- Cholesterol screening
- STD screening
- Lab testing for anemia, diabetes, and/or urinary tract infection
- Testing for Sickle Cell Trait
- Lead screening (lead level checks at ages 12 months and 24 months, or between 24 months and 72 months when a child has not had a documented lead screening.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.3: California Regulatory Required Programs

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

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

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

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

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

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

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

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

Federal Refugee Guidelines for Lead Screening

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

- Blood lead test all refugee children 6 months to 16 years old at entry to the U.S.
- Within 3 - 6 months post-resettlement, follow-up blood lead tests should be conducted on all refugee children aged 6 months to 6 years, regardless of initial screening blood lead level.
- Within 90 days of their arrival in the United States, children aged 6 months to 6 years of age should undergo nutritional assessment and testing for hemoglobin or hematocrit levels (e.g., a routine complete blood count with differential).
- Children under 6 months to 6 years should be given a daily multivitamin with iron.

California Vaccines for Children (VFC) Program

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

Reporting Diseases and Conditions to Public Health Authorities

All Blue Shield Promise providers must be compliant with the California regulatory requirement to report specific diseases and conditions to local and state public health authorities, as part of the state's Department of Public Health Disease Surveillance programs per California Code of Regulations (CCR), Title 17, Section 2500, 1500(a)(14), 2500(b), 2500(c),2500(h)(i)(j), 2505, 2508, 2593, 2641.5-2643.20, 2800-2812.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

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

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

All Blue Shield Promise providers are required to do the following:

1. Contracted Blue Shield Promise Primary Care Physicians or any health care practitioners are required to complete a Confidential Morbidity Report and fax the report to (213) 240-7821.
    - Los Angeles County Confidential Morbidity Report: lapublichealth.org/acd/reports/Reporting Forms/CMR.pdf
    - San Diego County Confidential Morbidity Report: www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/CMRa.pdf
2. Report the disease or condition by contacting the California Department of Health Care Services (DHCS) Hot Line at (800) 427-8700. The same number is used for urgent matters, evenings, weekends, or holidays.
3. To report sexually transmitted diseases, the morbidity report is to be faxed to (213) 749-9602.
4. To report Tuberculosis (TB) cases, the phone number is (213) 744-6271. For specific information on the screening and tracking of members with TB, the contracted provider will be encouraged to review the State of California - Health and Human Services Agency California Department of Public Health "Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)."
5. To report AIDS cases, call (213) 351-8516.
6. To report Animal Diseases (including West Nile Virus), call the Public Health Veterinary Unit at (877) 747-2243 or (562) 401-7088.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

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

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

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

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

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

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

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

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

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

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

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

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

Requested Medi-Cal Kids & Teens 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 Medi-Cal Kids & Teens screening.
- The supplies, items and/or equipment requested are medical in nature.
- The services requested are not solely for the convenience of the member, the family, the physician, or any other provider of service.
- 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 behavioral 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.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

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

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.

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

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

7.8.5: Regional Centers

Regional centers provide overall case coordination for eligible consumers and their families to ensure access to health, developmental, social, educational, and vocational services. Services are provided on a case-by-case basis, taking into consideration the availability of generic services appropriate to the consumer's needs.

Blue Shield Promise members who appear to qualify for regional center services will be appropriately identified and referred in accordance with the specifications of the Regional Center Program. This applies to the following:

1. Persons three (3) years of age and older with or suspected to have a developmental disability.
2. Persons from birth to 36 months who are at risk of developing a developmental disability.
3. Persons at risk of parenting a child with a developmental disability (genetic).
4. Behavioral Health Treatment (BHT) for persons 21 years of age and over when determined medically necessary and based upon a recommendation from a physician or a psychologist.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.5: Regional Centers *(cont'd.)*

5. Individuals with a medical diagnosis which includes:
    - Early Start (Birth to Three)
        - Has substantial delay in one or more areas of cognitive, physical and motor, communication, social or emotional, or adaptive development.
        - Infants and toddlers who are at high risk of having a substantial disability due to a combination of biomedical risk factors that have been diagnosed by a qualified.
    - Aged three and above: Children and adults over the age of 3 diagnosed with a developmental disability such as:
        - Autism
        - Cerebral Palsy
        - Epilepsy
        - Intellectual Disability

Other handicapping conditions closely related to mental retardation and requiring treatment similar to that required by persons with mental retardation.

Other applicable factors are that the condition:

- Must manifest prior to age 18
- Is likely to continue indefinitely
- Constitutes a substantial handicap

Factors that do ***not*** apply:

- Solely psychiatric disorders
- Solely learning disabilities
- Solely physical in nature (i.e., hearing impairment, vision impairment, orthopedic, etc.)

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

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.6: Women, Infants, and Children Program (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides temporary nutrition, education and assistance for needy woman, infants, and children.

Supplemental foods are selected to meet specific nutritional needs of pregnant or breastfeeding women and young children by using WIC vouchers. WIC is a free service for members who meet eligibility requirements.

All WIC eligible Blue Shield Promise members who are pregnant, breastfeeding, postpartum, infants and children will be referred to WIC.

Screening of Nutritional Needs and WIC Eligibility Identification and Referral

PCPs are to identify pregnant, breastfeeding, or postpartum women, and children under the age of five who are eligible for WIC supplemental food services.

PCPs are to perform a nutritional assessment and hemoglobin or hematocrit laboratory tests; and assess for a history of frequent illness or a general poor state of health.

In the case of pregnant women, PCPs may refer members to nutritionists for further assessment.

The PCP or nutritionist is to initiate the referral to WIC, if appropriate. Test results reported on the CPSP assessment tool for OB members, or on the CHDP Form PM-160 for children, are to be provided to the WIC Program with all referrals.

The PCP must document the WIC referral in the member's medical record.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.7: Comprehensive Perinatal Services Program (CPSP)

Pregnancy and Postpartum Services

All pregnant and postpartum members are to be provided optimal, comprehensive, multidisciplinary pregnancy and postpartum services with case coordination by Blue Shield Promise contracted obstetric (OB) providers.

All pregnancy and postpartum services must be in accordance with the standards of the American College of Obstetrics and Gynecology (ACOG). All pregnant and post-partum members must be offered and provided services that meet Comprehensive Perinatal Services Program (CPSP) standards, per Title 22 of the California Code of Regulations (CCR), Section 51348. In addition, Blue Shield Promise contracted OB providers must establish mechanisms to refer pregnant and post-partum members to appropriate providers, and to track, monitor, authorize, and report the utilization of these services.

Comprehensive pregnancy and postpartum services, at a minimum, include the following:

Pregnancy Care

1. The initial prenatal visit must be available within (7) seven business days of the initial referral or request for pregnancy-related services.
2. ACOG's Guidelines for Perinatal Care (8th edition), 2017, recommends the following - examination schedule for woman with an uncomplicated pregnancy:
    a. Every four (4) weeks for the first 28 weeks
    b. Every two (2) to three (3) weeks until thirty-six (36) weeks gestation
    c. Weekly thereafter
    d. Postpartum, with an initial visit within 3 weeks after delivery and a follow-up visit no later than 12 weeks after delivery
3. The risk assessments (medical/obstetrical, nutrition, psychosocial, and health education) are completed on all pregnant members at the initial prenatal visit, and at each subsequent trimester and post-partum. All identified risk conditions are followed up by interventions designed to ameliorate or remedy the condition or problem in a prioritized manner, which must be documented in the medical record.
4. Women with medical/obstetrical, nutrition, psychosocial, and health education risk may require closer surveillance. The OB provider, according to the nature and severity of the risk and /or identified problems determines the appropriate interval between visits.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.7: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

Recommended intervals for routine tests for individual patients during pregnancy is as follows:

Time (Weeks Gestation)	Assessment / Service
Initial (as early as possible)	• Hemoglobin or hematocrit measurement
	• Urinalysis, including microscopic
	• Examination and infection screen
	• Blood Group and RH type determination
	• Antibody Screen
	• Rubella antibody titer measurement
	• Syphilis screen (VDRL/RPR)
	• Cervical cytology
	• Hepatitis "B" virus screen
	• HIV education, counseling, and voluntary testing
	• Tuberculosis testing
	• Chlamydia testing and gonorrhea culture
	• Blood pressure
	• Complete medical/obstetrical history including genetic risk assessment and review of systems complete physical examination
	• Orientation to CPSP prescription and/or dispensing 300-day supply of vitamins /mineral supplements as indicated counseling related to danger signs: what to do in an emergency, seat belt, safety, teratogens, smoking, alcohol, and other substance use
	• Referral to WIC
	• Referral to Department of Health Services (DHS) – certified genetic services if indicated comprehensive nutrition, psychosocial, and health education risk assessment (ideally at the initial visit, but within four (4) weeks of initial visits, development of an individualized care plan
8 – 18 weeks	• Ultrasound if indicated amniocentesis if indicated Chorionic villus sampling if indicated.
16 - 18 weeks	• Maternal serum alpha-fetoprotein (by California law, must be offered to all pregnant women entering prenatal care prior to the 20th completed weeks of gestation
27 weeks	• Re-assessment of nutritional, psychosocial, and health education

	needs.
26 - 28 weeks	• Diabetes screening at 26-28 weeks is appropriate for all pregnant women assessed to be at low risk for developing gestational diabetes. However, pregnant women at high risk for developing gestational diabetes, should be screened earlier. Pregnant women at high risk for developing gestational diabetes, would include: a. Members with a history of gestational diabetes b. Family history of diabetes c. Obesity d. Medical conditions associated with the development of gestational diabetes which includes metabolic syndrome or polycystic ovary syndrome.
28 weeks	• Repeat antibody test for un-sensitized Rh-negative patients
	• Prophylactic administration of Rho (D) immune globulin if needed.
32 - 36 weeks	• Ultrasound if indicated
	• Repeat testing for sexually transmitted disease, if indicated
	• Repeat hemoglobin or hematocrit if indicated
	• Family planning counseling/plan offer
	• HIV tests again if previously refused or continued high-risk health behaviors.
By 39 weeks	• Re-assessment of nutrition, psychosocial, and health education needs
	• Inquiry related to the member's plan for Pediatric Services provide information about Child Health and Disability Prevention (CHDP) Program.
Every Prenatal Visit	• Urine checks for glucose and protein. • After quickening, report of fetal movement, blood pressure, weight, uterine size, fetal heart rate, edema, • Leopold's maneuvers interval history. Opportunity for questions. • Continual risk assessment and revision of the individualized Care Plan and referral as indicated.
Initial Postpartum: –within 3 weeks following delivery AND Follow-up Comprehensive visit no later than 12 weeks after birth	<u>Physical exam to include</u>: 1. Breast examination. 2. Recto vaginal evaluation. 3. Bi-manual examination of the uterus and adnexa. 4. Weight, blood pressure. 5. Abdominal examination. 6. Interval history/adaptation to a newborn. 7. Discussion of normal symptoms vs. warning of postpartum depression. 8. Family adaptation. 9. Immunization status (especially rubella for non-immune women). 10. Breastfeeding inquiries.

	11. Counseling regarding future health and pregnancies (gestational diabetes, vaginal birth after cesarean, genetic anomalies, hypertension, etc. Laboratory as indicated (Hemoglobin, if anemic on discharge from hospital, etc.) 12. Family planning counseling/prescription. 13. Well childcare inquiry/referral. 14. Re-assessment of nutrition, psychosocial, and health education needs-revise or close Individual Care Plan as indicated. CPSP support services are available to members for up to (60) days postpartum. 15. Medical, gynecological, nutritional, psychosocial, and/or health education needs/problems persisting beyond this period are communicated to the members PCP for further follow-up and service coordination. This is accomplished by the transfer of a copy of the Individualized Care Plan, which clearly indicates unresolved problems/needs, and interventions to date, from the perinatal provider to the PCP.

At-Risk Pregnancy/Postpartum Conditions

Identification of risk factors is critical to minimizing maternal and neonatal morbidity and mortality. Blue Shield Promise contracted OB providers are responsible for identifying women with a high risk of a poor pregnancy outcome conditions and providing appropriate referrals to perinatal specialists, coordinating other medically necessary services, and making appropriate referrals to public health programs, social services, and community support agencies at any time during the pregnancy when the high-risk indicator is identified. Blue Shield Promise contracted OB providers are required to follow the "Early Pregnancy Risk Identification for Consultation" Guidelines for Perinatal Care, 8th Edition, American College of Obstetricians and Gynecologists (ACOG) 2017 regarding identifying women with a high risk of a poor pregnancy outcome conditions and providing appropriate referrals.

Comprehensive Perinatal and Postpartum Risk Assessment Tools

Blue Shield Promise contracted OB providers must implement a comprehensive risk assessment tool for all pregnant members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Blue Shield Promise contracted OB providers must maintain the results of this assessment as part of the member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate time frames, then the Blue Shield Promise contracted obstetric providers must ensure case management and care coordination are working directly with the member to accomplish the assessment. Blue Shield Promise contracted obstetric providers must follow up on all identified risks with

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.7: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the member's Medical Record. The risk assessment may be completed virtually through a telehealth visit with the member's consent.

Blue Shield Promise selected and implemented the following comprehensive perinatal and postpartum risk assessment tools and recommends that our contracted obstetric providers utilize the following CPSP Perinatal and Postpartum Risk Assessment tools:

- CPSP Perinatal Assessment Reassessment and Individualized Care Plan LA County 2017 http://publichealth.lacounty.gov/mch/cpsp/forms/Prenatal%20Assessment%20&%20ICP%20LAC%20CPSP%202017.pdf
- CPSP Postpartum Assessment Reassessment and Individualized Care Plan LA County 2017 http://publichealth.lacounty.gov/mch/cpsp/forms/Postpartum%20Assessment%20&%20ICP%20tool%20LAC%20CPSP%202017.pdf

Obstetric providers may obtain a copy of the above comprehensive perinatal and postpartum risk assessment tools by contacting Blue Shield Promise Provider Relations.

Individualized Care Plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors.

The Blue Shield Promise obstetric provider is responsible for the personal supervision of the members' Individualized Care Plan to ensure that all identified risk conditions are followed-up with interventions expected to ameliorate or remedy the condition or problem in a prioritized manner. This supervision is the obstetric responsibility whether the support services (nutrition, psychosocial, and health education), assessment and interventions are accomplished in his/her practice or are conducted at another location.

Case Coordination Elements

Case coordination is the responsibility of the Blue Shield Promise contracted OB providers although care coordination may be delegated to a member of the OB provider's staff who is directly accountable to the OB provider.

Components of Case Coordination

Case coordination includes all clinical aspects of care, as well as record keeping and communication, as detailed below. Every part of the multidisciplinary system should support personal attention to the member and interaction with the Blue Shield Promise contracted OB provider.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.7: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

- Assessments (obstetrical, nutrition, health education, and psychosocial).
- Written, individualized care plan based on all assessments.
- Appropriate interventions/treatments provided according to the care plan and approved protocols.
- Continuous assessments of the member's status and progress relative to care plan interventions, with appropriate revision of care plan when necessary.
- Case conferences, or other appropriate communications, involving all team members regarding each member's care.
- Comprehensive record system where all information relating to member care is documented and is available to all team members.
- Screening for prenatal and postpartum mental health conditions and referrals for mental health services, as appropriate.

Multidisciplinary Conditions/Issues

Common pregnancy and postpartum conditions and issues for multidisciplinary team discussion/ action include areas of nutrition (N), psychosocial conditions and services (PS), or health education (HE) such as those listed below:

<u>Pregnancy Conditions/Issues</u>

- Fear of physicians, hospitals, and medical personnel (HE)
- Housing and transportation problems (PS)
- Lack of basic reproductive awareness (HE)
- Language barriers (HE)
- Multiple gestation (HE), (PS), (N)
- Need for bed rest during pregnancy (PS), (HE)
- No previous contact with health care systems (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)
- Previous receipt of unfriendly health care services (HE)
- Teenage pregnancy (PS)
- Unintended or unwanted pregnancy (PS)

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.7: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

Postpartum Conditions/Issues

- Breastfeeding difficulties (HE)
- Housing, food, and transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Postpartum blues, postpartum depression (PS)
- Severe anemia (N)
- Sexual pain/difficulties (HE)

Conditions Requiring Medical Referrals

- Alcohol or Drug Abuse
- Diabetes
- Epilepsy or Neurological Disorder
- Genetic Problems
- Hepatitis
- HIV Infection
- Hypertension
- Maternal Cardiac Disorders
- Renal Disease
- Thyroid or Other Endocrine Disorders

Conditions/Issues Requiring Social Work Referrals

- Chemical Abuse
- Family Abuse
- Financial Problems
- Insufficient home care resources/capabilities
- Psychiatric Problems
- Related Programs (e.g., CPSP, WIC, CHDP, family planning and dental services).

Blue Shield Promise contracted OB providers are to inform members of pregnancy and prenatal related programs and refer members to them when appropriate.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.7: Comprehensive Perinatal Services Program (CPSP) *(cont'd.)*

Monitoring and Oversight

Blue Shield Promise needs your assistance to ensure that our members get optimal perinatal care and the best possible pregnancy outcomes. In addition, we must maintain compliance with the Department of Health Care Services (DHCS) Policy Letter (PL) 12-003 Obstetrical Care–Perinatal Services.

Blue Shield Promise is required to ensure that our providers are following American College of Obstetricians and Gynecologists (ACOG) practice guidelines and are compliant with the Comprehensive Perinatal Services Program (CPSP). Blue Shield Promise conducts medical record reviews of Blue Shield Promise contracted OB provider medical records to monitor compliance with this requirement. If a Blue Shield Promise contracted OB provider receives a request from Blue Shield Promise for medical records for a CPSP monitoring audit, please return the requested medical records as soon as possible. Please notify us via email at CPSPMonitoring@blueshieldca.com if requests for your medical records are to be sent to a specific contact, centralized location, or if access to your electronic medical record (EMR) system is available, or if you have any other questions.

The CPSP Medical Record Review Tool will be included with medical record requests and is available upon request. Once we have completed our medical record review, we will share your results with you. Blue Shield Promise contracted OB providers must achieve a score of 80% or higher to receive a passing score. Any score lower than 80% or noted trending deficiencies may require a Corrective Action Plan (CAP). In the event a CAP is required, Blue Shield Promise will provide additional training and resources as needed. Compliance gaps in Blue Shield Promise's provider network will be tracked, trended, and reported in Quality Management Committee meetings.

The Maternal Health Oversight and Monitoring Program is one component of the overall Maternal Health Program, which includes Blue Shield Promise's Quality, Delegation Oversight, and Care Management Programs.

For more information about the California Department of Public Health (CDPH) Comprehensive Perinatal Services Program (CPSP) and/or the American College of Obstetricians and Gynecologists (ACOG) see below.

Resources

blueshieldca.com/en/bsp/providers/programs/maternity-program

www.cdph.ca.gov/programs/cfh/dmcah/cpsp/pages/default.aspx

www.acog.org/

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.8: Family Planning

Family planning includes the following services:

- Health education and counseling services necessary for members to make informed choices and understand contraceptive methods.
- Limited history taking and physical examinations. PCPs or OB/GYNs are responsible for the comprehensive history taking and physical examinations.
- Laboratory tests, if medically indicated for the chosen contraceptive method. Pap smears, if not provided per USTF guidelines by PCPs or OB/GYNs.
- Diagnosis and treatment of sexually transmitted diseases, if medically indicated, pursuant to the sexually transmitted diseases section of this manual.
- Screening, testing, and counseling of individuals at-risk for HIV and referral for treatment for HIV-infected members.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Provision of contraceptive pills, devices, and supplies, as approved by Medi-Cal.

Providers will be required to obtain informed consent for all contraceptive devices.

- Pregnancy testing and counseling
- Tubal ligation
- Vasectomies

The stipulations below apply to the provision of family planning services:

1. Each physician/provider must be licensed in the state of California and have training/ experience in family planning.
2. A Medical Director who meets at least the above qualifications must oversee, if services are provided in a clinic setting, the clinic and all services provided there.
3. Informed consent must be obtained, in writing, from all members for the provision of all-contraceptive devices and/or procedures. This consent will be filed in the member's medical records.
4. In general, OB/GYN, family practice, or internal medicine physicians and nurse practitioners will provide family planning services to members.

Members may receive care from:

- Their own Blue Shield Promise PCP or OB/GYN
- A Blue Shield Promise Participating Family Planning provider
- Any out-of-plan Family Planning provider (This is limited to Medi-Cal members only.)

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.9: Sensitive Services

"Sensitive services" are health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

Benefit Coverage

Members 12 years of age and older may sign an Authorization for Treatment form for any sensitive services (without parental consent). Parental or guardian consent is required for members under 12 years of age who seek substance or alcohol abuse treatment services, or for treatment of sexually transmitted diseases.

The member's PCP should encourage members to use in-plan services to enhance coordination of care. However, members may access sensitive services through out-of-network providers without prior authorization.

Family Planning (sensitive) services shall include, but not be limited to:

- Medical treatment and procedures defined as family planning services under current Medi-Cal scope of benefits
- Medical contraceptive services including diagnosis, treatment, supplies, and follow-up
- Informational and education services

In compliance with federal regulations, Blue Shield Promise members have free access to confidential family planning services from any family planning provider or agency without obtaining authorization for these services. Access to sensitive services will be timely. Services to treat sexually transmitted diseases or referrals to substance and alcohol treatment are confidential.

Examples of Covered Services:

- Birth control pills
- Contraceptive foam, male and female condoms, cervical caps, sponges, etc.
- Depo-Provera as routine birth control
- Diaphragm
- Elective therapeutic abortions
- Elective tubal ligation
- Elective vasectomy
- Intra-uterine device (IUD) including device, insertion, and removal
- "Morning after pill" to avoid pregnancy is approved by the FDA for emergency treatment only (e.g., rape, incest, etc.)
- Routine pregnancy testing

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.9: Sensitive Services *(cont'd.)*

Office visits for education and instruction for birth control, including symptom-thermal method, billings method, rhythm method; and instruction and education regarding the methods and devices listed above.

- HIV screening, testing, diagnosis, education, and referrals for treatment
- STD screening, testing, diagnosis, education, and referrals for treatment

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:

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

7.8.10: Sexually Transmitted Disease (STD)

Blue Shield Promise will provide members with confidential sexually transmitted disease (STD) screening and testing, diagnosis, treatment, follow-up, counseling, education, and preventive care. Members should be encouraged to obtain these services from their PCPs. However, members have the right to receive some services outside of the PCP without prior authorization.

STD Reporting

State law mandates that specified STDs be reported to local health departments. All diagnosed members that fail to complete treatment must also be reported to the applicable local health department.

7.8.11: Mental Health (Medi-Cal Managed Care)

Inpatient and specialty outpatient mental health services are carved out of the Blue Shield Promise Medi-Cal benefit agreement. Blue Shield Promise members may directly access specialty mental health services through the Department of Mental Health.

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.11: Mental Health (Medi-Cal Managed Care) *(cont'd.)*

Behavioral Health Services Access

There are multiple entry paths for Blue Shield Promise members to access behavioral health services. Referrals may be requested by primary care physicians (PCPs), specialty providers, County Departments, Community Based Organizations, case managers and member self-referrals. The completed referral form should be emailed to Blue Shield Promise at MediCalmentalhealth@blueshieldca.com, or faxed to (323) 889-2109 (Los Angeles County) or (619) 219-3320 (San Diego County). The Blue Shield Promise Behavioral Health team is available Monday through Friday from 8 a.m. to 5 p.m. for behavioral health service requests by phone at (888) 297-1325. Blue Shield Promise has a toll free 800 number that is available 24/7 for general inquiries, eligibility verification, business hour service authorization requests and after hour service authorization requests. After hour requests are coordinated by cross connecting callers to the afterhours Blue Shield Promise on call nurses. The nurses have 24-hour access to Blue Shield Promise physicians for assistance in making any medical necessity determinations that are beyond the nursing scope of practice. The after-hour nurses are educated and trained in coordinating behavioral health service referrals for all levels of mental health treatment to the appropriate provider network for behavioral health care.

Medi-Cal Managed Care Plan Behavioral Health Benefits and Services

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

Role of Primary Care Physicians

The Primary Care Physician is responsible for:

- Initial Health Appointment (IHA) and Individual Health Education Behavior Assessment (IHEBA) using an age appropriate DHCS approved assessment tool
- Screening for Mental health Conditions
- Offering brief behavioral/counseling intervention(s) to members ages 11 and older, including pregnant women, that provider identifies as having risky or hazardous alcohol or drug use, when a member responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified, in accordance with Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT).

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.11: Mental Health (Medi-Cal Managed Care) *(cont'd.)*

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

Primary Care Physicians appropriately provide significant amounts of mental health care that fall within their scope of practice, including the prescribing of psychotherapeutic drugs.

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

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.

Any member identified with possible alcohol or substance use disorders shall be referred to the County Alcohol and Drug Program in the county where the member resides for evaluation and treatment.

Resources for Substance Use Disorder Services

- SUD Directories www.dhcs.ca.gov/provgovpart/Pages/sud-directories.aspx
- Los Angeles County Substance Abuse Service Helpline: (844) 804-7500
- San Diego County Drug-Medi-Cal Organized Delivery System: (888) 724-7240 TTY 711

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.11: Mental Health (Medi-Cal Managed Care) *(cont'd.)*

Behavioral Health Services

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

1. Individual/group mental health evaluation and treatment (psychotherapy).
2. Psychological testing when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purpose of monitoring drug therapy.
4. Psychiatric consultation for medication management.
5. Outpatient laboratory, medications, supplies, and supplements.

7.8.12: Vision

Blue Shield Promise members are eligible to receive vision care services, including the provision of examinations and eyewear at the same location.

Blue Shield Promise is contracted with a network of participating ophthalmologists, optometrists, hospital outpatient departments, and organized outpatient clinics strategically throughout Los Angeles County in order to provide enrolled members with convenient access to vision care services. If the member belongs to a contracted IPA/medical group, the PCP should submit the referral to the IPA/medical group.

Participating vision care providers are authorized to submit claims for vision care services and appliances to Blue Shield Promise, in accordance with Medi-Cal vision care policies and billing instructions.

Members may obtain, as a covered benefit, one pair of corrective lenses every two (2) years. Additional services and lenses are to be provided based on medical necessity.

If the optometrist for any reason feels the member should be referred to an ophthalmologist or other physician, they must call the member's PCP for a telephone referral authorization. This is necessary to ensure the PCP is aware of any potential conditions that may be related to the general health of the member (such as diabetes).

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.13: Dental

PCPs will conduct primary care dental screenings and facilitate appropriate and timely referrals to dental providers. Services delivered by dental providers are carved out of the Blue Shield Promise benefit agreement.

PCPs shall perform an inspection of the teeth and gums for any signs of infection, abnormalities, malocclusion, and inflammation of gums, plaque deposits, caries, or missing teeth. If any of the above conditions are observed, PCPs should instruct the member to make an appointment to see a dentist. Blue Shield Promise maintains a current list of Medi-Cal dental providers and will be available to assist PCPs in the dental referral process.

As part of the Child Health and Disability Prevention (CHDP) health assessment, children are to be referred to a Medi-Cal dentist if a dentist has not seen them within the prior six (6) months. Dental screenings of adults are accomplished, at a minimum, as part of the periodic examinations recommended by the United States Preventive Services Task Force (USPSTF) in addition to the course of other encounters. PCPs are encouraged to educate members about the importance of dental care and to make corrective and preventive referrals.

PCPs are to document screenings and referrals in the member's medical record.

7.8.14: Organ Transplant

Blue Shield Promise is required to cover the Major Organ Transplant (MOT) benefit for adult and non-California Children's Services (CCS) eligible pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.

Blue Shield Promise will refer, coordinate, and authorize the delivery of the MOT benefit and all medically necessary services associated with MOTs up to 180 days post transplant, including, but not limited to:

- Care coordination
- Discharge planning
- Hospitalization
- Medications
- Organ procurement costs
- Post-operative services
- Pre-transplantation assessments and appointments
- Readmissions from complications
- Surgery

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.14: Organ Transplant *(cont'd.)*

Blue Shield Promise will cover all medically necessary services for both living donors and cadaver organ transplants. Blue Shield will only authorize MOTs to be performed in approved transplant programs located within a Medi-Cal approved Center of Excellence (COE) or hospital that meets the Department of Health Care Services' (DHCS) criteria. Blue Shield Promise must directly refer adult members and authorize referrals to a transplant program that meets Medi-Cal for an evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for the organ transplant.

All covered benefits related to the following major organs will be provided for at a Medi-Cal approved COE:

- Bone marrow
- Combined liver and small bowel
- Heart
- Heart-lung
- Liver
- Lung
- Pancreas
- Simultaneous kidney-pancreas
- Small bowel

California Children's Services (CCS) and Transplant

Blue Shield Promise must refer pediatric members to the County CCS program for CCS eligibility determination within 72 hours of the member's PCP or specialist identifying the member as potential candidate for the MOT. Blue Shield Promise will assist in referring and coordinating the delivery of the MOT benefit and all medically necessary services associated with MOT. Blue Shield Promise will not be required to pay for costs associated with transplants that qualify as a CCS-eligible condition. The County CCS program will be responsible for referring the CCS-eligible member to the transplant SCC. Blue Shield Promise will provide case management and care coordination. If the CCS program determines that the member is not eligible for the CCS program, but the MOT is medically necessary, Blue Shield Promise will be responsible for authorizing the MOT.

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.14: Organ Transplant *(cont'd.)*

Authorization Time Frames

CCS MOT Service Authorization Requests (SARs) are typically authorized for one year. Non-CCS Treatment Authorization Requests (TARs) are authorized according to the type of MOT in the table below:

Transplant	Duration of TAR Authorization
Liver with Hepatocellular Carcinoma	4 Months
Cirrhosis	6 Months
Bone Marrow	6 Months
Heart	6 Months
Lungs	6 Months
All else	1 Year

7.8.15: Long Term Care (LTC)

For members that meet long-term care criteria, Blue Shield Promise UM Department will authorize, when medically appropriate, the admission and continued stay to the LTC facility including standardization on Skilled Nursing Facility (SNF), rehabilitation facility, or intermediate-care facility.

Blue Shield Promise will provide continuity of care for members that are transferred from 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.

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.16: Alcohol and Drug

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (Formerly AMSC)

It is the policy of Blue Shield Promise to ensure members 11 years of age and older receive alcohol and drug misuse screenings by their Primary Care Physician (PCP). Consistent with the American Academy of Pediatrics (AAP) Bright Futures initiative, the United States Preventive Services Task Force recommendations. PCPs must annually screen members 11 years of age and older for alcohol and drug misuse. Although Blue Shield Promise must provide one alcohol and drug misuse screening per year, additional screenings must be provided when medically necessary. Completion of the screening must be documented by the member's PCP. All care providers must obey confidentiality regulations as per 42 CFR Part 2.

Screening

PCPs must screen members for unhealthy alcohol and drug use using validated screening tools. Validated screening tools include, but are not limited to:

- Alcohol Use Disorders Identification Test (AUDIT-C)
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Drug Abuse Screening Test (DAST-10)
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
    - The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening.
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Tobacco, Alcohol, Prescription medication, and other Substances (TAPS)

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.16: Alcohol and Drug *(cont'd.)*

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services.

Brief interventions must include:

- Providing feedback to the patient regarding screening and assessment results
- Discussing negative consequences that have occurred and the overall severity of the problem
- Supporting the member in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated

PCPs must ensure that members who, upon screening and evaluation, meet the criteria for an AUD or SUD as defined by the current DSM (DSM-5, or as amended), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the county department for alcohol and substance use disorder treatment services, or a DHCS-certified treatment program.

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.16: Alcohol and Drug *(cont'd.)*

Documentation Requirements

Member medical records must include:

- The service provided (e.g., screen and brief intervention)
- The name of the screening tool and the score (unless the screening tool is embedded in the electronic health record)
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
- If and where a referral to an AUD or SUD program was made

Compliance with SABIRT services is subject to audit by Blue Shield Promise, including medical record review. PCPs must maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.

7.8.17: Tuberculosis

Blue Shield Promise and its providers will work in close coordination with the local health departments in the treatment and management of Blue Shield Promise members with tuberculosis (TB).

All efforts will be made to identify cases of tuberculosis among members as early as possible, to render infectious cases of TB to non-infectious as rapidly as possible, and to prevent non-infectious cases from becoming infectious. This will be done in accordance with the Los Angeles County Department of Health Services TB Control Program's developed guidelines and policies for suspected TB cases.

Primary Care Physicians 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.

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.18: Waiver Program

Waiver Programs provide services in the home for members who are currently receiving care in acute or skilled nursing facilities. Members meeting criteria for waiver services will be referred to those programs. Blue Shield Promise will efficiently arrange the member's disenrollment and transfer of care to fee-for-service Medi-Cal, thereby enabling the member to receive care appropriately and safely in a home environment rather than an institution.

Members suitable for the Medi-Cal Waiver Program are:

- Members who have been in a skilled nursing facility (SNF) beyond 30 days without improvement and unable to maintain self-care.
- Members in custodial care.
- Members with an AIDS diagnosis.
- Members with other factors as noted in specific waiver criteria.

7.8.19: Phenylketonuria (PKU)

The treatment and testing of PKU are covered benefits under the Medi-Cal Program. The benefit includes formula and special food products that are medically necessary for the treatment of PKU. The screening of PKU is provided through the Plan's contracted hospital after birth, but prior to discharge of the newborn.

Metabolic diseases may be a carve-out benefit and may be covered through California Children's Services (CCS). Infants and children up to the age of 21 years that are identified as having PKU will be referred by the Plan to CCS for case management.

Medically Necessary Enteral Nutrition Products

"***Therapeutic Medical Food***" is defined as food formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

Enteral nutrition products reviewed and evaluated are those that can be used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food.

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.

7.8: Carve-out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.19: Phenylketonuria (PKU) *(cont'd.)*

Requirements for Medical Authorization of Enteral Nutrition Products are:

- A prescription by a licensed provider is required
- Authorization procedures and review for approval of enteral nutrition products shall be supervised by qualified healthcare professionals
- Decisions and appeals regarding enteral nutrition products shall be performed in a timely manner based on the sensitivity of medical conditions and rendered as:
    - Emergency requests: in no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment (W&I Code Section 14103.6)
    - 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 time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function
    - Non-emergency requests: within five (5) working days when proposed treatment meets objective medical criteria, and is not contraindicated
    - A regimen already in place: within five (5) working days for review of a currently provided regimen as consistent with urgency the member's medical condition, as required by Health and Safety Code Section 1367.01
- Any decision on enteral nutrition products that is delayed beyond these time periods is considered approved and must be immediately processed as such
- Verbal or written notification shall be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by the provider
- Members shall be notified about denied, deferred, or modified services
- Plans shall publicize the appeals procedure for both providers and members

Definitions

"Formula" Is defined as an enteral product for use at home.

"Special food products" Is defined as products that are specially formulated to have less than one gram of protein or used in place of normal food products such as grocery store foods used by the general population.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.20: Cancer Screening

Cancer screening tests are covered benefits under the Medi-Cal Program. Blue Shield Promise follows the standards established by the United States Preventive Services Task Force (USPSTF) as outlined in Section 9.5 of this provider manual. In addition, annual cervical screenings include the conventional Pap test and the option of any cervical cancer screening test approved by the FDA upon the referral of the member's health care provider.

Prior authorization is not required for FDA approved Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer (includes progression/reoccurrence of the above mentioned). Coverage policy for Cancer Biomarker Testing is to not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial.

7.8.21: Cancer Clinical Trials

Blue Shield Promise covers routine member care services that are related to the clinical trial for a member diagnosed with cancer and accepted into a phase I, phase II, or phase IV clinical trial for cancer. The clinical trial program's endpoint shall be defined to test toxicity, and to have a therapeutic intent. The treatment shall be provided in a clinical trial that either (a) involves a drug that is exempt under federal regulations from a new drug application, or (b) is approved by one of the following:

- One of the National Institutes of Health (NIH)
- The Food and Drug Administration (FDA) in the form of an investigation new drug application
- The United States Department of Defense (DOD)
- The United States Veterans' Administration (VA)

7.8.22: AIDS Vaccine Coverage

In the event the FDA approves a vaccine for AIDS, it will be covered.

7.8.23: Services Under the End-of-Life Options Act (ABx2-15) for Medi-Cal Members

End of life services (EOL Services) under this Act, patient consultation by a physician and prescription of aid-in-dying medication, are carved out from Medi-Cal health plans like Blue Shield Promise. Medi-Cal Fee-For-Service (FFS) will provide coverage and reimbursement for physicians who provide EOL Services.

Provision of these services by health care providers is voluntary. Physicians enrolled in the Medi-Cal FFS program may voluntarily provide Blue Shield Promise Medi-Cal members with EOL Services under the Medi-Cal FFS services, not under your contract with Blue Shield Promise, and seek payment for EOL consultations from the Medi-Cal FFS program.

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.23: Services Under the End-of-Life Options Act (ABx2-15) for Medi-Cal Members *(cont'd.)*

Physicians are responsible for documenting an oral request by a Blue Shield Promise Medi-Cal member for EOL Services whether or not you volunteer to provide these services to the member.

7.8.24: Community Supports

Community Supports are services or settings that Blue Shield Promise may offer in place of services or settings covered under the California Medicaid State Plan that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for health plans to offer and for members to utilize. Blue Shield Promise may not require members to use Community Support instead of a service or setting listed in the Medicaid State Plan. These services are available to eligible Blue Shield Promise Medi-Cal members and provide additional support above and beyond Long Term Care Support Services (LTSS) to enhance member's care, allowing them to stay in their homes safely and preventing institutionalization. They can also be an additional part of care for members enrolled in Enhanced Care Management (ECM). Community Supports services are available for some Medi-Cal members not enrolled in ECM that need additional support in the community. These services will vary based on a member's needs and Blue Shield Promise's established Community Supports criteria and exclusions.

Blue Shield Promise offers the following Community Supports to eligible Medi-Cal members in Los Angeles and San Diego Counties:

- Asthma Remediation
- Community Transition Services/Nursing Facility Transition to a Home
- Day Habilitation Programs
- Environmental Accessibility Adaptations (Home Modifications)
- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Supportive Food/Meals and *Medically Tailored Meals (MTM)
    - *Los Angeles County: Medically Tailored Meals Only
    - *San Diego County: Medically Supportive Food/Meals and Medically Tailored Meals
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Personal Care & Homemaker Services

7.8: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information *(cont'd.)*

7.8.24: Community Supports *(cont'd.)*

- Recuperative Care (Medical Respite)
- Respite (for Caregivers)
- Short-Term Post-Hospitalization Housing
- Sobering Centers

Providers may reference the Community Supports Referral form on the Blue Shield Promise provider website at blueshieldca.com/promise/providers in the *Forms* section to determine a member's eligibility and submit a referral. Although these services are not Medi-Cal benefits, they are subject to Blue Shield Promise's grievance and appeals process in the event a concern arises regarding access to services.

For more information, refer to Appendix 10: DHCS Community Supports Categories and Definitions and Appendix 11: Community Supports Criteria and Exclusion Guide.

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

The purpose of UM reports is to provide ongoing monitoring for delegated UM functions and to ensure that services and decisions rendered by the delegated IPA/medical group are appropriate and meet DHCS, DMHC, and Blue Shield Promise standards. All delegated IPA/medical groups must report and submit UM information to Blue Shield Promise as described below. Reports must be submitted via secure email or via SFTP site. See also Appendix 1: Delegation of Utilization Management Responsibilities.

Monthly Reporting Requirements

Reports due to Blue Shield Promise by the 15th of the month following the month in which services were rendered or denials made, and include the following:

1. Authorization Turnaround Time Tracking Report – Include authorization, member name, requested date, approval date, provider notification date, diagnosis, and requested services.
2. Denials and Modifications – Include all Denial and Modification numbers, member name, requested date, decision date, provider notification date, and requested services.
3. Denials and Modifications – Include a complete copy of denial/modification letter, authorization/referral, doctor's notes, criteria used, and a copy of the DMHC self-addressed envelope.

7.9: Delegated UM Reporting Requirements (IPA/Medical Groups Only) *(cont'd.)*

4. HIV/ABR Report – Include CIN, Medi-Cal number, Blue Shield Promise ID, IPA/medical group, Mo/Yr diagnosed, Mo/Yr billed, date last billed, Aid Code, and AEVS Verification number.
5. Maternity/Deliveries Admission (MDAR) Report – Maternity and Delivery cases.

Quarterly Reporting Requirements

Reports must be submitted to Blue Shield Promise 45 days after the end of the quarter (May 15th, August 15th, October 15th, and February 15th).

1. UM HICE Work Plan Report – Include, at a minimum, UM activities, trending of utilization activities for under- and over-utilization, member and provider satisfaction activities and inter-rater reliability activities and improvement.
2. CCS Report – Include data for all CCS cases.
3. Quarterly Supplemental Report – Summary of Referrals, Case Management/Continuity of Care, Linked & Carved Out Services and After-Hours Calls Managed by RN/MD.

Annual Reporting Requirements

Reports must be submitted annually to Blue Shield Promise by February 15th of each calendar year:

1. UM Program Description – Reassessment of the UM Program description must be done on an annual basis by the UM/ QM Committee.
2. UM Work Plan – Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The work plan should include planned audits, follow-up activities and interventions related to the identified problem areas.
3. UM Program Annual Evaluation – The evaluation should include a description, trending, analysis, and evaluation of the overall effectiveness of the UM Program.
4. Sterilization Log – Sterilization and Information Consent data.

All reports must be submitted to Blue Shield Promise within the time frames specified. There must be separate reports generated for Medi-Cal members. Consistent failure to submit required reports may result in action that includes, but is not limited to, request for a corrective action plan (CAP), freezing of new member enrollment, or termination of the Blue Shield Promise Health Plan Agreement.

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8.1: Encounter Data - Medi-Cal

Policy and Procedures

Encounters include all services for which the medical group (IPA, MSO, PPG, Hospital, etc.) is responsible. Medical groups shall submit encounter data at least once monthly, but more frequently is preferred. Medical groups shall submit complete and accurate data in 837P, 837I & 837D formats using the national standard codes acceptable by Blue Shield Promise within thirty (30) calendar days from the Date of Service ("DOS") for Medi-Cal Los Angeles, and within sixty (60) calendar days from the DOS for Medi-Cal San Diego in which care was rendered. The medical group must meet all data quality measurements established by Blue Shield Promise Health Plan as stated in this document and the provider contract, and is responsible for correcting and re-submitting all rejections to Blue Shield Promise within 10 days of notice received.

It's your obligation to submit data that is accurate, complete, and within the required time frame. Failure to do so may result in being placed on a corrective action plan which can include one or more of the following:

- Closure of panel
- Withhold incentive payments
- Withhold ACO shared savings payments, if applicable
- Enforcement of penalties outlined in your contract with Blue Shield Promise
- Reduction in monthly capitation payment, as stated in your provider contract
- De-delegation
- Termination of contract

All encounters must be submitted electronically using the 837 5010 format. Standardized 5010 EDI Response files will be provided for all encounter files received.

Encounter Data submissions must meet all requirements outlined in the Companion Guides and are exchanged through the established secure server. The Companion Guides can be found on the Provider Portal at EDI Companion Guides.

Providers who are contracted with Blue Shield Promise through a delegated IPA/medical group must submit encounter data to their affiliated IPA/medical group in the format and within the timeframes established by the IPA/medical group.

On an annual basis, Blue Shield Promise re-evaluates the accuracy and completeness standards based on state and federal regulatory changes, results of the Healthcare Effectiveness Data and Information Set (HEDIS®) audit and historical encounter data experience.

Blue Shield Promise continually monitors regulatory policy and any changes to policy that may occur.

8.1: Encounter Data - Medi-Cal *(cont'd.)*

If a change is necessary to the policy outside the regular update schedule, Blue Shield Promise will make a mid-cycle/special update to stay in compliance.

Blue Shield Promise must conform with the Department of Health Care Services (DHCS) Quality Measures for Encounter Data. Additional information can be found on the DHCS website at www.dhcs.ca.gov/dataandstats/data/Pages/MMCDClmsEncDataRpt.aspx

8.1.1 Compliance Guidelines

Volume of the Data

It is important to comply with encounter submission requirements and to report all services to meet established encounter data quantity targets.

Complete Submission

Blue Shield Promise will measure encounter submissions based on a rolling year of utilization data.

Performance

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

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

Timeliness of Data

Medi-Cal Los Angeles: 65% received within 30 calendar days from the date of service

Medi-Cal San Diego: 65% received within 60 calendar days from the date of service

Accuracy/Quality of the Data

Data acceptance rate shall not be less than 95% of all data submitted.

Resubmissions

The medical group is responsible to correct the rejections and re-submit the corrections to Blue Shield Promise within 10 days of notice received.

Failure to meet these requirements may result in being placed on a corrective action plan as described in Section 8.1, Encounter Data Medi-Cal Policy and Procedures:

8.1: Encounter Data - Medi-Cal *(cont'd.)*

8.1.1 Compliance Guidelines *(cont'd.)*

It's your obligation to submit data that is accurate, complete, and within the required time frame. Failure to do so may result in being placed on a corrective action plan which can include one or more of the following:

- Closure of panel
- Withhold incentive payments
- Withhold ACO shared savings payments, if applicable
- Enforcement of penalties outlined in your contract with Blue Shield Promise
- Reduction in monthly capitation payment, as stated in your provider contract
- De-delegation
- Termination of contract

Corrective Action Plan

When encounter data does not meet the submission requirements within a rolling three (3) months, Blue Shield Promise may request a corrective action plan (CAP) from the provider to remedy the problem, as follows:

1. Blue Shield Promise sends a letter to the provider requesting a CAP. The letter details the following:
    a. The months that the encounter data did not meet the requirements.
    b. The dates when the encounter data was due to Blue Shield Promise, if applicable.
    c. The file names for all encounter data files that did not meet the requirements.
    d. The reasons the encounter data did not meet the requirements, whether it be timeliness, accuracy, or a combination of the two (2).
    e. The date the CAP is due to Blue Shield Promise.
    f. Request for submission of accurate and complete encounter data for the timeframes in question.
2. to Blue Shield Promise within thirty (30) days from the date of the CAP Request letter. The CAP must include the following:
    a. The name of the IPA/Medical Group
    b. The name of the person responsible for implementing the CAP, along with title, contact email and contact phone number
    c. A list of specific actions to be taken to ensure that encounter data meets the submission requirements.
    d. Completion dates for each of the corrective actions.
    e. An accurate and complete encounter data file (s).

8.1: Encounter Data - Medi-Cal *(cont'd.)*

8.1.1 Compliance Guidelines *(cont'd.)*

3. Blue Shield Promise sends the Capitated provider a letter of acceptance or rejection of the CAP within thirty (30) days of receipt of the CAP.
    a. Blue Shield Promise includes the specific reasons for rejection of any CAP.
    b. Any rejected CAP must be resubmitted within fifteen (15) days to Blue Shield Promise.
    c. Timeframes can be altered at the discretion of Blue Shield Promise depending on specific circumstances.
4. Capitated providers who fail to submit an acceptable CAP within the required timeframes and/or accurate and complete encounter data, shall be subject to:
    - Closure of panel
    - Withhold incentive payments
    - Withhold ACO shared savings payments, if applicable
    - Enforcement of penalties outlined in your contract with Blue Shield Promise
    - Reduction in monthly capitation payment, as stated in your provider contract
    - De-delegation
    - Termination of contract
5. In accordance with the terms of the provider agreement and this provider manual. Blue Shield Promise shall provide thirty (30) days written notice prior to the capitation deduction. Capitation deduction shall be retroactive to the date of non-compliant encounter data submission. The enrollment freeze and capitation deduction shall remain in effect until such time that the CAP and/or encounter data is approved and meets standards.

The responsibility for Encounter Data reporting as outlined above continues until all services rendered during the timeframe of the provider's agreement have been reported.

9.1: Quality Improvement Program

Mission Statement

Blue Shield Promise's mission is to ensure all Californians have access to high-quality health care at an affordable price. Blue Shield Promise's Quality Program is committed to promoting continuous and coordinated care in a patient-centered environment that recognizes the positive relationship between health education, a culture of wellness, and an emphasis on prevention and affordable healthcare.

Blue Shield Promise's Quality Program is comprehensive and designed to systematically and continuously monitor, evaluate, and improve the quality of care and/or services delivered to all Blue Shield Promise members and providers. Quality improvement activities are conducted in all areas and dimensions of clinical and non-clinical member care and service.

Performance improvement projects and activities are selected and conducted using methodologies and practices that conform to respected health services research entities, as well as standards and best practices established by regulatory and accrediting bodies.

Goals

- Deliver an exceptional quality program across the company
- Improve the quality, safety, and efficiency of healthcare services delivered
- Improve members' experiences with services, care, and their own health outcomes.
- Ensure care and services are provided to members in a way that is equitable and includes services that are culturally and linguistically appropriate

Objectives

- Maintain NCQA Health Plan Accreditation for Medi-Cal
- Maintain Multicultural Healthcare Distinction for Medi-Cal and obtain/transition to NCQA Health Equity Accreditation for Medi-Cal in 2024/2025.
- 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 Health Care 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).

9.1: Quality Improvement Program *(cont'd.)*

- Ensure adequate clinical resources are in place to administer the quality program, including a full-time Chief Medical Officer/ 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 Duals and Seniors, and Persons with Disabilities (SPD). Ensure the performance of delegated vendors and providers against Blue Shield Promise standards and requirements.
- Assess and meet the standards for the 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 a 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 healthcare disparities in our membership.
- Ensure the provider network is sufficient to meet the language needs and preferences of the membership.

9.1: Quality Improvement Program *(cont'd.)*

Scope

The scope of the Quality Program is to monitor care and service and identify opportunities for improvement of care and services to both our members and providers. This is accomplished by evaluating data and leading or supporting the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. A formal evaluation of the Quality Program is performed annually. Specific elements of the Quality Program include but are not limited to Effective and Efficient Quality of Clinical Care; Safety; Equity; Quality of Service and Timeliness of Care; Provider Support (provider experience, engagement, and performance); Patient-Centered member Experience and Satisfaction. Topics in these domains include:

- Quality Improvement Initiatives
- Continuity, Coordination, and Transitions of Care
- Population Health Management
- Care Management
- Wellness Initiatives and Preventive Care
- Delegation Oversight of credentialing entities; utilization management and claims processing entities
- Pharmacy initiatives to improve safety and avoid harm
- Individual and Organizational Provider Credentialing
- Potential Quality Issues
- Medical record documentation review
- member experience and satisfaction initiatives
- Cultural & Linguistic Services
- Appeals and grievances analysis
- Health Equity
- Access & Availability of Services
- Cost Data Transparency
- Customer Call Center
- Utilization management timeliness
- Provider Collaborations
- Provider Incentives
- Value-based programs
- Provider group engagement

9.1: Quality Improvement Program *(cont'd.)*

The Quality Program covers:

- All Blue Shield Promise members
- All types of covered services; including, but not limited to preventive, primary, specialty, emergency, inpatient, behavioral health (including parity), ancillary care, and long-term services and supports (LTSS).
- All professional and institutional care in all settings including provider offices, hospitals, skilled nursing facilities, outpatient facilities, emergency facilities, ancillary providers, pathology and laboratory facilities, urgent care, home health, and telehealth.
- All providers and any delegated or subcontracted providers.

Confidentiality and Conflict of Interest

All information related to the quality improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and reviews, are stored in designated, secured locations and access is granted based on minimum necessary standards. All aspects of a quality review are deemed confidential. All people involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All quality improvement activities including correspondence, documentation, and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPPA) for patient confidentiality. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

All persons attending the Quality Management Committee (QMC), or its related committee meetings sign a confidentiality statement annually. Blue Shield Promise personnel are required to sign a confidentiality agreement upon employment.

No persons shall be involved in the review process of quality improvement issues in which they were directly involved. If a potential conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical/financial decision making and all committee members, committee chairs and the Chief Medical Officer sign a statement of this understanding.

9.1: Quality Improvement Program *(cont'd.)*

9.1.1: Program Structure Governing Body

The Blue Shield of California Board of Directors is ultimately responsible for the Quality Program. Annually, the quality strategy, related goals, and metrics are provided to the Board of Directors (Board) for recommendations. The Board provides oversight on performance against the quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of all quality activities to the Board Quality Improvement Committee (BQIC).

Committees

Quality Management Committee (QMC)

The Quality Management Committee (QMC) is charged with the development, oversight, guidance, and coordination of Blue Shield Promise quality activities. Comprised of a voting membership of network providers and internal stakeholders of the Quality Program, the QMC approves Medi-Cal-specific policies and assures compliance with accrediting and regulatory quality activities from entities such as DHCS, DMHC, CMS, NCQA, and L.A. Care. The QMC monitors provisions of care, identifies problems, recommends corrective action, and informs educational opportunities for providers to improve health outcomes. Chaired by the Blue Shield Promise Chief Medical Officer or designee, the Quality Management Committee reports to the Quality Oversight Committee and meets at least four times per year.

The following sub-committees report to Quality Management Committee:

- Access and Availability Committee
- Blue Shield Promise Behavioral Health Committee
- Medical Services Committee

Scope (includes but not limited to):

1. Directing all Quality Improvement activities.
2. Monitoring, evaluating, and directing the overall compliance with the Quality Improvement Program.
3. Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
4. Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols. Recommending policy decisions.
5. Reviewing, analyzing, and evaluating Quality Improvement activity.
6. Ensuring practitioner participation in the QI program through planning, design, implementation, and review.

9.1: Quality Improvement Program *(cont'd.)*

9.1.1: Program Structure Governing Body *(cont'd.)*

7. Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA, and L.A. Care.
8. Reviewing reports of subcommittees (Medical Services and Access & Availability, others reporting as necessary).
9. Overseeing standing subcommittees through the review of regular reports and requires action if necessary; evaluates subcommittees for potential changes in scope or the need for ad hoc task forces/workgroups.
10. Evaluating and giving recommendations concerning Quality Improvement Initiatives' audit results, member satisfaction surveys, and provider satisfaction surveys.
11. Evaluating and giving recommendations from analysis and trending reports, including appeals and grievances, potential quality investigations, member service metrics, Initial Health Appointments, and Facility Site Review.
12. Ensuring follow-up, as appropriate.

Delegation Oversight Committee (DOC)

Blue Shield Promise may delegate any or all utilization management (UM), credentialing, and/or claims functions to Independent Practice Associations (IPAs), hospitals, medical groups, or vendors. A pre-delegation assessment is conducted within 12 months of implementing a delegated relationship, to assess the entity's ability to perform the proposed delegated functions.

Blue Shield Promise is ultimately responsible for all care and services provided to its members directly or through a delegated arrangement. Blue Shield Promise's ongoing delegation oversight activities are directed by the Delegation Oversight Committee (DOC).

Blue Shield Promise ensures all functions delegated by Blue Shield Promise to providers, vendors, or other organizations, are performed according to accreditation, regulatory, and Blue Shield Promise requirements. At least annually, Blue Shield Promise reviews the delegate's programs, policies and procedures, and data systems and files, if applicable to the delegated relationship. At least quarterly, delegates are required to submit performance reports, which are reviewed for compliance. Any identified deficiencies require a corrective action plan, which will be monitored until activities are compliant. If needed, additional actions, up to and including de-delegation, are taken for groups that do not correct deficiencies.

9.1: Quality Improvement Program *(cont'd.)*

9.1.2: Standards of Practice

Blue Shield Promise reviews and adopts standards of practice from professionally recognized sources in the development and implementation of criteria, policies and procedures, metrics, indicators, protocols, clinical practice guidelines, review standards, or benchmarks in its quality program. Sources include, but are not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Evidence-based medical literature
- State and federal requirements

Accepted thresholds and targets derived from these standards and norms will be:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines
- Valuable to the assessment quality or the potential improvement of quality for our member population

Providers are sent an annual notice with key information and links to resources that are available online, such as clinical guidelines, medical record standards, the annual quality evaluation, and prior authorization procedures.

9.1.3: Quality Improvement Process

Blue Shield Promise utilizes a Quality Improvement Process to identify opportunities to improve both the quality of care and quality of service for all Plan members. Blue Shield Promise adopts and maintains clinical guidelines, criteria, and other standards against which quality of care, access, and service can be measured.

Blue Shield Promise uses a continuous quality improvement (CQI) process to measure performance, conduct a quantitative and qualitative analysis, and assess and identify barriers and opportunities for improvement. Interventions are implemented to improve performance and are remeasured to determine the effectiveness of the interventions.

9.1: Quality Improvement Program *(cont'd.)*

9.1.3: Quality Improvement Process *(cont'd.)*

Quality improvement is a data-driven process. Blue Shield Promise uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives. These data sources include, but are not limited to:

- Chronic Care Improvement Plans
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Plan Do Study Act and Performance Improvement Plan Studies
- Monitors
- Indicators
- Medical Record Audits
- Facility Site Reviews
- Outcome Measures
- Focused Review Studies
- Member satisfaction surveys
- Member grievances and quality of care issues (see more below)
- Practitioner/Provider Satisfaction Surveys
- Access to Care Audits

Contracted providers, including IPA/medical groups, are required to abide by and comply with the provisions of and participate in, Plan's Quality Improvement Program as described in this Provider Manual.

Failure to comply with the requirements of the Quality Improvement Program or to abide by Blue Shield Promise's policies and procedures may be deemed by Blue Shield Promise as a material breach of this Agreement, and may, at Plan's option, be grounds for termination of contract.

Quality of Care Reviews

- Blue Shield Promise has a comprehensive review system to address potential quality of care issues. A potential quality issue arising from a member grievance or an internal department is forwarded to the Blue Shield Promise Clinical Quality Review Department where a clinical quality review nurse investigates and compiles a care summary from clinical documentation including, but not limited to, medical records and a provider written response, if available. The case may then be forwarded to the Blue Shield Promise Medical Director for review and determination of any quality-of-care issues. A case review may also include a review of the care provided by a like-peer specialist and/or a review by the Blue Shield Promise Peer Review Committee.

9.1: Quality Improvement Program *(cont'd.)*

9.1.3: Quality Improvement Process *(cont'd.)*

- During the review process, information is obtained from an IPA/medical group or directly from the involved provider. Upon review completion, depending upon the severity of any quality findings identified, follow-up actions may be taken and can include a request for corrective action or an education letter. Patient safety concerns or patterns of poor care can be considered during Blue Shield Promise re-credentialing activities or reviewed in more detail by the Blue Shield Promise Credentialing Committee and may result in termination from the Blue Shield Promise network.
- Contracted providers are obligated to participate in the quality of care review process and must provide documents, including medical records and corrective action plans upon request. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157.

Quality Studies (HEDIS/PIP/PDSA Focused Review Studies)

QI Department staff will perform quality studies, as indicated, based on findings from reviews of the quality-of-care issues, utilization data, pharmacy data, complaints and grievances, satisfaction survey results, medical record audit results, facility site review results, and other clinical indicators. In addition, Blue Shield Promise will participate with collaborative plans and regulatory agencies in state-required HEDIS/PIP/PDSA studies. Studies conducted jointly with regulatory agencies will be in accordance with regulatory agency and state requirements. Quality studies conducted independently of regulatory bodies will be in accordance with Blue Shield Promise policies and procedures. All network providers are required to participate in the quality studies process. This includes providing medical records upon request and at no cost to Blue Shield Promise (including network providers using an outside medical record vendor), in the requested time frames for the purposes of performance reporting and audits for the Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS).

Credentialing

Blue Shield Promise conducts a credentialing process that follows all regulatory and oversight requirements.

9.1: Quality Improvement Program *(cont'd.)*

9.1.4: Communication of Information

All Quality Improvement activities are presented and reviewed by the Quality Management Committee. Types of activities, analyses, and/or data may include:

- Access to Care (Appointment Availability, After-Hours, Ancillary)
- Delegation audit results
- Disability and Equality Program
- HEDIS and Quality Outreach summary
- Initial Health Appointment
- Facility Site Review (FSR) and Patient Safety
- Comprehensive Perinatal Services Program (CPSP)
- Early Preventive Screening, Diagnostic, and Treatment (EPSDT)
- Child Disability and Prevention Program (CHDP)
- Member Call Timeliness and Abandonment Rate summary
- Member grievance statistics and trends
- Medical Record and Facility review audit reports and trends
- Study outcomes (Geo Access – Distance and Language Accessibility to providers)
- Policies and Procedures
- Provider and Member (CAHPS) Satisfaction survey results
- Quality Compliance
- Quality Improvement activities
- Quality Improvement Program, Work Plan, Annual Evaluation, and Quarterly Reports
- Regulatory and legislative information

Results of Quality Improvement activities are communicated to providers in the most appropriate manner including, but not limited to:

- Correspondence with a provider displaying individual results and a comparison to the provider's group or affiliation, or against the peers in the network
- Correspondence with the IPA/medical groups showing results and comparisons to the network
- Announcements and informational communications as needed
- Online
- Provider Manual updates

9.1: Quality Improvement Program *(cont'd.)*

9.1.4: Communication of Information *(cont'd.)*

Quality Improvement Program Description and Policies and Procedures

The Quality Program Description and its policies and procedures are reviewed at least annually and will be amended to reflect changes in scope and identified needs resulting from new or revised regulatory and/or accreditation requirements, significant changes in membership, provider scope, scope of services, or operational changes occurring during the year. The program description, work plan, and annual evaluation are reviewed and approved by the Quality Management Committee and Board Quality Improvement Committee (BQIC). Quality Improvement policies and procedures are reviewed and approved by the Quality Management Committee.

Annual Work Plan

The Quality Work Plan outlines key activities for the year and includes any activities not completed during the previous year unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the Quality Management Committee, Quality Oversight Committee, and BQIC.

The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement.

Annual Program Evaluation

Blue Shield Promise's Quality Program is reviewed at least annually to assess the overall effectiveness of the program. Findings from the annual Quality Program Evaluation are considered at the time of the Quality Program revision.

The assessment of activities in the Quality Work Plan is conducted to evaluate the success of individual activities in meeting the specific goals and objectives of the Quality Program. The annual review of the Quality Program ensures that the overall program is comprehensive, meets current industry standards, and is effective in continuously improving the quality of health care and services delivered. Identified opportunities are addressed in the following year's program and work plan.

An executive summary is presented to the QMC, QOC, and BQIC for review and action which may include acceptance, clarification, modification, and follow-up as appropriate. An informational summary of the annual evaluation is available to providers.

9.2: Quality of Care-Focused Studies

Policy

The Blue Shield Promise Quality Improvement Department develops quality improvement studies based on data collected through various methods including, but not limited to, encounter data, claims data, complaints and grievances, potential quality of care issues (PQI), access and availability surveys, and satisfaction surveys. Blue Shield Promise annually reports to regulatory agencies on the performance of Healthcare Effectiveness Data and Information Set (HEDIS) and Managed Care Accountability Set (MCAS) measures and participates with regulatory agencies in the submission of state-mandated performance improvement plans (PIPs) and Plan Do Study Act (PDSA) cycles to test change through rapid-cycle improvement for measures falling below the minimum performance level. Studies conducted in collaboration with other health plans and state-wide collaborative Quality Improvement Projects will be conducted in accordance with regulatory agency requirements. Focused review studies conducted independently of a regulatory agency will be in accordance with the procedures as described herein.

Procedure

1. Focused review studies will include the following design elements:
    - Objective and reason for topic selection
    - Sampling framework and sampling methodology
    - Data collection criteria and analysis methodology
    - Report of data and/or findings
    - Quantitative/Qualitative analysis
    - Barrier analysis
    - Action plans, as appropriate
    - Reassessment, as appropriate
2. The study will be designed to produce accurate, reliable, and meaningful data in accordance with standards of statistical analysis. The study questions will be framed using information from scientific literature, professional organizations, practitioner/provider representatives, regulatory requirements, and outcome-related data. The practice guidelines/ quality indicators used in the study will be specified, whenever possible. The variables to be collected and analyzed will be defined and derived from the practice guideline/quality indicators.

    Data may be collected through a variety of methods including, but not limited to member surveys, practitioner/provider surveys, medical record audits, on-site practitioner/provider facility inspections, analysis of encounter/claims data, analysis of prior authorization data, and analysis of member complaints and grievances.

9.2: Quality of Care Focused Studies *(cont'd.)*

a. Data may be collected through sampling or may include the entire population that meets the study criteria. The following criteria should be considered in making this decision:
   - The size of the member population eligible for the study.
   - The method of data collection (e.g., administrative data, medical record review, or a hybrid of both).
   - The nature of data to be collected.
   - The degree of confidence required for the data.

b. The following questions will be used to determine the method for validating the results:
   - How will the raw data collected be verified?
   - What statistical analytical tests will be performed on the data?
   - What adjustments for age, the severity of illness, or other variables, which may affect the findings, will be made?
   - What is an acceptable level of performance?

3. The Quality Improvement Department, in conjunction with the Chief Medical Officer will analyze and interpret study results and develop a corrective action plan to address the findings. Results will be compared to recognized, relevant benchmarks, when available. Action plans will include:
   a. Expected outcomes that must be expressed in measurable terms
   b. Specific interventions/actions to be taken to positively impact the problem.
   c. Improvement actions/interventions may include but are not limited to the following:
      - Assign members to a case manager for specialized attention
      - Re-engineer organizational processes and structures
      - Provide members with educational materials or programs
      - Develop member incentive programs
      - Introduce new technology to streamline operations
      - Develop employee-training programs to improve understanding of health practices of various cultural groups
      - Disseminate practitioner/provider performance data to allow peer measurement and comparison to national and/or state benchmarks
      - Provide educational materials that may be relevant to understanding and treating the population to practitioners/providers

9.2: Quality of Care Focused Studies *(cont'd.)*

- Develop clinical practice guidelines through collaboration with plan partners and other collaborative plans
- Address any practitioner/provider-specific concerns through the peer review process

d. Implementation schedule
e. Monitoring plan

4. The results, interpretation, and action plan will be presented to the Quality Management Committee for review and approval and then forwarded to the Board Quality Improvement Committee.
5. Reports will be made to the Quality Management Committee as required by the action plan.
6. Results will be made available to members and practitioners through newsletters, bulletins, faxes, special mailings, etc., as appropriate.
7. Sources for standards, norms, and guidelines pertaining to the measurement of quality of care include, but are not limited to, the following:
    - National Committee for Quality Assurance standards for quality and utilization management.
    - Other independent credentialing, certification, and accreditation organizations, including the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), JCAHO, CMRI, The Quality Commission, AAAHC, and URAC.
    - Federal Agency guidelines including the Office of Technology Assessment (OTA), Agency for Healthcare Policy and Research (AHCPR), National Institute of Health (NIH), Department of Health and Human Services (DHHS), Center for Disease Control (CDC), and the United States Public Health Services (USPHS).
    - United States Preventive Services Task Force (USPSTF) guidelines.
    - National consensus organization guidelines for clinical practice.
    - Child Health and Disability Prevention (CHDP) program guidelines.
    - Professional specialty service guidelines, including the American Academy of Family Practice, American College of Physicians, American Academy of Pediatrics, American College of Obstetrics and Gynecology, and the American Medical Association.
    - English language peer-reviewed medical literature.
    - Milliman Care Guidelines.
    - Pharmacology guidelines extracted from the practice standards of the American Society of Hospital Pharmacists (ASHP) and the PDR.
    - Expert opinion.
    - HMO standards for access to ambulatory care.
    - InterQual Severity of Illness/Intensity of Service (ISSI).
    - Commission for Professional Activity Studies (PAS) length of stay norms.

9.3: Clinician and Member Satisfaction Surveys

Clinician Satisfaction Survey

Blue Shield Promise established and implemented one annual uniform satisfaction survey for clinician practices. The Clinician Satisfaction Survey gauges satisfaction rates to guide Blue Shield Promise's process enhancements geared toward improved access, care delivery, and quality that demonstrate year-over-year improvement in the majority of measured categories. Blue Shield Promise conducts the annual Clinician Satisfaction Survey with participating primary and specialty care clinicians using an NCQA-certified/CMS-approved consultant. Results of the Clinician Satisfaction Survey are summarized and reported to the appropriate departments and committees for follow-up and action.

Member Satisfaction Survey

Blue Shield Promise conducts a Member Satisfaction Survey at least annually using a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. Results will be summarized and reported to the appropriate departments and committees.

9.4: Clinical Practice Guidelines

Policy

Blue Shield adopts nationally recognized clinical practice guidelines which are reviewed and approved annually through our committees and is overseen by our Utilization Management department.

9.5: Initial Health Appointment

Purpose

To establish the patient/doctor relationship and obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status. All newly enrolled members must receive an Initial Health Appointment (IHA) within 120 days of enrollment. See DHCS All Plan Letter 22-030.

Policy

The IHA consists of a comprehensive health history, assessment of health education needs, complete physical assessment, psychosocial/behavioral assessment, screenings, lab tests appropriate to age and gender, TB risk assessments, Advisory Committee on Immunization Practice (ACIP) recommended immunizations, Tobacco usage assessment and interventions, unhealthy alcohol and drug use screening and interventions, review of Preventive Services (USPSTF), follow-up, treatments, and referrals (if necessary).

9.5: Initial Health Appointment *(cont'd.)*

Policy *(cont'd.)*

Effective January 1st, 2023, the completion of an Individual Health Education Behavioral Assessment (IHEBA) also known as an SHA (Staying Healthy Assessment form) will no longer be required at the IHA visit.

As referenced in Title XVII and the United States Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics (AAP) members are entitled to and should receive timely access to an IHA or, alternatively, should have documentation in the member's medical record that a comparable assessment has been performed within the last 12 months.

Although, there is no specific form(s) for use in conducting and documenting an IHA, complete documentation of this comprehensive health assessment visit is required to be kept in the member's medical record. To assist Blue Shield Promise providers with documentation of the IHA, age-appropriate physical evaluation templates are available on the Blue Shield Promise provider website at: blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms.

The Initial Health Appointment Services include:

A. Health Assessments for members under 21 years of age in accordance with the AAP/Bright Futures Periodicity Schedule must include, at a minimum:

- Complete health and developmental history.
- Review of organ systems.
- Behavioral/Social/Emotional Screening (annually from newborn to 21 years).
- Developmental disorder screening at 9th, 18th and 30th month visits
- Maternal Depression Screening at 1st, 2nd, 4th, and 6th month visits
- Screen adolescents for depression and suicide risk, making every effort to preserve the confidentiality of the adolescent. Adolescent depression screening beings routinely at 12 years of age.
- Risk assessment for high blood pressure starting with newborns, then blood pressure measurements starting at 3 years of age.
- Head circumference from newborn through 24 months; Length/Height and Weight from newborn; BMI starting at 24 months.
- Physical examination, including assessment of physical growth.
- Assessment of nutritional status.
- Hearing and vision screening, as appropriate.

9.5: Initial Health Appointment *(cont'd.)*

- Dental assessment to include inspection of the mouth, teeth, and gums beginning at 12 months of age and the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption and every 3 to 6 months thereafter in the primary care or dental office based on caries risk.
- If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
- Immunizations as recommended by ACIP and CDC schedules and reported to the California Immunization Registry (CAIR) within 14 days of administration.
- Risk assessment for sudden cardiac arrest and sudden cardiac death from 11 to 21 years.
- Tuberculosis (TB) risk assessments for all members and a PPD skin test and/or chest x-ray for those considered high-risk.
- Tobacco usage assessment (age 11 years and above) and provision of interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.
- HPV Vaccine is recommended by ACIP for girls and boys as young as 9 to 26 years old.
- HIV Screening, as appropriate.
- Risk assessment for hepatitis B (HBV) infection from newborn to 21 years of age.
- Hepatitis B screening for adolescents at increased risk of infection
- Hepatitis C screening starting at age 18 years.
- Intimate Partner Violence screening, as appropriate.
- Nutrition Assessment.
- Obesity Screening.
- Sexual Activity Assessment and contraceptive care.
- Sexually Transmitted Infection (STI) screening on all sexually active adolescents.
- Cervical Cancer Screening, as appropriate.
- Lab tests appropriate to age and sex, including anemia (Hemoglobin/ Hematocrit) starting at age 9-12 months.
- Diabetes risk assessment.
- Blood lead testing at appropriate intervals as well as appropriate reporting and treatment for abnormal levels.

9.5: Initial Health Appointment *(cont'd.)*

- The medical record reflects an assessment of alcohol/drug misuse, using a validated screening tool, for members ages 11 years and older, and the name of the screening tool and the member's score is documented in the medical record. For positive alcohol/drug misuse screening results, the medical record reflects assessment using a validated assessment tool, and documentation that brief misuse counseling has been offered and/or a referral for additional evaluation and treatment.

B. The IHA Health Assessments for Asymptomatic members 21 years of age and older must include, at a minimum:

- Complete history and physical examination which includes a review of organ systems that includes inspection of ears, nose, mouth, throat, teeth, and gums.
- Height, weight, and blood pressure documented.
- Diabetic screening as part of cardiovascular risk assessment in adults ages 40 to 70 who are overweight or obese.
- Dyslipidemia screening and calculation of 10-year Cardiovascular Disease (CVD) event risk in adults ages 40 to 75.
- Hepatitis B and hepatitis C screening for all adults.
- Mammography screening for breast cancer is completed every 2 years on all women starting at age 50 and concluding at age 75 unless pathology has been demonstrated.
- Cervical Cancer screen (Pap smear) for women beginning at the age 21-65 of first sexual intercourse and once every 3 years, or for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years.
- Chlamydia and gonorrhea screen for all sexually active females 24 years or younger and in women 25 years or older who are at high risk for infection (high risk—such as but not limited to, new or multiple sex partners, prior history of STD, not using condoms consistently and correctly).
- Tuberculosis (TB) risk assessments for all members and a PPD skin test and/or chest x-ray for those considered high-risk.
- Initial and annual assessment of tobacco use for each member and interventions, including education and counseling for those members using tobacco.

9.5: Initial Health Appointment *(cont'd.)*

- The medical record reflects an assessment of alcohol/drug misuse, using a validated screening tool, for members ages 11 years and older, and the name of the screening tool and the member's score is documented in the medical record. For positive alcohol/drug misuse screening results, the medical record reflects assessment using a validated assessment tool, and documentation that brief misuse counseling has been offered and/or a referral for additional evaluation and treatment.
- Intimate Partner Violence (IPV) Screening is recommended for women ages 18 and older and the provision of ongoing support services for women who screen positive.
- HIV Screening.
- Sexually Transmitted Infection (STI) Screening.
- Health education and anticipatory guidance appropriate to age and health statistics.
- Colorectal cancer screening performed for all adults at age 45 and concluding at age 75 years, or per current guidelines. Prostate Specific Antigen (PSA) testing for men annually at 45 years of age with high risk and ages 50 – 70 for men with average risk.
- Immunizations administered as recommended by the current ACIP and CDC schedules and reported to California Immunization Registry (CAIR) within 14 days of immunization.
- Lung cancer screening in adults aged 50 to 80 years who have a 20-pack-a-year smoking history and are currently smoking or have quit within the past 15 years.

Procedure

1. The Member Handbook, distributed at the time of enrollment, contains both basic information about PCP services and specific information describing the importance of the IHA. It encourages members to access this service. Members are specifically directed, in their Blue Shield Promise New Member packet, to contact their PCP's office to schedule an IHA.
2. Blue Shield Promise Provider Relations representatives educate both newly contracted practitioners/providers and contracted practitioners/providers about the 120-day IHA requirements for newly enrolled Medi-Cal members. Blue Shield Promise also uses bulletins and newsletters to reinforce practitioner/provider awareness of the 120-day IHA requirement for newly enrolled members.
3. In collaboration with our providers, Blue Shield Promise conducts outreach to all new members to ensure timely access to the IHA. Members will receive phone calls notifying them of the available service, offering assistance to schedule an IHA, offering transportation assistance to and from an IHA, or encouraging them to call their PCP to make an IHA appointment within 120 days of enrollment.

9.5: Initial Health Appointment *(cont'd.)*

Procedure *(cont'd.)*

4. To ensure that newly enrolled Blue Shield Promise members obtain an IHA with their new PCP within 120 days of enrollment, Blue Shield Promise will coordinate with our members and providers as follows:
    a. Blue Shield Promise will make a minimum of two documented attempts, with at least one phone call and one written attempt, to contact each new member to schedule the timely IHA.
    b. Blue Shield Promise will notify newly enrolled members of the importance and availability of IHAs through the Member Welcome Letter, member telephonic outreach, member handbook, EOC, and newsletters.
    c. Blue Shield Promise will notify PCPs of the requirement to schedule IHAs for newly enrolled members within 120 days of enrollment through the Blue Shield Promise Provider Manual, provider newsletters, Provider Connection, provider websites, fax blasts, and telephone calls.
    d. Blue Shield Promise will provide monthly eligibility lists to the PCPs notifying them of their newly assigned members and reminding them of the requirements to conduct a timely IHA.
5. To ensure that newly enrolled Blue Shield Promise members obtain an IHA within 120 days of their enrollment date, PCPs are responsible for the following actions:
    a. Upon receiving an updated eligibility list from Blue Shield Promise, PCP offices are required to contact new members by email, letter, and/or telephone to assess the current need for an IHA, and to schedule an IHA for the member within the required 120 days of enrollment, if warranted.
    b. If a comprehensive health assessment has recently been performed elsewhere and all elements of the IHA have been completed within 12 months prior to the member's enrollment date, then the new PCP may be given an exception to the 120-day IHA time frame requirement, provided that the PCP obtains the appropriate previous medical records and documents from the previous PCP and adds them to the member's current medical record.
    c. If a member refuses an IHA, the PCP must document the refusal in the member's medical record. The PCP is responsible for educating the member on the importance of scheduling an IHA appointment within 120 days of enrollment to establish the patient/doctor relationship and obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status, and the PCP's education efforts with the member and the member refusal to schedule an IHA must be recorded in the member's medical record.

9.5: Initial Health Appointment *(cont'd.)*

Procedure *(cont'd.)*

6. To ensure that newly enrolled Blue Shield Promise members complete an IHA t within 120 days of their enrollment date, Blue Shield Promise will conduct the following monitoring and oversight actions:
    a. Blue Shield Promise will monitor PCP compliance with the requirement to contact new members by email, letter, and/or telephone to assess the current need for an IHA, via randomized medical record reviews conducted on a quarterly basis.
    b. Blue Shield Promise will monitor PCP compliance with the requirement to schedule an IHA for all new members within 120 days of enrollment, via randomized file reviews conducted on a quarterly basis.
    c. After completing the medical record review, the Blue Shield Promise nurse auditor will score the PCP medical record according to the approved scoring guidelines. Compliance will fall into the following categories:
        (i) Pass: 90% and above
        (ii) Not Pass 89% and below
    d. A Corrective Action Plan (CAP) is required for all PCPs who do not pass the IHA medical record audit.
    e. Blue Shield Promise IHA nurse auditors will provide education and resources to PCPs needing assistance with CAP completion.
    f. PCPs currently in the network that are issued CAPS and do not complete applicable CAP or CAPS within the established time frames may be referred to 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.
    g. Blue Shield Promise and the practitioner's/provider's delegated IPA/medical groups may contact practitioners/providers who do not submit their CAP within the established time frames to offer education and resources for assistance.
7. To ensure that newly enrolled Blue Shield Promise members receive follow-up, further evaluation, or referral in a timely manner, when a significant health problem, requiring further evaluation or referral, is identified during the IHA, or another interaction with the PCP, the PCP is responsible for scheduling an appointment date with the member for follow-up within 60 days.
8. Blue Shield Promise will monitor PCP compliance with the requirement to schedule an appointment date for follow-up within 60 days for a member who was identified during the IHA, or another interaction with the PCP, as having a significant health problem, requiring further evaluation or referral enrollment, via randomized medical record reviews conducted on a quarterly basis.

9.5: Initial Health Appointment *(cont'd.)*

Procedure *(cont'd.)*

9. If a new member cancels an IHA or does not show up for the IHA, at least 3 outreach attempts to the member must be conducted by the PCP within 48 hours to reschedule the appointment. All PCP outreach to the member must be documented in the member's medical record.
10. Blue Shield Promise will monitor PCP documentation of the PCPs compliance with the requirement for the PCP to make at least 3 outreach attempts to a new member within 48 hours of a new member canceling or not showing up for an IHA, via randomized medical record reviews conducted on a quarterly basis.
11. If a member refuses to schedule an IHA, the refusal must be documented by the PCP in the member's medical record. The PCP is responsible for educating the member on the importance of scheduling an IHA within 120 days of enrollment to establish care, and the PCP's education efforts must be recorded in the member's medical record.

Provider Incentives

Blue Shield Promise is committed to providing supportive services for network providers and has developed an IHA provider incentive program for contracted network providers who perform IHAs for new Medi-Cal enrollees to Blue Shield Promise. The IHA provider incentive program rewards Blue Shield Promise network providers for ensuring that every member who requires an IHA receives the care they need. Eligible providers can receive payouts that will be made for every IHA completion demonstrated in Blue Shield Promise data systems, via encounter data with a date of service, within 120 days of the member's enrollment in the Blue Shield Promise Health Plan. If a network primary care physician is interested in participating in the Blue Shield Promise IHA Provider Incentive program, providers are encouraged to contact the Blue Shield Promise Provider Services number to inquire about applying for the incentive program.

9.6: Facility Site Review

Overview

The Facility Site Review (FSR) process is a comprehensive evaluation of Blue Shield Promise primary care physician (PCP) offices and includes a review of the physical site, administration, policies and procedures, medical record keeping practices, as well as other critical areas, to demonstrate contractual requirements are met and maintained. Blue Shield Promise maintains policies and procedures that ensure the FSR Program follows the DHCS All Plan Letter 22-017, or most current version, and Title 22 Regulatory requirements, which are mandatory under Blue Shield Promise's contract with DHCS and LA Care Health Plan (for Los Angeles County).

9.6: Facility Site Review *(cont'd.)*

Each PCP site will be evaluated at the time of initial credentialing and at least every three (3) years by Blue Shield Promise, a contracted reviewer, or a County Collaborative Health Plan, according to requirements. Blue Shield Promise participates in the Site Review Collaborative in the County where a site(s) is/are located and will accept reviews completed by Certified Site Reviewers from other contracted Health Plans in the same county. Complete facility site review audit tools and standards as well as additional resources are available under the QIP focus areas heading of the Quality Improvement Program page found at the following link: blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/quality-improvement.

9.6.1: FSR Evaluation

Procedure

1. New providers will be evaluated by the Provider Information and Enrollment (PIE) team to determine whether a valid FSR exists prior to adding a new IPA relationship to the Blue Shield Promise Medi-Cal provider network.
2. If an FSR cannot be validated, the FSR unit will be notified.
3. An FSR will be conducted by Blue Shield Promise upon receipt of a request from the PIE team prior to any Primary Care Physician's site being added to the provider network.
4. The FSR unit will process an FSR for all sites within 60 days of receipt of a request for an FSR or at least 30 days prior to their three-year or annual anniversary date.
5. The FSR will be conducted using the most current review Survey tool as directed by the DHCS and approved by the Blue Shield Promise Medical Directors.
6. Practitioners/Providers for initial credentialing and recredentialing will be contacted a minimum of three (3) times to schedule a mutually agreed-upon date and time to conduct the review. If Blue Shield Promise is unsuccessful in contacting an initial credentialing site, Provider Network Administrators or Credentialing will be notified. If Blue Shield Promise is unsuccessful in contacting a recredentialing site, an auto-scheduled date may be generated to complete the review by the required timelines.
7. The Facility Site Review unit will send a confirmation letter along with a link that contains sample copies of the tools to be used as well as a set of policies and procedures and forms that your office can use to update the office policies and procedures to meet criteria from the Center for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS).
8. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough, and helpful. If a reviewer cannot answer a question, the reviewer will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.

9.6: Facility Site Review *(cont'd.)*

9.6.1: FSR Evaluation *(cont'd.)*

9. After completing the review, the reviewer will score the facility according to the approved scoring guidelines. Compliance will fall into the following categories:
    - Exempted Pass: 90% and above without deficiencies in Critical Elements, Pharmaceutical, or Infection Control sections.
    - Conditional Pass 80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical, or Infection Control sections.
    - Not Pass 79% and below.
    - A Corrective Action Plan (CAP) is required for all sites that have a deficiency in a critical element, Pharmaceutical, or Infection Control sections, regardless of the score.
10. Any CAP considered critical is due within 10 business days of the date of the review. A non-critical CAP for remaining deficiencies will be due 30 days from the date of the issued CAP report.
11. Blue Shield Promise Facility Site Review unit will provide educational and technical support to assist practitioners/providers with the review preparation and applicable CAP completion.
12. New Practitioners/Providers' site locations may request an educational visit. Any non-contractual provider site location that does not receive a passing score on their initial FSR or passes but does not close any applicable CAP(s) per the established timelines, will be required to request a resurvey.
13. Practitioners/Providers currently in the network that are issued CAPS and do not complete applicable CAP or CAPS within the established time frames may be referred to 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.
14. 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 time frames.
15. Practitioners/providers that score below 80% in the FSR or MRR for two consecutive reviews must score a minimum of 80% for both FSR and MRR in the next review. Sites that don't score a minimum of 80% will be removed from the network for a period of three years, and the provider's members will be appropriately reassigned.
16. Blue Shield Promise follows the DHCS FSR standards as written in DHCS All Plan Letter 22-017, or the most current version.

9.6: Facility Site Review *(cont'd.)*

9.6.2: Facility Site Review Categories

1. Access/Safety
2. Personnel
3. Office Management
4. Clinical Services
    - Pharmaceutical Standards
    - Laboratory Review
    - Radiology Review
5. Preventive Services
6. Infection Control

For FSR Review tools and standards, see DHCS All Plan Letter 22-017 or most current version. The most current version may also be provided to the PCP site prior to the scheduled FSR.

9.7: Medical Records

9.7.1: Policy

The onsite or virtual practitioner/provider audit is a comprehensive evaluation of medical records. Through this process, Blue Shield Promise will identify areas of excellence and deficiencies based on approved criteria. Blue Shield Promise will provide information, suggestions, and recommendations to assist providers in meeting and exceeding standards. All primary care physicians will have a complete medical record review (MRR) at each practice location, conducted in conjunction with the facility site review process.

Blue Shield Promise will utilize the most current version of the DHCS Medical Record Review tool to evaluate compliance with DHCS requirements.

Certified Site Reviewers (CSRs) are expected to determine the most appropriate method(s) in each site to ascertain the information needed to complete the review. Review criteria shall be reviewed by approved clinical professionals only. CSRs will be, at a minimum, a registered nurse (RN) however, a nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife may also be able to obtain a CSR certification.

9.7: Medical Records *(cont'd.)*

9.7.1: Policy *(cont'd.)*

Reviewers will ensure the 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 the most current version.

9.7.2: Procedure

1. Medical records shall be randomly selected using the methodology decided upon by the reviewer. Ten (10) medical records are reviewed for each primary care physician (PCP) site. For sites with only adult or only pediatric patient members, all ten records reviewed will be in only one preventive care criteria. For sites with adult and pediatric members, five (5) adults and five (5) pediatric preventive criteria will be reviewed. For PCP sites where the OB-GYN provides both specialty and preventive services, based on the age of the patient, the reviewer must review either adult or pediatric preventive criteria as well as OB Comprehensive Perinatal Services Program (CPSP) criteria.
    a. PCP sites that document patient care performed by multiple PCPs in the same medical record are considered "shared." The MCP must consider shared medical records as those that are not identifiable as "separate" records belonging to any specific PCP. Scores calculated on shared medical records apply only to PCPs sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, 20 records for 4-6 PCPs, and 30 records for 7 or more PCPs based on specialty and/or population served.
        i. Example for determining the number of medical records to review:
            1. A site that has three (3) providers, two (2) providers see only adults and share records, and one (1) only sees pediatrics and does not share records, 10 medical records on the two providers who share medical records and 10 medical records on the provider who does not share records will be conducted and scored separately. A total of 20 medical records shall be reviewed for this site. Two (2) scores will be reported for this site.
2. The medical record review looks at member records related to format, documentation, Continuity/Coordination of Care, Pediatric Preventive Care, Adult Preventive Care, and, if applicable, OB/CPSP Preventive Care. Reviews are completed and scored. The Certified Site Reviewer will conduct the Medical Record Review in conjunction with the Facility Site Review utilizing the most current and approved Medical Record Review Tool.

9.7: Medical Records *(cont'd.)*

9.7.2: Procedure *(cont'd.)*

3. Initial medical records of a new provider will be reviewed within 90 calendar days of the date 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's 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.
5. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough, and helpful. If a reviewer cannot answer a question, he/she will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.
6. Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for review criteria determinations.
7. Compliance levels are:
    a. Exempted Pass = 90%
    b. Conditional Pass = 80-89%
    c. Not Pass is below 79%
8. The minimum passing score is 80%. A Corrective Action Plan (CAP) is required for a total MRR score below 90%. Also, any section 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 will be explained in the comment section.

9.7: Medical Records *(cont'd.)*

9.7.2: Procedure *(cont'd.)*

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. If the CAP is considered non-critical, the provider or designated person 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.
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. 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.
15. If the practitioner/provider's CAP is not received within the established time frames, 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 time frame, the Credentialing Committee may be consulted for additional action which may include panel closure to new members, conducting an annual review, and/or termination from the 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.

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories

Pertinent medical record criteria during Medical Record Review are as follows and is subject to change based on the latest DHCS review tools and standards or Blue Shield Promise discretion:

I. Format Criteria

A. Member identification is on each page.
B. Individual personal biographical information is documented.
C. Emergency "contact" is identified.
D. Medical records are maintained and organized.
E. Members assigned and/or rendering primary care physician (PCP) are identified.
F. Primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.
G. Person or entity providing medical interpretation is identified.
H. Signed Copy of the Notice of Privacy.

II. Documentation Criteria

A. Allergies are prominently noted.
B. Chronic problems and/or significant conditions are listed.
C. Current continuous medications are listed.
D. Appropriate consents are present:
   1) Release of Medical Records
   2) Informed Consent for invasive procedures
E. Advance Health Care Directive Information is offered.
F. All entries are signed, dated, and legible.
G. Errors are corrected according to legal medical documentation standards.

III. Coordination of Care Criteria

A. History of present illness or reason for the visit is documented.
B. Working diagnoses are consistent with findings.
C. Treatment plans are consistent with diagnoses.
D. Instruction for follow-up care is documented.
E. Unresolved/continuing problems are addressed in subsequent visit(s).
F. There is evidence of practitioner review of specialty/consult/referral reports and diagnostic test results.
G. There is evidence of follow-up of specialty consult/referrals made, and results/reports of diagnostic tests, when appropriate.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

IV. Pediatric Preventive Criteria

A. Initial Health Appointment (IHA) Includes H&P. Effective January 1st, 2023, the completion of an Individual Health Education Behavioral Assessment (IHEBA) also known as a SHA (Staying Healthy Assessment form) will no longer be required at the IHA visit.
   1) Comprehensive History and Physical

B. Subsequent Comprehensive Health Assessment.
   1) Comprehensive History and Physical exam completed at an age-appropriate frequency

C. Well-child visit.
   1) Alcohol Use Disorder Screening and Behavioral Counseling
   2) Anemia Screening
   3) Anthropometric Measurements
   4) Anticipatory Guidance
   5) Autism Spectrum Disorder Screening
   6) Blood Lead Screening
   7) Blood Pressure Screening
   8) Dental/Oral Health Assessment
      a) Fluoride Supplementation
      b) Fluoride Varnish
   9) Depression Screening
      a) Suicide-Risk Screening*
      b) Maternal Depression Screening
   10) Developmental Disorder Screening
   11) Developmental Surveillance
   12) Drug Use Disorder Screening and Behavioral Counseling
   13) Dyslipidemia Screening
   14) Hearing Screening
   15) Hepatitis B Virus Infection Screening*
   16) Hepatitis C Virus Infection Screening
   17) Human Immunodeficiency Virus (HIV) Infection Screening
   18) Psychosocial/Behavioral Assessment
   19) Sexually Transmitted Infections (STIs) Screening and Counseling
   20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening*
   21) Tobacco Use Screening, Prevention, and Cessation Services
   22) Tuberculosis Screening
   23) Vision Screening

D. Childhood Immunizations.
   1) Given according to Advisory Committee on Immunization Practices (ACIP) guidelines
   2) Vaccine administration documentation
   3) Vaccine Information Statement (VIS) documentation

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

V. Adult Preventive Criteria

A. Initial Health Appointment (IHA): Includes H&P. Effective January 1st, 2023, the completion of an Individual Health Education Behavioral Assessment (IHEBA) also known as a SHA (Staying Healthy Assessment form) will no longer be required at the IHA visit.
   1) Comprehensive History and Physical

B. Periodic Health Evaluation according to the most recent United States Preventive Services Taskforce (USPSTF) Guidelines.
   1) Comprehensive History and Physical Exam completed at an age-appropriate frequency

C. Adult Preventive Care Screenings.
   1) Abdominal Aneurysm Screening
   2) Alcohol Use Disorder Screening and Behavioral Counseling
   3) Breast Cancer Screening
   4) Cervical Cancer Screening
   5) Colorectal Cancer Screening
   6) Depression Screening
   7) Diabetic Screening
      a) Comprehensive Diabetic Care
   8) Drug Use Disorder Screening and Behavioral Counseling
   9) Dyslipidemia Screening
   10) Folic Acid Supplementation
   11) Hepatitis B Virus Screening
   12) Hepatitis C Virus Screening
   13) High Blood Pressure Screening
   14) HIV Screening
   15) Intimate Partner Violence Screening for Women of Reproductive Age
   16) Lung Cancer Screening
   17) Obesity Screening and Counseling
   18) Osteoporosis Screening
   19) Sexually Transmitted Infection (STI) Screening and Counseling
   20) Skin Cancer Behavioral Counseling
   21) Tobacco Use Screening, Counseling, and Intervention
   22) Tuberculosis Screening

D. Adult Immunizations.
   1) Given according to ACIP guidelines
   2) Vaccine administration documentation
   3) Vaccine Information Statement (VIS) documentation

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

VI. Obstetrician (OB)/Comprehensive Perinatal Services Program (CPSP) Preventive Criteria

A. Initial Comprehensive Prenatal Assessment (ICA).
   1) Initial prenatal visit
   2) Obstetrical and Medical History
   3) Physical Exam
   4) Dental Assessment
   5) Healthy Weight Gain and Behavioral Counseling
   6) Lab tests
      a) Bacteriuria Screening
      b) Rh Incompatibility Screening
      c) Diabetes Screening
      d) Hepatitis B Virus Screening
      e) Hepatitis C Virus Screening
      f) Chlamydia Infection Screening
      g) Syphilis Infection Screening
      h) Gonorrhea Infection Screening
      i) Human Immunodeficiency Virus (HIV) Screening

B. First Trimester Comprehensive Assessment.
   1) Individualized Care Plan (ICP)
   2) Nutrition Assessment
   3) Psychosocial Assessment
      a) Maternal Mental Health Screening
      b) Social Needs Assessment
      c) Substance Use Disorder
   4) Breast Feeding and other Health Education Assessment
   5) Preeclampsia Screening
   6) Intimate Partner Violence Screening

C. Second Trimester Comprehensive Assessment.
   1) ICP
   2) Nutrition Assessment
   3) Psychosocial Assessment
      a) Maternal Mental Health Screening
      b) Social Needs Assessment
      c) Substance Use Disorder Assessment
   4) Breast Feeding and other Health Education Assessment
   5) Preeclampsia Screening
      a) Low Dose of Aspirin
   6) Intimate Partner Violence Screening
   7) Diabetes Screening

9.7: Medical Records *(cont'd.)*

9.7.3: Medical Record Review Categories *(cont'd.)*

D. Third Trimester Comprehensive Assessment.
   1) ICP Update and Follow Up
   2) Nutrition Assessment
   3) Psychosocial Assessment
      a) Maternal Mental Health Screening
      b) Social Needs Assessment
      c) Substance Use Disorder Assessment
   4) Breastfeeding and other Health Education Assessments
   5) Preeclampsia Screening
      a) Low Dose of Aspirin
   6) Intimate Partner Violence Screening
   7) Diabetic Screening
   8) Screening for Strep B
   9) Screening for Syphilis
   10)Tdap Immunization

E. Prenatal care visit periodicity according to most recent American College of Obstetricians and Gynecologists (ACOG) standards.

F. Influenza Vaccine.

G. COVID Vaccine.

H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and assessment of Infant Feeding Status.

I. HIV-related services offered.

J. AFP/Genetic Screening offered.

K. Family Planning Evaluation.

L. Comprehensive Postpartum Assessment.
   1) ICP
   2) Nutrition Assessment
   3) Psychosocial Assessment
      a) Maternal Mental Health Screening/Postpartum Depression screening
      b) Social Needs Assessment
      c) Substance Use Disorder Assessment
   4) Breastfeeding and other Health Education Assessments
   5) Comprehensive Physical Exam

9.7: Medical Records *(cont'd.)*

9.7.4: Physical Accessibility Review Survey (PARS) (FSR Tool Attachment C)

Purpose

To establish Medi-Cal managed care health plan requirements for the implementation of the Facility Site Review (FSR) Tool Attachment C. The DHCS developed the requirements for FSR Attachment C pursuant to Welfare and Institutions (W&I) Code Section 14182(b)(9). The existing site review process, or FSR Tool, detailed in the Medi-Cal Managed Care Division's (MMCD) PL 02-02, remains in effect and will incorporate these requirements for assessing the level of physical accessibility of provider sites, including specialist and ancillary service providers, that serve a high volume of Seniors and Persons with Disabilities (SPDs).

Policy

The physical accessibility review will be conducted for providers servicing the seniors and persons with disabilities (SPD) population which includes PCPs, specialists, and ancillary providers to provide equal and appropriate access to health care treatment and services and network of our providers.

Blue Shield Promise will utilize the most appropriate and current DHCS Physical Accessibility Review Survey (PARS) tools to assess provider sites based on the following categories:

- Attachment C – Primary Care and Specialty Care Providers
- Attachment D – Ancillary Care Providers
- Attachment E – Community-Based Adult Services (CBAS) Providers

Blue Shield Promise has certified clinical and non-clinical personnel to conduct PARS audits.

Procedure

The FSR Attachment C survey is required and may be recertified if there are no structural changes or renovations from the last conducted on-site review date.

1. Accessibility indicators include the following areas:
   A. Parking
   B. Exterior Building
   C. Interior Building
   D. Restroom
   E. Exam Room
   F. Exam Table/Scale
2. Results of Level of Access include:
   A. Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room, and restroom. To meet. Basic Access requirements, all (29) Critical Elements (CE) must be met.

9.7: Medical Records *(cont'd.)*

9.7.4: Physical Accessibility Review Survey (PARS) (FSR Tool Attachment C)

B. Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.

C. Medical Equipment Access: PCP site has height adjustable exam table and patient-accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to the level of Basic or Limited Access as appropriate.

Note: The results of PARS/FSR Attachment Care are informational only and unlike Facility Site Review and Medical Records Reviews, results do not require corrective action. Results may be shared with the provider's office and a copy of the results can be provided upon request. If an office chooses to make a change based on PARS results or recommendations, reviewers can return to perform an additional assessment to update health plan results. The results of this survey are included in the provider directory.

9.8: Access to Care

Blue Shield Promise requires its provider to comply with the standards listed in the attachments of Appendix 4: Access to Care Standards.

Compliance with these standards is monitored through member complaints and grievances, Potential Quality Issues ("PQI"), member satisfaction surveys, medical record reviews, disenrollment, PCP transfers, and annual Access Surveys and Studies. Blue Shield Promise will ensure that accurate provider contact lists are generated for all provider types required to be surveyed for the current Measurement Year.

Blue Shield Promise shall ensure that its provider network is sufficient to provide accessibility, availability, and continuity of covered healthcare services established by regulatory and accreditation standards.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis. Provider network adherence to access standards are monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, and after-hours access.
2. Member complaint data – assessment of member complaints related to access to care.
3. Member satisfaction survey – evaluation of members' self-reported satisfaction with appointments and after-hours access.

9.8: Access to Care *(cont'd.)*

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. The results of the analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.

After Hours Care and Emergencies

Primary and specialty care physicians are required to be available to render emergency care to members 24 hours a day, 7 days a week, either directly or through arrangements for after-hours coverage with an appropriately qualified practitioner/provider. Physicians may provide care in their offices or based on the medical necessity of the case, refer the member to an urgent or emergency care facility. Blue Shield Promise has a nurse on call to arrange for care if a practitioner/provider is unavailable. If a member contacts the Plan about an emergency situation, the Plan will direct the member to an appropriate urgent or emergency care center for immediate assessment and treatment.

Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record.
3. When the Provider must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of members must be accommodated when scheduling appointments. This includes, but is not limited to, wheelchair-using members and members requiring language translation.
5. A process for member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and,
6. A process must be established for member follow-up in the case of missed appointments for a condition that requires treatment, abnormal diagnostic test results, or the scheduling of procedures that must be performed prior to the next visit.

9.8: Access to Care *(cont'd.)*

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any member based on age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental, or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a member's medical (physical or mental) condition or the expectation of the need for frequent or high-cost care. If a PCP chooses to close his/her panel to new members, Blue Shield Promise Health Plan must receive thirty (30) days advance written notice from the Provider.

IPA/medical groups are expected to ensure that each practitioner/provider in their network receives and complies with Appendix 4: Access to Care Standards.

Medi-Cal Laws require organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal manage care enrollee must be comparable to those for Medi-Cal fee-for-service members.

Plan-to-Plan Arrangements

In addition to measuring compliance with clinical appropriateness standards for each member's condition relative to good professional practice, Blue Shield Promise also ensures compliance with the network components offered under plan-to-plan arrangements. Plan-to-Plan arrangements include all or some behavioral health, dental, vision, chiropractic, and acupuncture provider services. Blue Shield Promise ensures that services covered under a plan-to-plan arrangement provide an adequate network for existing and potential member capacity as well as adequate availability of providers offering members appointments for covered services in accordance with the requirements.

9.8.1: Monitoring Process

The effectiveness of this policy will be monitored through oversight by regulatory agencies including DMHC, DHCS, and accrediting entities. Effectiveness will also be measured annually through the annual access to care studies and annual quality improvement program evaluation.

9.8.2: Subcontracted Network Certification Requirement

The Department of Health Care Services (DHCS) requires Medi-Cal managed care plans to implement a subcontracted annual network certification process effective July 1, 2021. A subcontracted network is a network in which Blue Shield Promise has delegated various functions, including but not limited to; claims, credentialing, financial solvency, and utilization management to entities such as groups, independent provider associations (IPAs), hospitals, and applicable vendors.

9.8: Access to Care *(cont'd.)*

9.8.2: Subcontracted Network Certification Requirement *(cont'd.)*

The goal of the subcontracted network certification requirement is to ensure managed care plans (MCPs) that delegate the responsibility of providing Medi-Cal covered healthcare services to subcontracted networks meet network adequacy requirements for each subcontracted network. All subcontracted networks will be subject to the same network adequacy standards required of the primary MCP, as outlined in DHCS APL 23-001, which include:

- Mandatory provider types
- Network capacity and ratios
- Network provider types
- Provider to member ratios
- Telehealth
- Time and distance standards
- Timely access to care

The below grid outlines the mandatory provider types:

Ancillary Services
Hospitals
Long Term Services and Support (LTSS)
Mandatory Provider Types (MPT): • Certified Nurse Midwives (CNM) • Federally Qualified Health Centers (FQHC) • Freestanding Birth Centers (FBC) • Indian Health Care Providers (IHCP) • Licensed Midwives (LM) • Rural Health Clinics (RHC)
Mental Health (non-psychiatry) Outpatient Services (Adult and Pediatric)
Obstetrician/Gynecologist (OB/GYN) Primary Care
Obstetrician/Gynecologist (OB/GYN) Specialty Care
Pharmacies
Primary Care (Adult and Pediatric)
Specialty Care (Adult and Pediatric) Adult and pediatric core specialists: • Cardiology/Interventional Cardiology • Dermatology • Endocrinology • ENT/Otolaryngology • Gastroenterology • General Surgery • Hematology • HIV/AIDS Specialists/Infectious Diseases • Nephrology • Neurology • Oncology • Ophthalmology • Orthopedic Surgery • Physical Medicine and Rehabilitation • Psychiatry • Pulmonology

9.8: Access to Care *(cont'd.)*

9.8.2: Subcontracted Network Certification Requirement *(cont'd.)*

The full list of network adequacy standards may be found on the DHCS website in Attachment A of APL 23-001.

Subcontracted networks will need to meet network adequacy standards for the scope of services they are contracted to provide. If Blue Shield Promise determines that a subcontracted network will not be certified, we must clearly explain the reason(s) and work with the subcontracted network to ensure that members within the network would otherwise be able to access appropriate care.

9.8.3: Advanced Access

Blue Shield Promise may collect information from participating providers and participating IPA/medical groups on an ongoing basis to identify those providers, and IPA/medical groups with affiliated primary care physicians who are compliant with California's appointment availability standards because of their Advanced Access Program or practices. Blue Shield Promise recognizes the definition of advanced access from the Knox Keene Act's regulations (see Rule 1300.67.2.2, subd. (b)(1)); the definition is as follows:

> "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care physician such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day."

Advanced Access is a way of scheduling appointments that allow patients to seek and receive care from a qualified provider the same day or the next day, as opposed to weeks in the future. Typical physician schedules are fully booked for days or weeks in advance, meaning that when patients call for appointments, they cannot be seen that day or the next day. Consequently, wait times for appointments can be long, and patients may opt to use an emergency department instead or may not show up for their appointment. By contrast, when a physician offers Advanced Access, there is less backlog; and patients needing to be seen are offered an appointment on the day that they call or within 24 hours.

There are many ways to offer Advanced Access and ultimately comply with timely access standards, such as saving a daily block of time for appointments or keeping a few appointments available throughout the day for same-day or next-day appointments.

9.8: Access to Care *(cont'd.)*

9.8.3: Advanced Access *(cont'd.)*

There has been ongoing interest in advanced access as waiting times for routine healthcare have lengthened over time, potentially leading to concerns about negative health outcomes and emergency department overuse. Participating providers and IPA/medical groups that use an Advanced Access Program contend that it reduces patient wait times, improves continuity of care, and reduces missed appointments.

Conversely, Blue Shield Promise requires participating providers and IPA/medical groups give written notice to Blue Shield Promise no more than 30 calendar days after a provider stops offering advanced access appointments to ensure compliance with Section 1367.03(d) and Rule 1300.67.2.2(b)(1), (c)(5)(I), (d)(2)(E) and (h)(6)(D) concerning Advanced Access verification requirements.

9.9: Broken/Failed Appointments

9.9.1: Broken/Failed Appointment Follow-up

Policy

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients. DHCS requires that missed/broken appointments must be documented in the medical record on the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours.

Procedure

The following is a sample "Broken/Failed Appointment" protocol which may be implemented by practitioner/provider offices if no other protocol is currently in place. Blue Shield Promise will monitor its provider network for compliance via oversight activities that may include medical record review, provider surveys, and/or review of provider policies.

1. To ensure timely and efficient recall of patients who fail to keep scheduled appointments. The primary care and/or specialty care practitioner/provider is responsible to:
    a. Determine daily whether and what type of follow-up is necessary.
    b. Document this decision in the patient chart, using a "Broken/Failed Appointment" rubber stamp. An example is provided here:

9.9: Broken/Failed Appointments *(cont'd.)*

9.9.1: Broken/Failed Appointment Follow-up *(cont'd.)*

Broken/Failed Appointments

Broken appt. date:
Review date:
Follow-up req:
Follow-up ASAP:
New appt. date:
Practitioner/provider signature:
Completed by:

2. At the end of each day the receptionist will determine which patients failed to keep their appointment by:
   a. Checking the appointment schedule and making a list of all failed appointments.
   b. Gathering the pulled charts which were ready for appointments (Charts are pulled the day before scheduled appointments).
3. Use a progress sheet with the latest date or a new progress sheet and stamp the sheet with the "Broken/Failed Appointment" rubber stamp.
4. Attach the progress sheet to the medical record and forward it to the primary care physician.
5. The medical assistant (M.A.) or designated individual will review all charts of those patients who missed an appointment and wait for further orders from the practitioner/provider.
6. The practitioner/provider will review the chart to determine the need for patient recall.
7. The practitioner/provider will complete items 2, 3, and 6 as needed, on the Broken/ Failed Appointment" rubber stamp, using the following guidelines:
   - Item 2 – Write in review data
   - Item 3 – Enter a checkmark if follow-up action is ordered
   - Item 4 – Enter a checkmark if the patient is to return to the clinic as soon as possible
   - Item 6 – Enter signature and title
8. If the patient needs follow-up, the M.A. or designated individual shall try to contact the patient.
9. one time by phone. If there are no results, a recall postcard or letter will be mailed out to the patient's current address of record. A copy will be filed in the chart.
10. Every attempt to contact the patient, with the date and time of each attempt, must be documented in the progress notes. Only the following staff may document patient recall activities in the medical record: M.D., P.A., N.P., R.N., L.V.N., or M.A.

9.9: Broken/Failed Appointments *(cont'd.)*

9.9.1: Broken/Failed Appointment Follow-up *(cont'd.)*

11. The M.A. completes items 1, 5, and 7 as needed on the broken/failed appointment stamp using the following guidelines:
    - Item 1 – Enter the date of the broken appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 6 – Enter the date, signature, and title of the person doing the recall activity.
12. The broken/ failed appointment will also be documented in the appointment schedule for tracking purposes.
13. The practitioner/provider is responsible for final decisions concerning a broken/ failed appointment follow-up. Patients being followed for reportable conditions shall also be reported to the local health authority.
14. The administrator or office manager is responsible for:
    a. Assuring that all clinic personnel are aware of their responsibilities under this procedure.
    b. Designating, in conjunction with the Medical Director, the persons responsible for implementing this policy.
    c. Periodically monitoring the performance of staff in carrying out their duties.

9.10: Advance Directives

A primary care physician is required to offer and/or educate each member 18 years or older about advance directives. This must be documented in the medical record. The member is not required to sign an advance directive but must be informed and educated about what an advance directive entails.

9.11: Clinical Telephone Advice

Policy

1. All telephone calls from patients with problems or medical questions must be documented (by date and time of call and return phone number) and promptly brought to the attention of the doctor.
2. At no time shall office personnel give medical advice without the direct involvement of the practitioner/provider or physician assistant.
3. The doctor must renew all prescriptions.
4. In the event a patient calls with a medical emergency, the patient will be instructed to call 911 immediately.
5. Medical groups that offer or contract with a company to offer telephone medical advice services must ensure that the service meets the requirements of Chapter 15 of Division 2 of the Business and Professionals Code, which include registration and monitoring.

9.11: Clinical Telephone Advice *(cont'd.)*

Services that only direct patients to the appropriate setting for care (e.g., hospital or urgent care clinic) or prioritize physician appointments are not considered telephone medical advice services.

Blue Shield Promise contracts with a certified vendor for a 24-hour Nurse Advice Line.

9.12: HEDIS Measurements

Use of Practitioners/Providers Performance Data

Practitioners and providers will allow Blue Shield Promise to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). Blue Shield Promise will also share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your Quality Program Manager.

Blue Shield Promise can assist providers in improving performance on quality measures. Various tools and resources are available, including HEDIS tip sheets. To obtain these resources and for the most current descriptions and list of HEDIS and MCAS measures, contact your Quality Program Manager.

Refer to Appendix 14: HEDIS Measurements for the list of all HEDIS measurements.

9.13: Credentialing Program

Purpose

To ensure that all network practitioners/providers meet the minimum credentials requirements set forth by Blue Shield Promise and the regulatory agencies including, but not limited to, the NCQA, DHCS, DMHC, CMS, L.A. Care, other regulatory agencies and credentialing mental health parity regulations for participation in the network. At least every three (3) years, the practitioners/providers are required to undergo recredentialing to ensure that they are in compliance with these standards.

9.13: Credentialing Program *(cont'd.)*

Scope

The credentialing program applies to all directly contracted and delegated practitioners, who are affiliated with Blue Shield Promise through their relationship with a contracted IPA/medical group. Blue Shield Promise requires the credentialing of the following independent contracted practitioners: physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), acupuncturists (AC), optometrists (OD), occupational therapists (OT), physical therapy (PT), speech therapists (SP), speech language pathology (SLP), certified orthotists, certified ocularists, dispensing opticians, telemedicine practitioners and mid-level practitioners/providers (PA, NP, CNS and CNM/NMW) 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), licensed psychologists (PhD, PsyD), qualified autism service providers or professionals with a license or certification, 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.

Blue Shield Promise does not credential hospital-based practitioners (i.e., radiologists, anesthesiologists, pathologists, and emergency medicine physicians) who practice exclusively in an inpatient setting and provide care of Blue Shield Promise members because Blue Shield Promise members are directed to the hospital.

Objectives

- To ensure that all practitioners/providers, including both directly contracted and delegated, who are added to the network meet the minimum Blue Shield Promise requirements.
- Blue Shield Promise practitioners/providers are evaluated for, but not limited to, education, training, experience, claims history, sanction activity, and performance monitoring.
- To ensure that network practitioners/providers maintain current and valid credentials.
- To ensure that network practitioners/providers are compliant with their respective state licensing agency and Medi-Cal programs, and Blue Shield Promise has a process to ensure that appropriate action is taken when sanction activity is identified.
- To establish and maintain standards for credentialing and to identify opportunities for improving the quality of practitioners/providers in the network.

Credentialing Policies and Procedures

Policies and procedures are reviewed annually and revised as needed to meet the NCQA, DHCS, DMHC, CMS, L.A. Care, state, federal, and credentialing mental health parity regulatory agencies' requirements.

9.13: Credentialing Program *(cont'd.)*

Policies and procedures are reviewed by the Medical Director and submitted to the Credentials Committee and Compliance Department for review and approval.

Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners/providers contracted with Blue Shield Promise. The Medical Director serves as chairman of the Credentials Committee, which is comprised of a multi- specialty panel of practitioners/providers in the Blue Shield Promise network, the Credentialing Manager and any additional physicians as needed, for their professional expertise. However, only physicians have the right to vote in the Credentials Committee Meeting. A minimum of three (3) voting members is considered a quorum. The Credentials Committee meets at least once a month but not less than quarterly. If there is a need, the committee will conduct an ad-hoc meeting.

The responsibilities of the Credentials Committee include but are not limited to:

- Review, recommend, and approve/deny initial credentialing, recredentialing, ongoing monitoring activities and inactivation/termination of directly contracted and delegated practitioners/providers for the Blue Shield Promise network;
- Review and approve credentialing policies and procedures and ensure they are in compliance;
- Review and recommend actions for all network practitioners/providers identified with sanction activities from the state licensing agency, Preclusion list, Medi-Cal suspended and ineligible list, SAM, CHHS (Medi-Cal Enrollment) and OIG;
- When there is a quality deficiency, appropriate authorities were reported; and
- Fair Hearings are offered and carried out in accordance with the established policies and procedures.

9.13.1: Credentials Process for Directly Contracted Physicians

The Credentials Committee is responsible for making decisions regarding initial credentialing, recredentialing, and changes to credentials, and inactivation of all directly contracted practitioners/providers.

Blue Shield Promise has adopted 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 needs to be included in the application process.

1. Reasons for inability to perform the essential functions as a provider, with or without accommodation.
2. Lack of present chemical dependency or substance abuse, including illegal drugs.
3. History of loss of license and felony convictions.

9.13: Credentialing Program *(cont'd.)*

9.13.1: Credentials Process for Directly Contracted Physicians *(cont'd.)*

4. History of loss or limitations of privileges or disciplinary activities.
5. Attestation regarding the correctness and completeness of the application.

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

1. A copy of his/her current professional license to practice.
2. A copy of a current and valid Drug Enforcement Administration (DEA) certificate (if applicable).
3. A copy of a current malpractice insurance certificate with the practitioner listed as insured with the minimum required coverage. For practitioners with federal tort coverage, a copy of the federal tort letter is required.
4. 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.
5. A copy of the board certificate (if applicable).
6. Medicare number, Medi-Cal number and NPI.
7. Physician Supervisory Agreement (for Midlevel only as applicable).
8. A copy of the ECFMG certificate (if applicable).
9. A written explanation regarding any sanction activity, malpractice judgments in the last five (5) years or pending claims, restriction of privileges, etc.

Upon receipt of a completed application, Blue Shield Promise for Behavior Health/Mental Health/Substance Abuse practitioners/providers will confirm receipt and completeness of application within 7 business days and complete review of application within 60 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.

An initial facility site review/medical record review of all PCP offices are required prior to inclusion into the Blue Shield Promise network. This will be a structured visit, in accordance with the QI facility site review and medical record procedures. The FSR must be conducted prior to the initial credentialing decision and every three (3) years thereafter.

Upon completion of the credentialing verification process, a report summarizing each applicant's credentials is forwarded to the Credentials Committee for review and action. If the Committee recommends denial, limitation, suspension, or termination of membership based on a medical disciplinary cause or reason, the practitioner shall be entitled to a formal hearing pursuant to the Fair Hearing policy. The Fair Hearing policy does not apply to mid-level practitioners.

9.13: Credentialing Program *(cont'd.)*

9.13.1: Credentials Process for Directly Contracted Physicians *(cont'd.)*

A report of the Credentialing activity is forwarded to the Quality Management Committee for approval. The Credentialing Committee's approval date is considered as the final credentialing approval date.

The Credentialing Department notifies the Contracting Department or the Promise Provider Relations (PPR) for credentialing activities on a monthly basis. The monthly distribution includes a practitioner/provider listing and practitioner/provider profiles. The Contracting Department and PPR will follow their procedures for executing the contract and adding the practitioner/provider to the network. If a practitioner chooses to opt-out of Medi-Cal due to not meeting Medi-Cal requirements, including Medi-Cal required New Provider Orientation, the provider will have to inform the plan that the practitioner is Opting-Out of Medi-Cal network. When a practitioner meets all Medi-Cal requirements, the practitioner will need to be re-submitted for practitioner to be Opted-back into Medi-Cal network. This does not replace meeting Minimum Credentialing Requirements and completing the Credentialing process.

9.13.2: Minimum Credentials Criteria

All practitioners will be credentialed and recredentialed in accordance with the approved policies established by Blue Shield Promise.

1. All applicants will meet the following minimum credentialing requirements:
    a. Name
    b. Professional Title
    c. Office Address
    d. Telephone and fax numbers
    e. Office Hours
    f. Provider Type (PCP/Specialist)
    g. Specialty with Board Certification Status or Complete Internship/Residency Training
    h. Languages Spoken by Provider and Staff; includes American Sign Language
    i. Non-English languages spoken by qualified medical interpreter
    j. California Medical License Number. Must hold and maintain a current and unrestricted State medical or professional license.
    k. Hold a current and valid DEA certificate, if applicable.
    l. Tax Identification Number
    m. National Provider Identifier (NPI)

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

n. Maintain current hospital privileges in the requested specialty at a Blue Shield Promise contracted hospital. This requirement may be waived only if the physician arranges for another Blue Shield Promise practitioner/provider to provide hospital coverage at a contracted hospital. This arrangement must be documented in writing by the covering physician and submitted to Blue Shield Promise. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, pathology, radiology, psychology, and optometry)

o. Initial Approved/Recredentialed Date

p. Birth Date

q. Medi-Cal Number

r. Gender

s. Ethnicity

t. Panel Status:

   1. Accepting new patients

   2. Accepting existing patients

   3. Available by Referral only

   4. Available only through a hospital or facility; or

   5. Not accepting new patients

u. Email address if permitted by provider via written communication

v. FQHC or Clinic name

w. If applicable, website URL for each service location

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.

y. Meet minimum training requirements for the requested specialty. The applicant must have no mental or physical conditions that would, with reasonable accommodation, interfere with his/her ability to practice within the scope of the privileges requested.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

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.

1. Have no felony convictions.

2. Be able to provide coverage to members, either personally or through appropriate physicians 24 hours per day, seven (7) days per week.

3. Agree to abide by Blue Shield Promise policies and procedures.

4. PCPs are required to have a passing score on the facility site review and medical record review.

2. All applicants will meet the following minimum training requirements: Physicians (MD, DO) must be either:

a. Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards;

b. Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board; or

c. A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969 and had been in practice full time since may be "grandfathered" into Family Practice.

1. The physician has completed an International Medical Graduate (IMG) training program and has completed a Canadian or British Isles residency program. (The ABMS formally recognizes Canadian and British medical schools and residencies as equivalent to US training but does not recognize Canadian and British Specialty Boards.)

2. Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Foot and Ankle Surgery (ABFAS) [formerly American Board of Podiatric Surgery ("ABPS")] or American Board of Podiatric Medicine (ABPM) [formerly American Board of Podiatric Orthopedics and Primary Podiatric Medicine ("ABPOPPM")];

3. Optometrists (OD) are required to complete a professional degree in Optometry.

4. 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).

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

5. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialist (CNS) and nurse midwives (NMW) must have successfully completed the academic program required for the requested status or required training. For example, a nurse practitioner must have completed a nurse practitioner academic program.
6. Allied health professionals are required to have successfully completed the professional degree/program required for their requested specialty.
7. The HIV specialist must meet any one of the following four criteria:
    - Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.
    - Board certified in HIV medicine by a member board of the American Board of Medical Specialties.
    - Board certified in Infectious Disease and meets the following qualifications:
        - In the immediately preceding 12 months, has provided continuous and direct medical care to a minimum of 25 patients who are infected with HIV.
        - In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
    - Meets the following qualifications:
        - In the immediately preceding 24 months, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV.
        - Has completed any of the following:
            i. In the immediately preceding 12 months, has obtained board certification or recertification in infectious disease.
            ii. In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients.
            iii. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

- The HIV specialist may utilize the services of a nurse practitioner or physician assistant if:
  - The nurse practitioner or physician assistant is under the supervision of an HIV specialist.
  - The nurse practitioner or physician assistant meets the qualifications specified above.
  - The nurse practitioner or physician assistant and the supervising HIV specialist have the capacity to see an additional patient.

Recredentialing

At least every three (3) years, a practitioner/provider must be recredentialed to maintain his/her membership with Blue Shield Promise. Six (6) months prior to the recredentialing due date, the Credentialing Department will mail out a recredentialing application to non-CAQH participant practitioner/provider or will retrieve the recredential application from CAQH for CAQH participant practitioner/provider. The non-CAQH participant practitioner/provider will be instructed to complete the application with current information, complete an attestation questionnaire, sign, date the appropriate pages, and return it with the supporting documentation as required to the Credentialing Department. A cover letter stating that failure to return the recredentialing application by its deadline may be considered a voluntary resignation by the practitioner/provider. Upon receipt of a completed recredentialing application, the Credentialing Department will follow its procedures in processing the application for recredentialing. If the recredentialing application is not received by Blue Shield Promise Credentialing Department by the given time frame, a follow- up for recredentialing will be mailed to the practitioner/provider. A final follow- up will be sent to practitioners/providers who have not returned their applications after 90 days from the initial mailing. The Contracting Department will be notified of the practitioners/providers who are non-responsive to the recredentialing requests and will follow their procedures for appropriate action, including administrative termination for non-compliance.

Credentialing Time Limit

The primary source verifications must be completed, and the provider's attestation must be signed and dated within 180 calendar days prior to the Credentialing Committee decision.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

Practitioners/Providers' Rights

Practitioners/Providers shall have the right to:

- Review all non-protected information obtained from any outside source in support of their credentialing applications, except references or recommendations protected by peer review laws from disclosure.
- Respond to information obtained during the credentialing process that varies substantially from the information provided by the practitioner/provider.
- Correct erroneous information supplied by another source during the credentialing verification process.
- Be notified of their rights in the initial and recredentialing application packet.

Confidentiality of Credentials Information

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in locked file cabinets in the Credentialing Department, which is kept locked when not occupied. Only authorized personnel will have access to credentials files. Practitioners/providers may access their files in accordance with the established policies. All confidential electronic data will be access-controlled through passwords. Access will be assigned based on job responsibility, and on a need-to-know basis. All Credentials Committee members, guests, and staff involved in the credentialing process will sign a confidentiality agreement at least annually.

Sanction Review

Blue Shield Promise queries the National Practitioner Data Bank, Office of Inspector General (OIG), Medi-Cal Suspended, Ineligible, SAM, and state licensing agencies at the time of initial and recredentialing to determine if there have been any sanctions placed or lifted against a practitioner/provider. Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner/provider is directly contracted with Blue Shield Promise, then the practitioner/provider is notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome. If the practitioner/provider is delegated to an IPA/medical group, then the affected IPA/medical group is notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the IPA/medical group's response, is forwarded to the Credentials Committee for review and action.

Blue Shield Promise also monitors the practitioner for license, DEA, and malpractice insurance expiration dates. On a monthly basis, the Credentialing Department runs a report for the medical/ professional license, DEA, and malpractice insurance due to expire within the following month.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the U.S. Drug Enforcement Administration or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

Summary Suspension of a Practitioner's Privileges

- Immediate action will be taken to suspend a practitioner's privileges in the event of a serious adverse event. A serious adverse event is defined as any event that could substantially impair the health or safety of any member.
- Immediate action will also be taken to suspend a practitioner's privileges in the event the practitioner fails to meet the following minimum credentialing criteria:
    1. The practitioner's license to practice has been revoked, suspended, or under any type of restriction or stipulation, including probation, by the state licensing agency.
    2. The practitioner has been suspended from the Medi-Cal program; however, this does not apply to practitioners who participate in only in the Medicare program.
    3. The practitioner fails to maintain the minimum malpractice liability coverage.
- Should a practitioner/provider fail to meet the minimum credentialing criteria as described above, Blue Shield Promise will allow the practitioner/provider a chance to correct the deficiency before inactivating the practitioner/provider. Upon knowing that a practitioner/provider is noncompliant, the Credentialing Department will notify the practitioner/provider immediately in writing of the deficiency. The notification will specify the methods available for correcting the deficiency and the time frame allowed for the submission, and that failure to correct the deficiency will result in immediate inactivation.
- Any information regarding an adverse event will be forwarded to the QI Department as a potential quality issue (PQI) and handled in accordance with the established policies and procedures.
- The Medical Director has the authority to immediately suspend any or all portions of a practitioner/provider's privileges in the event of a serious adverse event (as defined above). The written notice will include a notice of the practitioner's right to a Fair Hearing. (Please refer to Policy CR109 formally 70.1.3.10 Fair Hearing Plan for detail.)
- A summary suspension of a practitioner's membership or employment is imposed for a period in excess of fourteen (14) days.
- The notice of suspension shall be given to the legal department for ratification. In the event of suspension, the practitioner's members shall be assigned to another practitioner/provider. The wishes of the patient shall be considered, where feasible, in choosing another practitioner/provider.

9.13: Credentialing Program *(cont'd.)*

9.13.2: Minimum Credentials Criteria *(cont'd.)*

Blue Shield Promise will adhere to the California Business and Professional Codes requirements for submitting 805 and 805.01 reports to the Medical Board of California and to the Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner Data Bank and to the State Medical Board.

Health Delivery Organizations

Prior to contracting with, and at least every three (3) years thereafter, Blue Shield Promise will re- evaluate health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, clinical laboratories, hospices, birthing centers, 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 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: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications

Primary Care Physicians

A primary care physician (PCP) is a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care. This means providing care for the majority of health care problems, including but not limited to, preventive services, basic case management, acute and chronic conditions, and psychosocial issues.

PCP services will be provided by appropriately trained personnel, typically, although not exclusively:

- General practitioners;
- Providers board certified or board qualified in family practice, internal medicine, or pediatrics; or
- OB/GYN practitioners with at least one year of a stateside rotating internship in primary care medicine and attest to practicing primary care medicine for the last 5 years.

PCP Procedure

1. The PCP is responsible for the management and coordination of the patient's complete medical care for covered services. A PCP must be knowledgeable about preventive care and is expected to provide their patients with a periodic evaluation of all body systems. It is expected that a PCP will have the expertise to perform the basic medical services. The PCP provides those services that can be provided appropriately within their skills and refers to specialty care when additional knowledge or skills are required.
2. The PCP will arrange for laboratory tests, x-rays, referral to specialists, hospitalization, or any other covered health care services that are medically necessary.
3. A referral is required for cases that are difficult to manage and/or when care is beyond the scope of practice for the PCP. All procedures and care for which the PCP has not received training or has had experience will be referred to a specialist.
4. Referrals to participating and non-participating specialists for capitated members are subject to any additional rules imposed by the contracting medical group.
5. The PCP must ensure timely receipt of the specialist's report. If the PCP has not received the specialist's report within 30 days, the PCP should contact the specialist to obtain the report. When appropriate, a follow-up appointment with the PCP should be scheduled within 30 days of the specialty care.
6. Medical record documentation should be legible and include reason for the referral to specialty care; written report from the specialist regarding the findings, treatment, and recommendations; date of return visit or a notation that no-follow up appointment is required. When the patient has been hospitalized, there should be evidence that the PCP is aware of the patient's status and follow-up.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

7. Medical record documentation should be legible and include reason for the referral to specialty care; written report from the specialist regarding the findings, treatment, and recommendations; date of return visit or a notation that no-follow up appointment is required. When the patient has been hospitalized, there should be evidence that the PCP is aware of the patient's status and follow-up.
8. PCPs are also expected to:
    a. Ensure access to care 24 hours a day in the most appropriate setting;
    b. Refer members to specialists and ancillary services as necessary;
    c. Maintain confidentiality of medical records;
    d. Provide preventive health services and health education services;
    e. Comply with Blue Shield of California Promise Health Plan requirements and procedures;
    f. Ensure medical records are available to Blue Shield Promise and other regulatory and oversight agencies;
    g. Forward to Blue Shield Promise, within 24 hours, all member grievances received at the practitioner level through an established and documented grievance process;
    h. Comply with Blue Shield Promise credentialing requirements; and;
    i. Ensure adherence to all aspects of office and facility audits.

Additional Requirements

- A practitioner applying for General Practice in the Medi-Cal line of business must meet one of the following requirements:
    - Has completed at least one (1) year of stateside training in primary care medicine (Internal Med or Family Practice) and must complete two years training in the requesting specialty program; or
    - Has completed at least one (1) year of specialized training (not in primary care medicine) in the United States and provide two (2) letters of recommendation from other primary care physicians.

  Age Limitation Exception: General Practice 0-110, Internal Medicine 16-110, Pediatrics 0-21, Family Practice 0-110 and OB/Gyn 13-110.
- OB/GYN: An OB/GYN requesting to participate as a PCP must meet the following requirements:
    - Have completed at least one (1) year of stateside primary care medicine.
    - If an OB/GYN has completed at least one (1) year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from primary care physicians for the primary care training.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Non-Physician Medical Practitioners (NPMP)

Non-Physician Medical Practitioners include Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (C.N.S.). Blue Shield Promise must ensure that the applicable NPMP's are under the supervision of a direct-contracted physician. A supervising physician directs the practice of the NPMP's, who act as an agent to the supervising physician. The number of non-physician medical practitioners who may be supervised by a single primary care physician shall be in accordance with applicable professional licensing statutes and regulations.

The use of NPMP's must fall within the individual's scope of practice, as determined by the respective licensing board. The responsibility to comply with regulations of the NPMP's respective licensing board belongs to the supervising physician.

NPMP requiring supervision must have a supervising practitioner agreement, completed, and signed by both the NPMP and a contracted supervising physician.

Street Medicine NPMP: A supervising physician must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols.

Nurse Practitioners (NP)

Assembly Bill 890 (AB 890) grants nurse practitioners full practice authority allowing them to work without physician supervision. To practice in an integrated setting, NPs must hold national certification and carry liability insurance. If an NP is interested in solo practice, completion of a three (3) year transition to practice will be required as well.

AB 890 allows NPs to practice to the full extent of their education and training and allows direct access to health care for millions of Californians who now have coverage, but often struggle to find healthcare providers. A nurse practitioner shall verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada." A nurse practitioner shall post a notice in a conspicuous location accessible to the public that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Certified Nurse-Midwife (CNM)

Senate Bill 1237 (SB 1237) states that certified nurse-midwives who attend cases of low-risk pregnancy and childbirth and provide prenatal, intrapartum, and postpartum care, including family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board, are not required to practice under the supervision of a physician.

SB 1237 authorizes a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-up policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon to provide a patient with specified services. If the nurse-midwife does not have those mutually agreed-upon policies and protocols in place, the bill, except as specified, would requires the patient to be transferred to the care of the physician and surgeon to provide those services, and would authorize the return of the patient to the care of the nurse-midwife after the physician has determined that the condition of circumstance that required, or would require, the transfer is resolved. Hospital privileges are required if the certified nurse-midwife patient's planned place of birth is in the hospital. DEA schedule II and III controlled substances furnished certificate is required if the certified nurse-midwife who is ordering controlled substances ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. Certified nurse-midwives must be certified by the American Midwifery Certification Board.

SB 1237 requires a certified nurse-midwife to refer all emergencies to a physician and surgeon immediately and authorizes a certified nurse-midwife to provide emergency care until the assistance of a physician and surgeon is obtained. SB 1237 requires a certified nurse-midwife who is not under the supervision of a physician and surgeon to provide oral and written disclosure to a patient and obtain a patient's written consent, as specified. The bill requires a certified nurse-midwife who is authorized to furnish or issue a drug order for a controlled substance to additionally register with the Controlled Substance Utilization Review and Enforcement System (CURES).

9.13: Credentialing Program *(cont'd.)*

9.13.3: Specialty Credentialing Specifications *(cont'd.)*

Mental Health and Substance Use Disorder Providers

Assembly Bill 2581 requires the following procedures be put in place for Mental Health/Substance Use Disorder providers, effective January 1, 2023:

- All Mental Health/Substance Use Disorder providers, upon receipt of a completed application, will receive an application received letter within seven days to verify receipt and inform the applicant whether the application is complete.
- All complete Mental Health/Substance Use Disorder provider applications for credentialing will be completed within sixty days.

Street Medicine Providers

Street Medicine is defined as being provided to an individual experiencing unsheltered homelessness in their living environment, in places not intended for human habitation. Mobile units and RVs that go to the individual experiencing unsheltered homelessness in their living environment ("on the street") are considered street medicine as specified in APL 22-023.

Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location do not qualify as street medicine, it is considered mobile medicine, as it requires people experiencing unsheltered homelessness to visit a health care Provider at the Provider's fixed, specified location.

DHCS does not require a street medicine provider to be affiliated with a brick-and-mortar facility and does not prescribe any particular contracting type for MCPs and street medicine providers.

Street Medicine providers may provide medical services in the role of the members assigned primary care physician (PCP) for members experiencing homelessness and must meet eligibility criteria for being a PCP.

Non-Specialty Mental Health Services (NSMHS)

Non-Specialty Mental Health Services Practitioners include Licensed Clinical Social Workers (LCSW), License Professional Counselors (LPCC), License Marriage and Family Therapist (LMFT), Licensed Psychologist, Psychiatric Physician Assistants (PA), Psychiatric Nurse Practitioners (NP), and psychiatrists with practitioner training and licensure requirements.

The Credentialing Committee may consider other exceptions as it deems necessary and/or appropriate. The Chief Medical Officer may recommend the acceptance of an applicant even if the practitioner/provider does not satisfy minimum criteria if there is a determined need and if there is credible evidence that the practitioner/provider is capable of providing the services requested.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups

IPA/medical groups that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non-physician practitioners/providers in accordance with the above Blue Shield Promise policies and procedures, NCQA, DHCS, DMHC, CMS, L.A. Care guidelines, and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years. Medi-Cal enrollment is required to participate in the network.

Blue Shield Promise retains ultimate responsibility and authority for all credentialing activities. Blue Shield Promise will assess and monitor the IPA/medical group's delegated credentialing activities as follows:

1. The Credentialing Delegation Oversight Auditor will conduct pre-delegation and annual audits in accordance with the Delegated Oversight Policies and Procedures. The audit will include a review of the IPA/medical group's policies and procedures, credentialing system controls process and oversight monitoring, Credentialing Committee minutes, ongoing monitoring, organizational provider credentialing, sub-delegation oversight activities, quarterly reports, Medi-Cal enrollment verification process, and credentials files, as applicable. The Health Industry Collaboration Effort (HICE) standardized audit tool will be used to conduct an audit. The audit tool can be found on the HICE website under *Approved HICE Documents.* The IPA/medical group will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, at least two (2) weeks prior to the scheduled audit date.
2. Blue Shield Promise will use one of the following techniques for the file review:
    a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield Promise auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed for the audit to the IPA/medical group. The Blue Shield Promise auditor will audit the files in the order indicated on the file selection list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files for the non-compliant element.
    b. The NCQA's 5 percent or 50 file review methodology of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

3. After completion of the initial file review, the auditor will follow the same procedure for the recredential file review and review performance monitoring data and recredentialing timeliness (work history and education/training is not applicable at recredentialing).
4. To be delegated and to continue delegation for credentialing, IPA/medical groups must meet the minimum standards by scoring at least 95%. If the IPA/medical group scored below 95%, a corrective action plan (CAP) is required. IPA/medical groups must submit a response addressing all deficiencies and action plan to Blue Shield Promise Credentialing Delegation Oversight Department within 30 days of the receipt of the notification. After reviewing the CAP, the IPA/medical group will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.
5. The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements prior to closing the audit.
6. Delegated credentialing status may be terminated by Blue Shield Promise at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
7. Blue Shield Promise retains the right to approve, suspended and terminate practitioners/providers or sites based on issues with quality of care.
8. Delegated IPA/medical groups are required to submit a quarterly report for practitioners/providers credentialing, recredentialing, termination and suspension activities, and quality improvement activities utilizing the Health Industry Collaboration Effort (HICE) standardized reporting tools found on the HICE website under *Approved HICE Documents*.

   Quarterly reports are due on the following dates:

   - 1st Quarter due May 15th (January 1st – March 31st)
   - 2nd Quarter due August 15th (April 1st – June 30th)
   - 3rd Quarter due November 15th (July 1st – September 30th)
   - 4th Quarter due February 15th (October 1st - December 31st)

   Reports may also include credentialing and recredentialing activity of Organizational Providers if oversight responsibility is delegated.

   Reports are submitted to the designated credentialing mailbox, and/or the Delegation Oversight Auditor assigned to the group.
9. The IPA/medical group must develop and implement policy and procedures describing its credentialing system controls and monitoring process. (Applies to paper and electronic processes.)

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

The credentialing system controls policy and procedures include:

1. How primary source verification information is received, dated, and stored.
2. How modified information is tracked and dated from its initial verification to include:
   - When the information was modified.
   - How the information was modified.
   - Staff who made the modification.
   - Why the information was modified.
3. All staff titles or roles authorized to review, access, modify, and delete information, and circumstances when modification or deletion is appropriate.
4. The security controls in place to protect the information from unauthorized modifications. Policies must describe the following and must comply with NCQA standards and guidelines:
   - Limiting physical access to the operating environment that houses credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.
     - Physical access may include, but is not limited to, the organization's computer servers, hardware and physical records and files.
     - Physical access does not refer to the organization's building or office location.
   - Preventing unauthorized access, changes to and release of credentialing information.
   - Password-protecting electronic systems, including user requirements to:
     - Use strong passwords.
     - Discourage staff from writing down passwords.
     - Use IDs and passwords unique to each user.
     - Change passwords when requested by staff or if passwords are compromised.
       Note: If the organization's policies and procedures state that it follows the 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.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

5. Describes how the IPA/medical group monitors compliance with the policies and procedures in number 9 above, items 1–4, at least annually and takes appropriate action when applicable. The policies and procedures describe the process for at least annually monitoring:
    - Demonstrating that specified policies and procedures in number 9 above, items 1–4 are followed.
    - Analyzing modifications that do not meet the IPA/medical group's established policy.

    At a minimum, the description includes:

    - The method used to monitor compliance with the IPA/medical group's policies and procedures described in number 9 above, items 1-4/NCQA, CR 1, Element C, factors 1–4.
        - Staff titles or roles responsible for oversight of the monitoring process
        - If the IPA/medical group has advanced system control capabilities, and the credentialing system does not allow modifications under any circumstances, the system must have both capabilities below:
            i. Automatically records dates, and
            ii. Prevent changes that do not meet their policy and procedures.

            If the IPA/medical group has advanced system controls capabilities, it is only required to describe how the functionality of the system that ensures compliance with established policy and monitoring is not required.
        - If the credentialing system allows modifications only under specific circumstances established by policy, the description includes the process for monitoring compliance with established policy.
            - If the organization uses system alerts or flags to identify noncompliance, the description indicates how this process is conducted and monitored.
            - 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 IPA/medical group's process for taking actions if it identifies modifications that do not meet its established policy, includes the following:
            - A quarterly monitoring process assesses the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.
            - The staff roles or department responsible for the actions.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

  - The process for documenting and reporting modifications that do not meet established policy.
- The IPA/medical group must use the following method to audit files if sampling is utilized.
  - 5 percent or 50 of its files, whichever is less, from each applicable type to review against requirements.
  - At a minimum the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit the universe is audited rather than a sample.
  - The file universe includes all files with or without modifications. The sample that will be audited must include only files with modification (whether modifications are compliant or noncompliant with the IPA/medical group's policies and procedures)
  - Once the sample size is calculated from the entire file universe, the IPA/medical group determines how it selects the sample.

Credentialing Systems Controls Oversight

At least annually, IPA/medical group demonstrates that it monitors compliance with its CR controls, as described above, number 9 above, item 5/NCQA CR 1, Element D by:

1. Identifying all modifications to credentialing and recredentialing information that did not meet the IPA/medial group's policies and procedures for modifications.
2. Analyzing all instances of modifications that did not meet the IPA/medical group's policies and procedures for modifications.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

Credentialing System Controls Oversight Monitoring

Blue Shield Promise will annually monitor the IPA/medical group's credentialing systems security controls to ensure that the IPA/medical group monitors its compliance and the compliance of any subdelegates with the delegation agreement or with the delegates procedures, at least annually. Monitoring will be conducted by the IPA/medical group submitting a monitoring report of their credentialing system controls oversight process. At a minimum, the report will include:

- Name of delegate
- Person/title of who conducted the oversight
- Date of oversight
- Timer period of oversight
- Type of review: Electronic, paper or both
- Audit frequency
- A brief description of the method utilized to ensure compliance with their policies/ procedures for each factor (number 9 above, items 1-4)
- Results of the review
- Follow-up on findings, if applicable

If noncompliant modifications were identified, the IPA/medical group will complete a Monitoring and Reporting of Inappropriate Modification Report form. At a minimum, the report will include the name of the delegate, staff member and title that conducted the oversight and the time period of the review. The report will indicate the type of review: paper files, electronic system, or both. The report will document the following information from the delegate and Blue Shield Promise will conduct its own review and follow-up for three (3) consecutive months:

- Date non-compliant modification was made.
- Identifier (delegate to provide something that can be used as an identifier of the record that was noncompliant for modifications, e.g., practitioner last name, initials, unique system #, etc.).
- Description of the modification that did not meet the delegates policies, procedures and/or delegation agreement (each modification needs a line item).
- Actions taken to correct the modifications that did not meet the delegates policies, procedures and/or delegation agreement.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

- Qualitative Review: An examination of the underlying reason for (root cause analysis) the results, including identifying any deficiencies or processes that may create barriers to improvement or cause additional failures.
- Quantitative Review: A comparison of numeric results against a standard or benchmark, (number of modifications vs number noncompliant modifications) trended over time. Must draw conclusions about what the results mean.
- Date of Quarterly monitoring of the findings.
- Results of Quarterly Monitoring. Blue Shield Promise will conduct its own review of all noncompliant findings and monitor compliance quarterly until the IPA/medical group or the Group's Subdelegate demonstrates improvement for one finding over three (3) consecutive quarters.

10. The IPA/medical group must develop and implement policies and procedures for ongoing monitoring of practitioner's sanctions, complaints, and quality issues between recredentialing cycles and taking appropriate action against practitioners when it identifies occurrences of poor quality. At a minimum, the IPA/medical group must collect and review the following:
    - Medicare and Medicaid sanctions;
    - Sanctions or limitations on licensure;
    - Medi-Cal Suspended and Ineligible Provider List at Initial and Recredentialing, as well as monthly;
    - Member complaints; and
    - Identified adverse events.
11. The IPA/medical group is required to review all Blue Shield Promise practitioners/ providers sanction activities within the 30 calendar days of the reports release by the reporting entity and report the findings to Blue Shield Promise as Blue Shield Promise practitioners/providers are identified.
12. The IPA/medical group is responsible for providing and assisting in any credentials document needed for investigation and audit which includes but not limited to specific information related to a provider's training, action related to any sanctions, etc.
13. The IPA/medical group is required to submit copies of originals files for selected practitioners/providers at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audits, by the requested due date.
14. The IPA/medical group is responsible for Identifying Qualified HIV/AIDS Specialist in accordance with CA H&SC §1374.16; DMHC TAG (QM-004), DHCS MMCD All-Plan Letter 01001).

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

- The IPA/medical group must develop and implement policy and procedures describing the process that the organization identifies and reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations on an annual basis. The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist and criteria which can be accessed at dmhc.ca.gov.
- Annually conducts screening of HIV/Aids Specialists to ensure qualifications and criteria of the DMHC are met.
- Notify department responsible for authorizing standing referrals of its physician's that qualify as HIV/AIDS specialists according to DMHC regulations.

15. The IPA/medical group will be required to sign and abide by the credentialing delegation agreement.
16. If the IPA/medical group subdelegates any credentialing activities the IPA/medical group will be responsible for oversight activities of the subdelegate.
17. In addition to delegation agreement requirements specified in the delegation exhibit if the IPA medical group contracts with delegates that store, create, modify, or use credentialing data on their behalf the delegation agreement specifies:
    1. The IPA/medical group has credentialing system security controls in place to protect data from unauthorized modifications as outlined in Item 9 above/NCQA CR1, Element C (Credentialing System Controls)
    2. The IPA/medical group must monitor its credentialing system security controls at least annually as required by NCQA CR 8, Element C, factor 5.
    3. The Plan monitors the delegates credentialing system security controls at least annually as required by NCQA CR 8, Element C, factor 5.
18. The IPA/medical group will conduct a pre-delegation evaluation prior to implementing delegation.
19. IPA/medical group must review delegates credentialing activities annually to include:
    1. Annually reviews its delegate's credentialing policies and procedures.
    2. Annually audits credentialing and recredentialing files against NCQA and any other applicable regulatory requirements.
    3. Annually evaluates the delegates performance against any NCQA and any other applicable regulatory requirements.
    4. Quarterly evaluates regular reports as specified in the delegation agreement.
    5. At least annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or the delegates policy and procedures. Delegates must comply with NCQA requirements.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

The Plan's process for monitoring system security controls covers IPA/medical groups that store, create, modify, or use credentialing or recredentialing data on its behalf. If the organization contracts with such delegates, it has a process for:

- Monitoring the IPA/medical group's credentialing system security controls in place to protect data from unauthorized modification, as outlined in CR 1, Element C (Credentialing System Controls), factor 4, at least annually.
- Ensuring that the delegate monitors, at least annually, that it follows the delegation agreement or its own policies and procedures.

Both the Plan and IPA/medical must monitor the delegate's system security controls as part of the delegation oversight requirements.

Plan's monitoring of the delegate's system security controls. The organization provides documentation (e.g., a report or other type of evidence) that it completed the monitoring process at least annually during the look-back period.

IPA/medical group's monitoring of its system security controls. The IPA/medical group provides documentation of modifications that did not comply with its policies and procedures or with the delegation agreement at least annually during the look-back period.

Documentation of monitoring must be provided regardless of system functionality (e.g., the system prevents changes to the original record under any circumstances but allows creation of a new record to modify dates; allows date modifications only under specific circumstances; uses alerts or flags to identify noncompliance), with the exception of advanced system controls capabilities.

Advanced system controls capabilities. If the credentialing system has advanced system control capabilities, the following are provided in lieu of monitoring reports or other monitoring evidence:

- A description of system functionality that ensures compliance with established policies and procedures with the delegation agreement.
- Documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modifications criteria; the system must have both capabilities.

Audit. Auditing may be chosen as the method for monitoring.

- If the credentialing system can identify noncompliant modifications, all noncompliant modifications must be reviewed.
- Sampling is allowed only if the credentialing system cannot identify all noncompliant modifications.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

The Plan is not required to conduct an audit if it determines that the IPA/medical group adequately monitored and reported noncompliant modifications; the organization reviews the delegate's findings in the audit report instead of conducting its own audit of the delegate's system controls. The IPA/medical group provides documentation (e.g., a report, meeting minutes, other evidence) that it reviewed and agreed with the delegate's findings.

If the Plan determines that the IPA/medical group did not adequately monitor noncompliant modifications, it must conduct its own audit of the delegate's system controls.

The Plan must submit its documentation and the IPA/medical group's documentation. Documentation indicates the staff roles or departments involved in the audit.

Delegate files may be audited using one of the following methods:

- 5% or 50 files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
- The NCQA "8/30 methodology" available at www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual file audits.

20. At least annually, the delegate acts on all findings from number 9, item 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.

9.13: Credentialing Program *(cont'd.)*

9.13.4: Credentials Process for IPA/Medical Groups *(cont'd.)*

Annual Actions

The IPA/medical group identifies and documents all actions it has taken, or plans to take, to address all modifications (findings from factor 5) that did not meet the delegation agreement or the delegate's policies and procedures, if applicable. One action may be used to address more than one finding for each delegate or across multiple delegates, if appropriate.

The IPA/medical group also implements a quarterly monitoring process for each delegate to assess the effectiveness of its actions on all findings.

- The IPA/medical group must continue to monitor each delegate until the delegate demonstrates improvement of at least one finding over three consecutive quarters.
- If a delegate did not demonstrate improvement of at least one finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring.
- If the IPA/medical group identified findings less than three quarters before the survey submission date, it submits all monitoring information it has available.

Effective January 1, 2022, the Department of Health Care Services (DHCS) transitioned Medi-Cal pharmacy services from the Medi-Cal managed care plans to a centralized delivery system. This new centralized delivery system is called Medi-Cal Rx. Magellan is DHCS' contracted pharmacy benefit management vendor that will administer Medi-Cal Rx benefits.

Blue Shield Promise Health Plan will continue to provide medical benefits and support services such as provider network, customer care support, and utilization management as well as appeals and grievances for prescription medications that are covered under the medical benefit.

Blue Shield Promise Health Plan is in compliance with all DHCS and Department of Managed Health Care (DMHC) All Plan Letters (APLs) and requirements related to this carve out.

For questions regarding Medi-Cal Rx pharmacy benefits, policies, and procedures, contact the Medi-Cal Rx Customer Service Center at (800) 977-2273 or visit medi-calrx.dhcs.ca.gov/home/.

10.1: Pharmaceutical Utilization Management

This program incorporates utilization management to encourage appropriate and cost-effective use of medications. This will apply to drugs billed through medical or institutional claims. The Blue Shield of California Pharmacy & Therapeutics Committee is the governing committee responsible for oversight and approval of policies and procedures pertaining to drug utilization including medication policies that fall under the medical benefit to help us provide quality coverage to our members.

Review of Medication Requests for Non-FDA Approved Indications

1. In accordance with Section 1367.21 of the California Health and Safety Code, Blue Shield Promise will not limit or exclude coverage for a drug on the basis that the drug prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
    a. The drug is approved by the FDA;
    b. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition, or for the treatment of a chronic and/or seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is covered by Blue Shield Promise; and,
    c. The drug has been recognized for treatment of that condition by one of the following:

10.1: Pharmaceutical Utilization Management *(cont'd.)*

- American Hospital Formulary Service Drug Information.
- Two peer-reviewed articles from major medical journals supporting the proposed off-label use as safe and effective.
- For chemotherapy and biologic agents:
  - IBM Micromedex DRUGDEX.
  - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium for chemotherapy and biologic agents.
  - Elsevier Gold Standard Clinical Pharmacology.

2. It shall be the responsibility of the participating prescriber to submit to Blue Shield Promise documentation supporting compliance with the above-mentioned requirements when requested by the plan.
3. Criteria utilized in the review of a prior authorization request for a non-FDA approved indication will include, at a minimum, the following:
   a. Submission of the required medical information.
   b. Contraindications or previous treatment failures with FDA approved medications that have FDA approved indications for the intended use of the requested medication.
4. Any coverage required by this section shall also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.
5. For purposes of this section, "life-threatening" means either or both of the following:
   a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
   b. Diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
6. For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.
7. The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of Blue Shield Promise.
8. Nothing in this section shall be construed to prohibit the use of a copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

10.2: Specialty Pharmaceuticals

Purpose

To establish clear policy and procedures for prescribing specialty pharmaceuticals covered under the medical benefit and ensuring reliable access to these medications.

Policy

As of July 1, 2003, Blue Shield Promise no longer requires a health care service provider to assume or be at financial risk for any item described as a qualifying specialty pharmaceutical covered under the medical benefit. The health care provider is permitted to assume financial risk for these items after making the request in writing at the time of negotiating an initial contract or renewing a contract with Blue Shield Promise.

The items included in AB 2420 are:

- Injectable chemotherapeutic medications and adjunct injectable pharmaceutical therapies for side effects.
- Injectable medications or blood products used for the treatment of hemophilia, including Hemlibra.
- Injectable medications related to transplant services.
- Adult vaccines.
- Self-injectable medications.
- Other injectable medication or medication in an implantable dosage form costing more than $250 per dose.

All medical benefit specialty pharmaceuticals prescribed for members associated with a non-risk medical group will require prior authorization review that may include requirements for step therapy with preferred drugs or biosimilar agents, and place of service. The Blue Shield Promise Pharmacy Department will conduct the prior authorization review utilizing criteria and guidelines approved by the Blue Shield of California Pharmacy & Therapeutics Committee unless the health care provider has been delegated to perform the prior authorization review.

Procedure

IPA/Medical Groups Not Retaining Specialty Pharmaceutical Risk and Blue Shield Promise Directly Contracted Physicians

1. In situations where the member is assigned to an IPA/medical group or a directly contracted physician, where Blue Shield Promise assumes the risk for providing specialty pharmaceuticals, physicians must obtain a prior authorization approval from the health plan regardless of whether they utilize office stock, refer patient to a home infusion provider, direct the member to an outpatient facility for administration or require the services of a specialty pharmacy vendor.

10.2: Specialty Pharmaceuticals *(cont'd.)*

2. Physicians who plan to prescribe a specialty pharmaceutical will submit a prior authorization request to the Blue Shield Promise Pharmacy Department. Physicians may obtain a prior authorization form by calling the Blue Shield Promise Pharmacy Department.
3. The Blue Shield Promise Pharmacy Department will review the submitted request. All determinations will be based on the Blue Shield Promise prior authorization guidelines, step therapy, site of service requirements and nationally accepted evidence-based guidelines.
4. If additional information is needed to make a final determination, the Pharmacy Department will send a request to the prescribing physician or the primary care physician. Pharmacy personnel will adhere to the HIPAA minimum necessary information requirements.
5. If the prior authorization request is approved the Blue Shield Promise Pharmacy Department will enter a prior authorization override that permits the processing of the prescription drug claim under the medical benefit.
6. The Blue Shield Promise Pharmacy Department will notify the provider, member, and the specialty pharmacy in writing of the medication approval. Letters of approval will be mailed to the Blue Shield Promise member and a copy will be faxed to the provider. The specialty pharmacy will receive a faxed copy of the approved prior authorization form.
7. If the prior authorization request is modified or denied, the Blue Shield Promise Pharmacy Department will notify the member and the physician in writing.
8. All denials based on insufficient medical necessity will reference the appropriate guidelines utilized when evaluating the prior authorization request. For denials based on treatment of a condition that is not a covered benefit, the denial letter will reference the applicable state or federal regulation.
9. Upon notice of an authorized prescription, the specialty pharmacy will process the prescription in accordance with their dispensing procedures. The dispensing process will include coordination of delivery with the physician, facility, or home infusion provider.
10. The specialty pharmacy will be responsible for verifying ongoing member eligibility and an IPA/medical group assignment for all new and refill prescriptions. If the member is no longer eligible with Blue Shield Promise, then subsequent authorizations and dispensing of the specialty pharmaceutical will be based on the procedures established by the newly assigned health plan.
11. In the event that the physician needs to utilize a medication stocked in his/her office, he or she will need to indicate this on the prior authorization form. If the medication and the in-office stock use are approved the physician will receive an approval notice.

10.2: Specialty Pharmaceuticals *(cont'd.)*

12. Approval notices for specialty pharmaceuticals will include the specific medication NDC (National Drug Code) and the HCPCS (Health Care Common Procedure Coding System). All claims should be billed utilizing the appropriate NDC code. A manual HCFA 1500 claim with NDC and HCPCS may be subsequently submitted to Blue Shield Promise for reimbursement.

IPA/Medical Group Retaining Specialty Pharmaceutical Risk

If a member is assigned to an IPA/medical group that has elected to keep the financial risk for medical benefit specialty pharmaceuticals, Blue Shield Promise will refer the provider and member to the IPA/medical group for review of the prior authorization request. The IPA/medical group will be expected to conduct the prior authorization review utilizing Blue Shield Promise criteria and guidelines approved by the Blue Shield of California Pharmacy & Therapeutics Committee. Adherence to Blue Shield Promise's medical necessity, site of service and biosimilar first policies is required and will be subject to the delegation audit.

IPA/medical groups are responsible for complying with California Health and Safety Code Section 1367.206(b) and California Insurance Code 10123.201(c)(2) for medically necessary exception requests. IPA/medical groups will approve a medication prior authorization request if:

1. Trial of preferred drugs has been attempted, but caused intolerable side effects, inadequate response achieved, diminished effect, or unable to try due to contraindications.
2. Rationale is submitted by provider that states one of the following:
    a. Preferred drugs are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.
    b. Preferred drugs are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

10.3: Reporting

Medi-Cal Pharmacy CALINX claim files are available by the 15th of each month and can be accessed via a secure web portal. Participating Provider Groups that do not have access to these files should email BSCCalinxRx@blueshieldca.com to ask for an access request form. Once the access request form has been submitted and approved, access instructions and additional information will be sent to the requestor.

10.4: Drug Storage and Dispensing in Provider Offices

Policy

All medications, including vaccines and drug samples, used at provider sites will be stored, handled, and administered according to State Department of Health Services and other state or federal regulations and according to manufacturers' recommendations.

Procedure

1. Each site shall maintain and periodically update a set of internal medication/ pharmacy policies and procedures.
2. All medications shall be stored in their original containers. This does not apply to cleaning or antiseptic solutions that may be poured into other dispensing containers.
3. Germicides, disinfectants, test reagents and household cleaning substances shall be stored separately from medications.
4. All multiple dose containers shall be labeled with the date they are originally opened.
5. All medications and related items including sample drugs shall be routinely checked for expired items.
6. All medications shall be discarded, per Title 22 requirements, when they reach their expiration date.
7. Medications shall be stored in a segregated manner according to their route of administration (i.e., oral, injectable, topical).
8. All medications, needles, and syringes are to be stored in an area only to authorized personnel.
9. Medications shall be stored at temperature levels specified by the manufacturer (i.e., room temperature, refrigerated at 35-45 degrees F or frozen at less than 7 degrees F).
10. Controlled substances (Schedule II or III) are to be stored separately from other medications in a securely locked cabinet. Controlled substances shall be inventoried, logged, and controlled. The physician is responsible for the use, storage, and inventory of all controlled substances.
11. Items other than medications that are stored in a refrigerator are kept in a separate compartment from drugs.
12. Medications that are transferred from the original container into another are classified as "re-packaged." The following information is required on the new container: date of re-packaging, initials of re-packager, manufacturer name, and original lot number.
13. Medications shall be prepared in a designated, clean area of sufficient size as to minimize the potential for medication errors.
14. Drugs for emergency use should be stored in a secure, locked area and a location that is accessible in an emergency.

10.4: Drug Storage and Dispensing in Provider Offices *(cont'd.)*

15. A list of contents and expiration dates should be on the outside of the emergency "box."
16. The contents of the emergency "box" should match the contents list.
17. The use and/or dispensing of sample medications are discouraged. If a provider elects to use and/or dispense sample medications, the following standards must be met:
    a. A physician or pharmacist shall be responsible for the storage, inventory, and dispensing of sample medications.
    b. Only a physician or pharmacist shall dispense sample medications. This cannot be delegated to other office staff.
    c. Sample medications shall be logged when received, including the medication name, quantity, manufacturer name, lot number, and expiration date.
    d. Samples may only be dispensed to the provider's own patients.
    e. Samples may not be sold.
    f. Samples must be stored in a secure manner.
    g. If samples are dispensed, they must meet all labeling requirements.
    h. An appropriate entry is made in the patient's medical chart in a similar manner as if a prescription had been written.
    i. Samples may not be used to satisfy prior authorization requirements for trial and failure of a medication.

10.5: Access to Pharmaceutical Care and Services

Blue Shield Promise will ensure appropriate member access to pharmaceutical care or services billed under medical or institutional claims.

Access to pharmaceutical care or services will be monitored through a variety of methods. The Chief Medical Officer is ultimately responsible for resolving all member issues related to pharmaceutical access.

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11.1: Health Education Program

Purpose

The Health Education (HE) Program is committed to improving and maintaining the health and wellness of Blue Shield Promise members through health education, health promotion, skill training, interventions and disease management offered in a culturally sensitive and linguistically appropriate manner. Educational interventions address health categories and topics that align with findings from Blue Shield Promise's Population Needs Assessment and Department of Health Care Services requirements, including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

Goals

- Promote appropriate use of health services.
- Promote health education services.
- Encourage member involvement with their Primary Care Physician (PCP) in the management of his or her personal health.
- Increase member knowledge on preventive health care services and screenings.
- Encourage risk reduction and lifestyle changes to improve health.
- Increase use of preventive services for early detection of disease according to current guidelines for age and gender.
- Increase member's knowledge and skills to enable him or her to cope with chronic disease.
- Increase member's feelings of self-efficacy in managing chronic diseases.
- Increase health equity through targeted member engagement in evidence-based disease management programs that use health education interventions and seek to close care gaps for members that participate in these programs.

11.2: Scope of the Health Education Program

11.2.1: Member Education

The Blue Shield Promise Health Education program is committed to ensuring its member population receives quality health education services that are appropriate to their cultural and linguistic needs. The Health Education program promotes knowledge, skills, and behavior change to increase feelings of self-efficacy so that members can manage chronic disease as well as maintain optimum health for themselves and their families. The following programs are available to Blue Shield Promise members through self-referral and referral from their PCP or internal departments.

Members and providers may obtain more information about these programs and services by calling the HE Department.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.1: Member Education *(cont'd.)*

Health Education Classes

The Blue Shield Promise Health Education (HE) Department or the Blue Shield Promise Utilization Management (UM) Department receives and processes referrals for HE classes and/or other interventions. Blue Shield Promise providers may refer their patients to HE services by completing and submitting the Health Education Referral Form (See www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms to the HE Department via fax or mail. Once the referral is received, HE will locate a health education class. If no class is available, HE will send written information to the member on the requested topic. For referrals to programs with a cost, the provider may submit their referral using a Treatment Authorization Request (TAR) Form to the UM Department, via fax or mail. The PCP will receive documentation of the final outcome for referrals submitted to the HE or UM Departments.

Additionally, Blue Shield Promise provides health education programs at various locations. Frequency of these classes varies depending on requests from providers and members. Most classes are implemented in English and Spanish. Some classes are implemented in Cantonese and Mandarin. Blue Shield Promise provides individual counseling in English, Spanish, Cantonese, and Mandarin. Access to an over-the-phone interpreter service is available for members requiring interpretation in other languages. Counseling topics include Hypertension, Hyperlipidemia, Diabetes and Weight Management. Blue Shield Promise also implements the Stanford Healthier Living Program (self-management of chronic conditions) in English, Spanish, Cantonese, and Mandarin.

The Blue Shield Promise HE Department works with the Community and Provider Education Department and Quality Improvement Department to coordinate activities for Blue Shield Promise's involvement in community outreach efforts, health fairs and health screening events.

Health Education Materials

A variety of brochures and handouts are available to providers and members at no cost on the Blue Shield Promise website at www.blueshieldca.com/en/bsp/health-and-wellness/health-education-materials. We encourage providers to give them to members at the point of service.

All materials selected are culturally sensitive and linguistically appropriate (refer to Section 17: Culturally and Linguistically Appropriate Services (CLAS) for definitions), and do not exceed the 6th grade reading level as required by the Department of Health Care Services (DHCS).

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.1: Member Education *(cont'd.)*

Accessing Health Education Materials

The HE Department has a variety of materials in threshold languages and alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) available to members and providers. Materials in languages other than English are also reviewed for cultural sensitivity and linguistic appropriateness for the target population. Providers may print materials from the Blue Shield Promise library at www.blueshieldca.com/en/bsp/health-and-wellness/health-education-materials. Providers who are unable to print materials from the library or who want to request materials in non-English, non-Spanish languages or in an alternative format can contact the Blue Shield Promise HE Department.

Member Resources

The HE Department informs members of available health education services through the Blue Shield Promise member newsletter, provider referrals, the Customer Care phone line, targeted mailings, Blue Shield Promise websites, and community outreach events. The member newsletter is mailed to each member household and includes brief articles on a variety of health topics as well as information on Blue Shield Promise Health Education programs.

Members may call the HE Department to request HE brochures or information on health education classes, and/or other interventions. Access to an over-the-phone interpreter service is available for members requiring interpretation.

Blue Shield Promise Health Plan develops Preventive Health Guidelines for adults and children/adolescents. These guidelines represent a compilation of recommendations from national and state organizations including the U.S. Department of Health and Human Services, National Institutes of Health, Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, California Department of Public Health, and Los Angeles County Department of Public Health. Preventive Health Guidelines for Adults and Children/Adolescents are available in English and Spanish on the Blue Shield Promise member website at www.blueshieldca.com/en/bsp/medi-cal-members/health-wellness.

Members may also call the Health Education Department to request a printed copy of the guidelines. Providers are notified about updates to the guidelines via the Blue Shield Provider Connection website at blueshieldca.com/provider, provider visits, or blast fax. Members are notified about updates to the guidelines via member newsletters.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.2: Mandated Health Education Topics

The following health related topics are mandated by the DHCS:

- Age Specific Anticipatory Guidance *
- Asthma
- Breastfeeding
- Complementary and Alternative Medicine
- Diabetes
- Exercise/Physical Activity
- Family Planning
- HIV/STD Prevention
- Hypertension
- Immunizations
- Injury Prevention (intentional & unintentional)
- Nutrition
- Obesity
- Parenting
- Perinatal
- Substance Abuse
- Tobacco Prevention and Cessation
- Unintended Pregnancy

*Includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.2: Mandated Health Education Topics *(cont'd.)*

The mandated health education topics will be provided to all members by the following methods:

- Displaying health education materials in PCP/IPA/medical group office
- Sending health education materials to the member's home
- Providing health education classes
- Providing member newsletters
- Providing outreach activities
- Referring to health education community services
- Providing 24-hour nurse availability
- Providing access to a Health and Wellness portal

11.2.3: Selection of Health Education Materials

Blue Shield Promise is highly committed to the delivery of quality health promotion and educational materials. Health Education materials are chosen to not only address DHCS requirement but to address the needs of the Blue Shield Promise member population. All materials selected are culturally sensitive and linguistically appropriate and meet the 6th grade reading level requirement.

Methods of Testing Reading Levels of Health Education Material

All member health education materials must be reviewed and tested using an approved tool. The Fry Readability Formula is based on the assessment of three 100-word passages from an article. The average number of syllables and average number of sentences per 100 words are plotted on a grade level graph to determine the approximate grade level. The Flesch-Kincaid Grade level is equivalent to the US grade level of education. It shows the required education to be able to understand a text. The Fry Readability Formula and Flesch-Kincaid Grade Level assessments are the commonly used methods to assess the readability of materials distributed by Blue Shield Promise.

Health Education Material Standards

In addition to the reading level methods listed above, standards for health education materials are based on the following:

- Content/style
- Layout/appearance
- Visuals

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.3: Selection of Health Education Materials *(cont'd.)*

- Cultural appropriateness: Represents the member population's ethnic group, practices and behaviors based on their cultural background. Understanding of the members' cultural background is a key factor in providing quality and appropriate delivery of health education.
- Linguistic appropriateness: Represents all appropriate languages based on member population in the provider office. Selection of translation methods plays a critical role. Patient rights mandate that patients receive understandable information on illness, injuries, etc. Proper translation of English language material ensures that these rights are not violated.
- Field testing (if applicable)
- Medical accuracy

Readability and Suitability Checklist

The Readability and Suitability Checklist (RSC) is used to document the reviewed material's reading level, medical accuracy, and cultural and linguistic appropriateness. It also includes a review of the material's content and layout. Materials are re-reviewed every five years or sooner if the material or health guidelines are updated.

Health Education Materials Library

Blue Shield Promise contracts with a health education library vendor that has received DHCS approval of their materials because they meet readability and suitability requirements. Materials from this library are exempt from the RSC review process. An RSC is completed for all other materials that are not part of the vendor library. These materials and their corresponding RSC are kept on file for review for audit purposes.

11.2.4: Provider Education

The Health Education Department coordinates provider education specific to health education. This includes providing materials on all state mandated health topics, cultural linguistic requirements, and effective techniques in patient education and communication. This is done via provider in-service education, blast faxes/email, and information posted on the Blue Shield Promise website. Health Education information is also disseminated via provider meetings (i.e., IPA Joint Operations Committees, IPA Forums, and Medical Services Committee meetings), and special mailings.

The Health Education Department also educates providers on the findings from the Population Needs Assessments.

11.2: Scope of the Health Education Program *(cont'd.)*

11.2.4: Provider Education *(cont'd.)*

All other operational provider information is the responsibility of the appropriate Blue Shield Promise department. Because provider issues may overlap with health education, the Health Education Department is readily available to assist these areas in the provision of provider educational services.

11.3: Member Education Contractual Requirements

11.3.1: Provider's Responsibility to Health Education

Pursuant to the contractual agreement under the Department of Health Care Services (DHCS), member education must include the following:

- Promotion of preventive services, education, and counseling
- Promotion of appropriate use of Medi-Cal managed care plan services
- Education of the availability of local social healthcare programs

The provider is responsible for providing culturally sensitive and linguistically appropriate health education, prevention, and counseling services to the member population based on their needs (See www.blueshieldca.com/en/bsp/providers/programs/health-education-providers). Providers are strongly encouraged to guide their patients to take increased responsibility for their personal health. The Blue Shield Promise HE Department is responsible for providing all state mandated health education materials and associated services to members via contracted providers. Also, 24-hour free interpretation services are available to providers with LEP patients needing interpreter services.

The provider is responsible for promoting breastfeeding to his or her patients. Research shows that breastfeeding brings many benefits to both the infant and mother. These benefits include health, nutritional, immunologic, developmental, economic, and environmental.

Additionally, providers should not distribute samples or materials with formula company logos on them to their patients, as per MMCD Policy Letter 98-10. Providers are encouraged to refer Medi-Cal patients to WIC services.

11.3: Member Education Contractual Requirements *(cont'd.)*

11.3.2: Monitoring Provisions of Health Education

The Blue Shield Promise HE Department assesses the effectiveness and quality of health education services offered by providers using the following methods:

- Audits of medical records at provider sites performed by Blue Shield Promise Health Plan or L.A. Care Health Plan.
- Focused review studies conducted by the Quality Management Department, assessing data obtained from various sources (i.e. medical records, encounter data, provider, and member surveys, etc.).

Medical Record Documentation of Health Education Services

Documentation of health education in medical records should include the following:

- Health education relative to the diagnosis and/or presenting problem
- Brochures or other HE information given to the patient
- Patient's understanding of the education provided
- Referral to HE services (i.e., classes, counseling, program, etc.)
- Documentation of interpreter services used by the patient
- Signature and title of all staff providing HE to patient

11.4: Tobacco Cessation Services

Per All Plan Letter (APL) 16-014, providers are required to implement tobacco cessation interventions and a tobacco user identification system into their practices. Providers must:

- Conduct initial and annual assessment of each patient's tobacco use and note this information in patient's medical record
- Offer FDA-approved tobacco cessation medications (for non-pregnant adults)
- Provide counseling using the "5 A's" model or other validated model for treating tobacco use and dependence
- Refer patients to available individual, group, and telephone counseling services
- Offer services for pregnant tobacco users
- Provide interventions to prevent the use of tobacco in children and adolescents

Recommendations on how to identify tobacco users include:

- Add tobacco use as a vital sign in the chart or Electronic Health Records

11.4: Tobacco Cessation Services Cessation Services *(cont'd.)*

- Use International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use
- Place a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco
- Record status on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160)

How to Start the Conversation

Provider: Discuss some of the health problems associated with smoking, for example:

"As your health care provider and someone who cares about you and your health, I'd like to help you quit smoking because it's the best thing you can do for your health and anyone who lives with you."

Tobacco Cessation Medications Available to Medi-Cal Patients

Smoking cessation agents for adults who use tobacco products are covered by the Medi-Cal RX program. Some of these medications require prior authorization, have quantity limits and are subject to change. For additional information, please see the Medi-Cal RX Contract Drugs List here: medi-calrx.dhcs.ca.gov/home/cdl/. Some of the agents (i.e., patches, lozenges, and gum) are found in the over-the-counter list: medi-calrx.dhcs.ca.gov/home/cdl/.

Providers play a key role in the member's journey in quitting smoking. Please work with your patient to find the best option for quitting smoking such as referring them to community resources and/or prescribing them tobacco cessation medication.

To view the policy letter, learn more about the required interventions, find training and patient resources, please visit the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers/programs/tobacco-cessation-medi-cal.

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

IPAs/medical groups are required to comply with the responsibilities outlined in Sections 11.1 through 11.4 and participate in health education activities that are required by Blue Shield Promise in order to best support health education goals for members and remain compliant with regulatory requirements.

11.6: Program Resources

11.6.1: Health Education Staff

Health Education and Cultural and Linguistic Senior Manager

The Health Education and Cultural and Linguistic Senior Manager (Senior Manager) works in conjunction with the Chief Medical Officer and other departments to implement health education programs appropriate to identified needs of members and providers. This position reports to the Senior Director of Lifestyle Medicine.

The Senior Manager is responsible for developing, implementing, managing, and evaluating member education programs and provider education programs related to Health Education. The Senior Manager ensures that materials and programs are culturally sensitive and linguistically appropriate to the member population under standards created by LA Care Health Plan and the DHCS. The Senior Manager ensures compliance with NCQA, Multicultural Distinction standards and National CLAS standards.

Responsibilities of the Senior Manager include but are not limited to:

- Development, implementation and evaluation of annual Health Education Work-plan and Program.
- Development, implementation and evaluation of Policies and Procedures.
- Oversight of development, implementation, and evaluation of health education provider, member, and condition specific programs.
- Oversight of evaluation and distribution of culturally and linguistically appropriate member education materials.
- Meeting the requirements of the DMHC, DHCS, and L.A. Care Health Plan and other regulatory agencies as appropriate.
- Collaborate with L.A. Care Health Plan to meet DHCS requirements.

The Health Education Manager

The Health Education Manager reports to the Health Education and Cultural and Linguistic Senior Manager. The Health Education Manager leads and manages health education initiatives and ensures compliance with NCQA, state, federal and L.A. Care requirements.

This position collaborates with external clients such as vendors, consultants, regulators, and internal teams such as case managers, customer services staff, QI staff and community outreach staff.

11.6: Program Resources *(cont'd.)*

11.6.1: Health Education Staff *(cont'd.)*

Health Educator

The Health Educator reports to the Health Education and Cultural and Linguistic Senior Manager and the Health Education Manager and works in conjunction with them to implement health education programs appropriate to our member and provider population.

In addition, the Health Educator supports provider relations, community outreach, and quality improvement activities associated with member education, as well as collaborates with outside agencies.

The Health Educator assists in all aspects of program development and implementation as designated by the HE Director and Health Education Manager. The Health Educator also assists in the development and review of member health education materials.

11.6.2: Health and Wellness Portal

The health and wellness portal is an online resource available to members. The goal of the portal is to increase members' ability to manage their health by helping them identify their risks via a wellness assessment and connecting them to self-management tools and resources that can help mitigate their risks. Members can also track their health over time on the portal. Some of the tools available on the portal include a health library on topics including physical activity, blood pressure, cholesterol, blood glucose, and nutrition. To access the portal, members can log on to the Blue Shield Promise website at www.blueshieldca.com/promise/hra and create an account.

11.6.3: Wellvolution

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. Members can choose programs ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow. Once the member receives their Blue Shield Promise member ID card, they can go to wellvolution.com/medi-cal to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs that are personalized and have proven results, at no cost.

11.6: Program Resources *(cont'd.)*

11.6.3: Wellvolution *(cont'd.)*

The following programs are offered through Wellvolution:

Mental & Behavioral Health Programs – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, a personalized care plan, and more.

Weight Loss Programs – Programs specifically designed to help members make changes that fit their lifestyle and promote a healthy weight. Members can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 pounds per week and improvement in their quality of life across the board.

Disease Prevention Programs - Targeting reduction of risk for type 2 diabetes, such as the Diabetes Prevention Program, and heart disease, prevention programs provide members with a health coach and an individualized plan that meet the unique needs and address several areas of a member's life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.

Chronic Condition Reversal Programs – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence.

Tobacco & Vaping Cessation Programs – All programs include a two-month supply of nicotine replacement therapy in the form of the patch, lozenge, or gum at no additional cost to our members.

All Wellvolution programs are 100% covered by Blue Shield Promise and there is no cost to Blue Shield Promise members to enroll in Wellvolution programs.

11.6: Program Resources *(cont'd.)*

11.6.4: Departments in Collaboration with Health Education

Cultural and Linguistic Department

The Health Education unit collaborates with the Cultural and Linguistic unit to develop and implement training sessions for providers, staff, and IPA/medical groups. These units also work together to ensure proper translation of health education materials into threshold languages and alternative formats. Blue Shield Promise adheres to NCQA Multicultural Distinction Standards and the National CLAS standards. The goal is to support the improvement of CLAS for our members, providers, and employees. For more information, refer to Section 17.

Quality Improvement

The Health Education Department works in conjunction with Quality Improvement (QI) to coordinate the exchange of data summarizing member needs and utilization for ongoing program planning. In addition, QI and HE work together in the implementation of various health education programs.

Customer Service Department

The Customer Care Department refers all health education related phone calls to the Health Education Department. The Customer Care Department provides 24-hour interpretation services to Blue Shield Promise members, who speak a language other than English, through an interpreter services vendor.

Provider Relations Department

The Provider Relations Department works with the Health Education Department in identifying provider needs for health education materials and services.

Community and Provider Education Department

The Health Education Department works with the Community and Provider Education Department to coordinate activities for Blue Shield Promise involvement in community outreach efforts and health fairs. Additionally, this department works with HE to help identify health education needs of the provider.

Utilization Management

The Health Education Department works with Utilization Management to direct appropriate health education interventions for patients identified through the UM/HE referral process. The HE Department assists the UM Department in educational efforts by identifying and supplying appropriate materials for UM to send to members and supports UM Case Management by assisting with HE interventions for members referred by Case Managers.

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Section 12: Provider Services

The Provider Services Department is dedicated to educating, training, and ensuring all participating providers have a resource to voice any concern they may have.

The Provider Services staff acts as a liaison between Blue Shield Promise departments and the external provider network to promote positive communication, facilitate the exchange of information, and seek efficient resolution of provider issues. Your Provider Relations Representative is your key contact and source of information. Please send all inquiries to your assigned Provider Relations Representative. If you are not sure who your Provider Network Representative is and/or need to contact Blue Shield Promise for any additional reason, please email ProviderRelations@blueshieldca.com or call (800) 468-9935.

The following resources are available to providers and staff:

- Provider Relations Representative
- Provider In-Services
- Provider Manual
- Provider Bulletin
- Provider Communication
- Joint Operation Committee (IPA/Medical Groups and Hospitals only)

We encourage providers to make recommendations and suggestions that will better allow us to serve our members and to improve the processes within our organization through open discussions and meetings.

12.1: Provider Manual Distribution

Provider Manuals are distributed to all new IPA/medical groups and hospitals during Joint Operation Committee meetings and for Blue Shield Promise directly contracted providers within ten (10) business days of placing provider on active status. Blue Shield Promise will request and maintain documented receipt of all Provider Manuals distributed. Provider Manuals are updated annually and/or as required. Updates to the Provider Manual are made available on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers under *Provider Manuals* or printed upon request.

12.2: Provider Orientations

Orientations are conducted by the Provider Services staff to educate new IPA/medical groups, hospitals, ancillary providers, and Blue Shield Promise directly contracted providers on Plan operations and policies and procedures within ten (10) business days of placing a provider on active status. Direct network providers must have completed training before entering provider into Blue Shield Promise network and/or provider directory. Training must have been conducted within the past 12 months of being added to the Medi-Cal network. If the provider is not available for an in-person orientation, the New Provider Orientation (NPO) will be conducted telephonically, WebEx, or via a self-directed online module.

12.2: Provider Orientations *(cont'd.)*

IPA/Medical Group Responsibilities

Blue Shield Promise's contracted IPA/medical groups are responsible for conducting provider training and orientation for its contracted providers within ten (10) business days of placing a provider on active status with the IPA/medical group regardless of their effective status with Blue Shield Promise. IPA/medical groups are required to provide evidence of the 10-day training as requested by Blue Shield Promise. When submitting provider to be added to the network, IPA/medical groups must attest to the completion of a 10-day provider orientation training by providing the training date of completion within submitted provider rosters or provider profiles. New Provider Training Attestation forms must also be completed for each individual practitioner and IPA/medical group must be prepared to provide a copy of the New Provider Training Attestation Form to Delegation Oversight.

12.3: Joint Operation Committee Meetings (IPA/Medical Groups and Hospitals Only)

Joint Operation Committee (JOC) meetings are conducted by the Provider Relations Representative at least annually or as needed to allow monitoring and oversight of delegated responsibilities, ensure effective problem resolution, and maintain ongoing communication between Blue Shield Promise and its contracted IPA/medical groups and hospitals. Blue Shield Promise will maintain documentation of attendees and issues discussed.

12.4: PCP Enrollment Limits

A primary care physician (PCP) may be assigned a maximum of 2,000 members total. When a PCP reaches the enrollment limit, the PCP's panel is closed to new enrollment until the PCP's membership drops below the maximum level. State regulations require Blue Shield Promise to ensure the network meets the following provider to member ratios:

- Primary Care Physician 1:2,000
- Capacity is added to PCP when supervising Mid-Level provider up to a max capacity of 1:5,000

A PCP can limit the growth of their enrollment by requesting to close their panel. When a provider closes their panel, the provider is no longer open for the auto assignment default process or member choice selection. Exceptions may be made for existing members.

Additionally, Blue Shield Promise has the capability of closing a provider's panel to new patients if the member experiences access issues, quality issues, or provider has failed a facility site review. The provider's panel will re-open upon an approved corrective action plan (CAP).

12.5: Mid-Level Medical Practitioners

The use of Mid-Level Practitioners increases primary and specialty care capacity and member access to professional services. Relative to primary care, the number of potential assigned members to a PCP can be increased by 1,000 members for each mid-level practitioner the PCP supervises to a maximum of 5,000 members.

PCPs may supervise up to four (4) mid-level practitioners in any combination according to the following state regulated physician supervisor to mid-level provider ratios:

Nurse Practitioner	1:4
Physician Assistant	1:2
Midwife	1:3

The delegation of specified medical services to mid-level practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the mid-level practitioner.

12.6: Provider Network Additions (IPA/Medical Groups)

Blue Shield Promise maintains the following per submission and notification by contracted IPA/medical groups:

- Primary Care Physicians
- Specialty Care Physicians
- Hospitals
- Urgent Care Centers

The addition of an IPA/medical group provider requires submission of a provider profile to the Blue Shield provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

Medi-Cal enrollment is required to participate in the network. New Provider Orientation (NPO) training completion is a requirement to add providers to the Medi-Cal network.

See Section 9.13: Credentialing Program for minimum credentialing data requirements.

12.7: Provider Network Changes

Provider network changes include terminations, leave of absences/vacation, enrollment status/restrictions, and changes in IPA/medical group affiliation.

Providers affiliated with Blue Shield Promise through an IPA/medical group must send notification to the IPA/medical group in accordance with their contractual agreement. Notification of changes should be directed to the Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

12.7: Provider Network Changes *(cont'd.)*

12.7.1: PCP Terminations

IPA/medical groups 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 90 days in advance. Blue Shield Promise cannot guarantee that members will remain with the same PCP/IPA/medical group due to member choice.

Blue Shield Promise retains the right to obligate the PCP/IPA/medical group to provide medical services for existing members until the effective date of member transfer. When an IPA/medical group fails to designate an appropriate provider, members will be reassigned as described below:

Blue Shield Promise Directly Contracted Physicians

1. If the terminating PCP practices under a group contract, the members will remain with the group.
2. If the terminating PCP practices under a solo contract, the members will be reassigned within the Blue Shield Promise Provider Network.

IPA/Medical Groups

1. If the terminating PCP practices in a Federally Qualified Health Center (FQHC), clinic, or staff model, the members will remain with the FQHC, clinic, or staff model and will remain with the group.
2. If the terminating PCP is a solo practitioner provider and is currently affiliated with more than one IPA/medical group, the members will be transferred to follow the PCP to another IPA/medical group that will cause least disruption to a) a hospital and/or b) a specialist panel.
3. If the PCP is administratively terminated by Blue Shield Promise and/or the IPA/medical group for reasons such as, but not limited to suspension of license, malpractice insurance, or Facility Site Review, the members will remain within the IPA/medical group.
4. If the IPA/medical group wants members reassigned to specific primary care physicians, the IPA/medical group must provide that information to Blue Shield Promise at the time of the notification of PCP termination. Blue Shield Promise will strive to accommodate such requests subject to the member's right to make a final PCP selection.

12.7: Provider Network Changes *(cont'd.)*

12.7.2: Termination Notification Requirements

Blue Shield Promise recognizes the importance of timely member notification prior to the termination of a regularly seen specialist or specialty group. The IPA/medical groups delegated for this function and/or Blue Shield Promise shall 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.

The specifics of the requirements are as follows:

1. All Blue Shield Promise contracted IPA/medical groups must notify members seen regularly by a specialist or specialty group whose contract is terminated at least 30 days prior to the effective termination date. The letter to the member must include notification of the specialist or specialty group's termination, the effective date of termination, and the procedures for selecting or assigning another specialist or specialty group. (Please refer to the Continuity of Care Guidelines in Section 7.8.5 for members qualifying for continuity of care.)
2. Contracted IPA/medical groups must have policies that define members seen regularly by a specialist or specialty group and which outline the provider's implementation plan for notifying members of the specialist/specialty group termination, as well as the procedures they may follow to select another specialist. Ways to identify affected members may include but are not limited to:
    - Number of visits within a specified time period such as two or more cardiac follow-up visits within one year.
    - Repeated referrals for the same type of care over a specified time period such as four referrals for the treatment of diabetes over a two-year period.
    - Receipt of periodic preventive care by the same specialist or specialty group such as a woman receiving an annual well woman exam by the same OB-GYN.
3. If the IPA/medical group does not provide Blue Shield Promise affected members with 30 days' advance written notice, the IPA/medical group is responsible for ensuring the specialist and/or specialty group continues to provide medical services to affected members until a 30-day advance notice of the termination is given.
4. Member notices must be sent in the members' preferred language within the threshold language requirements for each county, in accordance with APL 21-004. Blue Shield Promise will provide the IPA/Medical Groups with letter templates and enclosures, all translated in the threshold languages. Alternative Format Selection for members with visual Impairments or other disabilities requiring provisions of written materials in alternative formats must also be available upon request, in accordance with APL 22-002.

12.7: Provider Network Changes *(cont'd.)*

12.7.3: Blue Shield Promise Oversight

Blue Shield Promise provides appropriate oversight of each of its contracted IPA/medical groups, including, but not limited to:

- Specialist/Specialty Group Termination Policy and procedures as outlined above;
- Review of member notification letter regarding specialist/specialty group terminations. Note: Letters must be Blue Shield Promise approved template letters.

As such, Blue Shield Promise's Delegation Oversight Consultant will review each IPA/medical group policy and procedure and member notification letters during its annual delegation audit process.

The specialist termination notification policy and procedure will outline how your organization will:

1. Identify "affected members" regularly seen by a specialist or specialty group;
2. Inform affected members of the specialist/specialty group termination; and
3. Assign or direct affected members to select another specialist or specialty group.

In addition, the IPA/medical group is required to maintain copies of all notification correspondence between the IPA/medical group and affected members.

12.7.4: Office Relocation

IPA/medical groups or Blue Shield Promise directly contracted providers shall send 60-day prior written notification for all office relocations to the BSCProviderInfo@blueshieldca.com email. The PCP/IPA/medical group is responsible for submitting a coverage plan to Blue Shield Promise, if necessary.

PCP that changes office locations will require a facility site review (FSR). The PCP's panel will be closed to new membership until the new location has successfully completed the FSR review and been enrolled. Once the new site is enrolled and approved, members will be transferred from the existing site to the new site. If the PCP moves outside of the former office's geographic area, Blue Shield Promise will coordinate with the IPA/medical group to reassign the members to a new PCP within Blue Shield Promise's access standard of five (5) miles but no more than ten (10) miles. In transferring members, the provider's location, specialty, and language are taken into consideration. If the IPA/medical group is unable to meet this requirement, members will be transferred to a provider in the geographic area of the former office location.

12.7: Provider Network Changes *(cont'd.)*

12.7.5: Provider Leave of Absence or Vacation

PCPs/IPAs/medical groups must provide adequate coverage for providers on leave of absence or on vacation. PCPs/IPAs/medical groups must submit a coverage plan to their appointed Blue Shield Promise Provider Relations Representative for any absences greater than four (4) weeks. Absences over 90 days will require transfer of members to another Blue Shield Promise PCP.

12.7.6: Change in a Provider's IPA/Medical Group Affiliation

PCPs may change their Blue Shield Promise IPA/medical group affiliation by submitting written notification of the change request to the Provider information & Enrollment that the PCP wishes to change from in accordance with the contractual agreement and with contract regulators.

Blue Shield Promise will process the request in accordance with the member notification policy.

Blue Shield of California
Provider Information & Enrollment
P.O. 629017
EL Dorado Hills, CA 95762-9017
Email: BSCProviderInfo@blueshieldca.com

12.7.7: Change in a Provider's Panel Status

The IPA/medical group is required to inform the Plan within five (5) business days when either of the following occur:

1. One or more of their providers is not accepting new patients;
2. One or more of their providers previously did not accept new patients and is currently accepting new patients; or
3. If the one or more of their providers was not accepting new patients and is contacted by an enrollee/Plan member or potential enrollee/Plan member seeking to become a new patient, the provider shall direct the enrollee/Plan member or potential enrollee/Plan member to our Member Services Department at (800) 605-2556 (Los Angeles) or (855) 699-5557 (San Diego) TTY 711 for assistance in selecting a new provider. The provider is also to direct the enrollee/potential enrollee to the Department of Managed Care Services (DMHC) to report any provider directory inaccuracy.

12.7: Provider Network Changes *(cont'd.)*

12.7.7: Change in a Provider's Panel Status *(cont'd.)*

Provider Directory Inaccuracies

Providers can review their information on the Blue Shield Promise website and submit changes to the information listed in the directories through the following:

- Submit provider demographic changes on Blue Shield's provider portal, Provider Connection at blueshieldca.com/provider
- Email BSCProviderInfo@blueshieldca.com
- Complete an Online Interface Form
- Call Blue Shield Promise Member Services at (800) 605-2556 (Los Angeles) or (855) 699-5557 (San Diego)

When a report indicating that information listed in the provider directory is inaccurate, Provider Information & Enrollment will verify the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in the provider directory.

When verifying a provider directory inaccuracy, Blue Shield Promise shall, at a minimum:

1. Contact the affected provider no later than 5 business days following receipt of the report; and
2. Document the receipt and outcome of each report.

Documentation shall include the provider's name, location, and a description of the Blue Shield Promise validation, the outcome, and any changes or updates made to the provider directory.

Blue Shield Promise will terminate a provider upon confirming:

1. Provider has retired or otherwise has ceased to practice;
2. A provider or provider group is no longer under contract with the plan for any reason;
3. The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

12.7: Provider Network Changes *(cont'd.)*

12.7.7: Change in a Provider's Panel Status *(cont'd.)*

Online Interface Form

The Online Interface Form is an electronic web form that contains the required provider directory information Blue Shield Promise has on file for the provider. Providers can notify Blue Shield Promise of changes to their demographic data by completing the Online Interface Form and/or providing an affirmative response to Blue Shield Promise's Outreach Program, through the online interface.

A system generated acknowledgment is automatically sent upon submission of an Online Interface Form.

12.7.8: Network Validation

1. Quarterly Network Validation.
    a. Blue Shield Promise validates the IPA/medical groups provider network quarterly through established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels etc.
2. Bi-annual Network Validation.
    a. Blue Shield Promise directly contracted providers validate their data bi-annually. Providers are asked to validate the information and report any changes to their record(s) such as provider terminations, name changes, address changes, open/closed panels etc.
3. Annual Validation.

    Hospitals and Facilities validate their data annually through established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, etc.

    The validations include the following:

    a. Provider Notice:
        (1) Instructions to review and submit provider changes within 30 business days.
        (2) Instructions on how the plan provider can update the information listed in the provider directory using the online interface.
    b. Attestation:
        (1) Receipt of network validation.
        (2) Confirm that the information in the provider directory or directories is current and accurate; or
        (3) Update the information required to be in the directory or directories.

12.7: Provider Network Changes *(cont'd.)*

12.7.8: Network Validation *(cont'd.)*

4. Plan Provider Attestation Requirement:

   Blue Shield Promise requires an attestation from plan providers. If an attestation or an update is not received from the plan provider within 30 business days, Blue Shield Promise shall:

   a. Verify whether the information is correct or requires updates within 15 business days.
   b. Document the receipt and outcome of each attempt to verify the information.
   c. If unable to verify or update the information, Blue Shield Promise shall provide notification informing the provider that in 10 business days the provider will be removed from the provider directory.

5. Removing a Plan Provider:

   If no response to the provider notice(s) is received, after the required ten (10) business day notice period, the plan provider shall:

   a. Be removed from the provider directory by the next required update; or
   b. If provider responds within the 10-business day notice period, plan provider will not be removed.

6. Blue Shield Promise's Provider Directory Protocol:

   In order to reduce administrative burden on providers, Blue Shield Promise delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield Promise, the provider must work with the vendor in lieu of Blue Shield Promise to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.

12.8: IPA/Medical Group Specialty Network Oversight

See Section 9.8: Access to Care.

12.9: Changes in Management Service Organizations (IPA/Medical Groups Only)

IPA/medical groups must provide a 90-day advance written notification of a change in management service organization (MSO) along with a copy of the executed contract between the IPA/medical group and the new MSO to Blue Shield Promise's Provider Services Director.

The new MSO must meet Blue Shield Promise's pre-contractual criteria. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the IPA/medical group/MSO to comply will result in panel closure of all providers.

12.10: Provider Grievances

See Section 6: Grievances, Appeals, and Disputes, subsection 6.4: Provider Disputes – Claims Processing.

12.11: Provider Directory

The Blue Shield Promise provider directory is updated each month. Any member of the public may download a PDF copy of the directory from blueshieldca.com/en/bsp/medi-cal-members/find-provider. A searchable directory is also available online.

To request a printed copy of the directory, please contact Blue Shield Promise in writing at:

- Blue Shield of California Promise Health Plan
  Customer Care
  601 Potrero Grande Dr.
  Monterey Park, CA 91755

By phone:

- (800) 605-2556 (Los Angeles) [TTY:711]
- (855) 699-5557 (San Diego) [TTY:711]

Or online:

- blueshieldca.com/memberwebapp/bscphp/contact-us-medical

Blue Shield Promise will postmark the printed copy within five (5) business days of the request.

The directory lists primary care physicians, specialists, hospitals, vision providers, pharmacies, and Federally Qualified Health Clinics who see Medi-Cal patients. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted IPA/medical group and/or Blue Shield Provider Information & Enrollment department at BSCProviderInfo@blueshieldca.com. Providers may also review their information on the Blue Shield Promise website at www.blueshieldca.com/promise. Blue Shield Promise is committed to ensuring the integrity of the directory.

12.12: Prohibition of Billing Members

Each provider agrees that in no event including, but not limited to, nonpayment by the Plan, the Plan's insolvency or the Plan's breach of this agreement shall any Plan member be liable for any sums owed by the Plan.

A provider or its agent, trustee, assignee, or any subcontractor rendering covered medical services to Plan members may not bill, charge, collect a deposit or other sum; or seek compensation, remuneration or reimbursement from, or maintain any action at law or have any other recourse against, or make any surcharge upon, a Plan member or other person acting on a Plan member's behalf to collect sums owed by Plan.

Should Blue Shield Promise receive notice of any surcharge upon a Plan member, the Plan shall take appropriate action including but not limited to terminating the provider agreement for cause. Blue Shield Promise will require that the provider give the Plan member an immediate refund of such surcharge.

13.1: Introduction

The marketing of managed care services to Medi-Cal beneficiaries is strictly regulated and monitored by Blue Shield Promise Health Plan and the California Department of Health Care Services (DHCS); therefore, Blue Shield Promise and its providers must adhere to all regulatory guidelines.

13.2: Prohibited Conduct

Prohibited conduct includes but is not limited to:

1. False or misleading claims or representations that include, for example:
    a. A specific health plan is recommended or endorsed by any state or county agency.
    b. The state or county recommends that a Medi-Cal beneficiary enroll in a specific health plan.
    c. A Medi-Cal beneficiary will lose their Medi-Cal benefits or other welfare benefits if he/she does not enroll.
    d. Any representation that office staff is an employee(s) of the state or county.
2. The offering or giving of any form of compensation, reward, or loan to induce enrollment.
3. Making use of any list of Medi-Cal beneficiary names or information obtained originally from confidential state or county data sources.
4. Providing confidential beneficiary information or data sources to health plans or other third-party entities for enrollment purposes.
5. Marketing practices that discriminate against prospective members based on race, color, marital status, religion, age, sex, national origin, ancestry, gender, gender identity, sexual orientation, disability, language, or medical condition (e.g., pregnancy, disability, etc.).
6. Engaging in any Medi-Cal marketing activity on state or county premises or any other location not authorized in Blue Shield Promise's marketing plan or by DHCS.

Blue Shield Promise is responsible for monitoring marketing activities of its providers when such activity relates to Blue Shield Promise and Medi-Cal. Providers must receive approval on all marketing materials containing the Blue Shield Promise Health Plan name and logo prior to use.

In addition to monitoring provider marketing material development, usage, and distribution, Blue Shield Promise shall continuously and closely monitor provider outreach efforts.

13.2: Prohibited Conduct *(cont'd.)*

Primary care physicians (PCPs) may NOT:

1. Coerce, threaten, or intimidate patients into making a particular health plan or provider selection.
2. Influence patients to change health plan membership based on financial gain to the PCP.
3. Tell patients that they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
4. Make any reference to competing health plans (e.g., comparing plans in a positive or negative manner) for purposes of encouraging or influencing a patient to enroll or disenroll from a particular health plan based on the PCP's financial interest.
5. Mail complete enrollment forms to HCO on behalf of patients.
6. Photocopy sample enrollment forms with the health plan and PCP names filled in for distribution to patients or to fill in the health plan and PCP names on blank enrollment forms for patients to sign and mail.
7. Use photocopied blank forms or plain-printed enrollment forms. (Only DHCS-supplied forms will be accepted).
8. Have health plan marketers stationed and enrolling in or outside the PCP office.
9. Allow PCP staff to receive any remuneration for marketing or enrolling beneficiaries.

13.3: Monitoring Provider Marketing Material Development/Usage/ Activity Guidelines

When using the Blue Shield Promise Health Plan name/logo:

1. Providers must submit one (1) set of materials to Blue Shield Promise for review and approval prior to use:
    a. If materials are general in nature, and if the provider contracts with more than one health plan, only one (1) set must be submitted to a health plan.
    b. If the materials contain the names or logos of more than one health plan, the contracted provider must submit a set of materials to each health plan mentioned for review and approval.
2. Submitted materials must contain final content and be clear and legible. Rough ideas are unacceptable and will not be reviewed.
3. No marketing materials are to be used and/or activities done without prior consent from Blue Shield Promise. This includes general advertising used to reach Medi-Cal beneficiaries, tactical advertising with the Blue Shield Promise Health Plan name and/or logo, and collateral/promotional items such as brochures, pamphlets, pens, etc.

14.1: Claim Submission

Blue Shield Promise Health Plan applies the appropriate regulatory requirements related to claims processing.

A. Blue Shield Promise requires that providers submit all encounters electronically and encourage providers to submit all claims and receive payments electronically as well, for faster processing and payment, using electronic data interchange (EDI). To enroll in electronic claim submission, providers can use any approved clearinghouse listed in section G. 4. below. To enroll in electronic encounter submission, providers can use TransUnion or Office Ally.

   Paper claims must be submitted using the current versions of CMS-1450 (UB) and CMS 1500 forms. Paper claims and additional information such as medical records, daily summary charges and invoices must be submitted at the following address to avoid processing and payment delay:

   Blue Shield Promise Health Plan
   Exela - BSCPHP
   P.O. Box 272660
   Chico, CA 95926

B. Providers must follow the most recently updated Current Procedural Terminology (CPT) coding guidelines, National Drug Code (NDC) for drugs as well as the HCFA Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, and Department of Health Care Services (DHCS) coding guidelines.

C. Except as required by DHCS, any Medi-Cal Fee Schedule published on or after the fifteenth (15th) of the month will become effective for dates of service on or after the first (1st) day of the month following the month during which such change was published by DHCS. For example, the Medi-Cal Fee Schedule posted in October will be effective November 1.

D. Blue Shield Promise removes deleted HCPCS and CPT codes from its claims payment system. To ensure timely payment, providers are encouraged to only submit currently valid and recognized CPT and HCPCS codes. For drug codes, the CPT or HCPCS and NDC are required for consideration of payment.

E. Providers must ensure all claims submitted to Blue Shield Promise are complete and accurate. Complete claim means a claim or a portion thereof, if separable, including attachments and supplemental information or documentation which provides "reasonably relevant information" as defined in Title 28 Section 1300.71 Claims Settlement Practices, Section (a)(10), "information necessary to determine payer liability" as defined in Section (a)(11); and:

   1. For emergency services, legible emergency department reports.
   2. All required/mandatory fields in current CMS-1500 form for professional services and UB-04 form for facility services adopted by the National Uniform Billing Committee (NUBC).

14.1: Claim Submission *(cont'd.)*

3. All required/mandatory fields in current CMS-1500 adopted by the National Uniform Claim Committee (NUCC).
4. Any Medi-Cal designated requirements such as Universal Product Number (UPN) for medical supplies or National Drug Codes (NDC) for pharmacy related claims.

Claims submitted electronically must be HIPAA compliant and meet all requirements for EDI transactions.

F. Claim Filing Limits

1. Medi-Cal claims submissions must meet the following time requirements:
   a. Claims must be submitted within 180 days from the date of service.
   b. Claims submitted beyond 180 days from the date of service will be denied for timely filing unless documentation supporting the reason for delay meets one of the following situations:
      i. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four (4) months after the month of service.
      ii. If a provider has submitted a bill to a liable third party, the provider has one (1) year after the month of service to submit the bill for payment.
      iii. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one (1) year to submit the bill after the month in which the services have been rendered.
      iv. Blue Shield Promise finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.
      v. If the provider has submitted a bill to the Other Health Coverage (OHC), the provider has 90 calendar days from the date of the OHC plan's payment to submit the claim to Blue Shield Promise.
   c. Claims received after the 12th month after the month of service will be denied as untimely.

G. Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

1. ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. The ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.
2. Providers that are identified as a participant in the Blue Shield Promise provider network must receive the remittance advices and payments electronically for services provided to Blue Shield Promise members.
3. Blue Shield Promise will automatically enroll Blue Shield Promise providers with the clearinghouse Office Ally for their ERA/835 transactions.

14.1: Claim Submission *(cont'd.)*

4. If a Blue Shield Promise provider would like to enroll their ERA/835 transactions through a different clearinghouse, please see below for approved clearinghouses (not an inclusive list). Providers will need to send a completed ERA form indicating the clearinghouse selection. If a clearinghouse is not selected, providers will automatically be assigned to Office Ally.

Approved Clearinghouse	Website	Phone Number
Office Ally	cms.officeally.com	(360) 975-7000
Change Healthcare	www.changehealthcare.com	(866) 817-3813
Allscripts	www.allscripts.com	(800) 334-8534
Trizetto Provider Solutions	www.trizettoprovider.com	(888) 550-5637
Navicure	www.navicure.com	(770) 342-0800

5. To enroll in ERA/EFT, providers must download the enrollment form from the Blue Shield Promise provider website at blueshieldca.com/promise/provider and follow these steps:
   a. On the home page, click on *Working with us.*
   b. Scroll to the bottom of the page to the box labeled *Manage electronic claims and encounter*s then click on the link *learn more about electronic claims.*
   c. Scroll down to *Sign up for electronic remittance advice and electronic payments* and click on *Read enrollment instructions.*
   d. Click on *Sign up for ERA* in the box labeled *Electronic Remittance Advice.*
   e. Click on the link *ePayments Provider Authorization Form.* This form also includes the enrollment for electronic funds transfer (EFT).

   Enrollment forms must be faxed to the number listed on the form at (866) 276-8456. For questions regarding the ERA enrollment process, please email EDI_PHP@blueshieldca.com.

14.2: Claims Processing Overview

A. Blue Shield Promise makes every effort to ensure claims that are the Blue Shield Promise financial responsibility are paid, denied, or contested within 30 calendar days of receipt. At least 90% of claims that are the Blue Shield Promise financial responsibility to pay are processed within 30 calendar days of receipt or 95% within 45 working days.

- Receipt dates are based on when Blue Shield Promise receives the claim the first time.

B. Misdirected Claims

1. Claims that are the financial responsibility of the IPA/medical group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.

2. Billing Providers receive notices from Blue Shield Promise identifying the responsible payers.

C. Reimbursement Rates

1. To be eligible for payment, the claim must be complete and accurate.
2. Contracted providers are paid at contracted rate.
3. Non-contracted providers are paid at Medi-Cal established rates.

D. Interest payments are applied to complete claims that are not paid within 45 working days. Interest is paid for the period of the time that the payment is late.

1. Emergency services – The greater of $15 for each month period or 15% per annum.
2. All other complete claims - 15% per annum or daily rate of 0.000411.
3. Interest payments are not made for claims where additional information is received after the original claim payment or denial, claims denied due to untimely filing and later paid because evidence of timely prior filing to the incorrect payer is submitted, or claim denied due to untimely filing is paid because information about a good cause for the delay is accepted.

E. Balance Billing

Providers must not balance bill members for any covered/authorized services. Title 22, Section 51002 of the California Code of Regulations states "a provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service."

14.2: Claims Processing Overview *(cont'd.)*

F. Overpayment Recovery

Blue Shield Promise will notify provider of service, in writing, within 365 calendar days from the date of last payment to initiate an overpayment request. The provider of service must respond within 30 working days to contest and/or refund the overpayment. Blue Shield Promise will offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission if (1) the provider fails to reimburse within the 30-working day timeframe and (2) the provider has entered into a written contract specifically authorizing Blue Shield Promise to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions.

If a provider contests Blue Shield Promise's overpayment request within 30 working days, the Plan will treat the challenge as a Provider Dispute.

G. Emergency Claims

Emergency claims are paid without prior authorization. Legible emergency department reports must be submitted when billing with ER level 5.

H. Family Planning and Sensitive Services Claims

Claims for family planning and sensitive services (such as abortion, sexually transmitted diseases, HIV testing, and counseling) do not require authorizations. Claims for sterilization services must be submitted with completed and signed DHCS Consent Form (PM 330 Form). Claims submitted without the form will be rejected and not be paid. Claims will be paid upon receipt of completed and signed PM 330 Form.

I. Inpatient Hospital Claims – Emergency Admission

In the event emergency admission is not authorized prior to member's discharge, medical records must be submitted with the claims in order to determine medical necessity and avoid delay on payments. Claims with medical records are forwarded by Claims Department to Utilization Management ("UM") to determine appropriate level of care and medical necessity. Upon completion of UM's review, claims are processed and paid according to approved and authorized service.

J. Inpatient Hospital Claims – Elective Admission

All elective inpatient admissions require prior authorization. Prior authorization, bed type and days billed versus pre-certification are verified for inpatient claims. Claims are paid according to authorized level of care. Lack of prior authorization will result in payment denials.

14.2: Claims Processing Overview *(cont'd.)*

K. Outpatient and Other Claims

1. Ambulatory services, outpatient surgeries, ancillary, and specialty services require prior authorization. Claims for these services without prior authorization will result in payment denials.
2. Some services are established as no prior authorization required.
3. For Annual Cognitive Health Assessment claims, providers must complete the following steps in order to receive payment:

- Complete the Dementia Care Aware training prior to the assessment. Blue Shield Promise will check the DHCS list of providers who have completed the training.
  - Denied claims may be submitted to Provider Dispute Resolution, with dated proof that training was completed prior to the assessment.
- Meet all contracted provider billing requirements.
- Attach Medical Record updates to the claim. The updates must contain:
  - The screening tool(s) used, including one or more of the cognitive assessment tools required by All Plan Letter (APL) 22-025;
  - Verification that the screening results were reviewed by the provider;
  - The results of the screening, along with the provider's interpretation of them;
  - A summary of the details that were discussed with the member and/or their authorized representative; and
  - A description of appropriate actions taken in response to the results of the assessment.

L. Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services for which provider is reimbursed pursuant to the APG payment rate. Incidental procedure services and supplies are considered included in Ambulatory Patient Groups (APG) rates. A list of incidental procedures is provided in Appendix 7.

M. Facility Compliance Review (FCR)

In order to comply with our employer group and provider contract agreements and to ensure that appropriate billing practices are followed, the Plan has developed a comprehensive Facility Compliance Review (FCR) program that involves a comprehensive line-by-line bill audit. The program reviews inpatient and outpatient claims to validate their conformance with provisions of the facility's agreement.

14.2: Claims Processing Overview *(cont'd.)*

The Plan audits claims for billing accuracy, allowable charges, medical necessity, Hospital Acquired Conditions and Never Events to ensure consistency with currently accepted standards in the industry. These standards include but are not limited to those defined by Optum reference manuals and followed by other commercial payors, as well as the UB 04 Billing Manual guidelines and the National Uniform Billing Committee guidelines. The program encompasses Plan claims for all lines of business and all facilities.

Categories of charges that are subject to review and payment denial include but are not limited to those charges that are mutually agreed to in Plan's contracts (e.g., Disallowed Charges); those charges that are determined to be not medically necessary; those for which there is no substantiating documentation; and those considered to be unbundling of another global charge, such as room and board charges or other facility room charges. Precedence for denial of such charges has been established by Optum resource manuals, and other commercial payors, as well as the Uniform Bill (UB 04) Billing Manual guidelines and definitions.

To complete an audit as expeditiously as possible, the Plan may ask a hospital to submit medical records such as Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report, and Implant Log. The Plan may request a copy of the UB 04 (or successor) and a detailed itemization if the claim has been electronically submitted. Timely submission of requests will expedite claims processing.

For questions regarding this program, please contact Provider Information & Enrollment at (800) 258-3091.

Appeals to the Facility Compliance Review results must be submitted in writing and include specific detailed supporting documentation to the following address:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

14.3: Coordination of Benefits (COB)

Medi-Cal is considered a payer of last resort. Other coverage should be billed as the primary. When billing Plan, submit the primary payer's explanation of benefits (EOB) or remittance advice (RA) with the claim.

14.3: Coordination of Benefits (COB) *(cont'd.)*

Prior to delivering services to members, providers must review the Medi-Cal eligibility record for the presence of Other Health Coverage (OHC). If the member has OHC, providers must compare the OHC code (found in Appendix A on the DHCS website at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-010AttA.pdf) to the requested service. If the requested service is covered by the OHC, providers are to instruct the member to seek the service from the OHC carrier. As stated in Title 42 U.S. Code Section 1396a(a)(25)(D), regardless of presence of OHC, providers should not refuse a covered Medi-Cal service to a Medi-Cal member and should proceed as follows:

1. If a member has OHC, provider should consider OHC plan as the member's primary health plan.
2. If the member has OHC, the provider shall submit a claim for Covered Services provided to the member to the OHC prior to submitting the claim to Blue Shield Promise.
3. Blue Shield Promise shall remain the secondary health plan and payer of last resort for Medi-Cal eligible members.
4. If a member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the provider should bill the primary health plan for the medical, other care or treatment benefits. Blue Shield Promise Medi-Cal members will be considered the secondary health plan and payer of last resort.
5. A provider shall submit the claim for covered services along with the OHC plan's remittance advice to Blue Shield promise within 90 calendar days from the OHC plan's payment date.

Providers may access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295 or the Medi-Cal Online Eligibility Portal. Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.

14.4: Third-Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan, the member's designated medical group, or Independent Practice Association (IPA) will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from the third-party, third-party insurer, or from uninsured or underinsured motorist coverage, DHCS has the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

1. Notify the Plan, the member's designated medical group or the IPA in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party;
2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;
3. Agree, in writing, to reimburse Plan for benefits paid from any recovery received from the third party;
4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Respond to information requests regarding the claim against the third party and notify the Plan and the medical group or IPA, in writing, within ten (10) days of any recovery obtained.

14.5: Claims Status Inquiry

Providers may verify receipt of claims within 15 days of submission to Blue Shield Promise by calling (800) 468-9935 ext. 3, by checking Blue Shield's provider portal at blueshieldca.com/provider, or by submitting an EDI 276 claim inquiry request. Please allow for the appropriate processing timeframes when obtaining claim status. To enroll and setup EDI 276/277 claim inquiries, please contact your clearinghouse or software vendor. If available, claim status transactions may be integrated into your practice management system.

14.6: Claims Compliance and Monitoring

Please see Appendix 9: Delegation Oversight Claims, Compliance, IT System Integrity - Auditing and Monitoring for Blue Shield Promise claims, compliance and IT System Integrity requirements for Delegated Entities.

14.7: Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) Requirement for Personal Care and Home Health Care Services Providers:

In accordance with federal and state laws, Blue Shield Promise is required to implement electronic visit verification (EVV) for all Medi-Cal personal care services (PCS) and home health care services (HHCS) providers that are delivered during in-home visits by the provider. This includes, but is not limited to, PCS and HHCS that are delivered during in-home visits by a provider, PCS and HHCS delivered as a part of Community-Based Adult Services (CBAS) Emergency Remote Services (ERS), Community Supports – personal care and homemaker services, respite services, day habilitation programs and all other HHCS programs covered.

Electronic Visit Verification (EVV) is a telephone and computer-based solution that electronically verifies when in-home service visits occur.
Providers rendering in-home service visits are required to be registered and trained in an approved EVV system, while also submitting the following required six (6) data elements for each in-home visit:

1. The type of service performed.
2. The individual receiving the service.
3. The date of the service.
4. The location of service delivery.
5. The individual providing the service.
6. The time the service begins and ends.

Failure to meet these requirements will result in providers being considered out of compliance. As a result, DHCS may take disciplinary action(s) to address the non-compliant provider, per W & I §14043.51.
To learn how to register and take the training through the state-sponsored EVV system, Sandata Technologies, LLC (Sandata), view the DHCS Quick Reference Guide at https://www.dhcs.ca.gov/provgovpart/Documents/Step-By-Step-Onboarding-Process-Quick-Reference-Guide.pdf.
Information about the state-sponsored EVV can be found on DHCS's website at https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx. This link also provides details about Provider Types and Codes that are subject to EVV requirements.

15.1: Financial Ratio Analysis (IPA/medical groups and capitated Hospitals Only)

The Accounting Department is responsible for the accurate financial reporting of capitation and claims expense transactions. The Managed Care Finance Department is responsible for data generation and timely payment of capitation.

IPA/medical groups must submit year-end financial statements audited by an independent certified public accountant firm within 150 calendar days after the close of the fiscal year to Blue Shield Promise and the Department of Managed Health Care (DMHC). On a quarterly basis, financial statements must be submitted to DMHC within 45 calendar days after the quarter ends.

IPA/medical groups must estimate and document, on a quarterly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other actuarial firm certified methodology and calculation.

IPA/medical groups shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability).
- A positive tangible net equity as defined in regulation 1300.76(e).
- A cash to claims ratio as defined in regulation 1300.75(f).
- A claims timeliness requirement as defined in regulation SB 260.

15.2: Capitation Payment

The Managed Care Finance Department is responsible for sending the monthly capitation payments to its contracted IPA/medical groups. Capitation payments are made no later than the 10th of each month for Medi-Cal San Diego and no later than the 13th for Medi-Cal Los Angeles or within 10 days from receipt of revenue from DHCS or L.A. Care.

Capitation reports and eligibility reports are posted on a secured site or what is widely known as a Secure File Transfer Protocol (SFTP) server. These reports are available to the IPA/medical groups no later than the 10th of each month. Each IPA/medical group is responsible for coordinating with Blue Shield Promise on how to access the SFTP server. For security measures, only two individuals per IPA/medical group are issued a username and password to access this site. Any changes to the IPA/medical group's contact person will require a new password or PGP key. IPA/medical groups must request and fill out a new PGP Key Form and submit to their assigned Provider Relations Representative.

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Section 16: Regulatory, Compliance, and Anti-Fraud

16.1: Anti-Fraud Policy and Program

State and federal agencies have increased investigations based on health care fraud and abuse laws and enforcement against providers and enrollees who violate these laws. State and federal authorities have in recent times prosecuted numerous healthcare providers for various fraudulent practices, and also mandated health care service Plans to establish anti-fraud programs.

Following this mandate and resultant industry trends, Blue Shield Promise has developed an aggressive Compliance and Anti-Fraud Program that includes voluntary disclosure to appropriate agencies of alleged cases of fraud and abuse. Provider cooperation is essential for the success of anti-fraud and abuse efforts and as a provider of health care services to Blue Shield Promise Health Plan members, we would like to draw your attention to this program and request your cooperation.

Health care fraud includes, but is not limited to, knowingly making, or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, member, employee, supplier, or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud.

There are two ways in which providers can cooperate in Blue Shield Promise's anti-fraud and abuse efforts:

1. Review practices related to services to Blue Shield Promise members to ensure that:
    a. Fee-for-service bills, if any, accurately describe the actual services performed and duplicate billing is avoided.
    b. Fee-for-service bills are not generated for capitated services.
    c. Members are not billed for covered services except for applicable co- payments.
    d. Co-payments, when applicable, are collected.
    e. Encounter data is reported accurately.
    f. Providers participate in Blue Shield Promise Health Plan utilization reviews to detect and review underutilization in a capitated environment.
    g. Blue Shield Promise Health Plan is informed about renewals and changes to all licenses and other credentials.
    h. Diagnoses and medical necessity are stated accurately, and accurate medical records are maintained.
    i. Full cooperation is demonstrated in transferring members to Plan hospitals when medically appropriate.
    j. Any marketing efforts for enrollment as Blue Shield Promise members are within legal limits.

16.1: Anti-Fraud Policy and Program *(cont'd.)*

2. Report any fraud and abuse or suspicious activity that may come to your attention to the Special Investigation Unit Hotline at (855) 296-9092, anonymously. Such instances include:
    a. Any illegal or improper solicitations or offers made to you by Blue Shield Promise employees.
    b. Any illegal or improper solicitations or offers made to you regarding services to Blue Shield Promise members by other providers.
    c. Any attempts by patients to use a Medi-Cal card or Blue Shield Promise identity cards belonging to another.

If the matter relates to Medi-Cal services, providers may also call the State of California, Department of Health Services Medi-Cal Fraud Hotline at (800) 822-6222, email fraud@dhcs.ca.gov, or go to www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

16.2: False Claims Act

The False Claims Act (FCA) (31 U.S.C. Sections 3729-3733) imposes liability on any person or organization that submits a claim to the federal government that is known (or should be known) to be false and allows citizens with evidence of fraud against government contracts and programs to sue on behalf of the government in order to recover stolen funds.

The FCA provides a way for the government to recover money when someone submits or causes to be submitted false or fraudulent claims for payment to the government, including the Medicare and Medi-Cal programs.

Examples of health care claims that may be false include claims where the service is not actually rendered to the patient, is provided but is already provided under another claim, is up-coded, or is not supported by the patient's medical record.

Claims also may be false if they result from referrals made in violation of the Federal Anti-kickback statute or the Stark law.

When the government pursues violations of the False Claims Act, it does not target innocent billing mistakes. False claims are claims that the provider knew or should have known were false or fraudulent. "Should have known" means deliberate ignorance or reckless disregard of the truth. This means providers cannot avoid liability by ignoring inaccuracies in their claims. Health care providers need to understand the program rules and take proactive measures, such as conducting internal audits within their organizations, to ensure compliance.

If a provider makes an innocent billing mistake, that provider still has a duty to repay the money to the government.

16.2: False Claims Act *(cont'd.)*

For False Claims Act violations, a provider can be penalized up to three times the program's loss, also known as treble damages. The False Claims Act provides a strong financial incentive to whistleblowers to report fraud. Whistleblowers can receive up to 30 percent of any False Claims Act recovery.

Providers must ensure that the claims they submit to Medicare and Medi-Cal are true and accurate. One of the most important steps a provider can take is to have a robust internal audit program that monitors and reviews claims. If a provider identifies billing mistakes in the course of those audits, the provider must repay overpayments to Medicare and Medi-Cal within 60 days to avoid False Claims Act liability.

It is the provider's responsibility to consistently submit accurate claims.

16.3: Confidentiality of Substance Use Disorder Patient Records

In 1975, Congress enacted 42 U.S.C. 290dd-2 and its supporting regulations at 42 C.F.R. Part 2. The law is formally referred to as the Confidentiality of Substance Use Disorder Patient Records Act, and informally referred to as "Part 2." The purpose of Part 2 is to protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized use and disclosure of SUD patient records except with patient consent and in limited circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that regulates and enforces Part 2.

If, as a provider, you are a Part 2 Program, you must comply with all of the applicable legal requirements of the Part 2 laws and regulations.

To assist you in meeting your legal obligations, you may inform Blue Shield Promise that you have the patient's consent to disclose their SUD patient records to Blue Shield Promise when submitting an electronic claim (837 P or I) for Part 2 services by placing an "1" in the CLM09 field.

When submitting an electronic claim (837 P or I) for Part 2 services, under the NTE02 segment, you may include in the free-form narrative one of the following mandatory Part 2 disclaimer language options. The shorter version is preferable.

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or

- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless

16.3: Confidentiality of Substance Use Disorder Patient Records
(cont'd.)

> further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

To help you determine if you are a Part 2 Program, please refer to: www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

To learn more about the Part 2 laws and regulations, please refer to: www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records.

To learn more about how Part 2 limits the disclosure of SUD patient records, please refer to: www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf.

It is recommended that you consult legal counsel if you are uncertain whether or how these provisions apply to you.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

Purpose

To ensure that members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices, and preferred language, at every medical and non-medical encounter.

Procedure

Blue Shield Promise Health Plan has adopted a CLAS Policy which is consistent with the National Standards for CLAS. Contracts between Blue Shield Promise and IPA/medical groups, providers, hospitals, and ancillary providers include a provision requiring them to participate in and comply with the performance standards, policies, procedures, and programs established from time to time by the local initiative, and Plan with respect to cultural and linguistic services including without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to the local initiative, and Plan. IPA/medical groups will educate and communicate cultural and linguistic requirements, policies, procedures, and programs to their contracted providers on an ongoing basis.

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

Blue Shield Promise and its subcontractors will fully comply with federal and state regulations, DHCS, L.A. Care, and DMHC contract requirements relating to CLAS. Blue Shield Promise does not delegate overall responsibility for culturally and linguistically appropriate services provided to plan members to IPA/medical groups and other providers.

CLAS areas that Blue Shield Promise Health Plan will be responsible for include:

1. Hiring a cultural and linguistic specialist responsible for CLAS.
2. Developing policies and procedures on CLAS related topics and requirements and ensuring access to members' CLAS data is protected and only accessible by approved parties.
3. Sharing eligible individual member data on language needs with providers.
4. Sharing member data on the service area population for the top threshold languages and the U.S. Census data for the state of California to bring awareness of the language needs of our members. California population language data from the United States Census can be accessed online at www.census.gov/quickfacts/fact/table/CA/PST045221
5. Identifying LEP members and communicating information to IPA/medical groups.
6. Providing information on language patterns of Blue Shield Promise members.
7. Sharing providers' race and/or ethnicity upon member's request.
8. Updating language capability of physicians and clinic staff in the provider directory.

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS *(cont'd.)*

9. Informing members of their rights to: Interpreting services at no cost; not use family members, including minors, or friends for interpreting; request an interpreter during discussions of medical information and explanations of plans of care; receive translated subscriber materials in threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files); and file a complaint or grievance if their cultural and/or linguistic needs are not met.
10. Contracting, coordinating, and covering the cost of face-to-face and American Sign Language (ASL) interpreting services requested by IPA/medical groups, providers, and members.
11. Contracting, coordinating, and covering the cost of 24-hour/7-day telephonic interpreting services when requested by IPA/medical groups, providers, and members.
12. Developing protocol on how IPA/medical groups, providers, and clinic staff can access to free interpreting services through Blue Shield Promise.
13. Developing and distributing resources, tools, and materials to IPA/medical groups (e.g., signs, language ID cards, etc.).
14. Assessing and monitoring the effectiveness of linguistic services.
15. Contracting with a qualified translation company to translate written enrollment and member informing materials in the threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) including the Evidence of Coverage (EOC) booklet, Provider Directory, Marketing Materials, Form Letters (denial letters, complaint and grievance materials, medical care reminders, and other legal documents). Then sharing these translated materials with the IPA/medical groups.
16. Conducting or subcontracting with qualified agencies or qualified facilitators to provide cultural competency, sensitivity, health equity, diversity, and inclusion training courses for, health plan staff, IPA/medical groups, providers, clinic staff, and Downstream Subcontractors staff at key points of contact with members.
17. Conducting an annual analysis on the Blue Shield Promise's provider network capacity and members' needs. When gaps and/or barriers are identified, develop, and implement improvement opportunities to meet member needs.
18. Working with the QI Department to address CLAS related grievances presented by members and IPA/medical groups and explore opportunities for improvement.
19. Communicating and disseminating CLAS information and requirements, and cultural competency training opportunities to IPA/medical groups and providers on an ongoing basis.
20. Monitoring and overseeing CLAS programs and compliance with IPA/medical groups.
21. Maintaining a committee that oversees Multicultural Distinction and CLAS oversight and approve related documentation. Blue Shield Promise members will serve as active committee members.

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS *(cont'd.)*

CLAS areas that IPA/medical groups will be responsible for include:

1. Designating a person responsible for CLAS and including responsibilities in job description. CLAS function is reflected in the organizational chart.
2. Identifying member language on monthly eligibility list sent to providers.
3. Updating Provider Directory to include language capability of providers and clinic staff.
4. Distributing signs to contracted providers on the availability of free interpreter services for LEP members and ensuring signs are posted at key points of contact.
5. Having appropriate telephone numbers and protocol to access interpreting services through the IPA/medical group or Health Plan.
6. Ensuring access to free interpreting services to LEP and hard-of-hearing or deaf members on a 24-hour/7-day basis.
7. Educating and informing providers and clinic staff on how to access interpreting services.
8. Providing and/or promoting cultural competency, sensitivity, Health Equity, diversity, and inclusion training to providers, clinic staff, and Downstream Subcontractors staff at key points of contact with members.
9. Making member-informing materials available to LEP members in the threshold languages and ensuring quality translation and cultural and linguistic appropriateness of materials. Informing providers and clinic staff what alternative format materials (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) are available at Blue Shield Promise and how to get them.
10. Having procedures for handling CLAS-related complaints made at the clinic and IPA/medical group sites and logging grievances with CLAS-related issues.
11. Educating providers and clinic staff on the need to maintain a language capability form, certification of language proficiency or interpreting training, or similar documentation on file for bilingual staff, and staff providing interpreting services to members.
12. Educating providers and staff on the process, and availability of CLAS Community resources/agencies. A list of resources/agencies must be kept on file and can be obtained from Blue Shield Promise.
13. Including CLAS related questions in "Provider Satisfaction Survey" and analyzing these results to identify patterns of CLAS related problems for corrective action (optional).
14. Having written policies and procedures covering the above subjects.
15. Documenting all education of CLAS information and its dissemination to contracted providers, as well as retaining copies of agendas, sign-in sheets, handouts/materials from provider cultural competency trainings attended.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS *(cont'd.)*

16. Translating the Notice of Action (NOA) and Notice of Appeal Resolution (NAR), including the clinical rationale, into the member's preferred language.

17.2: Identification of Limited English Proficient (LEP) Members

Cultural competency and linguistic capability in managed care is critically important to allow Blue Shield Promise to meet the needs of our culturally and linguistically diverse population. Language is a medium used in every step of the health care system, from making appointments to understanding instructions and asking questions.

Definitions:

"Limited English proficient (LEP) members" are those members that cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

"Threshold Languages" are primary languages spoken by limited English proficient (LEP) population groups meeting a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiaries, whichever is lower. The Department of Health Care Services (DHCS) designates threshold languages in each county. Languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county.

The following threshold languages have been identified by DHCS for Los Angeles County: Arabic, Armenian, English, Chinese (Cantonese and Mandarin), Farsi, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese.

For San Diego County, the threshold languages are Arabic, Chinese, English, Farsi, Spanish, Tagalog, and Vietnamese, (Sources: www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/LanguageAssistance.aspx)

"Materials in Alternative Formats" are materials, such as health education materials and information on how to access health plan services, which are available in the following formats: audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files. All member-informing materials can be made available in alternative formats.

17.2: Identification of Limited English Proficient (LEP) Members *(cont'd.)*

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and IPA/medical groups will assess their member population's language preference distributions to determine special needs and develop appropriate plans and services.
2. Blue Shield Promise will provide a monthly new member eligibility list to IPA/medical groups and providers, which will include the primary language spoken by each member. IPA/medical groups and providers may use the eligibility list as a tool to track their LEP members.
3. Blue Shield Promise and subcontractors will ensure members are routinely given opportunities to declare their need for culturally and linguistically appropriate services (e.g., when making an appointment, during Initial Health Assessment, on arrival, and in the exam room, etc.). Providers and clinic staff should record each member's primary language in their medical chart.

17.3: Access to Free Interpretation Services

It is the responsibility of Blue Shield Promise and subcontractors to provide access to interpreter services, 24 hours a day, seven days a week, at no cost, to LEP and hard-of-hearing members when they access health care services.

Blue Shield Promise and its subcontractors must not require or suggest that LEP, hard-of-hearing, or deaf members provide their own interpreters or use family members or friends as interpreters. The use of such persons may compromise the reliability of medical information and could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. **Minors should not interpret for adults.**

If, after being notified of the availability of interpreters, the member elects to have a family member or friend serve as an interpreter, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality.

Providers **MUST** document the request or refusal of language interpreting services by an LEP, hard-of-hearing, or deaf member in the member's medical record. This will be monitored during facility site reviews and medical records review audits.

Providers and clinic staff shall follow Blue Shield Promise protocol for requesting interpreting services to access telephonic, or face-to-face interpreting services for LEP, American Sign Language, hard-of-hearing, or deaf members.

17.3: Access to Free Interpretation Services *(cont'd.)*

Providers and bilingual staff providing interpreting services **MUST** maintain an "Employee Language Skill Self-Assessment" form, certification of language proficiency or interpreting training on file.

Bilingual staff providing medical interpreting services are encouraged to take a language proficiency test by a qualified agency (e.g., Language Line) to determine if the candidate is qualified for medical interpreting. It is recommended that Bilingual staff who rate a 1=Novice or 2=Low Intermediate based on a scale of 1-5 on a language proficiency test use a telephonic or face-to-face interpreter for communicating with members. This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.

17.3.1: Posting of Signs at Key Medical and Non-Medical Points of Contact

Signs informing members of their right to request free interpreting services should be clearly posted at each provider office (i.e., reception area, waiting room, exam room). Blue Shield Promise and IPA/medical groups are responsible for ongoing distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural and Linguistic Department.

17.3.2: Proficiency of Interpreters

Blue Shield Promise and its subcontractors will ensure that limited English proficient (LEP), hard-of-hearing, or deaf members have equal access to healthcare services through the provision of high-quality interpreting and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the member's spoken language 24 hours a day, seven (7) days per week. This includes American Sign Language (ASL) interpreting services.

Definitions:

"Medical interpreter" is a qualified bilingual staff member, or contracted interpreter, who possesses conversational fluency in both the target language and English, and the ability to interpret medical terms (e.g., physiology, symptoms, common disease names and processes, clinical procedures, instructions and treatment plans and consent forms, etc.) in English and the target language of the LEP member.

"Non-medical interpreter" is a bilingual staff member, or contracted interpreter, with conversational fluency in both the target language and English and provides assistance to members for administrative services (i.e., Member Orientation, scheduling appointments, non-clinical consent forms, Customer Care).

17.3: Access to Free Interpretation Services *(cont'd.)*

17.3.2: Proficiency of Interpreters *(cont'd.)*

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and its subcontractors will use the 24-hour/7-day over-the- phone interpreting service as a supplement to in-person interpretation. Subcontractors may rely on Blue Shield Promise to access interpreting services by following the interpreting services protocol. (Please refer to Section 17.2.)
2. Documentation of linguistic competency of individuals providing interpreting services at Blue Shield Promise or the IPA/medical group must be on file. Documents may include:
    a. Written or oral assessment of bi-lingual skills.
    b. Documentation of years served as interpreter
    c. Successful completion of appropriate training programs.
    d. Confidentiality agreement or verification of confidentiality clause in contract signed by interpreter through agency.
    e. Other relevant documents signifying interpreter capability (e.g., out of state certificate or license).
3. All interpreter services vendors who perform interpreting duties must sign a confidentiality agreement with Blue Shield Promise and its subcontractors.
4. Blue Shield Promise will retain reports of all monitoring systems for interpreting services. Monitoring can include a record of performance measures (i.e., written and/or oral testing of bilingual skills, attendance of relevant training programs and number of years interpreting, etc.); log of 24-hour telephonic interpreting services; analysis of grievances and complaint logs regarding communication or language problems; and interpreting service satisfaction questions included in the annual member satisfaction survey.
5. IPA/medical groups should document interpreting services utilization and maintain on file. Documentation may include a log of 24-hour telephonic interpreting services and/or number of over-the-phone and face-to-face interpreting services requests received from contracted providers.
6. Blue Shield Promise and its IPA/medical groups may subcontract with interpreting services agencies to determine the qualifications of its interpreters used at provider sites.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.4: Cultural Competency and Health Equity Training

Blue Shield Promise values diversity, equity, and inclusion as an integral component of our organization. Blue Shield Promise is a cultural competent and sensitivity organization that promotes Health Equity, diversity, and inclusion and views cultural competency, sensitivity, Health Equity, diversity, and inclusion as a responsibility at both the organizational and individual level.

Cultural competency, sensitivity, health equity, diversity, and inclusion training is designed to assist in the development and enhancement of interpersonal and intra-cultural skills to improve communication, access, and services, and to more effectively serve our diverse membership including Seniors and People with disabilities (SPD).

The Department of Health and Human Resources (HHS) offers free training "A Physician's Practical Guide to Culturally Competent Care" that is designed to increase knowledge and awareness of cultural and linguistically appropriate services (CLAS). This program provides Continuing Education Units (CEU) credits for physicians, physician assistants, nurse practitioners, and any other direct service providers interested in learning about CLAS.

This training covers the fundamentals of CLAS, communication, and language assistance, including how to work effectively with an interpreter, and much more. Please visit https://thinkculturalhealth.hhs.gov/education/physicians to access the free online training.

Additional provider resources and training are available on the Blue Shield Learning Resources webpage at www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/news_education/learning_resources.

Definitions:

"Culture" is a dynamic and evolving process comprised of a group's learned patterns of behavior, values, norms, and practices.

"Cultural competency" is an increased working knowledge of how behaviors, values, norms, practices, attitudes and beliefs of disease, preventative practices and treatment affect medical and non-medical encounters.

"Organizational cultural competency" is the ability of an organization to adapt to diversity and actively apply knowledge of culture and linguistic issues in serving our diverse membership for improved access and health outcomes.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and its subcontractors will provide and/or promote opportunities for ongoing cultural competency and cultural diversity trainings to providers and staff.

17.4: Cultural Competency and Health Equity Training *(cont'd.)*

2. Providers, staff, and Downstream Subcontractor's staff at key points of contact with members are strongly encouraged to attend cultural awareness/ competency, sensitivity, health equity, diversity, and inclusion training programs that are offered through L.A. Care, Blue Shield Promise Health Plan, IPA/medical groups, or other cultural awareness/competency training agencies.
3. Blue Shield Promise and its subcontractors will retain copies, if available, of training curriculum, documentation of attendance, and schedule of training dates.
4. Blue Shield Promise and its subcontractors will keep a list of cultural resource materials used during a training program.

17.5: Translation of Member-Informing and Health Education Materials

Written informing documents provide essential information to members about access and usage of services. It is the responsibility of Blue Shield Promise and the IPA/medical group to provide culturally and linguistically appropriate informing materials to members in the threshold languages and in alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) determined by the Department of Health Care Services (DHCS) and at a 6th grade reading level or below.

Member informing materials include but not limited to:

- Member Handbook
- Welcome packets
- Provider directory
- Access and availability of linguistic services
- Marketing materials
- Member surveys
- Member Newsletters
- Grievance and fair hearing process
- Form letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits, including clinical rationale.

17.5: Translation of Member-Informing and Health Education Materials *(cont'd.)*

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.
2. Blue Shield Promise and its IPA/medical groups will have common letters (i.e., denials letter, informed consent, etc.) available in the language(s) that is commonly encountered based on Health Plan and IPA/medical group membership; or a system to provide members the opportunity to receive these documents in their preferred languages. Blue Shield Promise will forward to the IPA/medical group translated member-informing materials and available health education materials.
3. A qualified translator will complete all translations. Memorandum of Understanding (MOU) contracts and information on the agencies' qualifications should be on file at Health Plan and IPA/medical groups.
4. Blue Shield Promise and its IPA/medical groups will use, at a minimum, the following translation process to ensure quality translation of written member informing materials and health education materials:
    a. The document needing translation will be submitted to the "qualified translator" for translation. A "***qualified translator***" is a person with a formal education in English, with the ability to read, write and understand the target language and with knowledge of, and experience with, the culture of the intended audience.

The following three steps are done when translating a source document into the target language: translation, editing, and proofreading. Each step is performed by a different linguist. Once the translation is complete, the requesting department will receive an email from the vendor containing the translation.

17.6: CLAS Related Grievances

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP.

Therefore, a Blue Shield Promise Health Plan Medi-Cal member has the right to file a grievance if their cultural and/or linguistic needs are not met.

17.6: CLAS Related Grievances *(cont'd.)*

Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office. (See Section 6: Grievances, Appeals, and Disputes.) CLAS related grievances presented to Blue Shield Promise Health Plan will be processed as follows:

1. The Grievance Unit receives member and provider grievances and determines if the case has a CLAS related issue.
2. Blue Shield Promise's Grievance Department will resolve the issue with the member whenever possible.
3. If a member or provider grievance is classified or coded to have cultural and/or linguistic issues, the case will be forwarded to the Cultural and Linguistic Department.
4. The Cultural and Linguistic (C&L) specialist will investigate, follow-up, and resolve the issue with the provider and/or office staff involved with the case.
5. The Cultural and Linguistic specialist may collaborate with the Grievance, Utilization Management, Quality Management, and Provider Network Operations (PNO) Departments, when necessary.
6. A copy of the actions taken will be kept on file with the Grievance Department, PNO, and Cultural and Linguistic Departments.
7. The Cultural and Linguistic specialist will keep statistics of CLAS related grievances for trends, and statistical information will be reviewed by the CLAS manager.

17.7: Referrals to Culturally Appropriate Community Resources and Services

1. Blue Shield Promise will distribute the *CLAS Community Resource Directory* to providers during site visits, trainings, and through mailings. This directory is designed to help providers locate culturally linguistically appropriate education and counseling resources and services. It covers topics such as domestic violence, counseling, cultural adaptation resources, elder care, and interpreter resources. Providers, clinic staff, and members can also access the *CLAS Community Resource Directory* from the Blue Shield Promise provider website at www.blueshieldca.com/promise/provider. Providers can obtain a copy by contacting the CLAS Department.
2. Providers should document all referrals in the member's medical chart.
3. Blue Shield Promise has a closed loop system in place to monitor those members being referred to CLAS Community Resources and Services. The CLAS referral request form can be faxed to the Blue Shield Promise Health Plan CLAS Department. Once the member is referred, the provider will be informed of the member's participation to the program in an effort to encourage further follow up.
4. Providers should maintain all information provided in the member's medical record.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.8: IPA/Medical Group Monitoring and Reporting Requirements

In order to assess the ability of an IPA/medical group to appropriately conduct CLAS, the IPA/medical group will be assessed at least annually thereafter by the Cultural and Linguistic Department. Blue Shield Promise will also educate the providers of their direct responsibility in complying with federal regulations relating to CLAS and the provision of services to Limited English Proficient (LEP), hard-of-hearing, or deaf members.

1. The Blue Shield Promise CLAS auditor will review, at a minimum, the following documents:
    - IPA/medical group policies and procedures on CLAS.
    - LEP identification and recording process.
    - Access to interpreting services including staff knowledge of handling interpreter needs.
    - Signs posted and other communication tools used to meet needs of LEP and hard-of-hearing or deaf members.
    - Recording requests/refusals for interpreting services in medical charts.
    - Documentation on promotion and/or attendance of CLAS Training for providers and staff.
    - Materials made available to LEP members in the threshold languages and alternative formats.
    - Provider satisfaction surveys conducted by the IPA/medical group.
    - IPA/medical group procedures for handling CLAS related complaints made at clinic and IPA sites.
    - Access to CLAS Community Resources and Services, the referral process for referring members to CLAS Community Resources and Services, and how providers are informed of the need to record the referrals in the member's medical chart.
    - Documentation on dissemination/communication of CLAS related information to providers and staff.

    Some of the items above will be reviewed by Blue Shield Promise Facility Site Review, Medical Care Solutions, Utilization Management, and Health Education staff whose reviews will be coordinated with the Cultural and Linguistic Department.
2. The CLAS monitoring review tool will be used by the Blue Shield Promise CLAS auditor. This monitoring tool will be provided to the IPA/medical group.
3. Blue Shield Promise will provide guidance and educational opportunities to the IPA/medical groups for those sections that do not meet section criteria(s) within 30 days of receiving notice of the review. Blue Shield Promise criteria for monitoring are based on federal and state regulations and contract requirements on Culturally and Linguistically Appropriate Services (CLAS).

17.9: Online Resources

Language Assistance Resources (Translation and Interpretation)

Providing services that support diverse languages is one way Blue Shield Promise is addressing some of the barriers to accessible health care. We provide documents and telephonic support in a variety of languages to improve access to healthcare services for our shared members. Additionally, we provide language assistances resources that are available for easy download on our website such as a multilingual interpretation services poster for your office and member forms that are already translated into the desired members threshold language. Please visit our Cultural awareness and linguistics program webpage at www.blueshieldca.com/en/bsp/providers/programs/cultural-linguistics to download a copy of the interpretation services poster.

To request interpreter services, written language translation, or our provider notice of availability of language assistance services, please call our Provider Customer Service at (800) 468-9935 or visit our Language Assistance Resources webpage at https://www.blueshieldca.com/en/bsp/medi-cal-members/plan-documents/language-help-interpreter-services.

Multilingual Resources

The Blue Shield Promise website at www.blueshieldca.com/promise/provider is offered in Chinese, English, Spanish, and Vietnamese formats. members can click the global icon located on the top left corner of our homepage to select their desired threshold language.

Members can request confidential information using multilingual request forms on our Confidential Communications Request page at www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/confidential-communications.

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Appendices

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Appendix 1: Delegation of Utilization Management Responsibilities

Blue Shield of California Promise Health Plan Participating IPA/Medical Group
Delegation of Utilization Management Responsibilities

This Participating Independent Physician Association/Medical Group Delegation of Utilization Management Responsibilities Agreement ("**Agreement**") is made and entered into **on <<Date>>** by and between **BLUE SHIELD OF CALIFORNIA/BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN,** a California corporation ("**PLAN**"), and **<<Contract Entity Name>>** ("**Medical Group**").

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
I. UM Program & Policies and Procedures	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No	Develop, implement, and submit to Plan the UM Program outlining structure, accountability, scope, adoption of criteria, processes and other regulatory and NCQA components of UM function.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** -UM Program -UM Program Evaluation -UM Workplan **Quarterly/Semi-Annual:** UM Updates (Coalition/ICE Report)	• Pre-delegation review • Annual due-diligence audit	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.
II. Outpatient specialty	MCL ☐Yes ☐ No MCR	• Conduct review utilizing Plan approved evidence-based UM criteria and	• Monitor and oversee delegated functions • Establish, publish, and	**Monthly**: -Approval logs -Denial logs	• Pre-delegation review	• Request Corrective Action Plan(s)

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
referrals Routine/ Urgent Pre-service and retrospective review that result in an approval or denial of services	☐Yes ☐ No Commercial ☐Yes ☐ No	Blue Shield Promise Evidence of Coverage • Adhere to regulatory turnaround time standards for decision making • Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM determinations are tracked/ monitored through UM Committee	distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	-Denial letters including patient clinical information **Quarterly/Semi-Annual:** UM Updates (Coalition/ ICE Report)	• Annual due-diligence audit Quarterly/ focus audits	(CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.
III. Outpatient/ ambulatory procedure referrals – Professional component Routine/ Urgent Pre-service and retrospective review that result in an	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No	Conduct review utilizing Plan approved evidence- based UM criteria and Blue Shield Promise Evidence of Coverage Adhere to regulatory turnaround time standards for UM decision making Use Blue Shield Promise-approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly:** -Approval logs -Denial Logs -Denial letters including patient clinical information **Quarterly/Semi-Annual:** UM Updates (Coalition/ICE Report)	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
approval or denial of services		determinations are tracked/monitored through UM Committee Contact Plan within 24 hours for tracking number for facility portion of referral **(Shared Risk only)**				if CAP objectives are not achieved.
IV. A. (Shared Risk) Inpatient hospitalization, SNF, and Acute Rehab. Routine/ Urgent Pre-service, retrospective and concurrent review that result in an approval or denial of services	☐ Shared responsibility MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No ☐ Delegated responsibility MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No ☐ N/A IPA/MG has no responsibility under this section	• Forward and coordinate all requests involving inpatient services to Plan UM Dept • Conduct review Utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage • Adhere to regulatory turnaround time standards for UM decision making • Use Blue Shield Promise approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations)	• Conduct UM review • for inpatient services • Forward information pertaining to the concurrent review to the delegate, if available • Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	• Not applicable **Weekly** submission of authorization and denial log including full/partial denials (for claims processing) **Monthly** Denial Logs Denial letters including patient clinical information **Quarterly/ Semi-Annual:** UM Updates (Coalition/ ICE Report)	• Not applicable • Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Not applicable • Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are not achieved.

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		• Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider • Report any acute stay over 6 days to Blue Shield Promise for coordination of care • UM determinations are tracked/ monitored through UM Committee				
IV. B. (Full Risk/ Global) Inpatient Hospitalization, SNF, and Acute Rehab. Routine/ Urgent Pre-service, retrospective and concurrent	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No ☐ N/A IPA/MG has no responsibility under this section	• Conduct review Utilizing Plan approved evidence-based UM criteria and Plan Evidence of Coverage • Adhere to regulatory turnaround time standards for UM decision making • Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Monthly** -Approval logs -Denial logs -Denial letters including patient clinical information **Quarterly / Semi-Annual:** UM updates (Coalition/ ICE Report)	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
review that result in an approval or denial of services		Determinations) • Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider. • UM determinations are tracked/ monitored through UM Committee				not achieved.
V. Linked Services **(Medi-Cal ONLY)**	MCL ONLY ☐Yes ☐ No	Identify the following and report number of cases to Blue Shield Promise: • CCS • DOT for TB • ESRD • Waiver Programs (home care, HIV/AIDS, etc.) • Transplants • Mental Health • Drug/Alcohol • Hospice • Custodial (Long Term Care) • EPSDT Supplemental Services	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting • Review and coordinate all LTSS services	**Monthly Logs** **Quarterly:** For LA County Only: Submit to Plan using Plan approved Quarterly Supplemental Report form.	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) for elements of non-compliance Sanction per • IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of delegation if CAP objectives are not achieved

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		• HCBS for DDS • DDS/EI/ES Identify the need for Long-Term Services and Supports (LTSS) and refer to: • CBAS • IHSS • MSSP • LTC				within agreed timeframe.
VI. A. Complex Case Management	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No ☐ N/A IPA/MG has no responsibility under this section	Identify and refer members for Complex Case Management Coordinate member care with the Plan	• Provide complex case management services to members meeting Plan criteria.	Not applicable	Not applicable	Not applicable
VI. B. Basic Case Management	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No	Provide basic case management to members not eligible for Plan Complex Case Management and Disease Management Programs.	• Provide assistance to delegate when needed • Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG	**Monthly Logs** **Quarterly:** For LA County Only: Submit to Plan using Plan approved	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) for elements of non-compliance • Sanctions per IPA's

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
			• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	Quarterly Supplemental Report form.		delegation agreement (i.e., CAP deduction from monthly capitation • Blue Shield Promise may conduct discretionary review to re-measure former areas of non-compliance • Termination of delegation if CAP objectives are not achieved within agreed timeframe.
VII. Member Communica-tions	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No	• Ensure member communications adhere to all regulatory standards • Obtain approval for all member Communications from Plan prior to	• Ongoing evaluation of member • Communication according to regulatory standards Provide regulatory updates to the delegate as they become available	**Ongoing**	• Pre-delegation review • Annual due-diligence audit • Quarterly/	•

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated UM Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/ Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		distribution to members			focus audit	
VIII. Member Appeals/ Grievances	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No ☐ N/A IPA/MG has no responsibility under this section	• Evidence of communication stating requests for appeals are forwarded to Plan upon receipt or per Blue Shield Promise guidelines	• Review and resolve all appeals and grievances within established timeframes	Not applicable	Not applicable	Not applicable
IV. Evaluation of New Technology	MCL ☐Yes ☐ No MCR ☐Yes ☐ No Commercial ☐Yes ☐ No	Not applicable	• Plan evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health procedures	Not applicable	Not applicable	Not applicable

Delegated Responsibility: Utilization Management Systems Controls – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting / Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
The organization has policies and procedures describing its 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. • Date modifications.	At least annually, monitors delegate's system control procedure for Element A, factors 1-7. 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. • All noncompliant modifications must be reviewed if the organization's system	Semi-annual reporting • System control procedural changes • System control reports of inappropriate changes If the delegate's UM system does not allow date modifications, annually the delegate: • Describes the functionality of the system that ensures compliance with established policy • Provides documentation or evidence of advanced system control capabilities that automatically record dates and	• Pre-delegation • Annual • Focus • Annually review delegates policies –UM 12a factor 7 • Annually review delegate's system control report or evidence of advanced system controls	• 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.

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated Responsibility: Utilization Management Systems Controls – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting / Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
• When the date was modified. • The staff who modified the date. • 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.	can identify noncompliant modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. 4. Annually reviews the delegates policy and system control audit or if advanced system controls are in place will review documentation of system control capabilities instead of an audit. 5. Documentation indicates the staff roles or department involved in the audit. The organization's process for monitoring system security controls covers delegates that store, create, modify, or use UM denial and notification dates covered by UM 5: Timeliness of UM	prevents modifications that do not meet modification criteria		

Delegated Responsibility: Utilization Management Systems Controls – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting / Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
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 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:	Decisions. If the organization contracts with such delegates, it has a process for: • Monitoring the delegate's UM denial and appeal system security controls in place to protect data from unauthorized modification, as outlined in UM 12, Element A (UM Denial System Controls) factor 6, at least annually. • Ensuring that the delegate monitors, at least annually, that it follows the delegation agreement or its own policies and procedures. 6. Describes system security controls. 7. If the organization conducts auditing as a method: The organization must use the "5% or 50			

Appendix 1: Delegation of Utilization Management Responsibilities

Delegated Responsibility: Utilization Management Systems Controls – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting / Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
• 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.	files" audit method: Randomly select 5% of files or 50 files (whichever is less), from each applicable file type, to review against requirements: • UM denials (5% or 50 files). • UM appeals (5% or 50 files). For each applicable file type noted above, the organization must determine the sample size of 5% or 50 files (whichever is less) based on all files in the file universe. The file universe includes all files, with or without modifications. The sample that will be audited must include only files with modifications (whether modifications are compliant or noncompliant with the organization's policies and procedures). Once the sample size is calculated from the			

Delegated Responsibility: Utilization Management Systems Controls – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting / Due Date (Submitted via sFTP or UM SharePoint site to the UMDO Dept)**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
▪ 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.	entire file universe, the organization determines how it selects the sample. NCQA does not specify how the organization selects the sample once the sample size is determined using the entire file universe. If the organization: • **Can identify files with modifications,** it may randomly select a sample from a universe that contains modified files. • **Cannot identify files with modifications,** it may randomly select a sample from the entire file universe; the organization continues to pull files from the entire universe until 5% or 50 files in the sample have modifications.			

Appendix 1: Delegation of Utilization Management Responsibilities

Blue Shield of California/Blue Shield of California Promise Health Plan will share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your delegation coordinator.

The Plan and Medical Group agree to accept the terms of the above.

Blue Shield of California Promise Health Plan			<<Contract Entity Name>>	
("Plan")			("Medical Group")	
By:			By:	
Name:			Name:	
Title:			Title:	
Date:			Date:	

Blue Shield of California Promise Health Plan Participating IPA/Medical Group Delegation of Credentialing Responsibilities

This Participating Independent Physician Association / Medical Group Delegation of Credentialing Responsibilities Agreement ("**Agreement**") is made and entered into **on <<Date>>** by and between **BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN,** a California corporation ("**PLAN**"), and **<<Contract Entity Name>>** ("**Medical Group**").

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
I. Credentialing Primary Source Verification – Credentialing and Recredentialing	☐Yes ☐No	Develop, implement, and submit to Plan the Credentialing Program/Policy and procedures outlining a well-defined credentialing process for evaluating and selecting licensed practitioners to provide care to its members that comply with the Plan, NCQA and state federal components of credentialing.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly/Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/Semi-annual audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
II. Credentialing Committee	☐Yes ☐No	Designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that the Credentialing Committee that: • Includes representation from participating network providers to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds or the Group's criteria for participation in the network, gives thoughtful consideration to credentialing information and documents discussions about credentialing in meeting minutes. • Ensures that files that meet established criteria are reviewed and approved by the designated medical director or designated qualified physician, or all files are submitted to the Credentialing Committee for review.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/Semi-annual audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
III. Credentialing Primary Source Verification – Credentialing and Recredentialing	☐Yes ☐No Behavioral Health Practitioners ☐Yes ☐No	Verifies credentialing information through approved primary sources for all elements below, as applicable. Verifications must be completed within one hundred eighty (180) calendar days of the credentialing decision. • A current and valid license to practice • A valid DEA or CDS certificate, as applicable • Education and training; (Initial Cred Only) • Board certification Status • Work history – Minimum of most recent five years as a health professional (Initial Cred Only) • A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the provider • Hospital admitting privileges in good standing, or coverage arrangements • Verifies Sanction Information: State sanctions, restrictions on licensure, limitation on scope of practice, Medicare and Medicaid/Medi-Cal sanctions	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly/Semi Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of credentialing delegation if CAP objectives are not achieved.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
	☐Yes ☐No Behavioral Health Practitioners ☐Yes ☐No	**Credentialing Application and Attestation - Credentialing and Recredentialing** Practitioner's application for membership includes a current and signed attestation regarding the following signed within one hundred eighty (180) calendar days of the credentialing decision: • Reasons for inability to perform the essential functions of the position • Lack of present illegal drug use • History of loss of license and felony convictions • History of loss or limitations of privileges or disciplinary actions • Current malpractice insurance coverage (Copy of malpractice insurance required for CMS and Medi-Cal) • Current and signed attestation confirming the correctness and completeness of the application	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly/Semi Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of delegation if CAP objectives are not achieved.

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
IV. Recredentialing Cycle Length	☐Yes ☐No	Recredentials participating practitioners/ providers within thirty-six (36) months of their prior approval date.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly/Semi Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/Semi-annual audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of delegation if CAP objectives are not achieved.
V. Ongoing Monitoring and Interventions	☐Yes ☐No	The Group develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. The Group implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/Semi-annual audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		2. Collecting and reviewing sanctions and limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1–4				credentialing delegation if CAP objectives are not achieved.
VI. Notification to Authorities and Practitioner Appeal Rights	☐Yes ☐No	If the Group takes action against a practitioner for quality reasons it reports the action to the appropriate authorities and offers the practitioner a formal appeal process. The Group has policies and procedures that address the following: • The range of actions available to the group • Making the appeal process known to practitioners • Policy must state that the Group cannot have an attorney, if the practitioner does not have attorney representation. [CA Business & Professions Code 809.3(c)]	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/Semi-annual audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
VII. Assessment of Organizational Providers	☐Yes ☐No	The Group has policies and procedures for assessing a health care delivery provider that specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited. • Policy includes at least the following medical providers in its assessment: Hospital, Home Health Agencies and Free-Standing surgical Centers • Policy includes behavioral health care facilities providing mental healthcare or substance abuse services in the following settings: Inpatient, Residential and Ambulatory. • Policy includes CMS providers and suppliers as applicable. • Performs an initial assessment and reassessment at least every thirty-six (36) months thereafter.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - File Review - CR Activity **Quarterly/Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit Quarterly/Semi-annual audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
VIII. A. Delegation Oversight Written Agreement	☐Yes ☐No	If the Group delegates any Credentialing functions the written delegation agreement/document includes the following: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the Group and the delegated entity that includes detailed language of specific credentialing activities. 3. Requires at least semiannual reporting by the delegated entity to the Group that specifies what information is reported regarding activities delegated, how and to whom information is reported. 4. Describes the process by which the Group evaluates the delegated entity's performance. 5. Specifies the Group retains the right to approve, suspend and terminate individual practitioners, providers, and sites, even if the Group delegates decision making. 6. Describes the remedies available to the Group if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly/Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
	☐Yes ☐No Commercial ☐Yes ☐No	Delegation agreement requires delegate/subdelegate to adhere to CMS regulations.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.
	☐Yes ☐No	Delegation agreement requires at least quarterly reporting of the delegated entity to the IPA/medical Group and evaluates quarterly reports.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
			review and analysis of performance reporting			• Termination of Credentialing delegation if CAP objectives are not achieved.
VIII.B Pre-Delegation Assessment	☐Yes ☐No	Oversight will be completed annually For new delegation agreements, the Group evaluates the delegate's capacity to meet NCQA/delegated functions requirements prior to delegation.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Pre-contractually** - CR Program - CR Program Evaluation - CR Activity	• Pre-delegation review	• Request Corrective Action Plan(s) (CAPs) • Termination of Credentialing delegation if CAP objectives are not achieved.
VIII.C. Review of Delegated Credentialing Activities	☐Yes ☐No	**Review of Delegate Credentialing Activities (oversight will be completed annually) according to NCQA and other regulatory requirements as applicable.** For delegation arrangements in effect for twelve (12) months or longer, the Group:	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		1. Annually reviews its delegates credentialing policy and procedures. 2. Annually audits credentialing and re-credentialing files against regulatory standards. 3. Annually evaluates delegate performance against all standards for delegated activities. 4. Semi-annually or quarterly (Medi-Cal) evaluates regular reports, as specified. **5.** Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policy and procedures at least annually. **Note: IPA/Medical Group must comply with all aspect of this factor and NCQA requirements.** Group must review all modifications made in all delegates' credentialing systems during the look-back period that did not meet the modification criteria allowed by the delegation	a substantive evaluation through review and analysis of performance reporting	Reports		deduction from monthly capitation) • Termination of Credentialing delegation if CAP objectives are not achieved.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		agreement or by the delegates' policies and procedures. The Group provides documentation (which may be a report or other type of evidence) that it completed the monitoring process at least annually during the look-back period. If the delegate's CR system does not allow modifications, the delegate: • Describes the functionality of the system that ensures compliance with established policy. • Provides documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modification criteria. *Audit.* Auditing is allowed only if the Group or delegate does not use a CR system that can identify all noncompliant modifications.				

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		• Documentation indicates the staff roles or department involved in the audit. • The Group or delegate identifies all CR system modifications but may use sampling to identify potential noncompliant changes for the audit. • The Group uses one of the following methods to audit files: - NCQA 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the Group audits the universe of files rather than a sample. • NCQA "8/30 methodology"				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		6. Annually acts on all finding from item five (5) above for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters **Opportunities for Improvement** Identify and followed up on opportunities for improvement, if applicable.				
IX. Identification of HIV/AIDS Specialist (DMHC/ DHCS Requirement)	☐Yes ☐No	1. Establish a written process describing how it identifies and reconfirms that appropriately qualified physicians meet the definition of an HIV/AIDS specialist as established by DMHC. 2. On an annual basis, identifies or reconfirm the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations. 3. Notifies the appropriate referral department of qualified practitioners	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of CR delegation if CAP objectives are not achieved.

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
X. Credentialing UM Medical Directors and UM Physician Reviewers (L.A. Care and Health Plan	☐Yes ☐No	Group credentials Utilization Management Medical Directors and all administrative physician reviewers responsible for making medical decisions.	• Monitor and oversee delegated function • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit or Attestation • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Termination of CR delegation if CAP objectives are not achieved.
XI. Mid-Level Supervisor or Delegated Serves Agreements	☐Yes ☐No	Group ensures that there is a signed Supervisory Agreement or Delegated Services Agreement between the Physician Assistants, Nurse Practitioners, Nurse Mid-Wives with the Supervising Physician at initial and re-credentialing.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit or Attestation • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction • from monthly capitation) • Termination of CR delegation if

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
						CAP objectives are not achieved.
XII. Medi-Cal Enrollment Verification	☐Yes ☐No	Establish policy and procedures to verify Medi-Cal Enrollment, validate and document that Group providers are appropriately enrolled in Medi-Cal.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit or Attestation • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of CR delegation if CAP objectives are not achieved.
XIII. Mental Health and Substance Use Disorder Providers	☐Yes ☐No	Assembly Bill 2581 requires the following procedures be put in place for Mental Health/Substance Use Disorder providers, effective January 1, 2023: • All Mental Health/Substance Use Disorder providers, upon receipt of a completed application, will receive an application received	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly /Semi-Annual:** via HICE	• Pre-delegation review • Annual due-diligence audit or Attestation • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
		letter within seven days to verify receipt and inform the applicant whether the application is complete. • All complete Mental Health/Substance Use Disorder provider applications for credentialing will be completed within sixty days.	a substantive evaluation through review and analysis of performance reporting	Reports		from monthly capitation) • Termination of CR delegation if CAP objectives are not achieved.

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
Credentialing Systems Controls (Applies to paper and electronic processes) **Delegate must comply with the following standards according to NCQA requirements.** The credentialing system controls policy and procedures describe: 1. How primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification and includes a minimum: • When the information was modified • How the information was modified • Staff who modified the information • Why the information was modified. 3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.	• At least annually, monitors delegate's system control procedure for factors 1-5 via report from the Group or assessment by the Plan. • At least annually, the group demonstrates that it monitors compliance with its delegate credentialing system controls, as described in Element C, factor 5, by: 1. Identifying all modifications that did not meet the Group's policies and procedures. 2. Analyze all instances of modifications that did not meet the Group's policies and procedures. • All noncompliant modifications must be reviewed if the Group's system can identify noncompliant modifications. 3. Act on all findings and implementing a quarterly monitoring	Annual reporting: · System control modification report · System control reports of inappropriate changes Quarterly reporting if inappropriate modifications are identified.	• Pre-delegation • Annual • Focus • Annually review delegate's system control report or evidence of advanced system controls	• Request Corrective Action Plan(s) for elements of non-compliance. • Implementing a quarterly monitoring process until Group demonstrates improvement for one finding over three consecutive quarters. • 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.

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
4. The security controls in place to protect the information from unauthorized modifications. Policies must describe: • Limiting physical access, the operating environment that houses credentialing information, to protect the accuracy of the information gathered from primary sources and NCQA-approved sources. o Physical access may include, but is not limited to, the group's computer servers, hardware and physical records and files. o Physical access does not refer to the groups building or office location. • Preventing unauthorized access, changes to and release of credentialing Information • Password protecting electronic systems, including user requirements to: o Use strong passwords o Discourage staff from	process until it demonstrates improvement for one finding over three consecutive quarters. 4. Annually review the delegates policy and system control audit or if advanced system controls are in place will review documentation that. o Describes the functionality of the system that ensures compliance with established policy o Review documentation or evidence of advanced system control capabilities that automatically record dates and prevents modifications that do not meet modification criteria.			

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
writing down passwords ○ Use IDs and passwords unique to each user. ○ Change passwords when requested by staff or if passwords are compromised. If the group's policy and procedures state that it follows the National Institute of Standards and Technology guidelines, this is acceptable to describe the process for password-protecting electronic systems. ○ Disabling or removing staff who oversee computer security. 5. How the Group monitors compliance with the policies and procedures in items 1–4, at least annually and takes appropriate action when applicable. The policies and procedures describe the Group's process for at least annual monitoring: • Monitoring compliance with policies and procedures for				

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
items 1–4. • Analyzing modifications that do not meet the Group's established policy and taking actions, when applicable. At a minimum, the description includes: • The method used to monitor compliance with the Group's policies and procedures described in items 1–4. - If the Group conducts auditing as the method for monitoring: - All noncompliant modifications must be reviewed if the group's system can identify noncompliant modifications. - Sampling is allowed only if the Group does not use a credentialing system that can identify all noncompliant modifications. See Sampling method below.				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
• The staff titles or roles responsible for oversight of the monitoring process. • The Group's process for taking actions if it identifies modifications that do not meet its established policy, including: - 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. - The staff roles or department responsible for the actions. - The process for documenting and reporting modifications that do not meet its established policy. The group's policies and procedures must include a description of the monitoring process outlined above, regardless of system functionality (e.g., the system prevents changes to				

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
the original record under any circumstances but allows creation of a new record to modify dates; allows date modifications only under specific circumstances; uses alerts or flags to identify noncompliance), with the exception of advanced system controls capabilities. Methods of monitoring activities may include: • An annual process for identifying modifications that did not meet policies and procedures in the past 12 months and taking actions to update credentialing system controls accordingly. • A review of automatic system alerts or flags for modifications or events in real time, and a separate process for annually testing performance of the system's automatic alerts or flags and taking actions to update credentialing system controls accordingly. • A monthly, quarterly or semiannual process to audit files from a system-generated report of all date modifications to				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
identify modifications that did not meet policies and procedures and take actions to update credentialing system controls according *Advanced system controls capabilities.* An advanced system must have both capabilities: • Automatically record dates, ***and*** • Prevent changes that do not meet the Group's policies and procedures If the Group has advanced system controls capabilities, it is only required to describe how the functionality of the system ensures compliance with established policies in factors 1–4. Monitoring is not required. *Sampling methodology for auditing.* Sampling is allowed for Groups that use auditing as the monitoring method in Elements C and D. The group must use the "5% or 50 files" audit method: Randomly select 5% of files or 50 files (whichever is				

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
less) from each applicable file type, to review against requirements. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the group audits the universe of files rather than a sample. The file universe includes all files, with or without modifications. The sample that will be audited must include only files with modifications (whether modifications are compliant or noncompliant with the Group's policies and procedures). Once the sample size is calculated from the entire file universe, the group determines how it selects the sample. NCQA does not specify how the Group selects the sample once the sample size is determined using the entire file universe. If the group: • *Can identify files with modifications,* it may randomly				

Appendix 2: Delegation of Credentialing Responsibilities

Delegated Responsibility: Credentialing Systems Controls and Monitoring – Delegated for all lines of business: ☒ Yes ☐ No				
Group Responsibility	**Health Plan Process for Performance Evaluation**	**Frequency of Reporting/Due Date submitted via email box or Cred Auditor**	**Health Plan Responsibility**	**Corrective Action if Group Fails to Meet Responsibilities**
select a sample from a universe that contains modified files. • *Cannot identify files with modifications,* it may randomly select a sample from the entire file universe; the Group continues to pull files from the entire universe until 5% or 50 files in the sample have modifications. **Credentialing Monitoring Oversight** At least annually, the group demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the group's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the Group's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.				

Blue Shield of California Promise Health Plan will share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your delegation coordinator.

The Plan and Medical Group agree to accept the terms of the above.

Blue Shield of California Promise Health Plan			<<Contract Entity Name>>	
("Plan")			("Medical Group")	
By:			By:	
Name:			Name:	
Title:			Title:	
Date:			Date:	

Appendix 2: Delegation of Credentialing Responsibilities

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Blue Shield of California Promise Health Plan Participating IPA/Medical Group

Delegation of Claims Processing Responsibilities

This Participating Independent Physician Association / Medical Group Delegation of Utilization Management Responsibilities Agreement ("**Agreement**") is made and entered into **on <<Date>>** by and between **BLUE SHIELD OF CALIFORNIA/BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN,** a California corporation ("**PLAN**"), and **<<Contract Entity Name>>** ("**Medical Group**").

Delegated Claims Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via sFTP or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
I. Claims Processing End to End	MCL ☒Yes ☐ No MCR ☒Yes ☐ No Commercial ☒Yes ☐ No	• Annual, follow-up and monitoring audit participation to demonstrate compliance with end-to-end claims processing requirements as outlined by CMS, DMHC, DHCS, DOI and Blue Shield|Blue Shield Promise contracts. • Submission annually updated/reviewed/approved policies and procedures • Evidence of sub-delegated oversight • Universes and audit material as requested • Completed HICE	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/ MG a substantive evaluation through review and analysis of performance reporting		• Pre-delegation review • Annual Oversight audit to include any necessary follow-up audits, CAPs and/or monitoring processes.	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of Claims delegation if CAP objectives are not achieved.

Appendix 3: Delegation of Claims Processing Responsibilities

Delegated Claims Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via sFTP or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
I. Claims Processing End to End *(cont'd.)*		Questionnaire – to be updated annually • Attestations as required by line of business • Other activities and material to evidence compliance with claims processing regulations, i.e. contracted provider rate sheet to validate pricing, sweep universe as required to identify other claims with similar error, etc.				
II. Required Claims Compliance Reporting	MCL ☒Yes ☐ No MCR ☒Yes ☐ No Commercial ☒Yes ☐ No	• Monthly Timeliness Reports • Quarterly Timeliness Reports • ODAG – Medicare only • Claims Settlement Practices Report – Quarterly Survey Certification (Commercial and Medi-Cal) • Quarterly Provider Dispute Reports (All lines of business)	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	• **Monthly Timeliness Reports by the 15th day of the following month:** Monthly timeliness reports as outlined in the Claims Delegation Oversight Reporting Instruction Manual	Pre-delegation review • Annual due-diligence audit Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of UM delegation if CAP objectives are

Delegated Claims Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via sFTP or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
II. Required Claims Compliance Reporting *(cont'd.)*		• Annual Principal Officer Form		• **Quarterly Timeliness Reports by the last day of the month following Quarter End:** Quarterly timeliness reports as outlined in the Claims Delegation Oversight Reporting Instruction Manual • **ODAG:** Due dates are outlined in the Claims Delegation Oversight Reporting Instruction Manual • **Quarterly Claims Settlement Practices Report Survey Certification:** Quarterly certification document as outlined in the Claims Delegation		not achieved.

Appendix 3: Delegation of Claims Processing Responsibilities

Delegated Claims Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via sFTP or Claims SharePoint site to the Claims Delegation Oversight Team	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
II. Required Claims Compliance Reporting *(cont'd.)*				Oversight Reporting Instruction Manual • **Quarterly Provider Dispute Reports (All lines of business):** Quarterly Provider Dispute Reports as outlined in the Claims Delegation Oversight Reporting Instruction Manual • **Annual Principal Officer Form:** Due by the end of September each year as outlined in the Claims Delegation Oversight Reporting Instruction Manual		

The Plan and Medical Group agree to accept the terms of the above.

Blue Shield of California Promise Health Plan			<<Contract Entity Name>>	
("Plan")			("Medical Group")	
By:			By:	
Name:			Name:	
Title:			Title:	
Date:			Date:	

Appendix 3: Delegation of Claims Processing Responsibilities

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BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Access to Care Standards

ATTACHMENT A

Type of Care and Service	Blue Shield Promise Health Plan Standard
Emergency Services	Immediately, 24 hours a day, 7 days a week.
PCP Urgent Care Services without prior authorization	Within forty-eight (48) hours of the request.
PCP (and OB/GYN) Urgent Care with prior authorization (including referrals made by a physician to another physician)	Within ninety-six (96) hours of the request.
PCP (and OB/GYN) Routine or Non-Urgent Care Appointments	Within ten (10) business days of the request.
Specialist Urgent Care without prior authorization	Within forty-eight (48) hours of the request.
Specialist Urgent Care with prior authorization	Within ninety-six (96) hours of the request.
Specialist Routine or Non-Urgent Care	Within fifteen (15) business days of the request.
OB/GYN Specialty Care	Within ten (10) business days of the request.
Routine and follow-up visits with behavioral health non-physician practitioners	Within ten (10) business days of the request.
Routine and follow-up visits with behavioral health physicians	Within fifteen (15) business days of the request.
Behavioral Health initial appointments with non-physician practitioners	Within ten (10) business days of the request.
Behavioral Health initial appointments with behavioral health physicians	Within ten (10) business days of the request.
Behavioral Health Urgent Care Visits	Within forty-eight (48) hours of the request.
Behavioral Health Non-life-threatening emergency	Within six (6) hours of the request.
Routine or Non-Urgent Care Appointment for Ancillary Services	Within fifteen (15) business days of the request.

Appendix 4: Access to Care Standards

Type of Care and Service	Blue Shield Promise Health Plan Standard
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within ten (10) business days of the request.
After Hours Care	24 hours/day; 7 day/week availability
Initial Health Assessment for a New members (under eighteen (18) months of age)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when a member becomes eligible).
Initial Health Assessment for a New members (over eighteen (18) months of age)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when a member becomes eligible) or within periodicity timelines established by the American Academy of Pediatrics (AAP).
Maternity Care Appointments for First Prenatal Care	Within ten (10) business days of the request.
Office Wait Time to be Seen by Physician (for a scheduled appointment)	Should not exceed thirty (30) minutes from the appointment time. All PCPs are required to monitor waiting times and adhere to this standard.
After-Hour Instruction for Life-Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911."
Physician Response Time to After-Hour Phone Message, Calls and/or Pages	Within thirty (30) minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for members.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Long Term Services and Support Access to Care Standards

ATTACHMENT B

Criteria	Standard
Skilled Nursing Facility	Skilled Nursing Facility services will be available within 5 business days of request.
Intermediate Care Facility/ Developmentally Disabled (ICF-DD)	ICF-DD services will be available within 5 business days of request. These services are provided by Skilled Nursing Facilities and Nursing Facilities (LTC) where 24-hour nursing services are provided.
Community Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment.

Appendix 4: Access to Care Standards

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blue california | Promise Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: Blue Shield of California Promise Health Plan
Plan/Medical Group Fax#: (323) 889-6254 or (866) 712-2731
Plan/Medical Group Phone#: (877) 792-2731

Urgent or Non-Urgent: _____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request.
Information contained in this form is Protected Health Information under HIPAA.

Patient Information					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		State:	Zip Code:	
Date of Birth:	☐Male ☐Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____		Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			
Insurance Information					
Primary Insurance Name:		Patient ID Number:			
Secondary Insurance Name:		Patient ID Number:			
Prescriber Information					
First Name:	Last Name:		Specialty:		
Address:	City:		State:	Zip Code:	
Requestor (if different than prescriber):		Office Contact Person:			
NPI Number (individual):		Phone Number:			
DEA Number (if required):		Fax Number (in HIPAA compliant area):			
Email Address:					
Medication / Medical and Dispensing Information					
Medication Name:					
☐ New Therapy ☐Renewal ☐ Step Therapy Exception Request If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):					
How did the patient receive the medication? ☐ Paid under Insurance _____ Prior Auth Number (if known): _____ ☐Name: Other (explain):					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:		
Administration: ☐Oral/SL ☐Topical ☐Injection ☐IV ☐Other:					
Administration Location: ☐ Patient's Home ☐ Long Term Care ☐ Physician's Office ☐ Home Care Agency ☐Other (explain): _____ ☐Ambulatory Infusion Center ☐Outpatient Hospital Care _____					

blue california | Promise Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐**YES (if yes, complete below)** ☐**NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date**: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number: ( ) _____

☐Approved ☐Denied Comments/Information Requested: _____

Appendix 6: Reimbursement for Ambulatory Surgery Center Services

Reimbursement for ambulatory surgery center (ASC) services is based on the ASC's contractual agreement in effect at the time services are rendered. To receive payment, ASCs must properly identify services provided by submitting a completed UB 04 (or successor), or other HIPAA-compliant claim form and include all applicable codes (Revenue, CPT/HCPCS, modifiers) for each service. Revenue Codes should be appropriate for the bill type.

Plan periodically reviews, and makes appropriate updates to, procedure listings based on industry standards. Updated listings are provided electronically and available upon request.

In calculating allowed amounts, Plan may round the figure to the nearest whole dollar.

I. Outpatient Surgical Services Reimbursed at APG Payment Rate

The Plan has implemented a payment system for outpatient surgical services that classifies ambulatory procedures into related groups. The groups are based on the relative resource needs (costs) for that group of procedures. The core of this payment system is the CPT-specific coding. ASCs must bill with appropriate revenue codes, CPT/HCPCS codes and modifiers in order to receive applicable payment. Plan reimburses ASCs for outpatient surgical services using the APG Payment Schedule.

In the event your listing contains groupers not included in your payment schedule, reimbursement will be issued at the applicable rate for ungrouped surgical procedures. If you have not received the fee schedule CD, contact your Plan Network Manager, who will provide you with a copy.

Appendix 6: Reimbursement for Ambulatory Surgery Center Services

A. Example of Reimbursement Calculation

SURGICAL SERVICES APG PAYMENT SCHEDULE CALCULATION EXAMPLE		
Formula	ASC Payment = (APG Grouper (corresponding APG Weight)) x (APG Payment Rate)	
Example Assumptions	• Revenue code billed is 0360 • CPT code billed is 10021 • CPT code 10021 is assigned to Grouper 001 • Grouper 001 has a **weight** of **0.2000** • Hospital's negotiated value of **APG at 1.0000** (APG Payment Rate) is **$1,000**	
Total Case Rate Payment = 0.2000 x $1,000 = (The case rate payment may be rounded to the nearest whole dollar.)		**$200**

Appendix 7: List of Incidental Procedures for APG Payment Rate

CPT	Description
10004	Fna bx w/o img gdn ea addl
10006	Fna bx w/us gdn ea addl
10008	Fna bx w/fluor gdn ea addl
10010	Fna bx w/ct gdn ea addl
10012	Fna bx w/mr gdn ea addl
10036	Perq dev soft tiss add imag
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11103	Tangntl bx skin ea sep/addl
11105	Punch bx skin ea sep/ addl
11107	Incal bx skn ea sep/addl
15772	Grfg autol fat lipo ea addl
15774	Each additional 25cc
15777	Acellular derm matrix implt
15853	Removal Sutr/Stapl Xreq Anes
15854	Removal Sutr&Stapl Xreq Anes
19030	Injection for breast x-ray
19082	Bx breast add Lesion strtctc
19084	Bx breast add Lesion US imag
19086	BX breast add lesion MR imag
19281	Perq device breast 1st imag
19282	Perq device breast ea imag
19283	Perq dev breast 1st strtctc
19284	Perq dev breast add strtctc
19285	Perq dev breast 1st US imag
19286	Perq dev breast add US imag
19287	Perq dev breast 1st mr guide
19288	Perq dev breast add mr guide
20501	Inject sinus tract for x-ray
20700	Prep and insert drug deliv dev
20701	Removal (deep)
20702	Prep and insert drug deliv dev
20703	Removal (intramedullary)
20704	Prep and insert drug deliv dev
20705	Removal (intra-articular)
20932	Osteoart algrft w/surf & b1
20933	Hemicrt intrclry algrft prtl
20934	Intercalary algrft compl
20985	Cptr-asst dir ms px
21116	Injection, jaw joint x-ray
22552	Addl neck spine fusion
22853	Insj Biomechanical Device
22854	Insj Biomechanical Device
22859	Insj Biomechanical Device
22868	Insj Stablj Dev W/dcmprn

CPT	Description
22870	Insj Stablj Dev w/o Dcmprn
23350	Injection for shoulder x-ray
24220	Injection for elbow x-ray
25246	Injection for wrist x-ray
27093	Injection for hip x-ray
27095	Injection for hip x-ray
27369	Njx Cntrst kne arthg/ct/mri
27648	Injection for ankle x-ray
31627	Navigational bronchoscopy
31649	Bronchial valve remov init
31651	Bronchial valve remov addl
32506	Wedge resect of lung add-on
32507	Wedge resect of lung diag
33508	Endoscopic vein harvest
33866	Aortic hemiarch graft
35572	Harvest femoropopliteal vein
36000	Place needle in vein
36005	Injection ext venography
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36013	Place catheter in artery
36014	Place catheter in artery
36015	Place catheter in artery
36100	Establish access to artery
36140	Establish access to artery
36160	Establish access to aorta
36200	Place catheter in aorta
36215	Place catheter in artery
36216	Place catheter in artery
36217	Place catheter in artery
36218	Place catheter in artery
36245	Place catheter in artery
36246	Place catheter in artery
36247	Place catheter in artery
36248	Place catheter in artery
36251	Ins cath ren art 1st unilat
36252	Ins cath ren art 1st bilat
36253	Ins cath ren art 2nd+ unilat
36254	Ins cath ren art 2nd+ bilat
36299	Vessel injection procedure
36400	Bl draw < 3 yrs fem/jugular
36405	Bl draw < 3 yrs scalp vein
36406	Bl draw < 3 yrs other vein
36410	Non-routine bl draw > 3 yrs
36416	Capillary blood draw

Appendix 7: List of Incidental Procedures for APG Payment Rate

CPT	Description
36474	Endovenous Mchnchem add-on
36481	Insertion of catheter, vein
36500	Insertion of catheter, vein
36510	Insertion of catheter, vein
36591	Draw blood off venous device
36592	Collect blood from picc
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
37247	Trluml Balo Angiop Addl Art
37249	Trluml Balo Angiop Addl Vein
37252	Intravasc us noncoronary 1st
37253	Intravasc us noncoronary addl
38200	Injection for spleen x-ray
38790	Inject for lymphatic x-ray
38792	Identify sentinel node
38794	Access thoracic lymph duct
38900	Io map of sent lymph node
42550	Injection for salivary x-ray
44701	Intraop colon lavage add-on
47001	Needle biopsy, liver add-on
49327	Lap ins device for rt
49400	Air injection into abdomen
49412	Ins device for rt guide open
49424	Assess cyst, contrast inject
49427	Injection, abdominal shunt
50606	Endoluminal bx urtr rnl plvs
50684	Injection for ureter x-ray
50690	Injection for ureter x-ray
50705	Ureteral embolization/occl
50706	Balloon dialate urtrl strix
51600	Injection for bladder x-ray
51605	Preparation for bladder xray
51610	Injection for bladder x-ray
51701	Insert bladder catheter
51702	Insert temp bladder cath
54230	Prepare penis study
55300	Prepare, sperm duct x-ray
58340	Catheter for hysterography
61781	Scan proc cranial intra
61782	Scan proc cranial extra
61783	Scan proc spinal
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
64634	Destroy c/th facet jnt addl

CPT	Description
64636	Destroy l/s facet jnt addl
64643	Chemodenerv 1 extrem 1 - 4 ea
64645	Chemodenerv 1 extrem 5/> ea
66990	Ophthalmic endoscope add-on
68850	Injection for tear sac x-ray
69990	Microsurgery add-on
78808	Iv inj ra drug dx study
92973	Percut coronary thrombectomy
92974	Cath place, cardio brachytx
93462	L hrt cath trnsptl puncture
93463	Drug admin & hemodynmic meas
93561	Cardiac output measurement
93562	Cardiac output measurement
93563	Inject congenital card cath
93564	Inject hrt congntl art/grft
93565	Inject l ventr/atrial angio
93566	Inject r ventr/atrial angio
93567	Inject suprvlv aortography
93568	Inject pulm art hrt cath
93569	NJX CTH SLCT P-ART ANGRP UNI
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93573	NJX CATH SLCT P-ART ANGRP BI
93574	NJX CATH SLCT PULM VN ANGRPH
93575	NJX CATH SLCT P ANGRPH MAPCA
95940	Ionm in operating room 15 min
95941	Ionm remote/>1 pt per hour
96904	Whole body photography
96934	Rcm celulr subcelulr img skn
96935	Rcm celulr subcelulr img skn
96936	Rcm celulr subcelulr img skn
0042T	Ct perfusion w/contrast, cbf
0054T	Bone surgery using computer
0055T	Bone surgery using computer
0095T	Each additional interspace
0098T	Each additional interspace
0198T	Ocular blood flow measure
0348T	Rsa spine exam
0349T	Rsa upper extr exam
0350T	Rsa lower extr exam
0397T	Ercp w/optical endomicroscpy
0437T	Impltj Synth Rnfcmt Abdl Wal
0439T	Myocrd Contrast Prfuj Echo
0444T	1st Plmt Drug Elut OC Ins

Appendix 7: List of Incidental Procedures for APG Payment Rate

CPT	DESCRIPTION
0445T	Sbsqt plmt Drug Elut OC Ins
0466T	Insj ch wal respir eltrd/ra
0513T	Esw integ wnd hlg ea addl
0523T	Ntrapx c ffr w/3d funcil map
0602T	Transdermal GFR Measurements
0603T	Transdermal GFR Monitoring
0604T	Rem Oct Rta Dev Stup&Edu
0605T	Rem Oct Rta Tech Sprt Min 8
0615T	Eye Mvmt alys w/o Calbrj I&R
0777T	R-t prs sensing edrl gdn sys
A4337	Incontinent rectal insert
A4435	1 pc ost pch drain hgh output
A4555	Ca tx e-stim electr/transduc
A4650	Implant radiation dosimeter
A7027	Combination oral/nasal mask
A9575	Inj gadoterate meglumi 0.1ml
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C1822	Gen, neuro, hf, rechg bat
C5272	Low cost skin substitute app
C5274	Low cost skin substitute app
C5276	Low cost skin substitute app
C5278	Low cost skin substitute app
C9143	Cocaine hcl nasal (numbrino)
C9144	Inj, bupivacaine (posimir)
C9254	Inj, lacosamide
C9359	Porous purifi colgn matrx bone vd filler
C9363	Skin sub,(meshd wound matrx)
C9364	Porcine implnt (permacol)
C9756	Fluorescence lymph map w/icg
E0766	Elec stim cancer treatment
G0316	Prolong inpt eval add15 m
G2211	Complex e/m visit add on
G2212	Prolong outpt/office visit
G2213	Initiat med assist tx in er
L8604	Inject bulk agent,dextranomer acid,1ml
Q4100	Skin substitute, NOS
Q4101	Apligraf skin sub
Q4102	Oasis wound matrix skin sub
Q4103	Oasis burn matrix skin sub
Q4104	Integra BMWD skin sub
Q4105	Integra DRT skin sub
Q4106	Dermagraft skin sub

CPT	DESCRIPTION
Q4107	Graftjacket skin sub
Q4108	Integra matrix skin sub
Q4110	Primatrix skin sub
Q4111	Gammagraft skin sub
Q4112	Cymetra allograft
Q4113	Graftjacket express allograf
Q4114	Integra flowable wound matri
Q4115	Alloskin skin sub
Q4116	Alloderm skin sub
S9433	Medical food oral 100% nutr

Appendix 7: List of Incidental Procedures for APG Payment Rate

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Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12011	Repair superficial wound(s)

CPT	Description
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20560	Needle insert w/o inj 1 or 2 mscl
20561	Needle insert w/o inj 3 or more
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst

Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
20615	Treatment of bone cyst
20950	Fluid pressure, muscle
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast
29010	Application of body cast

CPT	Description
29015	Application of body cast
29035	Application of body cast
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast

Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
29740	Wedging of cast
29750	Wedging of clubfoot cast
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
42975	Dise eval slp do brth flx dx
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
44705	Prepare fecal microbiota
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure

CPT	Description
51100	Drain bladder by needle
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
53454	Tprnl balo cntnc dev adjmt
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
59020	Fetal contract stress test
59025	Fetal non-stress test
59050	Fetal monitor w/report

Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	Description
59051	Fetal monitor/interpret only
59200	Insert cervical dilator
59412	Antepartum manipulation
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital
64445	N block inj, sciatic, sng
64454	Inj Aa&/Strd Gen Nrv Brnch w/img
64455	N block inj, plantar digit
64611	Chemodenerv saliv glands
64615	Chemodenerv musc migraine
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle laryny EMG
64624	Dest neurolytic agt gen nrv w/img
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli

CPT	Description
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rprt
0379T	Vis field assmnt tech suppt
0419T	Dstrj Neurofibroma Xtnsv
0420T	Dstrj Neurofibroma Xtnsv
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0529T	Interrog dev eval iims ip
0530T	Removal complete iims
0563T	Evac meibomian glnd heat bilat
0566T	Autol cell impt adps tiss njx implt knee uni
0588T	Rev or remvl isdns post tib nrv
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol
C8929	Transthoracic Echo, w or w/o contrst followd with

Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

CPT	DESCRIPTION
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Appendix 8: List of Office-Based Ambulatory Procedures for APG Payment Rate

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

A Supplement to the Blue Shield Promise
Medi-Cal Provider Manual

October 2023

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

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

Definitions

"*Delegated Entity*" describes any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

Blue Shield Promise is dedicated to ensuring that claim functions assigned to Delegated Entities are processed in accordance with regulatory requirements and contractual provisions. Blue Shield Promise monitors Delegated Entities' monthly and quarterly claims processing timeliness via the Delegated Entity's submission of the monthly/quarterly timeliness report. Additionally, Blue Shield Promise monitors the Delegated Entity's provider dispute resolution (PDR) process via submission of the quarterly Medi-Cal Provider Dispute Report. Both report templates are available from Delegation Oversight Claims Team or located on the Health Industry Collaborative Effort (HICE) website under *Approved ICE Documents*.

Claims Oversight Audit Review Process

Audits and Audit Preparation

Blue Shield Promise and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield Promise's audit, Blue Shield Promise will send a written notification 60 days prior to the audit that includes the documents the Delegated Entity 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. Also provided is a cover sheet that needs to be completed and attached to each claim sample. Note that the claim sample must include the following from the contract with the provider: the first and last page (signature) of contract, rate sheet from contract e.g., all documentation is required to be submitted with sample claim as noted on the cover sheet.

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.

Claims Oversight Audit Review Process *(cont'd.)*

Audits and Audit Preparation *(cont'd.)*

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

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

Blue Shield Promise will provide the Delegated Entity with written results within 30 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.

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 the delegated payor's office. The number of days measured are both calendar and working days. The time limit to make payment applies to <u>all</u> claims, without regard to whether the billing provider is contracted or non-contracted.

Claims Oversight Audit Review Process *(cont'd.)*

Regulatory Audit *(cont'd.)*

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.

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 provider 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.

Interest is due on adjustments found in favor of the provider (in whole or in part) when the Delegated Entity was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15 percent annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below.

To avoid a mandated $10.00 per claim penalty, the interest must be paid "automatically." Automatically means that the full amount of interest warranted must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due. (CCR Title 28 Section 1300.71(i)).

If the interest amount is less than $2.00, the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included. (CCR Title 28 Section 1300.71 (a)(b)).

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Acknowledgement: The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of receipt and paper claims within 15 working days of receipt. Acknowledgement should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic

Claims Oversight Audit Review Process *(cont'd.)*

Regulatory Audit *(cont'd.)*

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

Adjustments: Claims where additional monies are being paid on a previously paid or zero paid claim. (CCR Title 28 1300.71 (d)).

Contested Claim: A contested claim is defined as a claim or portion thereof that is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims must be adjudicated within 45 working days of the received date to be considered compliant. (CCR Title 28 Sections 1300.71 (d) and (h)).

Provider Denial: Provider Denial is a denial in which the provider is liable and not the member. These are separate from contested claims. A Delegated Entity 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)).

Timely Filing: The DMHC enacted regulations related to claims settlement and dispute resolution practices. Timeframes for filing claims for contracted and non-contracted providers are as follows. (CCR Title 28 Section 1300.71(b)(1)).

> Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
>
> Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed.

AB 1324: (Health and Safety Code Section 1371.8; CCR Section 1300.71 (a)(8)(T)). Blue Shield Promise validates that Delegated Entities pay incurred services if the specific service was pre-authorized or referred, even if the member is later found to be ineligible for any reason, when the provider of service relied on the authorization or referral in good faith and validated the eligibility of the member prior to service being rendered. If the Delegated Entity has an approved authorization and service has not been rendered, the delegated entity needs to formally rescind the authorization by sending a notice to the authorized rendering provider and to the member.

Direct Referral – if the service does not require a physical/paper/electronic referral, AB 1324 does not affect these services.

Claims Oversight Audit Review Process *(cont'd.)*

Regulatory Audit *(cont'd.)*

Accurate and Clear Written Explanation (Specific to Denying, Adjusting and Contesting Claims): The EOB/EOP must contain data that is the same as what was submitted on the claim: the member financial liability (if applicable), same denied date as indicated in claim system, denial rights, the reason why the claim was denied, contested or adjusted and must include where to file a provider dispute including Provider Dispute timely filing requirements to be within 365 days from the last claim action. The EOB/EOP should include procedures for obtaining dispute forms, instructions for filing the dispute, and a mailing address. For Non-Contracted providers the Delegated Entity needs to provide payment methodology. (Title 28 1300.71.38(b) Time Period for Submission) (Title 28 1300.71.38(b) Notice to Provider of Dispute Resolution Mechanism.)

Provider Dispute Resolution (PDR): Section 1300.71.38 CCR, Title 28. The Delegated Entity shall establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. Time Period for Resolution and Written Determination requires that a Delegated Entity must resolve each provider dispute within 45 working days after the date of receipt of the provider dispute. Provider Disputes must be in writing and include the following:

a. Provider Name.
b. Provider Identification Number.
c. Provider Contact Information.
d. Clearly identify the disputed item.
e. Date of Service (DOS).
f. A clear explanation of basis for provider's reason that the payment, request for overpayment return, request for additional information, contest, denial, or adjustment is correct.

Misdirected/Forwarded Claims: Regulations require the Delegated Entity to forward misdirected claims to the responsible payor within ten (10) working days of receipt. Blue Shield Promise requires that Delegated Entities forward these claims directly to the financially responsible entity, if known, otherwise deny to the provider with a remit message informing the provider the delegate is not financially responsible for processing of the claim. The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office boxes, or designated claims processor or to the plan's contracted Delegated Entity for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim. If a Management Service Organization (MSO) that manages several Delegated Entities receives a claim from one of their post office boxes and it loads the claim

Claims Oversight Audit Review Process *(cont'd.)*

Regulatory Audit *(cont'd.)*

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. (Title 28 Section 1300.71(a)(8)(B) & Section 1300.71(b)(3)).

Family Planning/Sensitive Services: members have the right to access family planning services through any family planning provider without prior authorization. Health Plan shall inform its members in writing of their right to access any qualified family planning provider without prior authorization in its Member Services Guide. Health Plan shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the provider network and members shall be informed of the availability of these services. Minors do not need parental consent to access these services. (WIC Section 14105.181).

a. 90% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims from practitioners within 90 days from the date of receipt. (Title 42 Section 447.75).
b. 95% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities within 45 working days after the date of receipt of the claim. (CCR Title 28 Section 1300.71 (g)).
c. Claim paid at Medi-Cal rate or appropriate clinic rates per SB 94.

Check Clearing: Blue Shield Promise accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. Blue Shield Promise will confirm the date the check or electronic transfer was cleared to the Delegated Entity's bank account during the audit process. Blue Shield Promise requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield Promise requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. This attestation can be requested from your assigned claims delegation oversight auditor.

Claims Oversight Audit Review Process *(cont'd.)*

Regulatory Audit *(cont'd.)*

Corrective Action/Follow Up Audits

Blue Shield Promise performs, at a minimum, an annual claims and PDR audit. Follow-up audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or remediation validation audits will be performed based upon outcome of escalation to the Delegation Oversight Committee. For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield Promise by the date provided by the auditor. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators.

Newly Contracted Provider Training Oversight Audit

To operate in full compliance with the DHCS and L.A. Care Contract requirements and all applicable federal and state regulations, Delegated Entities are required to provide all newly contracted 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. Annual audits are conducted on the review of Delegated Entities training materials and/or the Delegated Entities website that contains the training materials. 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

Evidence of training must be demonstrated in the form of a universe report and signed training attestation from each trained provider and submitted to the Blue Shield Promise Delegation Oversight Compliance Team. To download a copy of the Delegation Oversight Newly Contracted Provider Training Attestation form, go to the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers and navigate to the *Forms* section, then *Delegation oversight forms*. The reports are due every quarter by the 15th day of the month following quarter end to the following dedicated email address BSCProviderTraining@blueshieldca.com. ***Providers will not be uploaded into the Blue Shield's provider directory for members to access or approval for any authorized services until your organization provides evidence that the provider has completed the training.***

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.

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

Compliance Program Effectiveness Oversight Audit

Delegation Oversight will perform an annual audit of the effectiveness of your organization'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 Compliance Audit Evidence Grid, go to the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers and navigate to the *Forms* section, then *Delegation oversight forms*. 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 www.iceforhealth.org/teamactivities.asp.

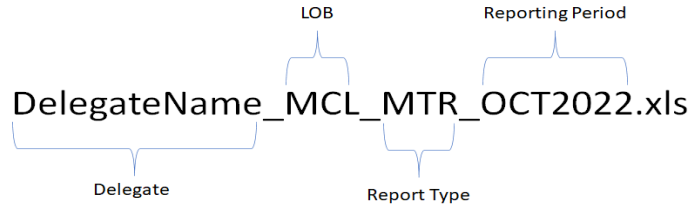
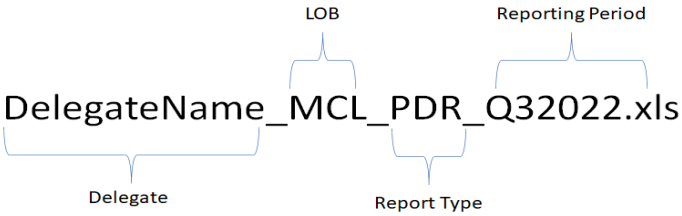
IT System Integrity Oversight and Monitoring

Delegation Oversight will perform an IT system security and integrity audit to assure system access controls, policy and procedures regarding system changes, security of data, etc. are maintained. The oversight is also performed either via shared audit through HICE or individually on a bi-annual basis with quarterly monitoring. 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.

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

Claims Delegate Reporting Instructions

Report Submission	
Submit Reports To:	ClaimsDelegateReport@blueshieldca.com
Report Template:	Submit results using the BSC Promise report template.
Report Format:	If submitting an Adobe PDF in order to satisfy the Designated Principal Officer signature requirements, please also submit the report on the original Excel template.

Report Naming Convention	
 	
Delegate	The delegated entity's name or an acronym which represents the group.
LOB	COMM (Commercial) MCR (Medicare) MCL (Medi-Cal) CMC (Cal Medi-Connect)
Report Type	DECD (Disclosure of Emerging Claim Deficiencies MTR (Monthly Timeliness Reporting) PDR (Provider Dispute Resolution) POF (Principal Officer Form)
Reporting Period	Identify the period being reported on e.g., OCT2022, Q32022, etc.

Designated Principal Officer	
Who Can Sign:	Results for the quarter must be attested to/signed by a Designated Principal Officer. The person attesting to the accuracy and completeness of the report must be an executive of the organization, Vice President level of above.

Claims Delegate Reporting Instructions *(cont'd.)*

Reports

Please review all the Monthly/Quarterly report requirements. Please submit the Excel/Word report in addition to the signed document. Reports that do not meet reporting standards or have issues will be returned with a request to correct the inconsistencies. Prompt submission is expected to ensure timely reporting.

1. Disclosure of Emerging Claim Deficiencies

In accordance with the California Code Regulation (Title 28, Section 1300.71- Claims Settlement Practices), Delegated Entities that report claims deficiencies, must complete a Disclosures of Emerging Claims Payment Deficiencies form. The delegated entity will identify the reason for such reported deficiencies by selecting series of check mark boxes, which explain the lack or thereof compliance during the reporting period.

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Medi-Cal	Claims Settlement Practice reports are submitted quarterly. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 30th • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year.	Blue Shield Promise Provider Portal under *Delegation oversight forms*

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

Claims Delegate Reporting Instructions *(cont'd.)*

Reports *(cont'd.)*

2. Monthly Timeliness Report (Medi-Cal)

Claims must be processed within 30 calendar days and 45 working days.

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Medi-Cal	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • October report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	Blue Shield Promise Provider Portal under *Delegation oversight forms*

Claims Delegate Reporting Instructions *(cont'd.)*

Reports *(cont'd.)*

3. Provider Dispute Resolution Report (Commercial and Medi-Cal)

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Location
Commercial and Medi-Cal	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	Blue Shield Promise Provider Portal under *Delegation oversight forms*

4. Principal Officer Form

The Principal Officer is the president, vice-president, secretary, treasurer, or chairperson of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Line of Business (LOB)	Due Date	Report Location
All LOBs	Reports are due by the end of September each year (annually). Also, submit updated reports whenever changes occur to Principal Officer(s) at the delegated entity.	Blue Shield Promise Provider Portal under *Delegation oversight forms*

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

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Appendix 10: DHCS Community Supports Categories and Definitions

Asthma Remediation

Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Day Habilitation Programs

Description: Day Habilitation Programs are provided in a member's home or an out-of-home, non-facility setting. The programs are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Environmental Accessibility Adaptations (Home Modifications)

Description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Homelessness[1]

Definition:

- An individual or family who lacks adequate nighttime residence
- An individual or family with a primary residence that is a public or private place not designed for our ordinarily used for habitation
- An individual or family living in a shelter
- An individual existing an institution to homelessness[2]
- An individual or family who will imminently lose housing in next **30 days**[3]
- Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes
- Victims fleeing domestic violence

[1] DHCS definition; this definition is based on HUD definition of homeless with modification as noted below.

[2] If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.

[3] The timeframe for an individual or family who will imminently lose housing has been extended from 14 (HUD definition) to 30 days.

Appendix 10: DHCS Community Supports Categories and Definitions

Housing Tenancy and Sustaining Services

Description: This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Housing Transition Navigation Services

Description: Housing Transition Navigation services assist members with obtaining housing.

Housing Deposits

Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board.

Medically Supportive Food/Meals and Medically Tailored Meals

Description: Medically Supportive Food/Meals delivered to the home: Meals provided immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.

Medically Tailored Meals: Meals provided to the member at home that meet the unique dietary needs of those with chronic diseases. Medically Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD), reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and/or side effects to ensure the best possible nutrition-related health outcomes.

Nursing Facility Transition/Diversion to Assisted Living Facilities

Description: Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible. For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADL). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board.

Community Transition Services/Nursing Facility Transition to a Home

Description: Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization. They are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that does not constitute room and board.

Personal Care & Homemaker Services

Description: Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who otherwise could not remain in their homes.

Recuperative Care

Description: Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

Respite

Description: Respite services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Short-Term Post-Hospitalization Housing

Description: Short-Term Post-Hospitalization housing provides members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential alcohol or drug abuse recovery or treatment facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of state plan services.

Appendix 10: DHCS Community Supports Categories and Definitions

Sobering Centers

Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services and homeless care support services.

Appendix 11: Community Supports Criteria and Exclusion Guide

Community Supports Services and Eligibility Criteria Checklist
Blue Shield Promise Health Plan
Los Angeles County

This guide provides information for both **General (Section A)** and **Service-Specific (Section B)** criteria for Community Supports (CS) under CalAIM.

A. GENERAL CRITERIA AND EXCLUSIONS

General Criteria for Community Supports (CS) Referrals:
☐ Active Medi-Cal with Blue Shield Promise at the time of request for referral.
☐ Documentation of member's written or verbal consent for the CS referral.
General Exclusions:
☐ Member is receiving a similar or program and a referral for CS would be duplication of services.
☐ If member is in facility-based care at the time of referral, the earliest start of Community Supports, if member meets eligibility criteria, will be at the time of discharge from the facility.
☐ Member is unable to contact within 1 business day from the time of referral (member can be re-referred at a later date, if appropriate).

B. SERVICE-SPECIFIC CRITIERA AND EXCLUSIONS

Environmental Accessibility Adaptations (Home Modifications)
Description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization. EAAs also include asthma remediation.
Eligibility Criteria (must meet all criteria):
☐ Individuals at risk for institutionalization in a nursing facility.
☐ Order from the member's current primary care physician or other health specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate.
☐ Member owns, rents, leases, or occupies the home where services are needed. For a home that is not owned by the member, the member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
☐ Member has received a physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
☐ An evaluation of the member and the current equipment needs specific to the member, describing how/why the current equipment does not meet the needs of the member;
☐ B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the member *and reduces the risk of institutionalization*. This should also include information on the ability of the member and/or the primary caregiver to learn about and appropriately use any requested item, and
☐ A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the member and a description of the inadequacy.
☐ A home visit has been conducted to determine the suitability of any requested equipment or service.

Exclusion Criteria:
☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used. ☐ Member has exceeded the total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the member's place of residence changes or if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. ☐ EAAs do not include aesthetic embellishments. ☐ Modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). ☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Housing Deposits
Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board.
Eligibility Criteria:
☐ Enrolled in and receiving housing navigation through Homeless and Housing Supports Services (HHSS); and ☐ Currently in the process of moving into permanent housing; and ☐ Unable to meet requested housing deposit expenses.
Exclusion Criteria:
☐ Not currently enrolled in HHSS. ☐ Receiving housing deposit resources from a duplicate program. ☐ Already living in permanent housing at the point of request, but reasonable accommodation could be considered. ☐ Not moving into permanent housing setting. ☐ Previously received housing deposit services from Blue Shield Promise Health Plan or other Medi-Cal Managed Care plans. Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

Housing Tenancy and Sustaining Services

Description: This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Eligibility Criteria: Members must meet one criterion from the Homeless criteria **AND** one from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members participating in Permanent Supportive Housing):

Homeless Criteria:	High Utilizer/High Acuity Criteria:
Member must meet **one** of the following statuses: ☐ Member who received Housing Navigation Community Supports prior to entering housing; or ☐ Member who met the HUD definition of homelessness[1] prior to entering housing and has been housed for less than six months; or ☐ Member who has exited from an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and has been housed for less than six months; or ☐ Member who met HUD chronic homelessness[2] definition prior to entering housing and has been housed for less than two years.	☐ Member is eligible or enrolled in ECM homeless population of focus; or ☐ Member has two or more chronic conditions*; or ☐ Member is a high utilizer, defined as: ☐ 7 or more Emergency Department visits in prior 12-month period; or ☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or ☐ Total health care costs of at least $50,000 in prior 12-month period

OR

☐ Member is participating in a publicly funded permanent supportive housing resource or program** in Los Angeles County.

Exclusion Criteria:

- ☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.
- ☐ Member is enrolled in a duplicative housing navigation or tenancy services program.
- ☐ Member declines services.
- ☐ Member has previously received Tenancy Services (limit of a single duration in the individual's lifetime; services may be approved one additional time with documentation as to what conditions have changed to demonstrate why services would be more successful on the second attempt).

*Any 2 of the following conditions: asthma, coronary artery disease (includes stroke and heart attack/MI), chronic/congestive heart failure, chronic obstructive pulmonary disease (includes emphysema), dementia, diabetes, hypertension, epilepsy, chronic liver disease (includes Hepatitis B and Hepatitis C), traumatic brain injury, bipolar disorder, major depressive disorder, psychotic disorder (includes schizophrenia), alcohol use disorder, chronic kidney disease, other serious mental illness, other substance use disorders, any cancer under treatment, except basal cell carcinoma (skin cancer), HIV, Lupus, and rheumatoid arthritis.
**Permanent Supportive Housing resources include programs to provide housing linked to supportive services in project-based or scattered site settings, and may include licensed residential facilities, or shared housing if part of an ongoing County, City, or other government program.

[1] HUD Definition of Homelessness
[2] HUD Definition of Chronic Homelessness

Appendix 11: Community Supports Criteria and Exclusion Guide

<table>
<tr><th colspan="2">Housing Transition Navigation Services</th></tr>
<tr><td colspan="2">Description: Housing Transition Navigation services assist beneficiaries with obtaining housing</td></tr>
<tr><td colspan="2">Eligibility Criteria: Members must meet <u>one</u> criterion from the Homeless criteria AND <u>one</u> from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members successfully matched for Permanent Supportive Housing):</td></tr>
<tr><td>Homeless Criteria:</td><td>High Utilizer/High Acuity Criteria:</td></tr>
<tr><td>Member must meet <u>one</u> of the following homeless statuses:
☐ Member who meets the HUD definition of homelessness; or
☐ Member is exiting an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and would become homeless immediately upon release: or
☐ Member who meets HUD definition of chronic homelessness.</td><td>☐ Member is eligible or enrolled in ECM homeless population of focus; or
☐ Member has two or more chronic conditions*; or
☐ Member is a high utilizer, defined as:
☐ 7 or more Emergency Department visits in prior 12-month period; or
☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or
☐ Total health care costs of at least $50,000 in prior 12-month period</td></tr>
<tr><td colspan="2"><u>OR</u>
☐ Member is matched to a publicly funded permanent supportive housing resource or program** in Los Angeles County.</td></tr>
<tr><td colspan="2">Exclusion Criteria:</td></tr>
<tr><td colspan="2">☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.
☐ Member is enrolled in a duplicative housing navigation or tenancy services program.
☐ Member declines services.</td></tr>
</table>

Meals/Medically Tailored Meals (MTM)
Description: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases. Medically Tailored meals are approved by a Registered Dietitian (RD) that reflect appropriate dietary therapy based on evidence-based nutrition practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.
Eligibility (Population Subset) Criteria: Includes the following populations:
☐ Individuals aged 18 and over with Diabetes who have an HbA1c level equal to or greater than eight percent that are taking insulin greater than 200 units per 24-hour period, U500, or 3 or more oral anti-diabetes medications or non-insulin injectables; **and** ☐ Have 2 or more inpatient hospitalizations in the prior 12 months with diabetes as primary or secondary diagnosis; or, ☐ Have had 2 or more ED visits in the prior 12 months, with diabetes as primary or secondary diagnosis, or ☐ Individuals aged 18 and over with Chronic Kidney Disease (CKD) stage 3 and 4; **and** ☐ Have 2 or more inpatient hospitalizations in the prior 12 months with CKD as primary or secondary diagnosis; or, ☐ Have had 2 or more ED visits in the prior 12 months, with CKD as primary or secondary diagnosis.
☐ Individuals aged 40 and over with Congestive Heart Failure (CHF); and ☐ Have 2 or more inpatient hospitalizations in the prior 12 months with CHF as primary or secondary diagnosis; or, ☐ Have had 2 or more ED visits in the prior 12 months, with CHF as primary or secondary diagnosis.
Exclusion Criteria:
☐ Any of the following health conditions: Gestational Diabetes, Cancer, HIV, Dependence on Renal Dialysis, End-Stage Renal Disease (ESRD); or ☐ Member is currently in another MTM program; or ☐ Member does not have access to cold food storage; or ☐ Member is in Hospice; or ☐ Member is in Skilled Nursing Facility; or ☐ Member is incarcerated.

Appendix 11: Community Supports Criteria and Exclusion Guide

Personal Care & Homemaker Services
Description: Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.
Eligibility Criteria (must meet at least one of the following):
☐ Individuals at risk for hospitalization or institutionalization in a nursing facility; or ☐ Individuals with functional deficits and no other adequate support system; or ☐ Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at www.cdss.ca.gov/In-Home-Supportive-Services.
Exclusion Criteria:
This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Members must be referred to the In-Home Supportive Services program when they meet referral criteria. If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period. Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding. Members who are IHSS ineligible can receive up to a 2 month max limit of services.

Recuperative Care (Medical Respite)

Description: Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

Eligibility Criteria:

In order to qualify, members must:

- Be an active, homeless BSC Promise Medi-Cal or CMC member; **and**
    a. Homeless is defined as…
        i. Members who meet the HUD definition of homelessness or
        ii. Members who are exiting an institution (such as jail, hospital, or SNF) after more than 90 days and would become homeless immediately upon release
- Is post-hospitalization or post-skilled nursing facility; **and**
- Have one of the following:
    b. A defined home health skilled need, such as:
        i. Physical therapy, occupational therapy, or speech therapy
        ii. Ongoing IV antibiotics
        iii. Wound Care

OR

- Be in the midst of, or in need of, an outpatient treatment that if interrupted or delayed would cause undue harm.

Exclusion Criteria:

Members are not eligible if any of the following apply:

- Member is unable or unwilling to independently complete ADLs; except for short-term or limited assistance consistent with recuperative care facility capabilities;
- Member is dependent for medication administration;
- Member is incontinent of bladder and/or bowel and unable to self-care with adult briefs and/or other incontinence supplies;
- Member is gravely disabled;
- Members must be medically and psychiatrically stable enough that hospitalization or a different higher level of care (such as an LTACH or a residential treatment center) is not required;
- Member is cognitively impaired (e.g., needs constant supervision and monitoring and /or re-direction and verbal cues for basic functions/ADLs);
- Member has been recently combative, aggressive and/or threatening towards staff or other individuals;
- Member has a peripherally inserted central catheter ("PICC Line") and is on IV medications depending on other factors, e.g. type of medication administered, mobility, safety of member and other guests, etc. Decisions about placement of members with a PICC Line will be decided on a case-by-case basis;
- Member is unable to live independently in housing and/or needs licensed care, such as skilled nursing, 24/7 care and supervision, medication administration, Adult Residential Facility (ARF) / Residential Care Facility for the Elderly (RCFE), a.k.a. Board & Care services, or etc.;
- Member has tested positive for Covid-19 within the last 10 days and/or is still exhibiting symptoms;
- Active Tuberculosis/C-DIFF/MRSA of sputum (possibly of wound) or other communicable/contagious condition(s) may be a disqualifier;
- Members are generally ineligible with limited exceptions if member is oxygen dependent, has stage 3 or 4 decubitus, is actively detoxing or is quadriplegic. Decisions about placement of members with these needs will be decided on a case-by-case basis.

Appendix 11: Community Supports Criteria and Exclusion Guide

Short-Term Post-Hospitalization Housing
Description: Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential Alcohol or Drug Abuse Recovery or Treatment facility, residential mental health treatment facility, correctional facility, nursing facility or recuperative care.
Eligibility Criteria (must meet all criteria):
Member is homeless. 1 or more IP admission within 6 months from time of referral or at significant risk of hospitalization if not housed. No identified family or other housing supports.
Exclusion Criteria:
Already housed. In a duplicate program/receiving housing through alternative community support/program. Member exhausted the maximum lifetime amount (not to exceed 6 months).

Respite Services
Description: Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.
Eligibility Criteria (must meet all criteria):
Eligible individuals include those who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, members enrolled in California Children's Services or Genetically Handicapped Persons Program (GHPP), and members with Complex Care Needs.
Exclusion Criteria:
In the home setting, these services, in combination with any direct care services the member is receiving, can provide up to 24 hours per day of care. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the limit of 336 hours per calendar year can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit. This service is only provided to avoid placements for which the Medi-Cal managed care plan would be responsible. Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Sobering Centers
Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services.
Eligibility Criteria (must meet all criteria):
☐ Individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. ☐ Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms). ☐ Individuals may not be receiving duplicative support from other State, local, or federally funded programs.
Exclusion Criteria:
☐ Member is determined by medical and/or legal personnel to be transported to the ER or jail. ☐ Member required services beyond 24 hours. ☐ Individuals may not be receiving duplicative support from other State, local, or federally funded programs.

Day Habilitation
Description: Day Habilitation Programs are provided in a member's home or an out-of-home, non- facility setting. The programs are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.
Eligibility Criteria (must meet one criteria):
☐ Member experiencing homelessness, per HUD definition; or ☐ Member exited homelessness and entered housing in the last 24 months; or ☐ Member is at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.
Exclusion Criteria:
☐ Member declines services. ☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Appendix 11: Community Supports Criteria and Exclusion Guide

Asthma Remediation
Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.
Eligibility Criteria (must meet all criteria):
☐ Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services; ☐ Member or their caregiver owns, rents, leases, or occupies the home where services are to be delivered; ☐ Member's current licensed health care provider has submitted order specifying the requested remediation(s) for the member*; ☐ Member has a brief written evaluation specific to the member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective*; ☐ A home visit has been conducted to determine the suitability of any requested remediation(s) for the member*.
Exclusion Criteria:
☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations. ☐ Member has exceeded the total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. ☐ Services are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments. ☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

*Referring individual must provide written evidence when submitting the Referral.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
Description: Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.
Eligibility Criteria (Must meet all criteria):
A. For Nursing Facility Transition: • Has resided 60+ days in a nursing facility; • Willing to live in an assisted living setting as an alternative to a Nursing Facility; and • Able to reside safely in an assisted living facility with appropriate and cost- effective supports. B. For Nursing Facility Diversion: • Interested in remaining in the community; • Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and • Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.
Exclusion Criteria:
• Individuals are directly responsible for paying their own living expenses. • Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Community Transition Services/Nursing Facility Transition to a Home
Description: Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.
Eligibility Criteria (Must meet all criteria):
• Currently receiving medically necessary nursing facility Level of Care (LOC) • services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and • Has lived 60+ days in a nursing home and/or Medical Respite setting; and • Interested in moving back to the community; and • Able to reside safely in the community with appropriate and cost-effective supports and services.
Exclusion Criteria:
• Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes. • Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. • Community Transition Services must be necessary to ensure the health, welfare, and safety of the member, and without which the member would be unable to move to the private residence and would then require continued or re- institutionalization.

Appendix 11: Community Supports Criteria and Exclusion Guide

Community Supports Services and Eligibility Criteria Checklist
Blue Shield Promise Health Plan
San Diego County

This guide provides information for both **General (Section A)** and **Service-Specific (Section B)** criteria for Community Supports (CS) under CalAIM.

A. GENERAL CRITERIA AND EXCLUSIONS

General Criteria for Community Supports (CS) Referrals:
☐ Active Medi-Cal with Blue Shield Promise at the time of request for referral.
☐ Documentation of member's written or verbal consent for the CS referral.
General Exclusions:
☐ Member is receiving a similar or program and a referral for CS would be duplication of services.
☐ If member is in facility-based care at the time of referral, the earliest start of Community Supports, if member meets eligibility criteria, will be at the time of discharge from the facility.
☐ Member is unable to contact within 1 business day from the time of referral (member can be re-referred at a later date, if appropriate).

B. SERVICE-SPECIFIC CRITIERA AND EXCLUSIONS

Environmental Accessibility Adaptations (Home Modifications)
Description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization. EAAs also include asthma remediation.
Eligibility Criteria (must meet all criteria):
☐ Individuals at risk for institutionalization in a nursing facility.
☐ Order from the member's current primary care physician or other health specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate.
☐ Member owns, rents, leases, or occupies the home where services are needed. For a home that is not owned by the member, the member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
☐ Member has received a physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
☐ An evaluation of the member and the current equipment needs specific to the member, describing how/why the current equipment does not meet the needs of the member;
☐ An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the member *and reduces the risk of institutionalization*. This should also include information on the ability of the member and/or the primary caregiver to learn about and appropriately use any requested item; and
☐ A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the member and a description of the inadequacy.
☐ A home visit has been conducted to determine the suitability of any requested equipment or service.

Exclusion Criteria:
☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used. ☐ Member has exceeded the total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the member's place of residence changes or if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. ☐ EAAs do not include aesthetic embellishments. ☐ Modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). ☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Housing Deposits
Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board.
Eligibility Criteria:
☐ Enrolled in and receiving housing navigation through Homeless and Housing Supports Services (HHSS); and ☐ Currently in the process of moving into permanent housing; and ☐ Unable to meet requested housing deposit expenses.
Exclusion Criteria:
☐ Not currently enrolled in HHSS. ☐ Receiving housing deposit resources from a duplicate program. ☐ Already living in permanent housing at the point of request, but reasonable accommodation could be considered. ☐ Not moving into permanent housing setting. ☐ Previously received housing deposit services from Blue Shield Promise Health Plan or other Medi-Cal Managed Care plans. Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

Appendix 11: Community Supports Criteria and Exclusion Guide

<table>
<tr><th colspan="2">Housing Tenancy and Sustaining Services</th></tr>
<tr><td colspan="2">Description: This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.</td></tr>
<tr><td colspan="2">Eligibility Criteria: members must meet one criterion from the Homeless criteria AND one from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members participating in Permanent Supportive Housing):</td></tr>
<tr><td>Homeless Criteria:</td><td>High Utilizer/High Acuity Criteria:</td></tr>
<tr><td>Member must meet <u>one</u> of the following statuses:
☐ Member who received Housing Navigation Community Supports prior to entering housing; or
☐ Member who met the HUD definition of homelessness[3] prior to entering housing and has been housed for less than six months; or
☐ Member who has exited from an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and has been housed for less than six months; or
☐ Member who met HUD chronic homelessness[4] definition prior to entering housing and has been housed for less than two years.</td><td>☐ Member is eligible or enrolled in ECM homeless population of focus; or
☐ Member has two or more chronic conditions*; or
☐ Member is a high utilizer, defined as:
☐ 7 or more Emergency Department visits in prior 12-month period; or
☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or
☐ Total health care costs of at least $50,000 in prior 12-month period</td></tr>
<tr><td colspan="2"><u>OR</u>
☐ Member is participating in a publicly funded permanent supportive housing resource or program** in San Diego County.</td></tr>
<tr><td colspan="2">Exclusion Criteria:</td></tr>
<tr><td colspan="2">☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.
☐ Member is enrolled in a duplicative housing navigation or tenancy services program.
☐ Member declines services.
☐ Member has previously received Tenancy Services (limit of a single duration in the individual's lifetime; services may be approved one additional time with documentation as to what conditions have changed to demonstrate why services would be more successful on the second attempt).</td></tr>
</table>

*Any 2 of the following conditions: asthma, coronary artery disease (includes stroke and heart attack/MI), chronic/congestive heart failure, chronic obstructive pulmonary disease (includes emphysema), dementia, diabetes, hypertension, epilepsy, chronic liver disease (includes Hepatitis B and Hepatitis C), traumatic brain injury, bipolar disorder, major depressive disorder, psychotic disorder (includes schizophrenia), alcohol use disorder, chronic kidney disease, other serious mental illness, other substance use disorders, any cancer under treatment, except basal cell carcinoma (skin cancer), HIV, Lupus, and rheumatoid arthritis.

**Permanent Supportive Housing resources include programs to provide housing linked to supportive services in project-based or scattered site settings, and may include licensed residential facilities, or shared housing if part of an ongoing County, City, or other government program.

[3] HUD Definition of Homelessness

[4] HUD Definition of Chronic Homelessness

Housing Transition Navigation Services

Description: Housing Transition Navigation services assist beneficiaries with obtaining housing

Eligibility Criteria: members must meet **one** criterion from the **Homeless criteria AND one** from the **High Utilizer/High Acuity criteria** (High Utilizer/High Acuity criteria may be waived for members successfully matched for Permanent Supportive Housing):

Homeless Criteria:	High Utilizer/High Acuity Criteria:
Member must meet **one** of the following homeless statuses: ☐ Member who meets the HUD definition of homelessness; or ☐ Member is exiting an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and would become homeless immediately upon release: or ☐ Member who meets HUD definition of chronic homelessness.	☐ Member is eligible or enrolled in ECM homeless population of focus; or ☐ Member has two or more chronic conditions*; or ☐ Member is a high utilizer, defined as: ☐ 7 or more Emergency Department visits in prior 12-month period; or ☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or ☐ Total health care costs of at least $50,000 in prior 12-month period

OR

☐ Member is matched to a publicly funded permanent supportive housing resource or program** in San Diego County.

Exclusion Criteria:

☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.
☐ Member is enrolled in a duplicative housing navigation or tenancy services program.
☐ Member declines services.

Medically Supportive Food/Meals
(Food to support health-related situations for 4 to 12 weeks. Services approved on a month-to-month basis)

Description: Meals delivered to the home: immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.

Eligibility Criteria (member must meet at least one criteria):

☐ Recent discharge from the hospital or other inpatient healthcare facility and not physically able to obtain meals or prepare meals on their own after discharge.
☐ Newly diagnosed illness.
☐ Experiencing a health crisis.
☐ Documented need for nutritional food support to avoid exacerbation of a health crisis condition or episode (example Major organ transplant).

Exclusion Criteria:

☐ Member has adequate caregiver support in place to obtain and prepare meals after discharge or other.
☐ Member is enrolled in other meal programs (e.g., lives at and Independent Living Facility (IILF) which provides more than 7 meals per week to residents).
☐ Unsheltered individuals or without stable housing for the duration of service.
☐ Members with extreme food allergies.

Medically Tailored Meals (MTM)

Description: Meals provided to the member at home that meet the unique dietary needs of those with chronic

diseases. Medically Tailored meals are approved by a Registered Dietitian (RD) that reflect appropriate dietary therapy based on evidence-based nutrition practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.
Eligibility Criteria (member must meet all criteria):
☐ Must have Chronic Heart Failure (CHF), Diabetes (uncontrolled), Chronic Kidney Disease (CKD) diagnosis (stages 3-5 or on Dialysis), Cancer, Human Immunodeficiency Virus (HIV). ☐ If member has two or more qualifying conditions, must specify only one ICD Code for the primary reason for referral. ☐ Inpatient/SNF hospitalization or ER visit within the last 12 months. ☐ Must have life expectancy of more than 1 year. ☐ No Income requirement.
Exclusion Criteria:
☐ Life expectancy less than 1 year. ☐ Homeless or no stable housing in last 3 months. ☐ No to low motivation to actively participate in program – can explore other meals programs. ☐ Member is enrolled in other meal programs (ex: lives at ILF and provided more than 7 meals per week to residents). ☐ Members with extreme food allergies

Personal Care & Homemaker Services
Description: Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.
Eligibility Criteria (must meet at least one of the following):
☐ Individuals at risk for hospitalization or institutionalization in a nursing facility; or ☐ Individuals with functional deficits and no other adequate support system; or ☐ Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at www.cdss.ca.gov/In-Home-Supportive-Services
Exclusion Criteria:
This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. members must be referred to the In-Home Supportive Services program when they meet referral criteria. If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period. Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Recuperative Care (Medical Respite)
Description: Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing
Eligibility Criteria (must meet all criteria):
☐ Adult (18 years of age or older) and homeless. ☐ Acute medical or psychiatric problem requiring short-term medical respite care with an identifiable end point of care for discharge. ☐ Medically and behaviorally stable (not a risk to self/others, appropriate for group setting). ☐ Independent in Activities of Daily Living (mobility, transfer, toileting, feeding, dressing) and not known to be fall-risk. ☐ Able to independently administer medications. ☐ Agreeable to admission and receiving care from Recuperative Care staff. ☐ Be willing to comply with medical recommendations and treatment plan goals. ☐ Bladder and bowel continent. ☐ Have scheduled subspecialty follow-up appointments as indicated.
Exclusion Criteria:
☐ Unable to perform ADLS independently. ☐ Active Tuberculosis (TB). ☐ Fecal and/or urinary incontinence without management plan *(member must have the ability to independently to change themselves etc.).* ☐ Unstable medical or psychiatric conditions that require an inpatient level of care. ☐ Dangerous to self or others; unable to live in a group environment. ☐ Demonstrated history of using alcohol or illicit drugs onsite at a residential program, hospital, SNF, or similar program. ☐ IV hydration (*Individuals requiring IV antibiotics must be able to self-administer or the hospital must arrange a Home Health Nurse come to the Recuperative Care housing*). ☐ Contagious air-borne respiratory illness. ☐ Substance use- not onsite or abstain depending on RCU. ☐ In a duplicate program/receiving housing services through alternative Community Supports/Program.

Appendix 11: Community Supports Criteria and Exclusion Guide

Short-Term Post-Hospitalization Housing
Description: Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential Alcohol or Drug Abuse Recovery or Treatment facility, residential mental health treatment facility, correctional facility, nursing facility or recuperative care.
Eligibility Criteria (must meet all criteria):
☐ Member is homeless. ☐ 1 or more IP admission within 6 months from time of referral or at significant risk of hospitalization if not housed. ☐ No identified family or other housing supports.
Exclusion Criteria:
☐ Already housed. ☐ In a duplicate program/receiving housing through alternative community support/program. ☐ Member exhausted the maximum lifetime amount (not to exceed 6 months).

Sobering Centers
Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services.
Eligibility Criteria (must meet all criteria):
☐ Individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. ☐ Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms). ☐ Individuals may not be receiving duplicative support from other State, local, or federally funded programs.
Exclusion Criteria:
☐ Member is determined by medical and/or legal personnel to be transported to the ER or jail. ☐ Member required services beyond 24 hours. ☐ Individuals may not be receiving duplicative support from other State, local, or federally funded programs.

Day Habilitation
Description: Day Habilitation Programs are provided in a member's home or an out-of-home, non- facility setting. The programs are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.
Eligibility Criteria (must meet one criteria):
☐ Member experiencing homelessness, per HUD definition; or ☐ Member exited homelessness and entered housing in the last 24 months; or ☐ Member is at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.
Exclusion Criteria:
☐ Member declines services. ☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Appendix 11: Community Supports Criteria and Exclusion Guide

Asthma Remediation
Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.
Eligibility Criteria (must meet all criteria):
☐ Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services; ☐ Member or their caregiver owns, rents, leases, or occupies the home where services are to be delivered; ☐ Member's current licensed health care provider has submitted order specifying the requested remediation(s) for the member*; ☐ Member has a brief written evaluation specific to the member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective*; ☐ A home visit has been conducted to determine the suitability of any requested remediation(s) for the member*.
Exclusion Criteria:
☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations. ☐ Member has exceeded the total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. ☐ Services are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments. ☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

*Referring individual must provide written evidence when submitting the Referral.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
Description: Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.
Eligibility Criteria (Must meet all criteria):
A. For Nursing Facility Transition: ☐ Has resided 60+ days in a nursing facility; ☐ Willing to live in an assisted living setting as an alternative to a Nursing Facility; and ☐ Able to reside safely in an assisted living facility with appropriate and cost- effective supports. B. For Nursing Facility Diversion: ☐ Interested in remaining in the community; ☐ Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and ☐ Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.
Exclusion Criteria:
☐ Individuals are directly responsible for paying their own living expenses. ☐ Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Appendix 11: Community Supports Criteria and Exclusion Guide

Community Transition Services/Nursing Facility Transition to a Home
Description: Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.
Eligibility Criteria (Must meet all criteria):
☐ Currently receiving medically necessary nursing facility Level of Care (LOC) ☐ services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and ☐ Has lived 60+ days in a nursing home and/or Medical Respite setting; and ☐ Interested in moving back to the community; and ☐ Able to reside safely in the community with appropriate and cost-effective supports and services.
Exclusion Criteria:
☐ Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes. ☐ Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. ☐ Community Transition Services must be necessary to ensure the health, welfare, and safety of the member, and without which the member would be unable to move to the private residence and would then require continued or re- institutionalization.

Appendix 12: 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.	

Appendix 12: 2023 Actuarial Cost Model

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**

"Disclaimers:

The information presented herein regarding cost and utilization is provided by way of example only and is based broadly on historical data in Blue Shield Promise's possession. It is not a statement of fact or opinion of what will actually occur and is not offered as an accurate predictor of the experience of any specific IPA/medical group. It is not intended to reflect the actual cost or utilization incurred by any specific IPA/medical group, does not predict the actual costs to any specific group or patient mix, and has not been risk adjusted in any way. Each IPA/medical group recognizes that its actual utilization and unit costs will likely differ from the examples given and could be higher or lower. Each IPA/medical group should not rely on this information in evaluating its own financial risk, but, rather, should review its own patient mix, utilization, and cost information as well as other available information, consult with its own financial and actuarial advisors in evaluating the information contained herein, and make its own independent business judgment in deciding to enter into the financial risk arrangements under the Agreement based on its own independent assessment."

Appendix 12: 2023 Actuarial Cost Model

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Appendix 13: Utilization Management Timeliness Standards

Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request.	Within 5 working days of receipt of all information reasonably necessary to render a decision.	Practitioner: Within 24 hours of the decision. Member: None Specified.	Practitioner: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.

Appendix 13: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed (AKA: Deferral).	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the date additional information was requested. • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension, or the Health Plan / Provider group can provide justification upon request by the State for the need for additional information and how it is in the member's interest, not to exceed 28 calendar days from original receipt. • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date additional information was requested. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/ or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Practitioner: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

Appendix 13: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service. **Additional information incomplete or not received** • If requested information is not received by the end of the deferral period, then Blue Shield Promise will review the request with the information received.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Practitioner: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

Appendix 13: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Expedited Authorization (Pre- Service) • Requests where provider indicates or the provider group / Health Plan determines that the standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Within 72 hours of receipt of the request.	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 3 calendar days (72 hours) of receipt of the request. Member: Within 3 calendar days (72 hours) of receipt of the request. .

Appendix 13: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the provider group / Health Plan determines that the standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • Additional clinical information required.	Additional clinical information required: Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour time frame, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. • Note: The time limit may be extended by up to 14 calendar days if the member requests an extension, or if the provider group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the member's interest. **Additional information received** If requested information is received, decision must be made within 72 hours of receipt of information. **Additional information incomplete or not received** If requested information is not received by the end of the deferral period, Blue Shield Promise will review based on the information received.	Practitioner: Within 24 hours of making the decision. Member: None specified. Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension Member: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension Practitioner: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension Member: Within 2 working days of making the decision not to exceed 14 calendar days from the request for extension .

Appendix 13: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Concurrent review of treatment regimen already in place (i.e., inpatient, ongoing/ ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. **Note:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb or other major bodily function, or the normal time frame for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. **CA H&SC 1367.01 (h)(2)**	Practitioner: Within 24 hours of making the decision. Member: None specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.
Urgent Concurrent review of treatment regimen already in place (i.e., inpatient, ongoing ambulatory services). **Optional:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 72 hours of receipt of the request.	Practitioner: Within 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions).	Member & Practitioner: Within 3 calendar days (72 hours) of receipt of the request.

Appendix 13: Utilization Management Timeliness Standards

		Notification Time Frame	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Post-Service/ Retrospective Review- All necessary information received at time of request (decision and notification are required within 30 calendar days from request).	Within 30 calendar days from receipt or request.	Member & Practitioner: None specified.	Member & Practitioner: Within 30 calendar days of receipt of the request.
Hospice **Urgent** **Inpatient Care**	**Within 24 hours of receipt of request.**	Practitioner: Within 24 hours of making the decision. Member: None Specified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

Appendix 13: Utilization Management Timeliness Standards

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HEDIS Measurements

Measure	Criteria	Description
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Blue Shield Promise will audit the percentage of episodes for members ages 3 months or older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.	Dispensed prescription for an antibiotic medication on or 3 days after the episode date (i.e., the service date with the diagnosis of acute bronchitis/bronchiolitis). members diagnosed with acute bronchitis/bronchiolitis should not receive antibiotics.
Asthma Medication Ratio (AMR)	Blue Shield Promise will audit members that are 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	The member must have a ratio of controller medications to total asthma medications of at least 0.50.
Breast Cancer Screening (BCS)	Blue Shield Promise will audit members that are aged 50–74 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	The member must have at least one (1) bilateral mammogram screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
Cervical Cancer Screening (CCS)	Blue Shield Promise will audit female members that are 21-64 years of age who were screened for cervical cancer	Members who were screened for cervical cancer screening using either of the following criteria: • Women 21-64 years of age who had cervical cytology performed within the past 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30-64 years of age who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years.
Chlamydia Screening in women (CHL)	Blue Shield Promise will audit the percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia in the measurement year.	The member must have at least one (1) chlamydia test performed during the measurement year.

Appendix 14: HEDIS Guidelines

Measure	Criteria	Description
Colorectal Cancer Screening (COL)	Blue Shield Promise will audit the percentage of percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.	One or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test during the measurement year. • Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year. • Colonoscopy during the measurement year or the 9 years prior to the measurement year. • CT colonography during the measurement year or the 4 years prior to the measurement year. • Stool DNA (sDNA) with FIT test during the measurement year or the 2 years prior to the measurement year.
Appropriate Testing for Pharyngitis (CWP)	Blue Shield Promise will audit the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.	A group A streptococcus test in the seven-day period from three days prior to the Episode Date (i.e., when the member was diagnosed with pharyngitis) through three days after the Episode Date.
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	Blue Shield Promise will audit the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	At least one claim/encounter for spirometry (Spirometry Value Set) during the 730 days (2 years) prior to the IESD (Index Episode Start Date) through 180 days (6 months) after the IESD.
Pharmaco-therapy Management of COPD Exacerbation (PCE)	Blue Shield Promise will audit the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.	Dispensed prescription for systemic corticosteroid (Systemic Corticosteroid Medications List) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date. Dispensed prescription for

Measure	Criteria	Description
		bronchodilator on or 30 days after the episode date.
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Blue Shield Promise will audit the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	At least 135 days of treatment with beta-blockers (Beta-Blocker Medications List) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval. Assess for active prescriptions and include days supply that fall within the 180-day measurement interval. For members who were on beta-blockers prior to admission and those who have dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval.
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Blue Shield Promise will audit the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. Received Statin Therapy. Members were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.	The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.
Cardiac Rehabilitation (CRE)	Blue Shield Promise will audit the percentage of members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass	At least 2 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 30 days after the Episode

Measure	Criteria	Description
	grafting, heart and heart/lung transplantation, or heart valve repair/replacement. Four rates are reported: • Initiation. The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event. • Engagement 1. The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event. • Engagement 2. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. • Achievement. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.	Date (31 total days) (on the same or different dates of service). At least 12 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 90 days after the Episode Date (91 total days) (on the same or different dates of service). At least 24 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service). At least 36 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service).
Childhood Immunization Status (CIS)	Blue Shield Promise will audit the percentage of children 2 years of age who had DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and flu vaccines by their second birthday.	The member must have the following immunizations by their second birthday: • 4 diphtheria, tetanus, and acellular pertussis (DtaP) • 4 pneumococcal conjugate • (PCV) • 3 polio (IPV) • 3 Haemophilus influenza type B (HiB) • 3 Hepatitis B (HepB) • 1 measles, mumps, and rubella (MMR) • 1 chicken pox (VZV) • 1 hepatitis A (HepA) • 2 or 3 rotaviruses (RV) • 2 influenzas (flu)
Lead Screening in Children (LSC)	Blue Shield Promise will audit the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead	At least one lead capillary or venous blood test on or before the child's second birthday.

Measure	Criteria	Description
	poisoning by their second birthday.	
Controlling Blood Pressure (CBP)	Blue Shield Promise will audit members that are Aged 18 - 85 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.	Members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Hemoglobin A1c Control for Patients With Diabetes (HBD)	Blue Shield Promise will audit members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • HbA1c poor control (>9.0%).	HbA1c control <8.0%: The most recent HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review. HbA1c poor control >9.0%: The most recent HbA1c level (performed during the measurement year) is >9.0% as identified by laboratory data or medical record review.
Blood Pressure Control for Patients With Diabetes (BPD)	Blue Shield Promise will audit members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	The most recent BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.
Eye Exam for Patients With Diabetes (EED)	Blue Shield Promise will audit members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	Diabetic members must have one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year. • Bilateral eye enucleation at any time during the member's history through

Appendix 14: HEDIS Guidelines

Measure	Criteria	Description
		December 31 of the measurement year
Kidney Health Evaluation for Patients With Diabetes (KED)	Blue Shield Promise will audit the percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	Members who received both of the following during the measurement year on the same or different dates of service: • At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set). • At least one uACR was identified by both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
Statin Therapy for Patients With Diabetes (SPD)	Blue Shield Promise will audit the percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who met the following criteria. Two rates are reported: 1. Received Statin Therapy. Members who have dispensed at least one statin medication of any intensity during the measurement year. 2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	Rate 1: The number of members who had at least one dispensing event for a high-intensity, moderate-intensity, or low-intensity statin medication during the measurement year. Rate 2: The number of members who achieved a proportion of days covered of at least 80% during the treatment period.
Depression Screening and Follow-Up for	Blue Shield Promise will audit the percentage of members 12 years of age and older who were	The member must have had the following:

Measure	Criteria	Description
Adolescents and Adults (DSF)	screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	• Depression Screening: percentage of members who were screened for clinical depression using a standardized instrument. • Follow-up on Positive Screen: percentage of members who received follow-up care within 30 days of screening positive for depression

Immunizations for Adolescents (IMA)	Blue Shield Promise members that are 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Members must have the following immunizations completed by their 13th birthday:
		• At least one meningococcal vaccine (MCV) on or between the member's 11th and 13th birthday
		• At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine on or between the member's 10th and 13th birthday
		• At least two HPV vaccines with different dates of service on or between the member's 9th and 13th birthday
		  • There must be at least 146 days between the first and second dose of the HPV vaccine
		  • OR at least 3 HPV vaccines with different dates of service on or between the member's 9th and 13th birthday

Antidepressant Medication Management (AMM)	Blue Shield Promise will audit the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The	• Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication, beginning on the Index Prescription Start

Measure	Criteria	Description
	percentage of members who remained on antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of members who remained on antidepressant medication for at least 180 days (6 months).	Date (IPSD) through 114 days after the IPSD (115 total days). • At least 180 days (6 months) of treatment with antidepressant medication, beginning on the IPSD through 231 days after the IPSD.
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Blue Shield Promise will audit the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: *1. Initiation Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *2. Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	Initiation Phase: A follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date (i.e., the earliest prescription dispensing date for an ADHD medication). Continuation and Maintenance Phase: Numerator compliant for rate 1 (Initiation Phase) and at least two follow-up visits on different dates of service with any practitioner, from 31-300 days (9 months) after the IPSD.
Follow-Up After Hospitalization for Mental Illness (FUH)	Blue Shield Promise will audit the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.	A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge. A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.
Follow-Up After Emergency Department Visits	Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of	A follow-up visit with any practitioner, with a principal diagnosis of a mental health

Measure	Criteria	Description
for Mental Illness (FUM)	mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Blue Shield Promise will audit the percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported: 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.	• A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode of substance use disorder. Do not include visits that occur on the date of the denominator episode. • A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within 7 days after an episode of substance use disorder. Do not include visits that occur on the date of the denominator episode.
Follow-Up After Emergency Department Visits for Alcohol and Other Drug Abuse or Dependence (FUA)	Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

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Measure	Criteria	Description
	member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
Pharmacotherapy for Opioid Use Disorder (POD)	Blue Shield Promise will audit the percentage of new opioid use disorder (OUD) pharmaco-therapy events with OUD pharmacotherapy for 180 or more days among members aged 16 and older with a diagnosis of OUD.	New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in the treatment of 8 or more consecutive days.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Blue Shield Promise will audit the percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who have dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	A glucose test or an HbA1c test performed during the measurement year.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Blue Shield Promise will audit the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:
	1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
	2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
	3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.
		• Blood Glucose: members who received at least one test for blood glucose or HbA1c during the measurement year.
		• Cholesterol: members who received at least one test for LDL-C or cholesterol during the measurement year.
		• Blood Glucose and Cholesterol: members who received both of the following during the measurement year on the same or different dates of service.
		  ◦ At least one test for blood glucose or HbA1c
		  ◦ At least one test for LDL-C or cholesterol

Use of Imaging Studies for Low Back Pain (LBP)	Blue Shield Promise will audit the percentage of members 18-75 years of age who had a primary diagnosis of low back pain and did not have an imaging study within 28 days of the diagnosis.	Members that have had a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan).

Measure	Criteria	Description
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	Blue Shield Promise will audit the percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer.	Cervical cytology or an HPV performed during the measurement year.
Appropriate Treatment for Upper Respiratory Infection (URI)	Blue Shield Promise will audit the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.	Dispensed prescription for an antibiotic medication on or 3 days after the Episode Date (i.e., date of service with a diagnosis of URI).
Depression Remission or Response for Adolescents and Adults (DRR)	Blue Shield Promise will audit the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.	• Depression Follow-Up (Follow-Up PHQ-9): The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score. • Depression Remission. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score (PHQ-9 score of <5). • Depression Response. The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score (most recent PHQ-9 total score at least 50% lower than the PHQ-9 score associated with the index episode start date).
Developmental Screening in the First Three Years of Life (DEV)	Blue Shield Promise will audit the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	A developmental screening (CPT 96110) in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.
Adults Access to Preventive/ Ambulatory Health Services (AAP)	Blue Shield Promise will audit the percentage of Members 20 years and older who had an ambulatory or preventive care visit.	One or more ambulatory or preventive care visits during the measurement year.

Appendix 14: HEDIS Guidelines

Measure	Criteria	Description
Prenatal and Postpartum Care (PPC)	Blue Shield Promise will audit the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Women are assessed for the timeliness of prenatal care and postpartum care.	For the timeliness of prenatal care, the member must have had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with a PCP or an OB/GYN. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal visit occurred and evidence of one of the following: • Documentation of pregnancy or referencing pregnancy. • A basic physical obstetrical examination that includes auscultation for fetal heart tone or pelvic exam with obstetric observations or measurement of fundus height. • Evidence that a prenatal care procedure was performed. For postpartum compliance, the member must have had a postpartum visit or Pap test on or between 7 and 84 days after delivery.
Well-Child Visits in the First 30 Months of Life (W30)	Blue Shield Promise will audit the percentage of members who had the following number of well-child visits with a PCP during the last 15 months. 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	1. Six or more well-child visits on different dates of service on or before the 15-month birthday. 2. Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Measure	Criteria	Description
Child and Adolescent Well-Care Visit (WCV)	Blue Shield Promise will audit the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	One or more well-care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.
Frequency of Selected Procedures (FSP)	This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.	
Ambulatory Care (AMB)	This measure summarizes utilization of ambulatory care in the following categories: • Outpatient Visits including telehealth • ED Visits	
Inpatient Utilization–General Hospital/Acute Care (IPU)	This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total inpatient (the sum of Maternity, Surgery and Medicine)	
Mental Health Utilization (MPT)	This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year: • Inpatient • Intensive outpatient or partial hospitalization • Outpatient • ED • Telehealth • Any service	
Antibiotic Utilization (ABX)	This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender: • Total number of antibiotic prescriptions. • Average number of antibiotic prescriptions per member per year (PMPY). • Total days supplied for all antibiotic prescriptions. • Average days supplied per antibiotic prescription. • Total number of prescriptions for antibiotics of concern. • Average number of prescriptions PMPY for antibiotics of concern. • Percentage of antibiotics of concern for all antibiotic prescriptions. • Average number of antibiotics PMPY reported by drug class: – For selected "antibiotics of concern." – For all other antibiotics.	
Plan All-Cause Readmission (PCR)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any	At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Measure	Criteria	Description
	diagnosis within 30 days and the predicted probability of an acute readmission.	

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	Blue Shield Promise members that are 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and physical activity	Members that have had an outpatient visit with a PCP or OB/ GYN during the measurement year with the following documented:
		• Documentation of BMI Percentile, Height, and Weight
		• Counseling for nutrition
		  • Discussion of current nutrition behaviors
		  • A checklist indicating nutrition was addressed.
		  • Counseling or referral for nutrition education
		  • Anticipatory guidance for nutrition
		  • Weight or obesity counseling
		• Counseling for physical activity
		  • Discussion of current physical activity behaviors
		  • A checklist indicating physical activity was addressed.
		  • Counseling or referral for physical activity
		  • Anticipatory guidance specific to the child's physical activity
		  • Weight or obesity counseling

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	The number of members who achieved a proportion of at least 80% for their antipsychotic medications during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics –	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Documentation of psychosocial care in the 121-day period from 90 days prior to the Index Prescription Start Date through 30 days after

Measure	Criteria	Description
Total (APP)		the Index Prescription Start Date.
Initiation and Engagement of Substance Use Disorder – Engagement of SUD Treatment – Total (IET)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Initiation of SUD treatment within 14 days of the SUD Episode Date. Engagement of SUD Treatment comprises of one of the following: • SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration on the day after the initiation encounter through 34 days after the initiation event. • Long-acting SUD medication • Engagement visits and engagement medication treatment event.
Topical Fluoride for Children (TFL-CH)	The percentage of enrolled children ages 1 through 20 who received at least two fluoride varnish applications as: 1) dental or oral health services, 2) dental services, and 3) oral health services within the measurement year.	Two or more fluoride varnish applications during the measurement year, on different dates of service.
Postpartum Depression Screening and Follow Up (PDS)	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Numerator 1: Depression Screening A documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the date of delivery. Numerator 2: Follow-Up on Positive Screen Received follow-up care on or up to 30 days after the date of the first positive screen. Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in

Measure	Criteria	Description
		follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. • A dispensed antidepressant medication. OR • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. Note: For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.
Prenatal Depression Screening and Follow Up (PND)	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. • Depression Screening. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.	Numerator 1: Depression Screening A documented result for depression screening, using an age-appropriate standardized screening instrument, performed during pregnancy.

Measure	Criteria	Description
	• Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.	Numerator 2: Follow-Up on Positive Screen Follow-up care on or up to 30 days after the date of the first positive screen. Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. • A dispensed antidepressant medication. OR • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. Note: For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.

Appendix 14: HEDIS Guidelines

Measure	Criteria	Description
Prenatal Immunization Status (PRS)	The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.	Numerator 1: Immunization Status: Influenza • Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, or • Deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date. Numerator 2: Immunization Status: Tdap • Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or • Deliveries where members had anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine on or before the delivery date, OR encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. Numerator 3: Immunization Status: Combination • Deliveries that met criteria for both numerator 1 and numerator 2.
Contraceptive Care – All Women: Most or Moderately Effective Contraception (CCW-MMEC)	Among women ages 21 to 44 who had a live birth, the percentage that were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.	Women 21-44 who had a live birth who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception within 3 and 60 days of

Measure	Criteria	Description
		delivery.
Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days (CCP-MMEC60)	Among women ages 21 to 44 who had a live birth, the percentage that: 1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery. 2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	Women 21-44 who had a live birth who were provided LARC in the 3 days after delivery or within 60 days of delivery.
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate (NTSV CB)	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Patients with cesarean births.
Adult Immunization Status (AIS-E)	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster and pneumococcal.	Numerator 1—Immunization Status: Numerator 1 - Influenza members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, or members with anaphylaxis due to the influenza vaccine any time before or during the measurement period. Numerator 2—Td/Tdap members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period, or members with a history of at least one of the following contraindications any time before or during the measurement period: – Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine.

Measure	Criteria	Description
		– Encephalitis due to the diphtheria, tetanus, or pertussis vaccine. Numerator 3—Zoster members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period, or members with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period. Numerator 4—Pneumococcal members who were administered at least one dose of an adult pneumococcal vaccine on or after the member's 19th birthday and before or during the measurement period, or members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.
Enrollment by Product Line (ENP)	Blue Shield Promise will audit the total number of members enrolled in the product line, stratified by age and gender.	
Enrollment by State (EBS)	Blue Shield Promise will audit the number of members enrolled as of December 31 of the measurement year, by state.	
Language Diversity of Membership (LDM)	Blue Shield Promise will audit an unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.	
Race/Ethnicity	Blue Shield Promise will audit an unduplicated count and percentage of members	

Measure	Criteria	Description
Diversity of Membership (RDM)	enrolled any time during the measurement year, by race and ethnicity.	
Total Membership (TLM)	Blue Shield Promise will audit the number of members enrolled as of December 31 of the measurement year.	
Number of Outpatient ED Visits per 1,000 Long Stay Resident Days (HFS)	Number of unplanned hospitalizations (including observation stays) for long-stay residents per 1,000 long-stay resident days. For this measure, long-stay resident days are all days after the resident's 100th cumulative day in the nursing home. Lower percentages are better.	
Skilled Nursing Facility Healthcare - Associated Infections (HAIs) Requiring Hospitalization (SNF HAI)	The rate of HAIs that are acquired during SNF care and result in hospitalization.	
Potentially Preventable 30-day Post-Discharge Readmission (PPR)	Readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable.	

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