

Section 6: Capitated Hospital Requirements

Blue Shield Hospital and Facility Guidelines

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Section 6: Capitated Hospital Requirements

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Section 6: Capitated Hospital Requirements

Overview

The following information applies only to hospitals with Blue Shield capitated payment arrangements.

In addition to the responsibilities described in Section 2: Hospital and Facility Responsibilities, capitated hospitals must also adhere to the requirements outlined in this section.

Capitated hospitals have Blue Shield contracts under which they are paid on a per member or percentage of revenue basis to provide, or assure provision of, an identified spectrum of services to eligible HMO members. When hospitalization is needed, the member is required to secure services from the capitated hospital to which they are assigned.

For assigned HMO members, capitated hospitals or facilities are obligated to provide, or to arrange for the provision of and payment for all medically necessary services specified in the Capitated Hospital Agreement. These services usually include, but are not limited to:

- Inpatient hospital services
- Facility services for facility-based (hospital or ambulatory surgery center) outpatient surgeries/procedures
- Skilled nursing facility (SNF) services
- Home health agency/hospice services
- Ambulance services
- Durable medical equipment (DME)
- Emergency services, as specifically defined in the hospital's Blue Shield Agreement

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Monthly Eligibility Reports

As a cost-effective measure, Blue Shield provides the Combined Eligibility/Capitation Report and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables capitated hospitals to use and sort the information in many ways to meet their specific reporting needs.

The monthly Combined Eligibility/Capitation Report shows capitation details for all capitated hospitals for a specific reporting period. It includes the calculated payment amounts for all currently-eligible capitated members. This file is the supporting documentation for the Monthly Capitation Reconciliation Report for the HMO and POS products. For Blue Shield Medicare Advantage, the Combined Eligibility/Capitation Report is the supporting documentation for the hospital's wire transfer payment.

Blue Shield distributes these eligibility reports via Blue Shield secure email, or via SFTP to all capitated hospitals for the Blue Shield Medicare Advantage HMO and PPO plans (Individual and Group-MAPD), HMO, and Point-of-Service (POS) products. For details on the file formats, refer to Appendix 6-A and 6-B in the back of this manual.

Both reports include the member's name and identification number as well as the activity code for all member status changes. The files also include the member's group number and Product ID. The Product IDs are codes that identify the member's standard office visit copayments. Product IDs and Physician Office Copayment Guides for commercial HMO plans and for the Blue Shield Medicare Advantage HMO and PPO (Individual and Group MAPD) plans are forwarded each month along with the Combined Eligibility/Capitation Reports.

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Capitation

For Commercial HMO and POS members, Blue Shield will be financially responsible for all covered services provided by a capitated hospital to an ineligible person or a retroactively cancelled member for the period of time for which capitation was retroactively adjusted and who had been previously verified as eligible by Blue Shield, as long as the capitated hospital has:

- Provided documentation to Blue Shield of the eligibility error, along with the claim for services.
- Provided documentation that payment was made by the capitated hospital to the provider of service, if applicable. Documentation should include:
 - Member name
 - Member ID number
 - Place, date, and provider of service
 - A claim showing the services provided and the billed/paid amount

If the member is determined to be ineligible or retroactively cancelled, Blue Shield will reimburse the capitated hospital using the payment methodology described in the Blue Shield contract.

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Capitated Services Claims Processing

Commercial

A capitated hospital is delegated the responsibility for timely and accurate processing/payment of all capitated service claims to its providers.

Section 1371 of the Knox-Keene Act requires health care service plans and their subcontracted hospitals to reimburse all claims, professional or institutional, within 45 working days after receipt of the claim unless the claim or portion thereof is contested. If contested, the health plan or their contracted hospital must notify their claimant in writing within 45 working days as to why the claim was contested. If the uncontested claim or contested claim (after the receipt of necessary information) is not paid within the specified time period, interest shall accrue at the rate of 15% per annum for all non-emergency care, or the greater of \$15.00 for each 12-month period or portion thereof or 15% per annum for emergency care beginning with the first calendar day after the 45 working day period.

All interest due should be automatically included with the claim payment. Interest must be issued within five working days of the payment of the claim without the need for any reminder or request by the provider. If the interest is less than \$2.00 at the time that the claim is paid, the health plan or the plan's capitated provider may pay the interest on that claim along with interest on other such claims within 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 was paid is included. If interest is not paid "automatically", the required interest and a \$10.00 penalty would be warranted. Delegation continues as long as processing and payment remain compliant with statutory, regulatory, and Blue Shield standards.

Medicare Advantage/Group Medicare Advantage

A capitated hospital is delegated the responsibility for timely and accurate processing/payment of all capitated service claims to its providers. Hospitals are required to reimburse all clean unaffiliated claims, professional or institutional, within 30 calendar days after receipt of the earliest received date of the claim. If the unaffiliated clean claim is not paid within the specified time period, interest shall accrue, if applicable, at the applicable current prompt payment rate. Interest payments are only applicable to out-of-network providers. All interest due should be automatically included with the claim payment. Hospitals are required to reimburse all affiliated and unclean unaffiliated claims, professional or institutional, within 60 calendar days after receipt of the earliest received date of the claim. If unclean, the health plan or their contracted hospital must develop the claim for the missing information from their claimant. Payment/denial must be made on all unclean claims within 60 calendar days.

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Capitated Services Claims Processing *(cont'd.)*

Balance Billing

For detailed information, please refer to Appendix 6-C: Claims, Compliance Program, IT System Security and Oversight Monitoring of this manual.

Incorrect Claims Submissions

Incorrect claims submissions, also known as misdirected claims, are claims for capitated services that providers erroneously submit to Blue Shield for processing/payment instead of submitting appropriate claims or encounter reports to the capitated hospital.

Commercial

In accordance with Section 1300.71, California Code of Regulations (CCR) Title 28, Blue Shield must forward non-contracted provider service claims and/or emergency service claims that are the responsibility of the capitated hospital to the correct hospital within ten (10) working days of the original receipt date. For all other capitated hospital claims in which the provider is contracted with the hospital and that are the responsibility of the capitated hospital, Blue Shield may either send the claimant a notice of denial, with instructions to bill the capitated provider or forward the claim to the appropriate capitated provider. Blue Shield has developed a process to allow us to forward applicable claim information, for paper- and electronically-submitted claims, to the appropriate capitated hospital in the form of a facsimile. Facsimiles forwarded to the capitated hospital must be treated as a claim. If additional information is required to make the determination to pay or deny, the capitated hospital may either develop or contest the claims for the missing information. Claims may only be contested if information is missing that is necessary to process the claim. Claims cannot be contested solely because the claim is submitted on a UB 04 or CMS 1500 facsimile claim form. If a claim that is payable by Blue Shield is submitted to the capitated hospital in error, the capitated hospital must forward the claim to Blue Shield within 10 working days.

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Capitated Services Claims Processing *(cont'd.)*

Incorrect Claims Submissions *(cont'd.)*

Medicare Advantage/Group Medicare Advantage

Any claim misdirected must be forwarded to the appropriate payor. The claim processing cycle begins with the received date of the forwarding entity (earliest received date). Health plans should forward claims within ten (10) working days of the original receipt date.

If the delegated hospital is receiving a significant number of claims that are forwarded late by any entity and the volume of those late claims is enough to impair the delegated hospital's timeliness performance, Blue Shield Medicare Advantage plan will work with the entity forwarding the late claims. Documentation should be sent to your Provider Claims Compliance Auditor for support.

Third-Party Organization or Administrator Services

Capitated hospitals may elect to use the services of a third-party organization (TPO) or third-party administrator (TPA) to handle claims, encounter data collection, and reimbursement responsibilities. In such instances, the capitated hospital is responsible for ensuring that the TPO/TPA complies with Blue Shield's compliance standards and encounter data submission requirements.

Claims Compliance and Monitoring

For detailed information, please refer to Appendix 6-C: Claims, Compliance Program, IT System Security and Oversight Monitoring of this manual.

If medical services (that are the financial responsibility of the capitated hospital) are not covered because they were performed without proper authorization from the member's IPA/medical group, or are considered non-covered under Blue Shield plan benefits, or fail to meet several other criteria, the capitated hospital must notify the member or responsible party in writing of the denial. The notice must indicate the specific reason for the denial and outline the appeals process in accordance with detailed regulatory and industry standards. If the hospital issues the notice instead of the IPA/medical group, it should consult Appendix 6-C: Claims, Compliance Program, IT System Security, and Oversight Monitoring for more details. Only one denial notice may be issued for each service rendered. All secondary claims for the same service should be denied as duplicates.

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Capitated Services Claims Processing *(cont'd.)*

Prepayment Claim Review

Blue Shield providers are expected to follow accepted ethical billing practices. Blue Shield is committed to high quality, cost-effective care and monitors the coding and billing patterns of health care providers. Our monitoring program is designed to detect billing irregularities, including “unbundling” of services and procedure coding inconsistent with current standardized guidelines.

Blue Shield strives to make its claim payment policies transparent to providers. Blue Shield has implemented claims editing software systems based on industry standards, in order to pay providers fairly, accurately, consistently and in a standardized manner. Our claims editing software systems provide additional levels of automated claims adjudication.

Billing for Copayments

Commercial

With the exception of authorized copayments, billing a member for covered benefits is absolutely prohibited under the Knox-Keene Act for contracted providers of all services and non-contracted providers of emergency services. The provider of services is responsible for collecting the applicable copayments from members. Whenever the provider fails to collect the copayment at the time of service and bills the member, the bill should clearly indicate that the amount due is for the copayment only. Copayments may not be waived. Providers or the sub-contracted hospital must issue receipts to members whenever copayments are collected.

Copayment amounts are detailed in the Summary of Benefits and Coverage documents found on Provider Connection at [OWK | Blue Shield of California \(blueshieldca.com\)](https://www.blueshieldca.com).

Members are informed of their copayment responsibility in the Blue Shield *Evidence of Coverage* (EOC) provided to all Blue Shield members

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Capitated Services Claims Processing (*cont'd.*)

Billing for Copayments (*cont'd.*)

Medicare Advantage/Group Medicare Advantage

With the exception of authorized deductibles, copayments and/or coinsurance, billing a member for covered benefits is absolutely prohibited under federal law. Whenever the provider fails to collect the deductibles, copayment or coinsurance at the time of service and bills the member, the bill should clearly indicate that the amount due is for the deductibles, copayment or coinsurance only. Deductibles, copayments, and coinsurances may not be waived. Providers or the sub-contracted hospital must issue receipts to members whenever deductibles, copayments or coinsurance are collected.

Members are informed of their deductibles, copayment and coinsurance responsibility in the Blue Shield *Evidence of Coverage* (EOC) provided to all Blue Shield members.

Paper Submissions

For compliance review, submission of claim information for denied services is not required for routine review purposes unless the hospital has been directed to do so by a Blue Shield auditor or the service falls into classifications that Blue Shield's Medical Care Solutions staff requires 100% submission. For more details, please refer to Section 3: Medical Care Solutions of this manual. For encounter data submission, if the hospital submits its encounter data on paper, denied claims should be marked as such and included with those encounter claim documents for reporting purposes only.

Electronic Submissions

Claim information for denied services *must not* be included in the capitated hospital's approved monthly encounter reports, since Blue Shield is unable to identify them in the electronic format and thus cannot record them correctly for reporting purposes. Denied claim information should be sent on paper or in pre-approved report format to the address listed in the next section for all encounter submissions, along with the reason for denial.

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Encounter Data Submission

Blue Shield Organization and Procedures

Capitated hospitals are required to submit all encounter data to Blue Shield for Access+ HMO and Blue Shield Medicare Advantage plan members. This includes encounters for inpatient, outpatient, and other facility-based services for which they are capitated. This also includes information on purchased services and any downstream sub-contracted services.

Denied encounters must also be sent to Blue Shield. In addition to all allowable inpatient and hospital outpatient encounter data, denied encounter information must be forwarded by Blue Shield Medicare Advantage plan to CMS for Medicare Advantage members.

For both commercial and Medicare encounter data, submissions may be made directly to Blue Shield or via a vendor. Regardless of the route of submission, providers may request further information on facility encounter data specifications and procedures from Blue Shield at one of the contacts listed below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

Commercial and Medicare Encounter Data

For EDI questions, contact the EDI Help Desk (800) 480-1221. For encounter processing questions, call the Customer Service number on back of the member's card.

A list of approved vendors can be found on Provider Connection at blueshieldca.com/provider. Click on *Claims, Manage Electronic Transactions*, then *Enroll in Electronic Data Interchange*.

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Encounter Data Submission *(cont'd.)*

Performance – Regular and Complete Submission of Encounter Data

Monthly Submission

Blue Shield requires encounter data be submitted at least once each month and each submission must be in the correct HIPAA-compliant electronic format with usable data. Files with significant data quality problems may be rejected and require correction of problems.

Complete Submission

Blue Shield measures encounter submissions on a rolling 12 months of utilization. For Medicare Advantage encounter data submissions to the federal government (CMS), there is also a compliance measurement reflecting the data collection period. The Medicare benchmark is modified periodically to reflect changes in CMS' expectations for Medicare encounter data. Contact the appropriate Blue Shield unit to inquire about specific benchmarks.

Blue Shield requires that, on a periodic basis, an officer of the capitated facility attest to the completeness and truthfulness of encounter data submission.

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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 that you have the patient’s consent to disclose their SUD patient records to Blue Shield 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 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 <https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf>.

To learn more about the Part 2 laws and regulations, please refer to: <https://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: <https://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.

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