2019 Medicare Provider Manual

On January 1, 2019, Care1st Health Plan will change its name to Blue Shield of California Promise Health Plan.

Care1st HEALTH PLAN
An affiliate of Blue Shield of California
Until 12/31/18

blue california
Promise Health Plan
Effective 1/1/2019

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WELCOME

Thank you for being a Blue Shield of California Promise Health Plan (Care1st Health Plan until 12/31/2018, "Blue Shield Promise" or "Blue Shield Promise Health Plan") provider. As a provider you play a very important role in the delivery of health care services to our members.

The Blue Shield Promise Health Plan Medicare Provider Manual is intended to be used as a guideline for the provision of covered services to Blue Shield Promise Health Plan Medicare beneficiaries. This manual contains policies, procedures, and general reference information, including minimum standards of care that are required of Blue Shield Promise Health Plan providers. This manual also contains a brief history of the company as well as an overview of the Medicare Advantage Program, which is one of our products.

We hope this information will help you better understand our operations. This Manual is applicable to the Blue Shield Promise Health Plan Medicare line of business only. Should you or your staff have any questions about the information contained in this manual or anything else pertaining to Blue Shield Promise Health Plan, please contact our Provider Services Department at 1-800-468-9935.

We work closely with our contracted Primary Care Physicians (PCPs), Specialists, and other providers to ensure that our members receive medically necessary and clinically appropriate covered services. We are a managed care delivery system in which the PCPs serve as a "gatekeeper" for member care. PCPs are responsible for coordinating and overseeing the delivery of services to members on their patient panel. We look forward to working with you and your staff to provide quality health care services to Blue Shield Promise Health Plan members.

INTRODUCTION

Medicare History

In December 2003, the U.S. Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act, or MMA). This federal law produced the largest overhaul of Medicare in the program's 38-year history, in part by establishing the Medicare Advantage program. Most significantly, it created the Medicare Prescription Drug program, Medicare Part D. The MMA also changed the name of the Medicare managed program from Medicare+Choice to Medicare Advantage (MA). Blue Shield Promise is a Medicare Advantage organization that also provides prescription drug coverage (MA-PD).

Blue Shield Promise Health Plan is under the oversight of the Centers for Medicare & Medicaid Services (CMS), which administers the requirements governing the Medicare Advantage Program. All practitioners and providers who are contracted with Blue Shield Promise are also subject to the requirements of the Medicare Advantage Program. To be a Blue Shield Promise Health Plan Medicare Advantage practitioner or provider you must be eligible for payment by Medicare. This means that you cannot be excluded from participation in any federal health care program or that you have not opted out of the Medicare Program.

Blue Shield Promise Health Plan is a Medicare contractor and is therefore a recipient of federal payments. As contractors of an organization that receive federal funds, Blue Shield Promise Health Plan's practitioners and providers are subject to the laws and requirements of the federal government.

CARE1ST/BLUE SHIELD PROMISE HEALTH PLAN HISTORY: A TIMELINE

1994

- Care1st Health Plan ("Care1st") is established as a California corporation by three Traditional Safety Net provider groups, and two large disproportionate share hospitals, all with extensive experience in providing health care services under government sponsored as well as commercial health care programs.

1995

- Care1st receives its California full service health plan ("Knox-Keene") license.
- Care1st becomes a Plan Partner of L.A. Care.

1998

- Care1st enters into a Global Services Agreement with LA Care, to provide Covered Services to eligible Healthy Families Program ("HFP") children through 2001.

2000

- Care1st receives its own direct HFP contract from the Managed Risk Medical Insurance Board ("MRMIB").
- Care1st enters into a contract with the Department of Health Services - Dental ("DHS - Dental") to provide dental services to eligible Medi-Cal enrollees.

2001

- Care1st adopts the National Standards for Culturally and Linguistically Appropriate Services ("CLAS Standards").
- With the approval of the U.S. Bankruptcy Court, the State Department of Health Service and the Department of Managed Care, Care1st acquires the contract between Maxicare and L.A. Care. ***(December)***

2002

- Through June 2004, Care1st is designated by Managed Risk Medical Insurance Board ("MRMIB") to be the administrator of its Access for Infants and Mothers ("AIM") program. ***(March)***

2003

- Care1st is selected by the Arizona Health Care Cost Containment System (AHCCCS), the State of Arizona's Medicaid management agency to provide services to Medicaid Members in Maricopa County of Arizona.

2004

- Care1st is one of seven (out of twenty-four) health plans recognized by the DMHC, in its survey of language services, as providing the highest rated (above average) level of language assistance services to limited English proficient Members.
- Care1st is awarded a contract by the State of Arizona Department of Economic Security, Division of Developmental Disabilities in September 2004 to provide acute care services to the developmentally disabled population in Maricopa County. In addition, Care1st begins serving small employers under the Health Care Group (HCG). ***(September)***

2005

- Care1st Health Plan Arizona receives a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD Special Needs Plan (SNP). The Plan is called OneCare by Care1st Health Plan of Arizona. ***(May)***
- Care1st is awarded a contract by DHCS to provide health care services to Medi- Cal beneficiaries in San Diego County. ***(March)***
- Care1st Health Plan acquires from Watts Health Foundation (dba UHP Healthcare) its Medi-Cal, Medi-Cal Dental, Medicare and Commercial lines of business. ***(September)***
- Care1st applies for and is granted a license by CMS to be an MAPD and MAPD- SNP Plan in Los Angeles, San Bernardino and Orange County.

2008

- In 2008 Care1st Health Plan receives the Senior Choice Gold Award of Excellence for its Medicare Plan Benefits for the San Bernardino and San Diego Counties. The Care1st Medicare Advantage Plan is the only plan in San Diego and San Bernardino counties to qualify for the 2008 Senior Choice Gold Award.
- Care1st is awarded a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD and MAPD-SNP Plan in San Diego County. ***(January)***
- Care1st Health Plan was awarded a three-year Commendable accreditation from the National Committee for Quality Assurance (NCQA) for both its Medicare Advantage, and Medi-Cal plans. In addition, "Achieving an accreditation status of 'Commendable' from NCQA, is a sign that a health plan is serious about quality. It is awarded to plans whose service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement." ***(November)***

2009

- Care1st is awarded a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD Plan in Riverside County, California.
- Care1st Health Plan receives the Senior Choice Gold Award for Excellence in 2009 Medicare Plan Benefits in Riverside, San Bernardino & San Diego Counties.

2010

- Care1st is awarded a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD-SNP plan in Riverside County and as an MAPD and MAPD-SNP plan in Santa Clara County, California, effective January 1, 2011.

2011

- Care1st is awarded a contract from Center of Medicare and Medicaid Services (CMS) to provide services as an MAPD Plan Provider in San Joaquin and Stanislaus counties.
- Care1st receives a three-year Commendable Re-Accreditation from the National Committee for Quality Assurance (NCQA) for Medicare and Medi-Cal.
- Receives a three-year Medicare Advantage Deemed status from National Committee for Quality Assurance (NCQA).
- Care1st receives NCQA HEDIS Compliance Audit Seal.

2012

- Care1st receives the Senior Choice Gold Award for Excellence in 2012 Medicare Plan Benefits.
- Care1st is selected by California Department of Health Care Services (DHCS) to participate as a health plan in San Diego County's Dual Eligible Demonstration Pilot Project.

2013

- Care1st is awarded a contract from the Center for Medicare and Medicaid Services (CMS) to provide services as an MAPD and D-SNP plan in Alameda and San Francisco Counties, effective January 1, 2013.
- Care1st receives the Senior Choice Gold Award for Excellence in 2013 Medicare Plan Benefits in three counties.

2014

- Care1st is awarded a contract from Center of Medicare and Medicaid Services (CMS) to provide services as an MAPD in Fresno and Kern Counties, effective January 1, 2014.
- Care1st receives the Senior Choice Gold Award for Excellence in 2014 Medicare Plan Benefits in six counties.

2015

- Care1st Health Plan is acquired by Blue Shield of California ("Blue Shield"). The acquisition increased Blue Shield's Medicare membership and marked its entry into Medicaid and Medi-Cal, expanding Blue Shield's ability to meet the needs of this underserved segment of the population and furthering its mission.

2016

- Blue Shield of California-Care1st Health Plan introduced important changes:
  - Introduced a pilot program for 'dual eligible' individuals who have both Medicare and Medi-Cal plans. The pilot provides insights into how to make it simpler for low-income patients, who are often disabled or elderly, to get the services they need and to stay independent in their own homes and communities.
  - Converted Care1st Health Plan into a nonprofit
  - Established a working group of key stakeholders – including providers, health plans and regulators – with the goal of implementing a statewide provider-directory database.
  - Contributed $34 million to Blue Shield of California Foundation, exceeding the $14 million minimum annual requirement from the California Department of Managed Care as part of the agreement to acquire Care1st in 2015.

2017

- Blue Shield of California-Care1st Health Plan continued to expand access to care with these initiatives:
  - Added three provider groups that represent physicians and community clinics in San Diego, increasing our capacity and enhancing member access to providers and specialists.
  - Opened a post- discharge clinic in Antelope Valley, where patients are seen within a week of leaving the hospital to ensure their medical, social and emotional needs are addressed.
  - Served as a model for a new state requirement for non-medical transportation, based on Care1st's longstanding transportation program to and from appointments.
  - The San Diego Care1st Partner Plan won an award in 2017 from the California Department of Health Care Services for the greatest improvement in quality.

2018: Today

- Blue Shield Promise Health Plan (Care1st Health Plan until 12/31/2018) currently provides healthcare benefits to a combined Membership (Medi-Cal, Medicare, and Cal Medi-Connect) of over 400,000. It is recognized as a health plan making a genuine effort to ensure that the health care it provides to its diverse membership is culturally and linguistically appropriate.
- To provide enrollment assistance to the public and its members. The resource center

provides diabetes management, obesity prevention, asthma self-management, baby showers, nutritional discussions and dental decay prevention classes for the community.

MISSION

Mission:

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

SECTION 1: 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 Health Plan departments and the external provider network to promote positive communication, facilitate the exchange of information, and seek efficient resolution of provider issues. Please send all requests to your Provider Relations Representative and keep in mind that your representative is your key contact and source of information. If you are not sure who your representative is and/or need to contact us for any additional reason, you can reach us by email at ProviderRelations@blueshieldca.com or by phone at (800) 468-9935.

The following resources are available to you and your staff:

- Provider Relations Representative
- Health Educator
- Quarterly Newsletters
- Joint Operation Committee for Participating Provider Group (PPG) and Hospitals only

We encourage you to make recommendations and suggestions to better serve our Members and to improve the processes within our organization through open discussions and meetings.

1.1: Provider Manual Distribution

Provider Manuals are distributed to all new PPGs, hospitals during Joint Operation Committee Meetings and to Blue Shield Promise Health Plan direct providers within 10 Business days of placing the Provider on active status. Blue Shield Promise Health Plan will maintain documented receipt of all Provider Manuals distributed. Provider Manuals are updated annually and/or as required. Updates to our provider manual are made available online or print upon request.

1.2: Provider Orientations

Orientations are conducted by the Provider Services staff to educate new PPGs, hospitals and Blue Shield Promise Health Plan direct contracted providers on Plan operations, policies and procedures within 10 Business days of placing the Provider on active status.

PPGs:

Blue Shield Promise Health Plan's contracted PPGs are responsible for conducting provider training and orientation for its contracted providers within 10 Business days of placing the Provider on active status regardless of their effective status with Blue Shield Promise Health Plan. PPG's are required to provide evidence of 10-day training as requested by Blue Shield Promise Health Plan.

1.3: Joint Operation Committee Meetings for PPGs & 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 Health Plan and its contracted PPGs and hospitals. Blue Shield Promise Health Plan will maintain documentation of attendees and issues discussed.

1.4: Provider Affiliations

Providers may become affiliated with Blue Shield Promise Health Plan through a contracted PPG or Affiliations are limited to five (5) affiliations regardless of line of business. Both PCPs and specialists must have hospital privileges at a Blue Shield Promise Health Plan contracted hospital, unless alternative admitting arrangements are made.

1.5: Provider Network Additions

PPGs are required to provide the necessary information for the physicians and non- physicians available through the Group be submitted to Blue Shield Promise Health Plan upon notification from the listed providers below. Blue Shield Promise Health Plan maintains a database of the following types of providers participating through a PPG.

- Primary Care Physicians
- Specialist Physicians
- Ancillary Providers
- Hospitals

The addition of a PPG provider requires submission of individual hardcopy documentation to the Blue Shield Promise Health Plan Provider Services Department. See SECTION 2: CREDENTIALING for credentialing guidelines

1.6: Provider Network Changes

Provider network changes include terminations, office relocations, leave of absences/vacation, enrollment status/restrictions, and changes in PPG affiliation.

PPGs:

To comply with the CMS 30-day prior notice to affected Members policy, a provider with a demographic change must provide a minimum '60-day' advance written notification to your assigned Blue Shield Promise Health Plan Provider Relations Representative.

1.6.1: PCP Terminations

PPGs shall send written notification of all provider terminations to their appointed Blue Shield Promise Health Plan Provider Relations Representative as soon as the PPG is notified and at a minimum of 60 days in advance of the proposed date of the change. The change shall become effective the first of the next consecutive month from the date of receipt. If a 60-day notification is not received, the PCP/PPG is responsible for submitting a written coverage plan to Blue Shield Promise Health Plan and this plan shall be reviewed by the Blue Shield Promise Health Plan Medical Director. If the plan is denied, Blue Shield Promise Health Plan will work with the PCP/PPG to determine an appropriate reassignment. Blue Shield Promise Health Plan cannot guarantee that Members will remain within the PCP/PPG due to Member choice.

In all Member notification, the Members are given an option to select a new different PCP and/or PPG. Thus, Blue Shield Promise Health Plan does not guarantee the assignment to remain with their current PCP/PPG.

Blue Shield Promise Health Plan retains the right to obligate the PCP/PPG to provide medical services for existing Members until the effective date of transfer.

PPGs:

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 be transferred to an existing PCP.
2. If the terminating PCP is a solo practitioner provider and is currently affiliated with more than one PPG, the Members will be transferred to follow PCP with the PPG 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 Health Plan and/or PPG for reasons such as, but not limited to suspension of license, malpractice insurance, or Facility Site Review, the Members will remain within the PPG with an existing PCP at the PPG's discretion.

When a PPG fails to designate an appropriate provider, Members will be reassigned according to policy number 70.5.15.0.

1.6.2 : Specialist Provider Terminations

PPG shall send written notification for all provider terminations to the appropriate Provider Relations Representative as soon as the group is notified and at a minimum of 60 days in advance of the proposed date of the change. The change shall become effective the first of the next consecutive month from the date of receipt to comply with the 30-day prior notification to affected Members. For continuity of care purposes, Blue Shield Promise Health Plan retains the right to obligate the PPG to provide medical services for existing Members until the effective date of termination according to the terms of its contract with the PPG. The PPG is responsible for transition of care for all Members of terminated providers.

1.6.3 : Office Relocation

PPGs shall send written notification 60 days in advance for all office relocations to their appointed Provider Relations Representative. The PCP/PPG is responsible for submitting a coverage plan to Blue Shield Promise Health Plan, if necessary.

The provider's address will be updated, and 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 Health Plan will coordinate with the PPG to reassign the Members to a new PCP within Blue Shield Promise Health Plan's access standard of five (5) miles. In transferring Members, the provider's location, specialty and language are taken into consideration. If the PPG is unable to meet this requirement, Members will be transferred to a provider in the geographic area of the former office location.

1.6.4 : Provider Leave of Absence or Vacation

PCPs/PPGs must provide adequate coverage for providers on leave of absence or on vacation. PCPs/PPGs must submit a coverage plan to their appointed Blue Shield Promise Health Plan 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 Health Plan PCP.

1.6.5 : Change in a Provider's PPG Affiliation

PCPs may change their Blue Shield Promise Health Plan PPG affiliation by submitting written notification of their change request to the PPG that the PCP wishes to change from in accordance with their contractual agreement. A separate request is also sent by the PCP to Blue Shield

Promise Health Plan along with a copy of the notification sent to the PPG.

Blue Shield Promise Health Plan Provider Relations Representative will request validation of this information with the PPG the PCP wishes to change from in writing via Certified Mail. If no response is received from the PPG, Blue Shield Promise Health Plan will process the request in accordance to the member notification policy. The terminating PPG will be notified of the effective date of the change and will be financially responsible for any covered services provided through the effective date of the transfer.

1.6.6: Change in a Provider's Panel Status

PPG/IPA shall notify their assigned Provider Relations Representative within five (5) business days of:

- Any Provider who is no longer accepting new patients
- Any Provider who was previously not accepting new patients and is now open to new patients
- A Provider who is now available by referral only
- A Provider who is available only through a hospital or facility

A Medical Group/IPA Plan Physician who is not accepting new patients and is contacted by Plan Member or potential member seeking to be assigned shall direct the Plan Member or potential member to Plan to find a Medical Group/IPA Plan Physician who is accepting new patients and to the Department of Managed Health Care (DMHC) to report any inaccuracy with Plan's provider directory.

1.6.7: Reporting Provider Inaccuracies

Providers can review their information on Blue Shield Promise Health Plan website and submit changes to the information listed in the directories through the following:

1. Providers can promptly verify or submit changes to the information listed in the directories through the following:
    a. By telephone (800) 468-9935 Option 7
    b. Fax: (916) 350-8860
    c. E-mail at: BSCProviderinfo@blueshieldca.com
    d. Completing an online interface for providers to submit verification with requested changes generating an acknowledgment of receipt
2. For San Diego Providers:
    a. By telephone: (800) 468-9935 Option 7
    b. Fax: (916) 350-8860
    c. E-mail at: BSCProviderinfo@blueshieldca.com
    d. Completing an online interface for providers to submit verification

When a report indicating that information listed in its provider directory(ies) is inaccurate, Provider Services 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 its provider directory(ies).

When verifying a provider directory inaccuracy, Blue Shield Promise Health Plan shall, at a minimum:

a. Contact the affected provider no later than 5 business days following receipt of the report; and

b. Document the receipt and outcome of each report.

c. Documentation shall include the provider's name, location, and a description of the Blue Shield Promise Health Plan validation, the outcome, and any changes or updates made to its provider directory(ies).

Blue Shield Promise Health Plan will terminate a provider upon confirming:

a. Provider has retired or otherwise has ceased to practice;

b. A provider or provider group is no longer under contract with the plan for any reason;

c. 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.

1.6.8: Online Interface Form

The Online Interface Form is an electronic web form that contains the required provider directory information Blue Shield Promise Health Plan has on file for the provider. Providers can notify Blue Shield Promise Health Plan of changes to their demographic data by completing the Online Interface Form and/or providing an affirmative response to Blue Shield Promise Health Plan's Outreach Program, through the online interface.

1. Practitioners (i.e., physicians and other health professionals (i.e., PT, OT, podiatrist))
2. PPGs
3. Hospital and Ancillary providers

A system generated acknowledgment is automatically sent upon submission of an Online Profile Form.

1.7: Provider Verification Requirements

Blue Shield Promise Health Plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the directories and shall review and update the entire provider directories for line of business. Blue Shield Promise Health Plan will conduct outreaches to all providers, with a request to validate the accuracy of their demographic data.

1. Quarterly – PPGs provider network will be validated quarterly.
   Blue Shield Promise Health Plan validates the PPGs provider network quarterly through the 274 transaction set. The 274 is sent to the PPG requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels etc.
2. Direct contracted providers will be validated bi-annually.
   Blue Shield Promise Health Plan Direct Providers receive a Provider Confirmation Data Form bi-annually containing information listed in the database. Providers are asked to validate the information and report any changes to their record(s).

3. Annual outreach –Hospitals and ancillary providers will be notified annually. Hospitals and Facilities are validated on an annual basis. Validation forms are sent to the contracted network requesting they verify the information in our database. Minimum data elements that are validated include:
    - Facility Name
    - Address(es)
    - City, Zip Code
    - Contact Information
    - Specialty
    - Accreditation Status
    - Line of Business
    - Accepting new patients
    - National Provider Identifier Number (NPI)
    - California License Number
    - Certification Numbers

Notification:

The notification will include:

1. The information Blue Shield Promise Health Plan has in its provider directories regarding the provider including a list of network and/or lines of business that the provider participates in.
2. Instructions on how the provider can update the information including the option to use an online interface for providers to submit verification or changes electronically and which shall generate an acknowledgement of receipt from Blue Shield Promise Health Plan.

A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the provider directories is current and accurate or to provide an update to the information required to be in the provider directories including whether or not the provider is accepting new patients or not accepting new patients for each applicable Blue Shield Promise Health Plan network and/ or line of business.

1.8: PPG Specialty Network Oversight

As part of Blue Shield Promise Health Plan's pre-contractual process, a complete specialist network deemed by State and Federal regulatory is required to cover the PPG's service area. Blue Shield Promise Health Plan monitors the specialty network to identify and communicate any deficiencies to the PPG. The PPG is responsible for obtaining specialist contracts to correct these deficiencies. If the PPG is unable to correct the deficiency, the PPG may make arrangements to utilize Blue Shield Promise Health Plan's directly contracted specialists.

1.9: Changes in Management Service Organizations (PPG Only)

PPGs 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 PPG and the new MSO to Blue Shield Promise Health Plan's Provider Services Department.

The new MSO must meet Blue Shield Promise Health Plan'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 PPG/MSO to comply will result in panel closure of all providers.

1.10Provider Grievances

See Sub-Section 3.3.3: Provider Disputes under Member Appeals & Grievance Process

1.11 : Provider Directory

The Blue Shield Promise Health Plan printed and online provider directories are updated every 30 calendar days. The directory is solely used as a Member handbook referencing participation of primary care physicians, hospitals, vision providers, and pharmacies. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted PPG and/or Blue Shield Promise Health Plan Provider Relations Representative. Providers may also review their information on the Blue Shield Promise Health Plan website at www.blueshieldca.com/promise. Blue Shield Promise Health Plan is committed to ensuring the integrity of the directory to the best of its ability dependent on notification by the group.

1.12: 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 Health Plan 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 Health Plan will require that the provider give the Plan Member an immediate refund of such surcharge.

SECTION 2: CREDENTIALING

The credentialing program applies to all direct-contracted and those who are affiliated with Blue Shield Promise Health Plan through their relationship with a contracted PPG (delegated IPA/MG). Blue Shield Promise Health Plan requires the credentialing of the following providers/practitioners:

- Physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), optometrists (OD), and non-physician medical practitioners (PA, NP CNS, and NMW) employed in these practitioners' offices and who see Blue Shield Promise Health Plan members.
- Blue Shield Promise Health Plan and its delegates may also credential other allied health professionals, such as psychologists (PhD, PsyD), audiologists (AU), registered dietitians (RD), and other practitioners authorized by law to deliver health care services and who are contracted by Blue Shield Promise Health Plan on an independent basis.

Blue Shield Promise Health Plan does not credential hospital-based practitioners (i.e. radiologists, anesthesiologists, pathologists, and emergency medicine physicians) who exclusively in an inpatient setting and provide care of Blue Shield Promise Health Plan members because Blue Shield Promise Health Plan members are directed to the hospital.

Objectives

1. To ensure that all practitioners, including both direct-contracted and delegated, who are added to the network meet the minimum Blue Shield Promise Health Plan requirements.
2. Blue Shield Promise Health Plan practitioners are evaluated for, but not limited to, education, training, experience, claim history, sanction activity, and performance monitoring.
3. To ensure that network practitioners/providers maintain current and valid credentials.
4. To ensure that network practitioners are compliant with their respective state licensing agency and Medicare programs, Blue Shield Promise Health Plan has a process to ensure that appropriate action is taken when sanction activity is identified.
5. To establish and maintain standards for credentialing and to identify opportunities for improving the quality of providers in the network.

2.1 : Credentialing Policies & Procedures

Policies and procedures are reviewed annually and revised, as needed, to meet the NCQA, CMS, DMHC, state and federal regulatory bodies' requirements. Policies and procedures are reviewed by the Chief Medical Officer and submitted to the Credentials Committee and P&P Committee for review and approval.

2.2 : Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners contracted with Blue Shield Promise Health Plan. The Chief Medical Officer serves as chairman of the Credentials Committee, which is comprised of a multi- specialty panel of practitioners in the Blue Shield Promise Health Plan network, the credentialing manager, and a range of additional physicians, as needed, for their professional expertise. However, only physicians may have the right to vote in Credentialing Committee Meeting. A minimum of three (3) voting Members is considered a quorum. The Credentials Committee will meet once a month but not less than quarterly. If there is a need, 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 of direct-contracted practitioners/providers for the Blue Shield Promise Health Plan network;
- Review and approve credentialing policies and procedures and ensure that they are in compliance;
- Review and recommend actions for all network practitioners identified with sanction activities from the state licensing agency, OIG, SAM and CMS OPT-Out reports;
- Ensure appropriate authorities were reported when there is quality deficiency; and
- Ensure Fair Hearings are offered and carried out in accordance to the established policies and procedures.

2.3 : Minimum Credentials Criteria

All practitioners will be credentialed and recredentialed in accordance with the approved policies established by Blue Shield Promise Health Plan.

1. All applicants will meet the following minimum credentialing requirements and provide a comprehensive profile sheet to include:
    a. Name
    b. Professional Title
    c. Office Address
    d. Telephone & 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. 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)
    n. 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).
    o. Maintain current hospital privileges in the requested specialty at a Blue Shield Promise Health Plan contracted hospital. This requirement may be waived only if the physician arranges for another Blue Shield Promise Health Plan practitioner 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 Health Plan. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, allergy & immunology, psychology, pathology, radiology, radiation oncology, dental surgery, physical therapy, audiology, chiropractic, acupuncture and optometry).

p. Initial Approved/Recredentialed Date
q. Birth Date
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, web site URL for each service location
x. 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.
y. Be eligible to participate in the Medicare program with no sanctions;
z. Have no felony convictions.
aa. For SNP participants must complete a MOC training attestation form
ab. Be able to provide coverage to members, either personally or through appropriate physicians, 24 hours per day, seven (7) days per week.
ac. Agree to abide by Blue Shield Promise Health Plan policies and procedures.
ad. 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:
    i. Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards.
    ii. Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board; or
    iii. A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969, and had been in practice full time since, may be “grandfathered” into Family Practice.

a. A specialist provider applying as primary care provider must credentialing in the Medicare line of business and must have completed at least one year stateside training in primary care medicine (internal Medicine or Family Practice);
b. A primary care provider applying as a specialist must completed at least one year of specialized training (not in primary care medicine) in United States and provide two letters of recommendation from other primary care physicians.

c. An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine. If an OB/GYN has completed at least one year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.

d. 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).

e. Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) and American Board of Podiatric Surgery (ABPS) or completed a podiatric residency program or doctorate in podiatric medicine.

f. Optometrists (OD) are required to complete a professional degree in optometry.

g. Oral Surgeons (DDS, DMD) are required to have completed a professional degree in dentistry.

h. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), and nurse mid-wives (NMW) must have successfully completed the academic program required for the requested status. For example, a nurse practitioner must have completed a nurse practitioner academic program.

i. Allied health professionals are required to have successfully completed the professional program required for their requested specialty.

j. The HIV specialist must meet any one of the following four criteria:

   i. Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.

   ii. Board certified in Infectious Disease by the American Board of Internal Medicine (ABIM) 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 and 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; or
   - In the immediately preceding 24 months, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV, and has completed any of the following:
     - In the immediately preceding 12 months, has obtained board certification or recertification in infectious disease.
     - 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.
     - 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.

k. The HIV specialist may utilize the services of a nurse practitioner or physician assistant if:
   i. The nurse practitioner or physician assistant is under the supervision of an HIV specialist.
   ii. The nurse practitioner or physician assistant meets the qualifications specified above.
   iii. The nurse practitioner or physician assistant and the supervising HIV specialist have the capacity to see an additional patient.

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 does not satisfy minimum criteria and if there is a determined need and if there is credible evidence that the practitioner can provide the services requested.

2.4 : Recredentialing

At least every three (3) years, a practitioner must be recredentialed to maintain his/her membership with Blue Shield Promise Health Plan. Six months prior to the recredentialing due date, Credentialing Department will mail out a pre-print recredentialing application to the practitioner/provider for review. The practitioner/provider will be instructed to review and update 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. 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 Health Plan Credentialing Department by the given timeframe, a follow-up for recredentialing will be mailed to the practitioner/provider. A final follow-up will be sent to any practitioner/provider who has not returned his/her applications after 90 days from the initial mailing. The Credentials Committee and the Contracting Department will be notified of the practitioner who is non- responsive to the recredentialing requests and will follow the procedures for appropriate action, including administrative termination for non-compliance.

2.5 : Credentialing Time Limit

The credentialing and recredentialing documents must be within 180 calendar days prior to the Credentialing Committee decision.

2.6 : Credentials Process for Participating Provider Group (PPG)

PPGs that are delegated credentialing activities are required to credential and recredential medical professionals, mid-level practitioner and non-physician medical practitioners, and allied health professionals in accordance with the above Blue Shield Promise Health Plan policies and procedures, NCQA, CMS, and DMHC guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

Blue Shield Promise Health Plan retains ultimate responsibility and authority for all credentialing activities. Blue Shield Promise Health Plan assess and monitor the PPG's delegated credentialing activities as follows:

- The Credentialing Delegation Oversight Auditor will conduct pre-contractual and annual onsite audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the PPG's policies and procedures, Credentialing Committee

minutes, ongoing monitoring, quarterly reports and the PPG's credentials files. The standardized audit tool (See **Appendix 1)** will be used to conduct the audit. The PPG will be required to submit a credentialing roster with specialty, credentialing and recredentialing dates, board certification status, and forward all the required documents to Blue Shield Promise Health Plan's credentialing department at least two (2) weeks prior to the scheduled audit date.

- Blue Shield Promise Health Plan will use one of the following techniques for the file review:
  a. Blue Shield Promise Health Plan pre-delegation or annual audits will have their credentialing files reviewed based on the NCQA's 8/30 Rule. Prior to the audit, the Blue Shield Promise Health Plan auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the PPG. The Blue Shield Promise Health Plan auditor will audit the files in the order indicated on the file pull 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. After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review.
- PPG will be required to sign and abide by the credentialing delegation agreement, which is attached to the capitated group agreement.
- To be delegated and to continue delegation for credentialing, PPGs must meet the minimum standards by scoring at least 95%. If the PPG scored below 95%, a corrective action plan (CAP) is required. PPG must submit all deficiencies to Blue Shield Promise Health Plan Credentialing Department within 30 days of notification is received. After reviewing the CAP, the PPG will be sent a letter noting acceptance of the CAP or any outstanding deficiencies. The Credentialing Department will ensure the CAP meets all regulatory requirements.
- Delegated credentialing status may be terminated by Blue Shield Promise Health Plan at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
- Blue Shield Promise Health Plan retains the right to approve, suspend and terminate practitioner/providers or sites based on issues with quality of care.
- Delegated PPGs are required to submit at least a quarterly report for practitioners/providers credentialing and recredentialing activities.
- The PPG is required to review all Blue Shield Promise Health Plan practitioners/providers sanction activities within the 30 days of the report issued date and report the finding to Blue Shield Promise Health Plan as practitioners/providers are identified. The PPG is responsible to provide and assist any credentials document needed for investigation and audit which include but not limited to specific information related to a provider's training, action related to any sanctions, etc.
- The PPG is required to submit copies of originals files for selected practitioners at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audit.

2.7 : Practitioners' Rights

Practitioners 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.
- Practitioners will be notified of their rights in the initial and recredentialing application packet.

2.8 : 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. Only authorized personnel will have access to credentials files. Practitioners 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.

2.9 : Sanction Review

Blue Shield Promise Health Plan queries the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), Opt-Out Report, SAM Report and state licensing agencies at the time of initial credentialing 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 is contracted directly with Blue Shield Promise Health Plan, then the practitioner 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 is delegated to a PPG, then the affected PPG 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 PPG's response, is forwarded to the Credentials Committee for review and action.

Blue Shield Promise Health Plan also monitors the practitioner for license, DEA and malpractice insurance expiration dates. Monthly, the Credentialing Department runs a report for the medical/professional license, DEA, and malpractice insurance due to expire within the following month. License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the National Technical Information Service (NTIS) or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

2.10 Medicare Opt-Out Report

The Credentialing Department will check the Medicare Opt-Out Report to verify whether the practitioner has chosen to opt-out of Medicare. The results of the findings will be documented in the credentialing file and applicants identified on the report will not be credentialed for Medicare line of business.

2.10.1 : Summary Suspension of a Practitioner's Privileges

1. 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.
2. 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:
   a. 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.
   b. The practitioner has been suspended from the Medicare program;
   c. The practitioner fails to maintain the minimum malpractice liability coverage.
3. Should a practitioner fail to meet the minimum credentialing criteria as described above, Blue Shield Promise Health Plan will allow the practitioner a chance to correct the deficiency before inactivating the practitioner. Upon knowing that a practitioner is noncompliant, the Credentialing Department will notify the practitioner immediately in writing of the deficiency. The notification will specify the methods available for correcting the deficiency and the timeframe allowed for the submission, and that failure to correct the deficiency will result in immediate inactivation.
4. Any information regarding an adverse event will be forwarded to the Quality Improvement (QI) Department as a Potential Quality Issue (PQI) and handled in accordance with the established policies and procedures. The Chief Medical Officer has the authority to immediately suspend any or all portions of a practitioner'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 70.1.3.10 Fair Hearing Plan for detail)
5. A summary suspension of a practitioner's membership or employment is imposed for a period in excess of fourteen (14) days.
6. 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. The wishes of the patient shall be considered, where feasible, in choosing another practitioner.

Blue Shield Promise Health Plan 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. Any summary suspension or restriction of a practitioner's privileges based on a medical disciplinary action for a period of 14 days or more will be reported to the Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California through the 805 reporting process and to the National Practitioner Data Bank in accordance to Blue Shield Promise Health Plan policy. The California Business and Professions Code Section 805 define medical disciplinary cause or reason as "that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care."

2.11 : Health Delivery Organizations

1. Prior to contracting with, and at least every three (3) years thereafter, Blue Shield Promise Health Plan will re- evaluate health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, and free standing surgical centers to ensure they have appropriate structures and mechanisms in place to render quality care and services.

The evaluation process includes confirmation within 180 calendar days of the following:

a. In good standing with the state and federal regulatory bodies.

b. Current accreditation by a Blue Shield Promise Health Plan recognized accrediting bodies.

c. If the HDO is not accredited, the Blue Shield Promise Health Plan facility site review, CMS or DHCS survey is required.

SECTION 3: MEMBER SERVICES

3.1 : Covered Benefits

The benefit designs associated with the Blue Shield of California Promise Health Plan Medicare Advantage plans are described in the Summary of Benefits and the Evidence of Coverage. Electronic copies of these documents are available on the Blue Shield of California Promise Health Plan website (https://www.blueshieldca.com/promise). To request printed copies of the publications, please contact the Provider Services Department at (800) 468-9935.

3.2: Member Rights & Responsibilities

Blue Shield of California Promise Health Plan is committed to providing quality health care and to communicate the Member's Rights and Responsibilities to its Members, providers, and staff.

Blue Shield of California Promise Health Plan 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 of California Promise Health Plan informs each Member of these Rights and Responsibilities in the 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.

- Know and receive information about Blue Shield of California Promise Health Plan
- Know and receive your rights and responsibilities
- Know about our services, doctors, and specialists and be informed when your doctor is no longer contracted with Blue Shield of California Promise Health Plan
- Know about all our other caregivers
- Be able to see your medical records. You must follow the State and Federal laws that apply

You have the right to be treated well.

- Always be treated with respect and recognition of your dignity
- Have your privacy kept safe by everyone in our health plan
- Know that we keep all your information private

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

- Choose your primary care doctor
- Say no to care from your primary care doctor or other caregivers
- Be able to make choices and to participate with your provider about your health care
- Make a living will (also called an Advance Directive)
- Have an honest talk with your doctor about all treatment options for your condition,

regardless of cost or benefit coverage

- Voice complaints or appeals about Blue Shield of California Promise Health Plan or the care it provides including the right to file a grievance if you do not receive services in the language you request

You have the right to get a range of services.

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

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

- Tell us what you don't like about our health plan
- Tell us what you don't like about the health care you get
- Question our decisions about your health care
- Tell us what you don't like about our right and responsibilities policy
- Ask CMS

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

- Understand your health problems and participate in developing a mutually agreed- upon treatment goal(s), to the degree possible
- 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

3.3: Member Appeals & Grievances

3.3.1 : Member Appeals

Different CMS terminologies are used in the appeals process:

Definitions:

Organization Determination - Any initial decision made by the managed care organization regarding a service or benefit, including payment or refusal to pay for medical care or services.

Coverage Determination – initial decisions regarding Part D drugs

Reconsideration – first step in the appeal process after an adverse organization determination of Medical Care or Services (Part C)

Redetermination - appeal of an adverse coverage determination under Prescriptions Drug (Part D)

All redetermination and reconsideration decisions made by Blue Shield of California Promise Health Plan may be appealed to MAXIMUS Center for Health Dispute Resolution (CHDR), an independent review entity (IRE).

Level 1 – Health Plan Appeal

A Medicare Member or representative may file a standard appeal. To ask for a standard appeal, written appeal request must be sent to Blue Shield of California Promise Health Plan Appeals and Grievances Dept. A fast appeal may be requested by calling, faxing, or writing to Blue Shield of California Promise Health Plan. If the physician provides a written or oral supporting statement explaining that the Member needs a fast appeal, then it is automatically granted to the member. If the Member or representative asks for a fast appeal without support from the physician, Blue Shield of California Promise Health Plan will decide if Member's health requires a fast decision. If a request for fast appeal is denied, the standard appeal will apply.

For Medicare Managed Care appeals, contracted providers do not have standard appeal rights, but may request an expedited reconsideration for the member. Thus, without being a member's appointed representative, a physician is prohibited from requesting a standard reconsideration (appeal) but may expedite a member's appeal.

For Part D appeals, a prescribing physician may request an expedited redetermination without being the member's appointed representative. However, this is the only appeal that a member's prescribing physician may request on a member's behalf unless he or she is the Member appointed

representative. Thus, without being the member appointed representative a member's physician is prohibited from requesting a standard redetermination (appeal).

Level 2 – Independent Review Entity (IRE)

Unfavorable appeal decisions made by Blue Shield of California Promise Health Plan regarding a Medicare Managed Care service that is not related to Part D are auto forwarded to the IRE for "reconsideration". A request by the appealing person is not necessary for managed care.

Part D unfavorable Member decisions made by Blue Shield of California Promise Health Plan are not auto forwarded. An appeal request from Blue Shield of California Promise Health Plan to the IRE is necessary for Part D. Blue Shield of California Promise Health Plan will comply with CMS's Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Manual and Chapter 18 - Part D Enrollee Grievances, Coverage Determinations, and Appeals Manual. The timeframes for filings and resolutions will be adhered to. Appeals should be filed within sixty (60) calendar days from the date of the initial determination. Appeals on behalf of the member must be in writing and state with specificity the action being appealed and what resolution is being requested. The provider should provide documentation supporting the Member's position. Providers are encouraged to exhaust all other available means of resolving an issue before filing a dispute.

Decisions will be issued in writing within the time frame allowed for the kind of appeal requested and approved by the health plan. Standard decision for a Part D drug that has been paid for and received is within 7 calendar days of receiving the appeal request; expedited decision for Part D that has been received is rendered within 72 hours after the appeal request is received, or sooner if health condition requires. Any decisions not given within these required timeframes automatically go to Level 2.

For Part C medical care or services, requests for payment of services already received are made within 60 days. For a standard decision for Part C that has not been received, the decision is given within 30 days, plus additional 14 days if an extension is requested. For expedited appeals for Part C for services not yet received, a decision is rendered within 72 hours or sooner if the health condition requires. If an extension is requested, an additional 14 days is given to make the decision. If no decision is rendered during the required timeframe or at the end of extended time period, the appeal automatically goes to Level 2.

If a provider disagrees with the resolution of a matter, CMS guidelines for appeals of health plan redeterminations and reconsiderations will be adhered to. Appeal rights will be provided as appropriate with health plan decisions.

3.3.2: Member Grievances

PURPOSE

Blue Shield of California Promise Health Plan has established a system for Members to communicate problems and concerns regarding their health care and to receive an immediate response through the Plan's grievance system. This is outlined in the Member Grievance Policy and Procedure Manual, which may be obtained from Blue Shield of California Promise Health Plan. There are 2 categories of Grievances:

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

PROCEDURE

Members are encouraged to speak with their PPG/PCP regarding any questions or concerns they may have. Members may also communicate their concerns directly to Blue Shield of California Promise Health Plan Member Services by telephone at 1-800-544-0088 (TTY 1- 800-735-2929), in writing, by e-mail, or in person.

Grievances can be filed by telephone, in writing, or in person no later than 60 calendar day after the event. Blue Shield of California Promise Health Plan will acknowledge receipt of all written formal grievances within five (5) business days. Blue Shield of California Promise Health Plan will resolve grievances within 30 days and/or as expeditiously as the enrollee's health status requires but no later than 30 calendar days from the date the oral or written request is received unless as extension is made and documented in the best interest of the enrollee and provides prompt notification to the enrollee when a 14-day calendar extension is taken. Blue Shield of California Promise Health Plan will provide a resolution letter in writing to the Member. Providers and PPGs are required to provide medical records, authorizations or responses within 7 calendar days of the request to resolve the grievance within the regulatory timelines.

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 of California Promise Health Plan is responsible for establishing and administering grievance procedures. The PPG and/or the PCP must participate with Blue Shield of California Promise Health Plan 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.

Expedited Grievance: The member may request an expedited grievance when the member disagrees with the decision not to expedite an appeal. In this situation, they can file a "*fast complaint"* with the health plan's refusal to expedite an appeal as the member feels that the appeal meets criteria to be expedited.

Blue Shield of California Promise Health Plan responds to an enrollee's expedited grievance request within 24 hours when Blue Shield of California Promise Health Plan invokes an extension relating to an organization determination or reconsideration or the complaint involves a refusal by Blue Shield of California Promise Health Plan to grant an expedited organization determination or reconsideration.

The complaint involves an MA organization's decision to invoke an extension relating to an organization determination or reconsideration. The complaint involves an MA organization's refusal to grant an enrollee's request for an expedited organization determination under CMS Managed Care Manual Chapter 13, Sections; §422.570 or reconsideration under§422.584

3.3.3 : Provider Disputes

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 42 CFR §405.1200 et.seq.

3.3.3.1 : Provider Questions, Concerns and Disputes

Providers can communicate questions and issues to the Blue Shield of California Promise Health Plan Provider Services Department or Provider Dispute Department by telephone, in writing, or in person. Many of these issues can be addressed very quickly following a brief investigation. Issues that cannot be resolved within one day or involve quality of care issues will be logged as a dispute. Examples of disputes are issues relating to noncompliant Members, non- payment or underpayment of claims by Medical Groups/PPGs. All disputes entered in the provider dispute database will be investigated and a response will be provided in writing.

3.3.3.2: Reconsiderations

A provider will have the ability to furnish the Blue Shield of California Promise Health Plan 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.

PROCEDURE FOR RECONSIDERATION:

1. A provider requesting reconsideration may call, fax, or submit in writing any additional information to the Blue Shield of California Promise Health Plan UM Department to support the original authorization request. The fax number to the UM Department is: 323- 889-6219**.**
2. A reconsideration request will occur within one (1) business day upon receipt of the provider telephone call, written or faxed request.
3. The additional information will be reviewed by the Chief Medical Officer (CMO) of Blue Shield of California Promise Health Plan or his/her designated physician reviewer.
4. If the CMO or designated physician reviewer reverses the original determination based on additional information provided by the provider, an approval letter will be sent to the provider and the Member.
5. If reconsideration does not resolve a difference of opinion, the provider may then submit an appeal and/or grievance in writing to the Provider Dispute Department.

3.3.3.3 : Provider Disputes Policy and Procedure

Non-contracted providers:

Non-contracted providers must include a signed Waiver of Liability (WOL) form holding the enrollee harmless regardless of the outcome of the appeal. If a signed WOL form is not submitted along with appeal letter, Blue Shield of California Promise Health Plan will make reasonable attempts to fax/ call provider to request for a signed WOL form. If a signed WOL form is not received by the 60th calendar day of receipt of the appeal, a dismissal letter will be sent to provider.

Waiver of Liability form can be obtained through the link below:
https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Appendix-7-Waiver-of-Liability-Notice.pdf

Contracted providers and non-contracted providers:

Providers may submit a written dispute to the Blue Shield of California Promise Health Plan Provider Dispute Department. Disputes may pertain to such issues such as authorization or denial of a service; nonpayment or underpayment of a claim; or disputes with our delegated entities. 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 15 working days of receiving the written dispute.

All provider disputes must be submitted in writing. If a provider attempts to file a provider dispute via telephone, Blue Shield of California Promise Health Plan staff will instruct the provider to submit the provider dispute to Blue Shield of California Promise Health Plan in writing.

A provider can submit a provider dispute in writing to Blue Shield of California Promise Health Plan by mail, e- mail or fax. All provider disputes are forwarded to the Appeal and Grievance Unit for processing.

3.3.3.4 : First Level Appeal

A provider may appeal a denial decision made by Blue Shield of California Promise Health Plan or one of its PPG's. Blue Shield of California Promise Health Plan will refer clinical provider appeals and other appropriate cases for clinical review.

When the appeal is referred for clinical review, the clinical reviewer shall evaluate the medical records and submit his/her findings and recommendations to the Physician Reviewers for approval:

> Provider Dispute Department will acknowledge and review all written requests. An acknowledgement letter will be submitted to provider within 15 working days of receipt of the appeal. A written letter of resolution outlining its conclusions with background information will be sent to provider within 45 working days of receipt of the appeal for contracted provider, within 30 calendar days of receipt of the appeal for non- contracted provider disputes and within 60 calendar days of receipt of the appeal for non- contracted provider appeals. Language in the letter will include the next appeal steps the provider can take to purse the dispute. Blue Shield of California Promise Health Plan shall retain all documentation related to the clinical review for a minimum of (5) five years.
>
> Please submit written provider disputes resolution requests to:
>
> Blue Shield of California Promise Health Plan
> ATTN: Provider Dispute Dept
> PO Box 3829
> Montebello, CA 90640

SECTION 4: ELIGIBILITY AND ENROLLMENT

To be eligible for enrollment at Blue Shield of California Promise Health Plan, the applicant must be entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date. In addition, enrollees in the Blue Shield of California Promise Health Plan Dual Special Needs Plan must be eligible for Medicare Parts A, B & D and Medicaid. Blue Shield of California Promise Health Plan does not discriminate against enrollees based on their health status. Each application received will be reviewed and processed according to CMS (Center for Medicare and Medicaid Services) regulations and guidelines.

Enrollees must reside within the CMS approved service area (defined by zip code) for Blue Shield of California Promise Health Plan. Enrollees who reside outside the approved service area will be denied enrollment. While a P.O. Box may be used for a mailing address, the enrollees must reside within the Blue Shield of California Promise Health Plan service area. In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

Enrollees with End-Stage Renal Disease (ESRD) would not be eligible unless they have received a transplant that restored kidney function and they no longer require a regular course of dialysis to maintain life (they would not be considered to have ESRD for purposes of Medicare Advantage (MA) eligibility). Such an individual may elect coverage in an MA plan if the individual makes an election during an election period and submits proper documentation from their physician that the individual has received a kidney transplant and no longer requires a regular course of dialysis to maintain life.

4.1: Provider Selection

The Enrollment Specialist will verify the provider and PPG chosen on the application. In general, if the Primary Care Physician (PCP) is confirmed as active in the system and accepting new members, then the chosen provider will be honored. The patient provider relationship is very important so in any circumstance where the chosen PCP and/or PPG cannot be met, then the enrollee will be contacted by Blue Shield of California Promise Health Plan's Member Services Department to review further options.

If for example, the PCP is not active or not accepting new Members, the enrollee is contacted to inform him/her that the PCP chosen is inactive and with the PCP, then asked to make another choice. If the application does not list a PCP, the enrollee is contacted to choose a PCP.

4.2: Change of Primary Care Physician

4.2.1 : 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 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.

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 of California Promise Health Plan Customer Service and Inquiry Module database by Member Services for future reference.

4.2.2: PCP Initiated Change

Occasionally, 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 of California Promise Health Plan 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, the Blue Shield of California Promise Health Plan Chief Medical Officer 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 of California Promise Health Plan 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 of California Promise Health Plan will contact and reassign the member according to their choice considering geographic location, linguistic congruity, and other variables.

4.3: Eligibility List

Each Blue Shield of California Promise Health Plan Participating Provider Group “PPG” and directly contracted primary care physician is provided an eligibility file monthly of all 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 contains at the minimum but not limited to the following information listed below. *Providers participating with Blue Shield of California Promise Health Plan through a delegated PPG will receive eligibility within the format and timeframe established by the PPG.*

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. PPG Effective Date
12. Sex
13. Special Remarks

4.4: Identification Cards

Blue Shield of California Promise Health Plan will furnish each new Member an Identification Card within the first seven (7) days of enrollment.

The member identification card is for identification purposes only and does not guarantee eligibility for Blue Shield of California Promise Health Plan providers. You should always refer to your Eligibility List for current eligibility information, log on to Blue Shield of California Promise Health Plan e-link to verify eligibility. If necessary, you may contact your Provider Network Administrator or call Blue Shield of California Promise Health Plan Member Services for eligibility verification.

4.5: Disenrollment

Disenrollment refers to the termination of a Member's enrollment with Blue Shield of California Promise Health Plan. It does not refer to a Member transferring from one primary care physician to another.

Typically, Medicare Advantage members may disenroll from Blue Shield of California Promise Health Plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Disenrollment Period from January 1 through February 14 of each year. Following this date, Members are "locked-in" throughout the benefit period.

For individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program, CMS allows individuals to enroll in, or disenroll from, an MA plan, on a continuous basis. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid.

Under certain circumstances it may be mandatory to disenroll a Member from Blue Shield of California Promise Health Plan. Some circumstances include but are not limited to:

- The member loses entitlement to either Medicare Part A or Part B
- The SNP enrollee loses special needs status and does not reestablish SNP eligibility within the CMS allowable timeframe.
- Relocation of the Member outside of Blue Shield of California Promise Health Plan's service areas.

SECTION 5: UTILIZATION MANAGEMENT

5.1 : Utilization Management Program

The role of the Utilization Management (UM) Department is to ensure consistent delivery of high-quality health care services to our Members through Blue Shield of California Promise Health Plan affiliated providers. Health care services are provided through full and shared risk networks structured to provide a continuum of care. The UM Department functions include authorization of the facility component for inpatient and outpatient procedures, home health, inpatient concurrent reviews, discharge planning, and retrospective reviews. Referrals for specialty care, diagnostic testing and other ancillary providers are reviewed by the PPG. If you have any questions regarding to whom you should submit a referral request, please contact your PPG.

Blue Shield of California Promise Health Plan makes Utilization Management (UM) decisions only on appropriateness of care and service, based on the current Evidence of Coverage and the community standard of care. Blue Shield of California Promise Health Plan does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives that would encourage UM decision makers to make decisions that would result in underutilization of services.

Blue Shield Promise Health Plan contracted PPG's may only utilize Blue Shield Promise Health Plan approved criteria as listed below. PPG's must first use either CMS Local Coverage Determinations (LCD) or CMS National Coverage Determination (NCD) for medical necessity determination. If an NCD or LCD is not available for the service being requested, the PPG may use one of the other guidelines listed below to establish whether a service is **reasonable and necessary.** The following is a complete list of the Blue Shield of California Promise Health Plan approved guidelines or sources that may be utilized for issuing approvals, denials or modifications. PPG/MSO Internal Policy or guidelines should not be used for any medical necessity determination on a Blue Shield Promise Health Plan member all benefit denials should either reference a CMS source or the Blue Shield of California Promise Health Plan Explanation of Coverage (EOC)

Medicare
CMS Local Coverage Determinations (LCD)
CMS National Coverage Determinations (NCD)
MCG 21st Edition
Apollo 16th Edition
Up to Date
National Guideline Clearinghouse
Inter-Qual
Hayes
NCCN

These criteria alone cannot ensure consistent UM decision making across the organization. Blue Shield of California Promise Health Plan recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan's review process. The UM review criteria are available for disclosure to providers, Members, and the public upon request either in writing or by contacting the Blue Shield of California Promise Health Plan UM Department at 1-800-468-9935.

Blue Shield of California Promise Health Plan uses nationally recognized clinical criteria to make UM decisions. These criteria are available to you upon request, by contacting 1-800-468-9935.

5.2: Authorization and Review Process

5.2.1: Authorization Timeframes

Inpatient and outpatient referral requests received from primary care and specialty care physicians shall be processed by the PPG according to the following designated time frames:

Standard – decision within 14 calendar days from the date of request; notification within 14 calendar days after the receipt of request.

Expedited (no extension) – decision within 72 hours from the date of the request (including weekends and holidays); notification within 72 hours after receipt of request.

Termination from Home Health Agency (HHA), Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF) – decision and Notice of Medicare Non-Coverage delivery no later than 2 calendar days or 2 visits before coverage ends.

NOTE: Clean referrals are those referrals that contain adequate documentation and/or information to medically support the request, such as patient history to date, current symptoms, proposed treatments etc. If the information submitted is not adequate, the determination will be based upon the available information and/or lack of medical information. To expedite the process and to ensure appropriateness of the decision, it is very important that relevant clinical information be submitted with the request.

Request for Extensions:

Blue Shield of California Promise Health Plan may extend the decision time frame up to 14 calendar days. This extension is allowed if the enrollee requests the extension or if the provider or organization can justify a need for additional information and documents how the delay is in the best interest of the enrollee (for example, the receipt of additional medical evidence from non-contracted providers may change Blue Shield of California Promise Health Plan's decision to deny). There are no extensions for collecting existing information from contracted providers.

Expedited Initial Organization Determination (EIOD):

When processing EIODs, it is necessary to determine if the expedited request is deemed to be expedited:

a. If expedited criteria are not met – the standard determination timeframe applies; give Member oral notice of the denial of expedited status and explains that the request will be processed using the 14-day timeframe. Follow the notification with written notice within 3 calendar days of the oral notice. The UM Department staff notifies the Member orally, then sends the standard denial letter informing the Member that the request did not qualify for expedited request and therefore, will be processed using 14 day-timeframe.

b. If no extension – decision within 72 hours of receipt after receipt of request (includes weekends and holidays); notification within 72 hours after receipt of request.

c. If extension requested – decision may extend up to 14 calendar days; written notification within 72 hours of receipt of request.

The physician reviewer rendering the determination will be available to discuss the decision with the requesting providers. The reviewer is available by calling (800) 468- 9935.

Blue Shield of California Promise Health Plan provides written notification to Members and practitioners a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. Blue Shield of California Promise Health Plan notifies Members of the reason for the denial in clear and understandable language.

5.2.1. a: Appeal Rights

When health care service is denied, the practitioners are notified of the appeal process. It includes the following:

1. Description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal;
2. Explanation of the appeal process, including the right to Member representation and time frames for deciding appeals;
3. Description of the expedited appeal process for urgent pre-service or urgent concurrent denials

   (Please see section 3.3 – Member Appeals and Grievances)

Please see Appendix 3 for the Utilization Management Timeliness Standards

5.2.2: Authorization Validity

Authorizations are generally approved for 30 days with a disclaimer stating that authorizations are valid only if the Member is eligible on the actual date of service. Blue Shield of California 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 Member Services at 1-800-544-0088.

Providers are responsible for re-verifying eligibility and obtaining an updated authorization once the authorization has expired.

5.2.3: Specialty Referrals

PCPs are responsible for providing all routine health care services, including preventive care, to their enrolled Members. However, Blue Shield of California Promise Health Plan recognizes that in many circumstances 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 PPG's UM Department for review and authorization except for services established as no prior authorization required under the direct referral process. Please refer to **APPENDIX 7** for the listing of services.

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. This log must be completed by indicating the date when the consultation report was received, and whether the Member made it to the appointment or not. The office must have a process for recalling patients if the Member missed the appointment.

The specialist is required to send a completed consultation report to the PCP.

After review of the consultation results and recommendations, the PCP may request additional treatment authorization if clinically indicated.

5.2.3: 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 Member's assigned PPG's UM Department for review and authorization. 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.

5.2.5: Outpatient Services

Ambulatory services and outpatient surgery procedures require authorization by the Member's assigned PPG's UM Department.

5.2.6: Elective Admission Requests

All elective inpatient admissions require an authorization by the Blue Shield of California Promise Health Plan UM Department. Requests for elective inpatient admissions should be submitted to the Member's assigned PPG's UM Department. These requests will then be forwarded to the Blue Shield of California Promise Health Plan UM Department for final authorization.

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

5.3: Emergency Services & Admissions Review

An "emergency medical condition" is defined as 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 (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

5.3.1 : Emergency Care

Blue Shield of California Promise Health Plan Members are entitled to access emergency care without prior authorization. However, Blue Shield of California Promise Health Plan requires that when an enrollee is stabilized, but requires additional medically-necessary health care services, providers must notify Blue Shield of California Promise Health Plan prior to, or at least during, the time of rendering these services. Blue Shield of California Promise Health Plan wishes to assess the appropriateness of care and assure that this care is rendered in the proper venue.

5.3.2: 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 care or soon after as possible.

5.3.3 : Business Hours

Blue Shield of California Promise Health Plan UM Department is available via telephone from 9:00 a.m. to 6:00 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) to give him/her the opportunity to direct or participate in the management of care.

5.3.4: Medical Screening Exam

Hospital emergency departments under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all Members presented to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Blue Shield of California Promise Health Plan 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.

5.3.5: After Business Hours

After regular Blue Shield of California Promise Health Plan 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. For information other than eligibility requests, the call service will cross connect the caller to a Blue Shield of California Promise Health Plan On-Call Nurse.

The following are some of the key services that the on-call Case Managers will provide:

- Issue urgent/emergent treatment authorization numbers to providers.
- Act as a liaison to PCPs, specialists, and other providers to ensure timely access and the coordination of follow-up care for Member's post emergency care.
- Facilitate Member transfers from emergency departments to contracted hospitals.
- Arrange facility transfer ambulance transport services.
- Assist Members with non-emergent transportation services for weekend appointments when needed.
- Provide network resource information to Members and providers.
- Assist in pharmacy issues.
- Link Blue Shield of California Promise Health Plan contracted physicians to ED physicians when necessary.

For additional support the on-call nurse has access to the Chief Medical Officer (CMO), or an alternate covering physician, to assist in physician related issues.

Upon receipt for a request for authorization from an emergency provider, a decision will be rendered by Blue Shield of California Promise Health Plan 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.

Nurse Advice Line

Blue Shield of California Promise Health Plan Medicare Members can access the Nurse Advice Line to receive fast and free medical advice over the phone. Registered nurses are available 24 hours a day – 7 days a week, including weekends and holidays. Members can call the nurse advice line at 1-800-609-4166.

5.3.6 : Urgent / Emergent Admissions

Prior authorization is not required for emergency admissions (see Emergency Services for definition of "Emergency Medical Condition"). However, authorization should be attempted for urgent admissions. If the admitting physician is not the Member's PCP, the PCP should be contacted prior to admission when possible.

Plan Notification

All contracted per-diem hospitals must notify the Blue Shield of California Promise Health Plan UM Department of inpatient admissions to the Blue Shield of California Promise Health Plan UM Department by faxing the hospital admission (face) sheets within 24 hours of admission, except for weekends and holidays. Upon receipt of the hospital admission sheet, the UM Department will record a tracking number on the hospital admission sheet and fax it back to the hospital. The hospital admission sheet comes from the hospital.

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 concurrent and/or retrospective review procedures.

5.3.7 : Concurrent Review

Blue Shield of California Promise Health Plan 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 of California Promise Health Plan. Review may be performed on-site or may be done telephonically. Authorization for payment of inpatient services is generally on a per diem basis. The authorization is given for the admission day and, on a day to day basis thereafter, contingent on the condition that the inpatient care day has been determined to satisfy criteria for that level of care for that day. Any exceptions to this (i.e., procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment.

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 chart, or the hospital Utilization Review (UR) Nurse. The Case Manager will compare the clinical presentation to pre-established criteria (MCG Guidelines). If the criteria are satisfied, an appropriate number of days will be authorized for that stay. If the Member remains inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized for elective admissions 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 CMO.

5.3.8: Discharge Planning

The purpose of discharge planning is to identify, evaluate and coordinate the discharge planning needs of Blue Shield of California Promise Health Plan 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. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process.

The goal of the discharge planning process is to follow Members through the continuum of levels of care until the Member is returned to his/her previous living condition prior to hospitalization, when possible. This approach is performed to ensure continuity of care and optimum outcomes for Blue Shield of California Promise Health Plan Members.

Multiple factors are taken into consideration to effectively evaluate the Member's clinical and psychosocial status for discharge needs. This includes the active problem, clinical findings, Member's past medical history and social circumstances, and the treatment plan.

If the PCP was not the Attending Physician of the Member while hospitalized, all efforts will be made to notify him/her of any arrangements made for the Member. 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 of California Promise Health Plan UM Case Manager
- Inpatient Hospital Notification Form faxed by the Case Manager

5.3.9 : Retrospective Review

Blue Shield of California Promise Health Plan 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 Case Manager does not receive sufficient information to meet the criteria (MCG Guidelines). When this occurs, the case will be pended for a full medical record review to the CMO or designated physician reviewer.

All retrospective review referrals are to be turned around within 30 business days after 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.

5.4: Direct Access to Women's Health Services

Blue Shield of California Promise Health Plan provides for direct access to women's health services for routine and preventive health care services such as annual well woman exams,

These services must be provided by a Gynecologist within the PPG network. These services do not require prior authorization. Any treatments, procedures or surgeries that are recommended as a result of this evaluation will require prior authorization from the PPG.

5.5: Advance Directive

Blue Shield of California Promise Health Plan implements policies and procedures on advance directives for its Members and allows a Member's representative to facilitate care or treatment decisions for a Member who is unable to do so. Blue Shield of California Promise Health Plan allows a Member or Member's representative to be involved in decisions about withholding resuscitative services or declining/withdrawing life- sustaining treatment.

5.6: Care Coordination and Integration

Blue Shield of California Promise Health Plan facilitates access to care for Members with specific care needs which includes arrangements with community and social services programs. This includes transition to and coordination of care by contracted and non-contracted providers. Blue Shield of California Promise Health Plan Case Managers implements procedures to ensure that services are appropriately coordinated. Blue Shield of California Promise Health Plan educates providers about coordinated Medicare benefits for which Members are eligible and about Members' special needs.

5.7: Non-discrimination in Healthcare Delivery

Blue Shield of California Promise Health Plan ensures that Members are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

5.8: Clinical Practice Guidelines

Blue Shield of California Promise Health Plan, in collaboration with the Blue Shield of California Promise Health Plan Medical Services Committee, approves clinical practice guidelines that are available for physician reference. Please contact the Blue Shield of California Promise Health Plan Quality Management Department if you would like to receive these guidelines.

The current set of clinical practice guidelines include:

- Cardiac Care Guideline
- COPD Care Guideline
- Asthma Management Guideline
- Diabetes Management Guideline
- Attention Deficit Hyperactivity Disorder (ADHD) Guideline
- Major Depressive Disorder Guideline
- Major Depressive Disorders Unique to Women Guideline
- Schizophrenia Guideline

Clinical Practice Guidelines

Clinical Practice guidelines provide evidence-based recommendations for the assessment and treatment of various disorders. Additionally, the Clinical Practice Guidelines are reviewed and approved every two (2) years through our Medical Services Committee.

All guidelines used for the Blue Shield of California Promise Health Plan CARES Disease Management Program are nationally recognized and represent appropriate standard of care for each condition.

Disease Management Program

Blue Shield of California Promise Health Plan provides a Disease Management Program that oversees and manages a defined Member population with chronic conditions by the consistent application of approved guidelines and criteria to achieve optimum Member outcomes with a focus on Member self-care efforts.

The intent of the Disease Management is to enhance quality of life and activities of daily living, improve the disease pathway, to reduce health care service usage and costs associated with avoidable complications, such as emergency room visits and hospitalizations.

A focus of the program is to ensure a standardized approach in providing an educational pathway to assist Members with management of their chronic condition(s).

Blue Shield of California Promise Health Plan Disease Management establishes on-going dialog and one-to-one communication with Members to assist in setting goals, developing actionable care plans, motivating the Member to succeed by achieving bench marks in their care and encouraging Members to make the right choices regarding lifestyle changes. This Program is designed to inspire Members to participate actively in the management of their chronic conditions and focuses on improving the Member's health and quality of life. Optimal care implementation can lead to measurable reduction in costs and improved outcomes.

Blue Shield of California Promise Health Plan Disease Management is considered a multidisciplinary, continuum- based approach to the delivery of health care, proactively identifying distinct populations with a chronic condition considered high-risk. Chronic conditions included in the program are Chronic Lung Disease, Congestive Heart Failure, Diabetes, and Coronary Artery Disease. It reinforces the Member-practitioner relationship, prescribed plan of care with a focus on Member self-management, prevention of condition exacerbation, understanding signs and symptoms, various lifestyle choices, medication management, and minimizing complications through the application of evidence-based practice guidelines within a structured program. The Blue Shield of California Promise Health Plan Disease Management Program continuously assesses the Member's clinical condition and reinforces a Member empowerment approach to improve overall health status through shared decision-making.

The Blue Shield of California Promise Health Plan Disease Management Program content addresses the following for each disease condition:

- Condition monitoring:
  - Includes Member reminders for self-monitoring tests or practitioner office testing
  - Initial and ongoing assessments by the Case Manager to assess how well the high-risk Member is managing their care
  - Quality of life/functional status questions included in assessment
  - Symptom monitoring
- Adherence to treatment plans:
  - Includes adherence to self-monitoring activities, medication adherence and scheduled practitioner visits
  - Telephonic calls to Member by the Case Manager to assess:
    - Adherence to medications
    - Preventative care

        - Disease specific education
            - Action plan
            - Daily treatment plan
            - Recognize signs and symptoms of worsening condition
            - Keeping appointments with providers
            - Community education classes
            - Educational mailings
            - Enhance communication between Member and Providers
- Consideration of other health conditions:
    - Assessing co-morbidities, cognitive/functional status
- Lifestyle issues
    - Addresses factors effecting chronic condition(s)
    - Targeted mailings and telephonic interventions including:
        - Smoking cessation
        - Nutrition
        - Triggers
        - Medication compliance
        - Obesity
        - Lack of exercise
        - Alcohol/drug abuse

Blue Shield of California Promise Health Plan Disease Management Program interaction with Members is conducted either telephonically and/or via written correspondence.

Medicare: CHF & COPD

Medi-Cal: Asthma & CHF

Please feel free to contact the Utilization Management Department if you have additional questions at 800-468-9935.

Blue Shield of California Promise Health Plan Transitional Care Management Program

It is clearly established that hospital readmissions contribute significantly to the health care costs for the Medicare program. The most vulnerable Members affected by this problem are our Special Needs Plan (SNP) Members. CMS requires that all SNP Plans have a Care Transition Program in place.

Blue Shield of California Promise Health Plan's Transitional Care Management (TCM) Program has been developed to meet all CMS requirements and deliver high quality care to our SNP Members during transition of care episodes. A care transition is defined as any time a Member moves from one care setting to another. Anytime a Member is admitted from home to the hospital or discharged from the hospital to the Skilled Nursing Facility and eventually back home they are experiencing a care transition.

Blue Shield of California Promise Health Plan's care transition team is comprised of Case Managers, Social Workers, Pharmacists, Physicians and Care Coordinators. This team will work closely with the

Member and/or caregivers to assist them through each care transition concurrently. Every time a care transition occurs, the PCP will be notified in writing. Once the Member transitions to their home, the Care Manager will call the Member and perform a comprehensive hospital discharge assessment and medication reconciliation. The Care Manager will also assist the Member with making an appointment to see the PCP and or any specialists needed. Copies of both the Hospital Discharge Assessment and a Medication Reconciliation Form will be mailed to the PCP.

We are confident that this program will be successful in lowering our readmission rates and improving the quality of care our SNP Members receive.

Please visit our website so you may review the various forms and documents both our Members and physicians will be receiving.

https:/ www.blueshieldca.com/promise/provider/transition-program.asp

Model of Care – Special Needs Plan

The Centers for Medicare & Medicaid issued final regulations on the Medicare Improvements for Patients and Providers Act of 2008, also known as MIPPA. As part of this regulation, the Special Needs Plan Model of Care has been implemented as of January 1, 2010.

The SNP Model of Care requires that all SNP Members receive an initial Health Risk Assessment (HRA) within 90 days of enrollment, and that an Individualized Care Plan (ICP) be created for each Member. The ICP will be developed and shared with the Member, the PCP and any other parties involved in managing the Member's care such as PPG case managers or social workers. The purpose is to encourage the early identification of the Member's health status and allow coordinated care to improve their overall health.

HRA Process:

Blue Shield of California Promise Health Plan has created a standardized HRA that evaluates the physical, psychosocial, cognitive, and functional needs of the SNP Member. Blue Shield of California Promise Health Plan has contracted with a vendor to perform the telephonic HRA. The process is as follows:

- All HRAs will be conducted telephonically from vendor's centralized call center.
- All successful and unsuccessful attempts will be documented and reported to Blue Shield Promise Health Plan on a weekly basis.

Care Plan Process:

Depending on the answers to specific HRA questions an Individualized Care Plan is generated. The Care Plan is comprised of problems, interventions and goals. The problem is specific to the identified issue based on the Member's answer to the particular question. The intervention is targeted to address the associated problem and either a short term or long-term goal is triggered.

The Member and Member's PCP receive a cover letter explaining the HRA process and the Individual Care Plan. The PCP also receives a summary of the Member's responses to the HRA. The Blue Shield of California Promise Health Plan HRA is available on the Blue Shield of California Promise Health Plan website at:
https:/ www.blueshieldca.com/promise/provider/snp-model-of-care.asp

SECTION 6: PHARMACEUTICAL MANAGEMENT

6.1 : Medication Therapy Management (MTM) Program

The Medication Therapy Management (MTM) Program, will ensure optimum therapeutic outcomes for targeted beneficiaries (multiple chronic medical conditions, taking many prescription medications, minimum medication cost threshold) through improved medication use. The goal of the program is to reduce the risk of adverse events, including adverse drug interactions and improve the quality and cost effectiveness of the pharmacy benefit. The Blue Shield of California Promise Health Plan MTM program is offered at no additional cost. By assisting in the reduction of both over and underutilization, this program helps us make sure that our Members are using the appropriate drugs to treat their medical conditions and to identify possible medication problems. This is a voluntary program.

6.2: Pharmaceutical Quality Assurance

Blue Shield of California Promise Health Plan established measures and systems to conduct drug utilization reviews for all our Members to make sure that they are getting safe and appropriate care. The programs include real-time and historic review of prescriptions claims to reduce medications errors and adverse drug interactions. These reviews are especially important for Members who have more than one doctor who prescribe their medications, use more than one drug, or have more than one pharmacy.

Blue Shield of California Promise Health Plan conducts drug utilization reviews when the pharmacy fills a prescription at the point- of- sale. The claim may be electronically reviewed for the following:

- Screen for duplicate drugs that are unnecessary because Member is taking another drug to treat the same medical condition.
- Age-related contraindications
- Gender-related contraindications
- Drug-Drug interactions
- Incorrect drug dosage
- Drug-Disease contraindications
- Drug-Pregnancy precautions
- Clinical abuse or misuse

In addition, retrospective drug utilization reviews identify inappropriate or medically unnecessary care. We perform ongoing, periodic review of claims data to evaluate prescribing patterns and drug utilization that may suggest potentially inappropriate use.

6.3: Pharmaceutical Utilization Management

This program incorporates utilization management tools to encourage appropriate and cost-effective use of Part D medications. The Blue Shield of California Promise Health Plan Pharmacy & Therapeutics Committee developed these requirements and limits to help us provide quality coverage to our Members. These tools include, but are not limited to: prior authorization, clinical edits, quantity limits and step therapy.

- Age Limits: Some drugs may require a prior authorization if the patient's age does not meet the manufacturer, FDA, and clinical practice guidelines.
- Quantity Limits: For certain drugs, we limit the amount of the drug we will cover per

prescription or for a defined period. Similar to the age limit, the quantity limit threshold is based on manufacturer, FDA, and clinical practice guidelines.

- Prior Authorization: Prior authorization is required for certain drugs. Typically, a prior authorization is established to ensure appropriate utilization.
- Step Therapy: In some cases, Blue Shield of California Promise Health Plan will require that the patient has a trial of a first-line medication, prior to approving a second-line medication.
- Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates "brand only". If an FDA-approved generic alternative is available on the Blue Shield of California Promise Health Plan formulary, the prescribing physician will need to submit medical justification for the use of the brand product.
- Therapeutic interchange: Is the practice of offering clinically appropriate, cost effective formulary alternatives. Therapeutic interchange programs are reviewed and approved by the Pharmacy and Therapeutics Committee. Blue Shield of California Promise Health Plan will work with the prescribing physicians to get this accomplished.

The Blue Shield of California Promise Health Plan formulary is available on the Blue Shield of California Promise Health Plan website (https:/ www.blueshieldca.com/promise). Blue Shield of California Promise Health Plan Members shall have access to all FDA-approved drugs that are medically necessary via the drug formulary or prior authorization procedures. To ensure Members receive high quality, cost-effective and appropriate drug therapy, Blue Shield of California Promise Health Plan will maintain drug formularies consistent with the required pharmacy benefit design for all contracted product lines. The formularies will be maintained by the Blue Shield of California Promise Health Plan Pharmacy & Therapeutics (P&T) Committee.

6.3.1 : Prior Authorizations("P.A.")

Policy

The Blue Shield of California Promise Health Plan Pharmacy Department will ensure a timely and accurate review of all medication authorization requests. Prior authorization requests will be determined 72 hours after receipt of complete information from the provider for Standard determinations. Expedited reviews will be determined within 24 hours after receipt of complete information from the provider. Blue Shield of California Promise Health Plan shall provide an expedited determination if it determines that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Medication authorizations requests may be submitted by the member, member's representative, member's prescribing physician, or other physicians.

Medications requiring authorization include (but are not limited to):

- Medications on the Blue Shield of California Promise Health Plan formularies requiring a prior authorization (P.A.) review.
- Non-formulary medications.
- Part B versus Part D determinations.

The Blue Shield of California Promise Health Plan Pharmacy Department will provide written communication of the prior authorization determination to the Member and provider.

Definitions

"***Approved***" – Blue Shield of California Promise Health Plan agrees to cover the requested medication.

"***Modified***" – The physician agrees to modify the original medication request to a formulary medication.

"***Denied***" – The medication request was not approved.

"***Non-formulary***" – A medication not listed on the Blue Shield of California Promise Health Plan formulary.

"P.A. Required" – A medication on the Blue Shield of California Promise Health Plan formulary that requires P.A. review.

"***Specialty Pharmaceutical***" – Defined by the criteria included in AB2420.

Procedure

1. **Timeliness: Standard and Expedited**

   Members, members' representatives, or members' prescribing physicians or other prescribers ("Prescriber") may submit an oral or written request to Blue Shield of California Promise Health Plan to expedite a request for Coverage Determination, Tiering Exception, or Formulary Exception. The Prescriber may provide oral or written support for a member's request for an expedited Coverage Determination, Tiering Exception, or Formulary Exception as required by Blue Shield of California Promise Health Plan. Blue Shield of California Promise Health Plan shall either: (i) process requests for expedited Coverage Determinations, Tiering Exceptions, or Formulary Exceptions as expedited; or (ii) issue a prompt decision on expediting a Coverage Determination, Tiering Exception, or Formulary Exception based on the following requirements:

   A. For a request made by a member, Blue Shield of California Promise Health Plan shall provide an expedited determination if it determines that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member or the member's ability to regain maximum function; or

   B. For a request made or supported by a Prescriber, Blue Shield of California Promise Health Plan shall provide an expedited determination if the Prescriber indicates that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

   C. All requests for expedited review will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer. The Blue Shield of California Promise Health Plan Physician Reviewer will determine the validity of the request for an expedited review.

   D. If the expedited review is denied by the Blue Shield of California Promise Health Plan Physician Reviewer, Blue Shield of California Promise Health Plan will give the member and Prescriber prompt oral notice and explain that the coverage determination request will be processed within the 72-hour timeframe for standard determinations. The member will be informed of his/her right to file an expedited grievance if he or she disagrees with the decision not to expedite. The member will also be informed of the right to resubmit a request for an expedited determination with the Prescriber's support and will receive information describing the Blue Shield of California Promise Health Plan grievance

process and timeframes. Written notice will also be faxed to the Prescriber and mailed to the member within 3 calendar days. Blue Shield of California Promise Health Plan uses the CMS model notice of denial for expedited request.

E. If the expedited review is granted, Blue Shield of California Promise Health Plan will follow the expedited review procedures.

F. Blue Shield of California Promise Health Plan has a 24/7 pharmacy phone line. A member of the clinical staff will be on call responding to claim-related requests.

All Coverage Determination requests that are requests for payment will be processed as standard Coverage Determination requests.

Note: Prior to processing a Coverage Determination, Tiering Exception, or Formulary Exception request from an appointed representative as detailed below, Blue Shield of California Promise Health Plan will determine whether the appointed representative has submitted the appropriate documentation. The documentation can be CMS form 1696 or equivalent. This includes requests from pharmacies that cannot be handled as point-of-sale transactions.

2. Outreach for Coverage Decisions

If complete information is not provided upon initial request for coverage determination, or exceptions request, sufficient outreach attempts will be made to obtain the information necessary to make informed coverage decisions. This is applicable to all coverage determinations or exceptions (CDE) requests as outlined below.

A. Reasonable and diligent efforts to obtain information include a minimum of three attempts.

B. The methods for requesting information will be a mix of faxes or telephone calls. All outreach attempts will be documented with the date and time of the fax/call in the prior authorization database.

C. The first request for information will be made within 24 hours of receipt of the coverage request for standard CDE's, and as soon as possible for expedited requests.

D. Although every effort will be made to perform outreach attempts during normal business hours, some attempts may need to be made outside of those hours, particularly for expedited requests which have a shortened timeframe.

3. Coverage Determinations

A. <u>Standard Coverage Determination Requests – Request for Payment:</u>

1. Members and member representatives may submit requests for payment to Blue Shield of California Promise Health Plan on an approved non-electronic claim form.
2. Upon receipt of a request for payment from a member or a member representative, Blue Shield of California Promise Health Plan processes the claim according to the member's benefit plan and the amount agreed to by plan for payment.
3. Processing reimbursement by members:
   a. If the reimbursement decision is unfavorable, Blue Shield of California Promise Health Plan makes the decision and provides notice of the decision not later than 14 calendar days after receiving the reimbursement request;
   b. If the reimbursement decision is favorable, Blue Shield of California Promise Health Plan makes the decision, provides notice of the decision and make payment not later than 14 calendar days after receiving the reimbursement request.
   c. If Blue Shield of California Promise Health Plan is not able to obtain all the information

it needs to reach a favorable decision on the merits of the case within the 14 calendar-day timeframe, Blue Shield of California Promise Health Plan issues an unfavorable decision.

d. If Blue Shield of California Promise Health Plan does not have all the information it needs to make a decision, Blue Shield of California Promise Health Plan makes reasonable and diligent efforts to obtain the missing information within the 14 calendar-day timeframe.

e. When Blue Shield of California Promise Health Plan issues a denial, it clearly explains in the decision letter the reason for the denial and how member might be able to receive reimbursement using the CMS model denial notification form in language the member can understand.

B. Standard Coverage Determination Requests –Benefit Coverage Determinations:

1. Member, member representative, or Prescriber may contact (either verbally or in writing) Blue Shield of California Promise Health Plan and request a Coverage Determination.

a. Verbal Requests.

i. Member and Member Representative. If the request is a verbal request from a member or a member representative, the Blue Shield of California Promise Health Plan Customer Service Representative (CSR) will document the verbal request in member's or member representative's words, repeat the request to the member or member representative, and forward request to PACSR for review.

ii. Prescriber. If the request is a verbal request from a Prescriber for an administrative override (i.e., vacation supply), the Prior Authorization Customer Service Representative (PACSR) will attempt to resolve the issue while the Prescriber is on the line. If the request is a verbal request from a Prescriber for a non-exception request (other than an administrative override), a PACSR reviews criteria during call and informs requestor during call if Coverage Determination request is approved. If approved, Blue Shield of California Promise Health Plan will fax the approval notification to the Prescriber and mail the approval notice to the member. If request cannot be approved during call, the PACSR will obtain as much relevant information as possible, inform the Prescriber that a decision or request for additional information will be faxed to him/her, then review with a Blue Shield of California Promise Health Plan Pharmacist. If the request is received after regular business hours, the Prescriber will be given the option to leave the verbal request on a voice mailbox that is checked on a regular basis per our "Handling of After-hours Pharmacy-Related Calls" desktop procedure.

b. Written Requests. If the request is in writing, the Coverage Determination request is forwarded to the PACSR for review.

i. Blue Shield of California Promise Health Plan will make a decision and enter authorization/provide notification (verbally and/or mail) within 72 hours of receiving the Coverage Determination request based on approval criteria for the drug.

ii. If the Coverage Determination request is approved, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail

the approval notice to the member.

iii. If the Coverage Determination request cannot be approved by the PACSR, the PACSR will forward the request to the Blue Shield of California Promise Health Plan Pharmacist to review.

iv. If the Blue Shield of California Promise Health Plan Pharmacist approves the Coverage Determination, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail the approval notice to the member.

v. If the Blue Shield of California Promise Health Plan Pharmacist does not approve the Coverage Determination, the case will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer.

vi. If the Blue Shield of California Promise Health Plan Physician Reviewer approves the Coverage Determination, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail the approval notice to the member.

vii. If the Blue Shield of California Promise Health Plan Physician Reviewer denies the Coverage Determination, Blue Shield of California Promise Health Plan will fax the Prescriber a denial notification and mail the denial notice to the member.

c. For Medications that could be covered under part D or B: the request is evaluated for part B v D determination and any additional information needed to clarify this determination is requested from the Provider. If a medication is determined to be covered under part B, Blue Shield of California Promise Health Plan verifies who is responsible for its review/payment and the request is a forwarded to the responsible part accordingly.

d. If Blue Shield of California Promise Health Plan's response to the Coverage Determination request does not meet the 72 hours requirement, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

C. Expedited/Urgent Coverage Determination Requests - Benefit Coverage Determinations:

1. Member, member representative, or Prescriber contacts (either verbally or in writing) Blue Shield of California Promise Health Plan and requests an Expedited Coverage Determination.

a. Verbal Requests.

i. Member and Member Representative. If the request is a verbal expedited/ urgent request from a member or a member representative, the Blue Shield of California Promise Health Plan Customer Service Representative (CSR) will document the verbal request in member's or member representative's words, repeat the request to the member or member representative, and forward request to PACSR for review.

ii. Prescriber. If the request is a verbal request from a Prescriber for an administrative override (i.e., vacation supply), the Prior Authorization Customer Service Representative (PACSR) will attempt to resolve the issue while the Prescriber is on the line. If the request is a verbal request from a Prescriber for a non-exception request (other than an administrative override), a PACSR reviews criteria during call and informs requestor during call if Coverage

Determination request is approved. If approved, Blue Shield of California Promise Health Plan will fax the approval notification to the Prescriber and mail the approval notice to the member. If request cannot be approved during call, the PACSR will obtain as much relevant information as possible, inform the Prescriber that a decision or request for additional information will be faxed to him/her, then review with a Blue Shield of California Promise Health Plan Pharmacist. If the request is received after regular business hours, the Prescriber will be given the option to leave the verbal request on a voice mailbox that is checked on a regular basis per our "Handling of After-hours Pharmacy-Related Calls" desktop procedure.

b. Written Requests. If the request is in writing, the Coverage Determination request is forwarded to the Blue Shield of California Promise Health Plan PACSR for review.

2. Blue Shield of California Promise Health Plan will make a decision and enter authorization/provide notification (verbally and/or mail) within 24 hours of receiving the Coverage Determination request based on approval criteria for the drug.
3. If the Coverage Determination request is approved, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail the approval notice to the member.
4. If the Coverage Determination request cannot be approved by the CSR or PACSR, it will be forwarded to the Blue Shield of California Promise Health Plan Pharmacist to review.
5. If the Blue Shield of California Promise Health Plan Pharmacist approves the Coverage Determination, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification, mail the approval notice to the member, and notify the member by phone.
6. If the Blue Shield of California Promise Health Plan Pharmacist does not approve the Coverage Determination, the case will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer.
7. If the Blue Shield of California Promise Health Plan Physician Reviewer approves the Coverage Determination, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification, mail the approval notice to the member, and notify the member by phone.
8. If the Blue Shield of California Promise Health Plan Physician Reviewer denies the Coverage Determination, Blue Shield of California Promise Health Plan will fax the Prescriber the denial notification, mail the denial notice to the member, and notify the member by phone.
9. If Blue Shield of California Promise Health Plan's response to the Coverage Determination request does not meet the 24 hours requirement, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

4. Tiering Exceptions

A. Standard Tiering Exception Requests:

1. Member, member representative, or Prescriber contacts (either verbally or in writing) Blue Shield of California Promise Health Plan and requests a Tiering Exception.

a. Verbal Requests. If the request is a verbal request from a member or a member representative, the Blue Shield of California Promise Health Plan Customer Service

Representative (CSR) will document the verbal request in member's or member representative's words, repeat the request to the member or member representative, and forward request to PACSR for review. If the tiering exception request is from a Prescriber, the PACSR will obtain as much relevant information as possible, inform the Prescriber that a decision or request for additional information will be faxed to him/her, then review with a Blue Shield of California Promise Health Plan Pharmacist. If the request is received after regular business hours, the Prescriber will be given the option to leave the verbal request on a voice mailbox that is checked on a regular basis per our "Handling of After-hours Pharmacy-Related Calls" desktop procedure.

b. Written Requests. If the exception request is in writing, the request is forwarded to the Blue Shield of California Promise Health Plan Pharmacist for review. If the request does not include a written provider/prescriber supporting statement, Blue Shield of California Promise Health Plan contacts Prescriber's office for a provider/prescriber supporting statement.

   i. Once Blue Shield of California Promise Health Plan receives the provider/prescriber supporting statement, it will make a decision and enter authorization/provide notification (verbally and/or mail) within 72 hours based on criteria. If Blue Shield of California Promise Health Plan does not receive a provider/prescriber supporting statement within 14 days, the request will be forwarded to the Blue Shield of California Promise Health Plan Pharmacist for a determination.

   ii. If the Tiering Exception request is approved, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail the approval notice to the member.

   iii. If the Tiering Exception request is not approved by the Blue Shield of California Promise Health Plan Pharmacist, the case will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer.

   iv. If the Blue Shield of California Promise Health Plan Physician Reviewer approves the Tiering Exception, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail the approval notice to the member.

   v. If the Blue Shield of California Promise Health Plan Physician Reviewer denies the Tiering Exception, Blue Shield of California Promise Health Plan will fax the Prescriber the denial notification and mail the denial notice to the member.

c. If Blue Shield of California Promise Health Plan's response to the Tiering Exception request does not meet the 72 hours requirement, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

B. Expedited/Urgent Tiering Exception Requests:

1. Member, member representative, or Prescriber contacts (either verbally or in writing) Blue Shield of California Promise Health Plan and requests an Expedited Tiering Exception Determination.

   a. Verbal Requests. If the request is a verbal request from a member or a member representative, the Blue Shield of California Promise Health Plan Customer Service Representative (CSR) will document the verbal request in member's or member representative's words, repeat the request to the member or member representative,

and forward request to PACSR for review. If the tiering exception request is from a Prescriber, the PACSR will obtain as much relevant information as possible, inform the Prescriber that a decision or request for additional information will be faxed to him/her, then review with a Blue Shield of California Promise Health Plan Pharmacist. If the request is received after regular business hours, the Prescriber will be given the option to leave the verbal request on a voice mailbox that is checked on a regular basis per our "Handling of After-hours Pharmacy-Related Calls" desktop procedure.

b. Written Requests. If the request is in writing, the exception request will be forwarded to the Blue Shield of California Promise Health Plan Pharmacist for review.

2. The Blue Shield of California Promise Health Plan Pharmacist will determine if the provider/prescriber supporting statement has been provided. If the provider/prescriber supporting statement has not been provided, Blue Shield of California Promise Health Plan will contact Prescriber's office for a provider/prescriber supporting statement.
3. Once Blue Shield of California Promise Health Plan receives the provider/prescriber supporting statement, it will make a decision and enter authorization/provide notification (verbally and/or mail) within 24 hours based on criteria. If Blue Shield of California Promise Health Plan does not receive a provider/prescriber supporting statement within 14 days, the request will be forwarded to the Blue Shield of California Promise Health Plan Pharmacist for a determination.
4. If the Tiering Exception request is approved, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification, mail the approval notice to the member, and notify the member by phone.
   a. If the Tiering Exception request is not approved, the case will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer.
   b. If the Blue Shield of California Promise Health Plan Physician Reviewer approves the Tiering Exception, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification, mail the approval notice to the member, and notify the member by phone.
   c. If the Blue Shield of California Promise Health Plan Physician Reviewer denies the Tiering Exception, Blue Shield of California Promise Health Plan will fax the physician the denial notification, mail the denial notice to the member, and notify the member by phone.
   d. If Blue Shield of California Promise Health Plan response to the Tiering Exception request does not meet the 24 hours requirement, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

5. Non-formulary Exceptions

A. Standard Formulary Exception Requests:

1. Member, member representative, or Prescriber contacts (either verbally or in writing) Blue Shield of California Promise Health Plan and requests a Formulary Exception.
   a. Verbal Requests. If the request is a verbal request from a member or a member representative, the Blue Shield of California Promise Health Plan Customer Service Representative (CSR) will document the verbal request in member's or member representative's words, repeat the request to the member or member representative, and forward request to PACSR for review. If the exceptions request is a verbal request from a Prescriber, a PACSR reviews criteria during call and informs requestor during

call if Non-formulary exceptions request is approved. If approved, Blue Shield of California Promise Health Plan will fax the approval notification to the Prescriber and mail the approval notice to the member. If request cannot be approved during call, the PACSR will obtain as much relevant information as possible, inform the Prescriber that a decision or request for additional information will be faxed to him/her, then review with a Blue Shield of California Promise Health Plan Pharmacist. If the request is received after regular business hours, the Prescriber will be given the option to leave the verbal request on a voice mailbox that is checked on a regular basis per our "Handling of After-hours Pharmacy- Related Calls" desktop procedure.

b. Written Requests. If the exception request is in writing, the request is forwarded to the Blue Shield of California Promise Health Plan Pharmacist for review. If the request does not include a written provider/prescriber supporting statement, Blue Shield of California Promise Health Plan will contact Prescriber's office for a provider/ prescriber supporting statement.

   i. Once Blue Shield of California Promise Health Plan receives the provider/ prescriber supporting statement, it will make a decision and enter authorization/provide notification (verbally and/or mail) within 72 hours. If Blue Shield of California Promise Health Plan does not receive a provider/ prescriber supporting statement within a reasonable amount of time (14 days) the request will be forwarded to the Blue Shield of California Promise Health Plan Pharmacist for a determination.

   ii. If the Formulary Exception request is approved, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification and mail the approval notice to the member.

   iii. If the Formulary Exception request is not approved, the request will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer.

   iv. In most cases, Blue Shield of California Promise Health Plan recommends formulary alternatives to the Prescriber for consideration prior to approval of a non-formulary drug request.

2. If Blue Shield of California Promise Health Plan's response to the Formulary Exception request does not meet the 72 hours requirement, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

B. Expedited/Urgent Formulary Exception Requests:

1. Member, member representative, or Prescriber contacts (either verbally or in writing) Blue Shield of California Promise Health Plan and requests an Expedited Formulary Exception Determination.

   a. Verbal Requests. If the request is a verbal request from a member or a member representative, the Blue Shield of California Promise Health Plan Customer Service Representative (CSR) will document the verbal request in member's or member representative's words, repeat the request to the member or member representative, and forward request to PACSR for review. If the exceptions request is a verbal request from a Prescriber, a PACSR reviews criteria during call and informs requestor during call if Non-formulary exceptions request is approved. If approved, Blue Shield of California Promise Health Plan will fax the approval notification to the Prescriber and mail the approval notice to the member. If request cannot be approved during call,

the PACSR will obtain as much relevant information as possible, inform the Prescriber that a decision or request for additional information will be faxed to him/her, then review with a Blue Shield of California Promise Health Plan Pharmacist. If the request is received after regular business hours, the Prescriber will be given the option to leave the verbal request on a voice mailbox that is checked on a regular basis per our "Handling of After-hours Pharmacy- Related Calls" desktop procedure.

b. Written Requests. If the request is in writing, the request is forwarded to the Blue Shield of California Promise Health Plan Pharmacist for review.

2. The Blue Shield of California Promise Health Plan Pharmacist will determine if the provider/prescriber supporting statement has been provided. If the provider/prescriber supporting statement has not been provided, Blue Shield of California Promise Health Plan will contact Prescriber's office for a provider/prescriber supporting statement.
3. Once Blue Shield of California Promise Health Plan receives the provider/prescriber supporting statement, it will make a decision within 24 hours and enter authorization/ provide notification (verbally and/or mail). If Blue Shield of California Promise Health Plan does not receive a provider/prescriber supporting statement within a reasonable amount of time, 3 days, the request will be forwarded to the Blue Shield of California Promise Health Plan Pharmacist for a determination.
4. If the Formulary Exception request is approved, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification, mail a copy of the approval notice to the member, and notify the member by phone.
5. If the Formulary Exception request is not approved, the case will be forwarded to the Blue Shield of California Promise Health Plan Physician Reviewer. For most cases, Blue Shield of California Promise Health Plan Pharmacist recommends formulary alternatives for the Prescriber's consideration.
6. If the Blue Shield of California Promise Health Plan Physician Reviewer approves the Formulary Exception, Blue Shield of California Promise Health Plan will fax the Prescriber an approval notification, mail the approval notice to the member, and notify the member by phone.
7. If the Blue Shield of California Promise Health Plan Physician Reviewer denies the Formulary Exception, Blue Shield of California Promise Health Plan will fax the Prescriber the denial notification, mail the denial notice to the member, and notify the member by phone.
8. If Blue Shield of California Promise Health Plan's response to the Formulary Exception request does not meet the 24 hours requirement, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

6. Refill too soon requests

A. If the request is for an early refill for a medication that is on formulary, it will be treated as a coverage determination and thus subject to the timelines mentioned above (i.e., 72 hours for standard request and 24 hours for an expedited request). If the request is not reviewed in a timely manner, Blue Shield of California Promise Health Plan will complete the IRE referral form and send it with other necessary documentation to the IRE.

B. As most of these requests are for medications on formulary without restrictions, there are no CMS-approved guidelines. As such, an internal refill too soon guideline (RTS Override Flow) was created to assist in these reviews.

7. Dismissals/Withdrawals

A. Only in very rare instances would a Coverage Determination/Exceptions request be withdrawn or dismissed. In both cases, the reason for withdrawal/dismissal will be clearly documented in the Blue Shield of California Promise Health Plan Prior Authorization database and the case will be closed.

B. Generally, a dismissal would occur when the procedural requirements for a valid request are not met and Blue Shield of California Promise Health Plan is unable to cure the defect. For example, a coverage determination request is received from a purported representative of the enrollee. Blue Shield of California Promise Health Plan is not able to obtain the required documentation (Appointment of Representative form) within a reasonable amount of time and therefore the case needs to be dismissed. In this case, the request will be closed with a status of "Dismissed."

C. A withdrawal would occur when the requestor withdraws his/her request for coverage.For example, a Coverage Determination is requested by an enrollee for a drug that requires step therapy. But before Blue Shield of California Promise Health Plan issues a decision, the enrollee speaks to her prescriber and learns that she can take the covered alternative, then calls Blue Shield of California Promise Health Plan and asks to not process her coverage request. If the requester is the prescriber, and he/she withdraws the request, the case will be closed with a denial reason of "Retracted (MD Request/MD retracts). If the requestor is the member, and he/she withdraws the request, the case will be closed with the status of "Member Withdrawal." No denial letter will be generated in either case as no coverage determination has been made.

8. Reopening and Revising Determinations and Decisions

A. A reopening is a remedial action taken to change a binding determination or decision even though the binding determination or decision may have been correct at the time it was made based on the evidence of record. Although cases will very rarely be reopened, a possible reason for reopening a previous determination includes clerical errors such as:

1. Mathematical or computational mistakes
2. Inaccurate data entry
3. Denials of claims as duplicates

B. A request for reopening must:

1. Be made in writing
2. Be clearly stated
3. Include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening); and
4. Be made within the time frames permitted for reopening:
   a. Within 1 year from the date of Coverage Determination for any reason
   b. Within 4 years from the date of Coverage Determination for good cause, which is defined as new and material evidence that was not available or known at the time of the decision, and may result in a different conclusion OR the evidence that was considered in making the decision clearly shows on its face that an obvious error was made at the time of the decision.
   c. At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the Coverage Determination was procured by fraud or similar fault.

C. When a reopening does occur, the case will be opened with a "PA Prompt" of "Reopening."

Record Keeping

Blue Shield of California Promise Health Plan will maintain a tracking database for all determinations, redeterminations and reconsiderations to meet CMS – Medicare Part D Reporting Requirements.

Notices to Members and Providers

Blue Shield of California Promise Health Plan will utilize the CMS model notices for all member and provider communication related to coverage determinations, redeterminations and reconsiderations.

In all written denial notification, Blue Shield of California Promise Health Plan explains clearly reasons for denial and helps member understand how s/he can access the drug.

All outgoing mail to members, approval or denial, have date and time-stamp to ensure timely fulfillment.

6.4: Member Coverage Determination, Exceptions, and Appeals

Blue Shield of California Promise Health Plan will follow the policy and procedures set forth in the Blue Shield of California Promise Health Plan Beneficiary Coverage Determination, Exceptions (Prior Authorization) P&P to administer and comply with the Medicare Part D requirements for performing these functions.

Providers may access the Pharmacy Prior Authorization request on the Blue Shield of California Promise Health Plan website (https:/ www.blueshieldca.com/promise) or by calling the Blue Shield of California Promise Health Plan Pharmacy Department. Verbal requests are accepted from medical providers.

6.5: Reporting

Blue Shield Promise Health Plan Health Plan provides Participating Provider Groups access to pharmacy claim files. These files are available by the 10th of each month and can be accessed via a secure web portal. To obtain access, Participating Provider Groups are required to complete an access request form. To request an access request form, an email can be sent to BSCCalinxRx@blueshieldca.com. Once the access request form has been submitted and approved, access instructions and additional information will be sent to the requestor.

Section 7: QUALITY IMPROVEMENT

7.1: Quality Improvement Program

Mission Statement

Blue Shield of California Promise Health Plan's Quality Improvement (QI) Department's mission is to provide an effective, system- wide plan and process for monitoring, evaluating and improving quality of care and services to our Members. Blue Shield of California Promise Health Plan is committed to achieving high standards of medical care in a cost effective and efficient manner through an integrated organizational approach.

Purpose

The QI Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care/services, the structures/processes by which they are delivered to Plan Members; to continuously pursue opportunities for improvement and problem resolution.

Goals

- To ensure Members receive the highest quality of care and services.
- To ensure Members have full access to care.
- To monitor and improve Member satisfaction with all aspects of the delivery system and network.
- To utilize a multi-disciplinary approach to assess, monitor and improve Plan policies and procedures.
- To promote physician involvement in quality improvement activities.
- To meet the changing demands of the healthcare industry.
- To promote the benefits of a managed care delivery system.
- To promote preventive health services and disease management.
- To emphasize the unique relationship among the patient, practitioner, provider and health plan.
- To seek out opportunities to improve the quality of care and service provided to our Members.
- To seek out opportunities to improve the quality of services to our practitioners/providers.
- To seek innovative solutions to identified challenges.

Objectives

- To ensure that timely, quality, medically necessary and appropriate care/services that meet professionally recognized standards of practice are available to Members by monitoring the processes/outcomes of care utilizing established and measurable standards. Emphasis will be placed on monitoring preventive services, clinical outcomes, ER usage, bed days, medication usage, access, and complaints/grievances.
- To systematically collect, screen, evaluate information about the quality and appropriateness of clinical care, and provide feedback to practitioners/providers about their performance and network-wide performance.

- To maintain a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity, facility site review, and performance.
- To ensure our Members are afforded accessible health care by continually assessing our network of practitioners/providers.
- To design and develop data systems to support QI monitoring and measurement activities.
- To assure compliance with the requirements of accrediting and regulatory agencies including, but not limited to, DMHC, DOC, SDHS, DHCS, CMS, NCQA and other regulatory agencies.
- To identify, review, monitor and assure resolution of known or suspected quality of care problems, trends that impact the healthcare of our Members, and implement monitoring of corrective actions to prevent recurrence.
- To appropriately oversee QI and credentialing activities of delegated PPGs.
- To ensure that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements.
- To establish and maintain standards for quality of care, accessibility of care and service.
- To identify opportunities for improving the quality of patient care and services and to implement monitoring of changes to achieve improvement.
- To establish and conduct focused review studies, with emphasis on preventive services, high-volume practitioners/providers or services and high- risk services.
- To ensure that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
- To measure and improve Member and practitioner/provider satisfaction.

Scope

The scope of the Quality Improvement Program is to monitor care and identify opportunities for improvement of care and services to both our Members and practitioners. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. This Quality Improvement Program covers all Medicare Members. Behavioral Health Care is a covered benefit for our Medicare line of business. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include but not limited to:

- Practitioner accessibility and availability
- Member satisfaction/grievances
- Member Safety
- Clinical measurement and improvement monitoring
- Chronic Care Improvement Program (CCIP)
- Credentialing and Recredentialing
- Peer Review
- IPA/MSO oversight
- Delegation Oversight
- Adverse outcomes/sentinel events

- Medical record keeping practices
- Facility site reviews
- Practitioner satisfaction
- Timeliness of handling claims
- High risk and high-volume services
- Medication Therapy and Management
- Predictive Modeling
- Compliance with regulatory requirements and reporting

Functional areas include:

- PQI/Grievances
- Preventive Services
- Credentialing
- Facility Site Review

Confidentiality & 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 housed in a designated, secured area in the QI Department. All aspects of quality review are deemed confidential. All persons 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's confidentiality. All persons attending the Quality Management Committee (QMC) or its related committee meetings will sign a confidentiality statement, and all Blue Shield of California Promise Health Plan personnel are required to sign a confidentiality agreement upon employment. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

No persons shall be involved in the review process of QI issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

7.1.1: Program Structure Governing Body

The governing body is the Board Quality Improvement Committee (BQIC). The BQIC is responsible for the establishment and implementation of the Plan's QI Program. The Chief Medical Officer reports all quality improvement and implementation of the Plan's QI Program. The Chief Medical Officer reports all quality improvement activities to the BQIC at least quarterly.

Chief Executive Officer

The Chief Executive Officer has overall organizational responsibility for the QI program; ensures program implementation, function and results; and provides adequate resources and staffing.

The Chief Executive Officer delegates functional responsibility for the QI program to the Chief

Medical Officer.

Chief Medical Officer

The Chief Medical Officer (CMO) is a physician who holds a current license to practice medicine with the Medical Board of California. The CMO is the BQIC designee responsible for implementation of QI program activities. The CMO works in conjunction with the Directors of Medical Services, the AVP of PI & QI, and the QI Directors to develop, implement and evaluate the QI Program. The CMO is chairperson of Quality Improvement Committee (QMC), Credentials/ Peer Review, Pharmacy & Therapeutics and delegated oversight committees. Responsibilities of the CMO also include but are not limited to:

- Ensure that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative responsibilities.
- Ensure that the medical care provided meets the standards for acceptable medical practice.
- Ensure that medical protocols and rules of conduct for Plan medical personnel are followed.
- Develop and implementing medical policy.
- Actively participate in the functioning and resolution of the Plan grievance procedures.
- Provide support and clinical guidance to the program and to all physicians in the network.
- Ensure that the QI and UM Departments interface appropriately to maximize opportunity for PQI improvement activities.
- Direct the implementation of the quality improvement process.
- Oversee the formulation and modification of comprehensive policies and procedures to support the Quality Improvement operations.
- Analyze quality improvement data.
- Review all clinical grievances, PQIs, QCIs; assign severity levels; and direct corrective actions to be taken, including peer review, if required.
- Review QI Program, work plan, annual evaluation and quarterly reports.
- Direct Health Education and Credentialing activities.
- Assist with the development, conduct, review and analysis of HEDIS, IQIP studies.

Quality Improvement Director(s)

A. AVP Performance Improvement & Quality Improvement

The AVP of PI & QI oversees the directors and managers in the administrative daily operations of the Quality Improvement Department and is responsible for the execution of Quality Improvement activities and the operations of the companies Quality Performance Metrics and Improvement Programs and is responsible for the execution and coordination of all reports to the Chief Medical Officer. The AVP of PI & QI reports to the Chief Medical Officer and helps to plan, develop, organize, monitor, communicate and recommend modifications to performance improvement projects and the quality improvement program. It is the AVP of PI & QI's responsibility to interface with other departments on performance improvement processes and issues and reports any areas of concern to the Chief Medical Officer and the Quality Management Committee meeting.

Additional responsibilities include but not limited to:

- Performing statistical analysis relevant to quality improvement functions and goals.
- Developing and/or revising annually the Performance Improvement functions of the Annual Evaluation and Work Plan and presenting for review and approval.
- Ensuring that quality trends and patterns are monitored, quality issues are identified, and corrective action plans are developed.
- Monitoring and reporting to the Quality Management Committee the status of Performance Improvement interventions and in accordance with the Quality Improvement Program.
- Overseeing compliance required by regulatory agencies.
- Interfacing with all internal departments to ensure compliance to the Performance Improvement activities and policies and procedures.
- Serving as liaison with Regulatory Agencies for Performance Improvement activities.
- Monitoring and follow up with all applicable Performance Improvement activities.
- Ensuring that staff collects and monitors data and report identified trends to the Chief Medical Officer and Quality Management Committee.
- Ensuring that HEDIS, QIP, PIP, PDSA, and IP studies are conducted appropriately.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Interfacing with the Chief Medical Officer for clinical quality of care and service issues.
- Assuring the department adheres to HIPAA compliance standards.
- Reviewing potential risk management issues and reports them to the Chief Medical Officer.
- Developing policies and procedures in conjunction with the Chief Medical Officer.
- Collecting, monitoring and reporting data for tracking and trending.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.

B. HEDIS and Stars Team

The HEDIS & STAR team is responsible for data collection, reporting, clinical abstraction and outreach programs for all quality related initiatives in collaboration with all departments and stakeholders that have input on quality. Additional responsibilities include medical record abstraction, provider network support and education related to Quality and HEDIS measures, data management and ensuring data integrity. The AVP of Performance Improvement and Quality Improvement provide subject matter expertise and guidance for the HEDIS STARS team.

Additional responsibilities include but not limited to:

- Subject matter expertise with clinical abstraction and medical record validation per NCQA Technical Specifications and PCS updates
- Data analysis and technical support throughout the organization and external partners, including data requirements for submission of standard and non-standard supplemental

data sources.

- Ensure integrity of data reporting
- Use of predictive analysis to maneuver outreach programs for maximum impact to increase rates
- Generate monthly Gaps list to share with Providers to minimize service gaps
- Collaborate with external partners to foster bi-directional data exchange to minimize data gaps
- Coordination, review and submission of the annual HEDIS Roadmap
- Subject matter expertise for the Annual Compliance audit and adherence to NCQA submission deadlines for reporting.
- Management of annual HEDIS project to include leveraging resources to retrieve, abstract and report data to maximize hybrid and administrative rates for reporting
- Vendor management throughout all phases of HEDIS
- Resource allocation to maximize impact to improve HEDIS rates year-round
- Direct Provider education, support and oversight of programs initiated by the QI team to maximize HEDIS scores and improve member services
- Monitor QI initiatives and incentives program for efficacy
- Provide annual HEDIS training and share updates within the department, throughout the organization and external partners (ex: Provider Groups, FQHCs)
- Initiate Provider and Member outreach calls to minimize service gaps and help improve member access to preventive services during the Proactive phase
- Implement, monitor, report and assess efficacy of Quality incentives program

C. Other Quality Improvement Staff and Resources

The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Blue Shield of California Promise Health Plan has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies.

The staff includes but is not limited to:

- PI/NCQA Clinical Specialist, QI Accreditation Project Manager, PI/QI Specialists & Coordinator
- Director, Facility Site Review (FSR), Clinical Review (PQI), IHA Maternity Case Finding Program
- Facility Site Review Nurses & Coordinators
- FSR Administrative Supervisor
- FSR Auditors
- IHA Coordinator
- QI/FSR Senior Project Coordinator
- Sr. QI Nurse Specialist, Case Finding
- PQI Clinical Supervisor

- Sr. PQI Nurses & PQI Nurse Specialists
- & PQI Coordinators
- Manager, Credentialing
- Sr. Credentialing Auditor & Credentialing Auditors
- Credentialing Coordinators
- Supervisor of QI Data Analytics
- Statistician & Sr. Business Analyst
- HEDIS Provider Network Specialist
- HEDIS Data Specialist
- HEDIS/Quality Outreach Coordinators
- Director, UM Delegation Oversight (UMDO)
- UMDO Clinical Auditors
- Claims Compliance Supervisors
- Claims Compliance Auditors
- Other support staff

Committees

Quality Management Committee

The Quality Management Committee is established by the authority of the Blue Shield Quality Improvement Committee (BQIC) as a standing committee and is charged with the development, oversight, guidance and coordination of all Medical Services Department activities, including Quality Improvement and Utilization Management. The Quality Management Committee has a specific portion of the meeting designated for the Quality Improvement Program. The Quality Management Committee has been delegated the responsibility of providing an effective Quality Improvement Program. The Quality Management Committee monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Practitioners to improve health care outcomes and quality of service. The Quality Management Committee is also responsible for Utilization Management activities as outlined in the Utilization Management Program.

Other responsibilities include but not limited to:

- Directing all Quality Improvement activity
- Recommending policy decisions
- Reviewing, analyzing and evaluating Quality Improvement activity
- Ensuring practitioner participation in the QI program through planning, design, implementation and review
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, or Delegated Oversight Committees)
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation

- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria
- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects
- Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events
- Reviewing and evaluating reports submitted by the Plan's counsel
- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff
- Evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner Satisfaction surveys, access audits, HEDIS
- Audits and IQIP studies
- Evaluating and giving recommendations from monitoring and tracking reports
- Ensuring follow-up, as appropriate

Credentials/Peer Review Committee

Responsibilities include but not limited to:

- As the peer review body, to review, recommend, take action and monitor the clinical practice activity of the practitioner/provider network and mid-level practitioners.
- As the credentialing body, to review, recommend, approve/deny initial credentialing and recredentialing of the direct-contracted practitioner/provider network.
- Review and approve credentialing policies and procedures and ensure they are carried out.
- Ensure appropriate reports, including 805, NPDB, etc, are made, as required.
- Ensure Fair Hearing procedures are offered and carried out in accordance with approved policies and procedures.

Delegation

Blue Shield of California Promise Health Plan delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PMGs. Blue Shield of California Promise Health Plan does not delegate Quality Improvement activities to contracted IPA's and Medical Groups and maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Credentialing, Quality Improvement, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to: preventive health services, health education activities, clinical practice guidelines, and access standards. Non-delegated functions include clinical studies, clinical grievances, ap-

peals, HEDIS/QIP studies, facility site/medical record reviews, access studies, Health Education materials development and review, member and practitioner satisfaction surveys. Delegated IPAs will be expected to have a functioning quality improvement program in place. Blue Shield of California Promise Health Plan retains the right to revoke any delegated function if compliance with standards is not met.

7.1.2 : Standards of Practice

The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the QI process are based on professionally recognized standards. Sources for standards include but not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Review of applicable medical literature
- Available medical knowledge
- State and federal requirements
- Standards are used to evaluate quality of care of practitioners/providers
- Standards are incorporated into policies and procedures

Established thresholds and targets are:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines
- Valuable to the assessment of quality or the potential improvement of quality for our Member population

Standards are communicated to practitioners/providers through the Plan in a systematic manner that may include but not limited to the Blue Shield of California Promise Health Plan Provider Manual, newsletters, and bulletins.

7.1.3 : Quality Improvement Process

Blue Shield of California Promise Health Plan utilizes a QI process to identify opportunities to improve both the quality of care and services for all Plan Members. Blue Shield of California Promise Health Plan adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Compliance with standards is measured using a variety of techniques including, but not limited to:

- Quality Screens
- Chronic Care Improvement Plans
- HEDIS
- QIA Studies
- Monitors
- Indicators
- Medical Record Audits

- Facility Site Reviews
- Outcome Measures
- Focused Review Studies
- Member Satisfaction Surveys
- Practitioner/Provider Satisfaction Surveys
- Access To Care Audits

Potential Quality Issues (PQI) and Quality of Care Issues (QCI)

A major component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action plans to address confirmed quality of care issues.

Clinical Complaint and Grievance Process

The Blue Shield of California Promise Health Plan clinical complaint and grievance process provides members a means by which they can report and seek resolution of concerns regarding practitioners' or Blue Shield of California Promise Health Plan's ability to provide appropriate health care services, access to care, quality of care, or service issues.

Peer Review

Peer review will be conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner/provider or to review aspects of care, behavior or practice, or deemed inappropriate. The CMO will be responsible for authorizing the referral of cases for peer review. All Peer review consultants (including Members of the Credentials/Peer Review or ad-hoc Peer Review Committees) will be duly licensed professionals in active practice. At least one consultant will be a practitioner/provider with the same or similar specialty training as the practitioner/provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty. The CMO will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand. The QI nurse specialist will prepare all materials for review by the Peer Review Committee and conducts all follow-ups, as required by the Committee.

Quality Improvement Intervention for Systemic Quality of Care Issues

The QI Department will implement opportunities to improve the delivery and quality of care through the design and execution of quality improvement interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, practitioners or services.

- Developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to practitioners/providers, Members or staff as appropriate.
- Educating practitioners/providers about clinical standards and practice guidelines.
- Monitoring the receipt of and compliance with standards and guidelines by practitioners/providers.
- Providing feedback to practitioners/providers to inform them of specific findings of QI reviews pertaining to the provider in question.

- Providing health promotion and health education programs to inform Members of ways to improve their health or their use of the health care delivery system.
- Modifying administrative processes to improve quality of care, accessibility and service. These processes may include, but not limited to, customer services, utilization management and case management activities, preventive services and health education.
- Modifying the practitioner/provider network, including adding practitioners/providers to improve accessibility.
- Taking disciplinary action against practitioners/providers.
- Conducting Joint Operations Committee (JOC) meetings with the delegated PPG for the purpose of education and dissemination of new materials, tools and standards.
- Providing information to members in the threshold languages.

Quality Studies (HEDIS/QISMC/QIA/Focused Review Studies)

QI Department staff will perform quality studies, as indicated, based on findings from reviews of QCIs, 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 of California Promise Health Plan will participate with collaborative plans and regulatory agencies in state- required HEDIS/QISMC/QIA studies. Studies conducted jointly with regulatory agencies will be in accordance with regulatory agency and state requirements. Quality studies conducted independent of regulatory bodies will be in accordance with Blue Shield of California Promise Health Plan policies and procedures.

Sentinel Events

A major component of the QI Program is the use of sentinel events to monitor important aspects of care, accessibility and service.

Credentialing

Blue Shield of California Promise Health Plan conducts a credentialing process that is in compliance with all regulatory and oversight requirements.

7.14 : Communication of Information

All QI activities are presented and reviewed by the Medical Services Committee. Communication to the Quality Management Committee may include but not limited to:

- Member grievance statistics and trends
- Sentinel events
- Study outcomes
- Policies and Procedures
- Medical record and facility audit reports and trends
- Delegation audit results
- Satisfaction survey results
- UM referral statistics and trends
- QI Activities
- QI Program, work plan, annual evaluation and quarterly reports

- Regulatory and legislative information
- Access & availability studies

Information concerning the QI Program and a progress report are communicated to practitioners/providers and Members in the most appropriate manner including, but not limited to:

- Correspondence with the practitioners/providers showing individual results and a comparison to the group
- Newsletter articles
- Fax Blast updates
- Practitioner/Provider Manual updates

The QI Program description is made available to all practitioners and members. Members and practitioners are notified of the availability of the QI Program through the Member Handbook and Provider Manual, and website, respectively.

QI Program and Policies & Procedures

The QI Program and its policies and procedures are reviewed annually and revised, as needed, to meet good medical practices; the needs of the Plan, its members and practitioners/providers; the changing demands of the healthcare industry, and regulatory requirements. The program and its policies and procedures are reviewed by the CMO then submitted to the Quality Management Committee and BQIC for review and approval.

Annual Work Plan

The QI work plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement. The work plan is developed annually outlining QI activities for the year, and includes all activities not completed during the previous year, unless identified in the annual evaluation as issues that are no longer relevant or feasible to pursue. The work plan is reviewed by the CMO then submitted quarterly to the Quality Management Committee and BQIC for evaluation, review and comment.

Annual Program Evaluation

Quality improvement activities, as defined by the QI work plan, will be evaluated annually to measure the Plan's performance for the year and to assist in revising the QI program and preparing the following year's work plan. The evaluation is reviewed by the CMO and submitted to the Quality Management Committee and BQIC for review and approval.

Interdepartmental Relationships

Utilization Management Department

The UM Department frequently identifies potential risk management, quality of care issues, and health education needs through case management, inpatient review, utilization review, referrals, etc. The Quality Improvement Department can refer cases to the UM Department for active Case Management of members with identified chronic conditions.

Member Services Department

When a Member Services representative identifies a potential quality of care issue from a member

call, it is forwarded to the QI Department for investigation and resolution.

Member Services records all incoming calls by specific indicators for tracking, trending and reporting.

Provider Relations/Contracting Department

The Provider Relations/Contracting Department assists the QI Department in obtaining QI information from and disseminating information to practitioners. In addition, the Provider Relations/Contracting Department:

- Serves as a liaison between the QI Department and practitioners/providers to facilitate education and compliance with approved Blue Shield of California Promise Health Plan standards.
- Schedules Joint Operating Committee meetings.
- Serves as a liaison with delegated Medical Groups/PMGs.
- Assists the QI Department with practitioners/providers who do not comply with requests from the QI Department.
- Ensures contracted ancillary practitioners/providers and facilities meet regulatory and accreditation requirements.

Health Education Department

The Health Education Department and QI Department work together on projects related to practitioner/provider and Member education. The Health Education Department is part of the UM Department. Educational opportunities identified through complaints, grievances, quality of care issues, facility site review audits, focused review studies, etc., are forwarded to the Health Education Department. The QI Department also works with the Health Education Department on preventive service guidelines, 120-day initial health assessments and Staying Healthy Assessment compliance.

Credentialing Department

The Credentialing Department is part of the QI Department. Quality improvement information is provided to the Credentialing Department for inclusion in the credentialing/recredentialing process. The QI Department provides the Credentialing Department with facility site review, medical record audit scores and any sanction activity related to those reviews and with identified QCIs, as appropriate. The AVP of PI & QI works with the Credentialing Department to take peer review cases, as directed by the CMO, to the Peer Review Committee for review and action.

7.2 : Policies & Procedures

7.2.1 : Confidentiality of Quality Improvement Information

Policy

All QI activities designed to monitor or improve medical care shall remain confidential. All information related to the QI process is considered confidential. All QI data and information including, but not limited to, minutes, reports, letters, correspondence, and reviews are housed in a secured area in the QI Department. All aspects of a quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the

Quality Management Committee and any of its subcommittees.

Confidentiality shall be maintained in accordance with all applicable laws and regulations and standards of practice.

Procedure

1. All Member-identified information is kept confidential by all employees, consultants and caregivers, except to the extent needed to accomplish appropriate coordination and continuity of care among medical, nursing, ancillary and other team Members who may need to exchange information for provision of care.
2. Member protected health information (PHI) can only be reviewed by QI personnel that are involved in the actual investigation of the issues. This includes the CMO, AVP of PI & QI, QI nurse specialist. The AVP of PI & QI is ultimately responsible for assuring the protection of PHI.
3. All Member information is considered PHI and will be de-identified prior to being presented to the committee for review. Member information includes but is not limited to: names, addresses, dates, telephone numbers, fax numbers, e-mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, serial numbers, URLs, internet address, biometric identifiers and photographs.
4. All case files will be protected and kept in a secured, locked area at all times. Printers and copiers used for this information will be kept in a secure location, where only the authorized personnel (see above) will have access.
5. Only the minimum necessary information will be requested for the review and investigation of these issues.
6. Member-identified information may also be shared in the following circumstances:
    a. As consented to as part of an insurance plan and then held in confidence as part of Plan policy.
    b. As required by state and federal agencies and their designees as part of medical record availability, eligibility information, requests for authorization or referral to their agencies or their designees. De-identified Member issues are discussed within the confidentiality protection of the Quality Management Committee and other peer review bodies.
    c. Committee Members and staff shall sign and adhere to a Confidentiality Statement as it relates to the committee's functions.
7. All Members of the QMC, Medical Services, Pharmacy & Therapeutics and Credentials/ Peer Review Committees and any subcommittees of those committees will sign a confidentiality statement, which shall remain in effect for a one-year period and will be maintained in the appropriate department.
8. Any employee, consultant or representative in any way involved in the QI process will sign a confidentiality statement upon employment or contract inception.

7.2.2 : Potential Quality Issue and Quality of Care Issues

Policy

To provide a process for the identification, investigation, and resolution of those issues, concerns, or complaints and clinical grievances received directly at Blue Shield of California Promise Health Plan which may Potential Quality Issues ("PQI") or are Quality of Care Issues ("QCI") for all

provider types, including dental providers.

Procedure

1. All cases which may be a PQI or QCI are forwarded to the QI Department for evaluation and review. PQIs and QCIs may be forwarded by any department or committee including, but not limited to, the following:
   - Appeals & Grievance Department
   - Member Services Department
   - Utilization Management Department
   - Provider Relations Department
   - Claims Department
   - Credentialing Department
   - Culturally and Linguistically Appropriate Services (CLAS) Department
   - Chief Medical Officer ("CMO")
   - Medical/Dental Director
   - QI Staff
   - Blue Shield of California Promise Health Plan or subcommittees
   - External Sources:
     a. Regulatory agencies
     b. Practitioner/Provider offices
     c. Medical facilities and hospitals
2. Any of the following descriptions, as perceived by the member or Practitioner, identified by a Blue Shield of California Promise Health Plan department, or referred from an external source, may be considered a PQI/QCI (clinical) issue and referred to the PQI Department:
   a. Appeals & Grievance Department – Any member issue, concern, relation to a practitioner or any allegation involving clinical practice or judgment, including dental related issues. Routine assessment of Primary Care Practitioner (PCP) transfer requests from member to identify any trend issues.
   b. Member Services – Any member issue, concern, relating to a practitioner or any allegation involving clinical practice or judgment, including dental related issues. Routine assessment of Primary Care Practitioner (PCP) transfer requests from member to identify trend issues.
   c. Utilization Management – Any systems-related issue such as delays or inconvenience caused by internal processes, delay in planned service at Practitioner or Provider level, or any Sentinel Event (see QI P&P 70.1.1.11).
   d. Provider Services – Any systems issues caused by internal processes at the Practitioner level or any contractual issues involving clinical practice and judgment.
   e. Claims Department – Any PQI/QCI issue identified by Claims staff or from ongoing Claims review process conducted by QI Nurse Specialist.
   f. Credentialing Department – Any PQI/QCI issue identified by Credentialing staff or Credentialing Committee.

g. Culturally and Linguistically Appropriate Services (CLAS) Department- Any PQI/QCI issue identified by the Culture and Linguistic staff.

h. Practitioner Complaint/Grievance – Any PQI/QCI issue identified by the QI staff, CMO/ Medical/Dental Director or any QI committees.

i. Quality Improvement Department- Any PCI/QCI issue identified by the QI staff, CMO/ Medical/Dental Director or any QI Committees.

3. When any of the above becomes aware of a PQI/QCI issue, a PQI referral with all pertaining information is forwarded to the Quality Department via the Quality.Review@blueshieldca.com inbox. The QI Clinical Nurse Specialist or designee will apply the appropriate issue code(s) to the case and forward it to the PQI Coordinator for entry into the QI database. Case will be reviewed by the QI Nurse Specialist following the PQI/QCI review process (refer to #5).

4. When the Appeals & Grievance Department receives a grievance:

   a. The QI Nurse Specialist or designee will code grievance received by the Appeals

   b. & Grievance department using the Quality of Service and Quality of Care codes within 24 hours of receipt.

   c. Grievance(s) coded with Quality of Care codes are considered clinical grievances and are automatically forwarded to PQI department for investigation.

   d. Grievance(s) coded with Quality of Service codes are reviewed and leveled in the grievance database. The QI Nurse Specialist or designee will review grievances and determine whether to close with Level 0 or Level 1 within the grievance database. (Refer to P&P Title: 70.1.1.5 Assigning Quality Improvement Severity level)

      - Level 0- No Quality of Care: No QI investigation warranted
      - Level 1- Acceptable Quality of Care: Track & Trend

   e. Any grievance, needing further investigation determined by the QI Nurse Specialist or designee, regardless of code, will be sent to the PQI department.

5. The PQI/QCI Review Process:

   The QI Nurse Specialist will professionally recognize standards of care to assess the care provided. A PQI/QCI may be a single event or occurrence. While one report alone may not represent a quality issue, trending of similar events may reveal a quality issue and may lead to the re-opening of a case previously reviewed or closed.

   a. The PQI Coordinator will date stamp the PQI/QCI upon receipt, enter the case into the QI database and assigns the case to the QI Nurse Specialist within 2 business days.

   b. The QI Nurse Specialist will clinically review the case to identify any potential quality of care related issues. The QI Nurse Specialist will request medical records and a written response from the appropriate source (e.g. clinic, practitioner/provider facility, PPG, ancillary agency) to be submitted within the designated timeframe. The medical records and a written response will be requested by mail, secure email, and or fax.

   c. When all information is obtained the PQI Coordinator, the QI Nurse Specialist completes the Case Summary and forwards the case along with all supporting documentation to the Chief Medical Officer (CMO)/Medical Director (MD) and or Physician Reviewer for recommendations. The case abstract with a completed chronology of events and conclusion should be forwarded to the CMO/MD/Physician Reviewer for determination.

d. The CMO/MD/Physician Reviewer designees will review the PQI/QCI utilizing all available information, including medical records and the provider response, specifically related to Quality of Care and will appropriately assign a severity level. If the MO/MD/Physician Reviewer designee determines a quality of care issue exists, one or more of the following actions will be taken by the CMO/MD/Physician Reviewer designee:

- Verbal or written communication to the PPGs requesting additional information for the identified issue(s). If warranted and within the 30-day timeframe.
- Assign a severity level if necessary information or documentation is complete.
- Assign the corrective action plan as warranted. A letter will be sent clearly stating the concerns, with a specific corrective action plan and timeframes, as applicable.
- Refer the case to the Peer Review Committee for action.
- Elect to send the case to a third-party review for consultative expertise.
- After final determination, the CMO/MD/Physician Reviewer designee will close the case by completing the Case Review Summary and assigning a Severity Level.
  Level 0: **No** Quality of Care issues
  Level 1: **Appropriate** Quality of Care
  Level 2: **Borderline** Quality of Care
  Level 3: **Moderate** Quality of Care
  Level 4: **Serious** Quality of Care Issue
  Level 5: **Significant** Quality of Care
  (Refer to policy 70.1.1.5 Assigning Quality Improvement Severity level)

e. On case closure, the QI Nurse Specialist enters final closure information into the QI database. On completion of the case closure, the QI Nurse Specialist will ensure the following:

- If CMO/MD/Physician Reviewer designee assigns a Level 2, a written notification will be sent to the identified entity.
- If CMO/MD/Physician Reviewer designee requests a corrective action plan, the written notification will clearly state the concerns, with a specific corrective action plan with timeframes, as applicable.
- Regardless of assigned level, if CMO/MD/Physician Reviewer designee warrants an education letter, a written notification will be sent to practitioner/provider.
- All follow up written notifications will be completed by the QI Nurse Specialist within (5) business days of the CMO/MD/Physician Reviewer designee request.
- If the CMO/MD/Physician Reviewer designee refers case to Peer Review committee, third party of Medical Services Committee, the QI Nurse Specialist will prepare the case.

f. PQI's cases will be completed within 180 days of receipt into the Quality Department unless there are extenuating circumstances.

g. Any follow-up or monitoring required by the assigned corrective action plan will be tracked by the QI Nurse Specialist and documented in the QI Database.

6. When a request is received in writing from a Practitioner/Provider for reconsideration on a closed case, the following actions will be taken:

a. The CMO/MD/Physician Reviewer designee will review the written response and may elect to reevaluate the case based on additional information.

b. If there is a change in severity level and/or corrective action plan, or the initial determination stands, the Practitioner/Provider will be notified in writing by the QI Nurse Specialist.

c. The QI Nurse Specialist will modify the database to reflect any changes as a result of reevaluation.

7. All information for each case, including all written correspondence, case summary, and all applicable documentation is maintained in the QI Database for a period of not less than ten (10) years or in accordance with applicable laws.

7.2.3 : Assigning QI Severity Level

Policy:

Upon completion of a case review, for either a member grievance or potential quality of care issue, the Blue Shield of California Promise Health Plan Chief Medical Officer (CMO)/Medical Director (MD) or Physician Reviewer will assign an appropriate severity level. The severity level system is a numerical system. The QI Department tracks and trends all cases with a severity level to identify any trends or issues.

Procedure

1. At the conclusion of a QI case review, the CMO/MD/Physician Reviewer determines if the care rendered was within acceptable professional standards.
2. After CMO/MD/Physician Review reviews the case, he or she assigns an appropriate severity level to the case or refers the case to Peer review for determination.
3. Severity level category guidelines include but are not limited to:

   Level 0 - No Quality of Care Issues:

   - Track and Tend
   - No QI Investigation warranted

   Level 1 - Appropriate Quality of Care:

   - Unsubstantiated allegations
   - Unavoidable complication
   - Known complication
   - Unavoidable progression of disease or condition

   Level 2 - Borderline Quality of Care Issue:

   - Illegibility
   - Incomplete, inappropriate documentation
   - Delay or failure in referral
   - Attitude issues
   - Miscommunication
   - System issue without adverse outcome
   - Access related issue without adverse outcome
   - Failure to respond to potential quality issue request

   Level 3 - Moderate Quality of Care Issue:

- Delay/inappropriate treatment
- Inadequate work-up
- Preventable hospitalization or re-admission
- Delay or failure in referral
- Medication error with adverse outcome
- Delayed/misdiagnosis

Level 4 - Serious Quality of Care Issue:

- Preventable serious complication
- Preventable death
- Preventable disability
- Practice that results in a serious adverse effect

Level 5 - Significant Quality of Care Issues:

- Loss of life
- Loss of limb

4. Issue Related Entity will be identified with severity level:

   A. Physician Related

   B. Site/Division Related

   C. System-Wide Related

5. If practitioner/provider does not provide a response and or supporting documentation to the potential quality issue; the QI department considers this a borderline Quality of Care Issue. The QI Nurse Specialist will automatically assign a Level 2 for no response/noncompliance.
6. If a practitioner/provider has had a previous case(s) with the same or similar circumstances, this may warrant the assigning of higher severity level and/or additional corrective action requirements, at the discretion of the CMO/MD/Physician Reviewer.

7.24 : Peer Review

Policy

The Chief Medical Officer (CMO) and or the QI Medical Director at Blue Shield of California Promise Health Plan reviews all quality of care or potential quality of care issues. In the event the CMO and or the QI Medical Director does not hold the expertise or feels the issue is of such a high severity level or needs additional input in any case, he/she may forward the case to the Peer Review Committee.

Blue Shield of California Promise Health Plan will utilize the appropriate specialties/subspecialties for peer review cases. Cases that the CMO determines need additional expertise and review will be sent to an outside review company and will be reviewed by a same specialty board-certified physician.

Procedure

1. The CMO will review and act on all complaint/grievance and PQI cases going to Peer review in accordance with established policies.

2. In the event the CMO decides additional expertise is needed, the case may be sent to an outside consultant or to the Peer Review Committee or Medical Services Committee, depending on the nature and urgency of the case.
3. Patient and practitioner/provider names in all peer review cases reviewed by an outside consultant, Peer Review Committee or Medical Services Committee will be de-identified to maintain patient and practitioner/provider confidentiality.
4. In the event the CMO or peer review body determines a case needs review by a specialty/subspecialty it will be sent to an outside review organization to be reviewed by a board-certified provider of the same specialty.
5. The CMO will be responsible for ensuring all actions of the peer review body are carried out and monitored. The CMO will make follow-up reports to the appropriate committee, as necessary.
6. The CMO will review all corrective action plans for completeness and appropriateness. The QI nurse specialist will track all required corrective action plan activities and report to the CMO.
7. In the event a practitioner/provider does not complete the actions required by the peer review body, the CMO will report such to the Peer Review Committee.
8. The QI nurse specialist will maintain case files for all peer review cases.

7.25 : Sentinel Events

Policy

The UM Department will identify sentinel events and refer cases to the QI Department as a potential quality issue (PQI). Sentinel events will be assessed for quality of care issues and actions will be taken, as appropriate, and reported to the Medical Services Committee to identify opportunities for improvement.

Procedure

1. The list of sentinel events below is approved annually by the Medical Services Committee.
2. When a sentinel event occurs, the UM Department refers the case to the QI department by submitting a PQI Referral via the Quality.Review@blueshieldca.com inbox. The QI nurse specialist processes the PQI in accordance with the PQI and OCI Policy and Procedure.

000	Mortality	**015**	Retired
001	Unexpected Death	**016**	More than 2 ER visits/month
002	Asthma Admission	**017**	Sepsis
003	Breast Malignancy	**018**	Retired
004	Pregnancy Induced Hypertension	**019**	Prescription Drug Related Admission
005	Pulmonary Emboli	**020**	Over and Under Utilization
006	Diabetic Admission	**021**	Continuity and Coordination of Care
007	Low Birth Weight Infant	**022**	Cultural and Linguistic Issues
008	GI Catastrophe	**023**	Access Issues
009	Readmission with 30 days	**024**	Admission for CVA
010	Medical Management Issue	**025**	Admission for COPD

011	Surgical Management Issue	**026**	Admission for CHF
012	Hypertensive Admission	**027**	Hip Fracture
013	Cervical Malignancy	**028**	Admission for CAD/MI
014	Delay in Service or Authorization	**015**	Retired

7.2.6 : Practitioner/Provider Requests to Terminate Patient-Provider Relationship

Policy

Blue Shield of California Promise Health Plan has a system in place for a practitioner/provider to report a Member's noncompliant or abusive behavior. Blue Shield of California Promise Health Plan will work with the practitioner/provider to improve the Member's compliance to their medical treatment plan. Blue Shield of California Promise Health Plan reviews cases for clear documentation of noncompliant behavior or abusive behavior and assists the practitioner/provider in transferring Members to a new practitioner/provider when the behavior has adversely affected the patient-practitioner/provider relationship.

Procedure

1. When a practitioner/provider has a Member that is exhibiting noncompliant behavior it is his/her responsibility to document this behavior in the Member's medical record.
2. Examples of noncompliant behavior include:
   a. A member not adhering to their treatment plan after several attempts by the practitioner/provider to change the behavior. Examples of this include:
      - Chronically missing appointments
      - Not taking medications or adhering to scheduled treatments
      - Narcotic drug seeking behavior
      - Inappropriate ER visits
   b. A Member or a family member of the Member exhibits abusive behavior. Examples of abusive behavior include:
      - Use of excessive profanity even after being asked to refrain from the behavior
      - Threatening behavior towards the practitioner/provider or office staff
      - Threatening behavior towards other Members or family Members
      - Constant abusive and disruptive behavior that hinders the practitioner/provider and office staff in the care of other Members in the facility
3. When a Member exhibits non-compliant or abusive behavior, it is the responsibility of the practitioner/provider to report it immediately to the Blue Shield of California Promise Health Plan QI nurse specialist.
4. When the practitioner/provider requests the Member be removed from his/her care, he/she must submit the request on the required form (*See* **Appendix: 5** Practitioner/Provider Request to Terminate Patient/Provider Relationship Form). The practitioner/provider is required to submit the request along with all necessary medical records and documentation of the Member's behavior.
5. The Chief Medical Officer/Medical Director/Physician Reviewer designee will review all

requests from practitioners/providers to terminate the provider/patient relationship. The CMO/MD/Physician Reviewer designee will take action and may include any of the following:

a. Refer the Member's case information to case management in an attempt to change the non-compliant behavior.
b. Instruct the practitioner/provider that more documentation is needed before a determination can be made.
c. Remove the Member from the practitioner/provider's care and reassign to another provider/practitioner.
d. Refer the case to peer review for review and action.

6. If it is determined that the Member is to be removed from the practitioner/provider's care, the practitioner/provider will be instructed to send the Member a Blue Shield of California Promise Health Plan approved letter explaining the decision.
7. The Blue Shield of California Promise Health Plan Member Services Department will contact the Member to assist them in selecting a new practitioner/provider.
8. If it is determined that the Member should not be removed from the practitioner/provider's care, the CMO/MD/Physician Reviewer designee will give the practitioner/provider guidance to successfully continue the relationship.
9. If the patient-practitioner/provider relationship is not terminated and the non- compliant or abusive behavior continues, the practitioner/provider may resubmit the request to terminate the relationship.

7.3: Quality of Care Focused Studies

Policy

The Blue Shield of California Promise Health Plan QI 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 of California Promise Health Plan participates with regulatory agencies in the state-mandated Quality Improvement System for Managed Care (QISMC), Health Plan Employer Data and Information Set (HEDIS), and Quality Improvement Activities or Projects (QIAs or QIPs). Studies conducted jointly with regulatory agencies will be in accordance with state requirements. Focused review studies conducted independent 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.
   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 study
      - The method of data collection (e.g., administrative data, medical record review or 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, severity of illness, or other variables, which may affect the findings, will be made?
      - What is an acceptable level of performance?
3. The QI Department, in conjunction with the CMO 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 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
- Provide educational materials that may be relevant to understanding and treating the population to practitioners/providers
- Develop clinical practice guidelines through collaboration with SDHS and other collaborative plans
- Address any practitioner/provider-specific concerns through the peer review process

d. Implementation schedule

e. Monitoring plan

The results, interpretation and action plan will be presented to the QMC for review and approval and then forwarded to the BQIC.

4. Reports will be made to the QMC as required by the action plan.
5. Results will be made available to Members and practitioners/providers through newsletters, bulletin faxes, special mailings, etc., as appropriate.
6. Sources for standards, norms and guidelines pertaining to the measurement of quality of care include, but are not limited to, the following:
   - NCQA standards for quality and utilization management
   - Other independent credentialing, certification and accreditation organizations, including JCAHO, CMRI, The Quality Commission, AAAHC and URAC
   - HEDIS Medicare performance standards
   - Medicare performance standards
   - Federal Agency guidelines including the Centers for Medicaid and Medicare Services (CMS), 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 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
   - MCG and Robertson 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

7.4: Practitioner/Provider and Member Satisfaction Surveys

Practitioner/Provider Satisfaction Survey

Blue Shield of California Promise Health Plan will conduct a practitioner/provider satisfaction survey with all contracted PCPs and high-volume specialists at least annually. Results will be summarized and reported to the appropriate departments and committees for follow-up and action.

Member Satisfaction Survey

Blue Shield of California Promise Health Plan will conduct a Member Satisfaction Survey at least annually. Results will be summarized and reported to the appropriate departments and committees.

7.5: Clinical Practice Guidelines

Policy

Blue Shield of California Promise Health Plan recognizes that clinical practice guidelines are a useful resource for improving the quality of clinical care and standardizing the level of care given to Members with acute and chronic diseases. Blue Shield of California Promise Health Plan has adopted the guidelines approved by local regulatory agencies as required and develops its own guidelines.

Procedure

1. The Medical Services Committee is responsible for developing, reviewing, and updating clinical practice guidelines that may be used by practitioners/providers. The Medical Services Committee will review and adopt the guidelines developed by local regulatory agencies and collaborative Plans. Guidelines will be reviewed at least every two (2) years.
2. Guidelines are distributed to direct-contracted PCPs and delegated PPGs as they are developed and/or revised through educational sessions, mailings, newsletters and updates to the Provider Manual.
3. Decision-making in UM, Member education, interpretation of covered benefits and other areas to which the clinical practice guidelines apply will be consistent with the guidelines.

7.6: Access to Care

7.6.1: Access to Care Standards

Policy

Blue Shield of California Promise Health Plan will ensure that all primary care practitioners/ providers are in compliance with approved Access to Care Standards *(**See** **Appendix 6**)*. Compliance with these standards is monitored through Member complaints and grievances, PQIs, Member Satisfaction Surveys, medical record reviews, disenrollments, PCP transfers and annual

access surveys.

Procedure

1. 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 of California Promise Health Plan 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. Afterhours access issues will be referred to QI as a potential quality issue (PQI) and handled in accordance with approved procedures.
2. The Plan's Access to Care standards provide that no Member be required to travel any unreasonable distance or for any unreasonable period of time in order to receive covered services. For the purposes of these standards, "reasonable" is determined by analysis of the following factors:
   a. The population density of the geographic area traveled.
   b. Typical patterns of traffic congestion throughout the day.
   c. Established travel patterns in the community.
   d. Established patterns of medical practice in the community.
   e. Natural boundaries and geographic barriers to travel.
   f. Any other relevant factors.

   For Medicare, the minimum number of provider/facilities, network time and distance criteria vary by county type, specialty type, and by year. Please refer to the attachments of CMS standards for network adequacy in Policy # 70.1.1.29.
3. The provider contract allows the Plan to monitor accessibility and requires contracted providers to abide by standards established for accessibility. The provider contract also specifically provides that Members will not be discriminated against with respect to physical accessibility to care. The provider will also ensure reasonable accessibility to emergency services, after hour's coverage and minimal weekly availability for the provision of health care services.
4. The practitioner/provider contract also mandates participation in the Plan's quality of care review program. Participation in the quality of care review program requires practitioner/ provider cooperation with the assessment of quality of care, accessibility and utilization patterns. The contracted practitioner/provider agrees to take any appropriate remedial action deemed necessary by the Plan.
5. Access & Availability surveys are conducted at least annually using the Access to Care standards as a benchmark. Performance is measured for compliance with the guidelines. Standardized methodology appropriate for this type of survey will be used. Provider types as

determined by established methodology are audited annually by the Plan.

6. Access & Availability survey results are reviewed by the Quality Improvement Department and the Medical Services Committee, where opportunities for improvement are identified and discussed. Results and quality activities are reported to the BQIC. Results are communicated to individual providers and to delegated PPGs through performance notifications, JOCs, newsletters, etc.
7. Selected interventions are implemented to improve performance. These may include written counseling and/or written corrective action plans for physicians not complying with the Access to Care standards. Continued noncompliance may result in referral to the Peer Review Committee for action up to and including termination. Interventions may also include global education for providers and PPGs regarding the standards.
8. The effectiveness of the interventions is evaluated or re-measured. Additional telephone or mail surveys may be conducted to further evaluate a particular finding.
9. Access to care is also monitored and tracked through Member satisfaction surveys, Member complaints and grievances, potential quality of care issues, Member requested disenrollments and transfers, emergency room utilization and facility site reviews.
10. PPGs are expected to ensure that each practitioner/provider in their network receives and complies with the attached Access to Care standards.

7.6.2 : Monitoring Process

The effectiveness of this policy will be monitored through oversight by regulatory agencies including DMHC, CMS and accrediting entities. Effectiveness will also be measured annually through the annual access to care studies.

7.7: Broken/Failed Appointments

7.7.1: 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 who fail to keep scheduled appointments.

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.

Procedure

1. To assure timely and efficient recall of patients who fail to keep scheduled appointments. The primary 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:

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 to the primary care practitioner/provider.
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 one time by phone. If 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.
9. Every attempt to contact the patient, with 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.
10. 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/failed appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 6 – Enter date, signature and title of person doing recall activity.

11. The broken/failed appointment will also be documented in the appointment schedule for tracking purposes.
12. 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.
13. 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.

7.8: Advance Directives

A primary care practitioner/provider is required to educate each Member 18 years or older about advance directives. This must be documented in the medical record. The Member does not need to sign any advance directive but must be informed and educated about what an advance directive entails.

7.9: 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.

Services which 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 of California Promise Health Plan contracts with a certified vendor for after-hours Nurse Advice line.

7.10 : HEDIS Measurements

Use of Practitioners/Providers Performance Data

Practitioners and Providers will allow Blue Shield of California Promise Health Plan to use your performance data for quality improvement activities (e.g., HEDIS, clinical performance data).

Measure	Criteria	Description
1. Adult BMI Assessment (ABA)	Blue Shield of California Promise Health Plan will audit Members records age 18–74 and have been continuously enrolled for two years and determine if a BMI was done during that timeframe.	Members should have a documented BMI within the past two years
2. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Blue Shield of California Promise Health Plan will audit Members that are age 18 years and older who were diagnosed with rheumatoid arthritis. There must not be more than a one- month gap in enrollment during the measurement year.	Members who were diagnosed with rheumatoid arthritis must have been dispensed at least one prescription for a disease modifying antirheumatic drug (DMARD) during the measurement year.
3. Controlling High Blood Pressure (CBP)	Blue Shield of California Promise Health Plan will audit Members that are Age 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
4. Comprehensive Diabetes Care (CDC)	Blue Shield of California Promise Health Plan will audit Diabetic Members that are age 18-75 years of age during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.	Diabetic Members must have the following done during the past year: • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) • Retinal eye exam performed • Medical attention for nephropathy • BP control (<140/90 mm Hg)

Measure	Criteria	Description
5. Care for Older Adults	Blue Shield of California Promise Health Plan will audit Members that are age 66 and older during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.	The Member must have each of the following during the measurement year: • Advanced Care Planning • Medication Review • Functional Status Assessment • Pain Screening
6. Colorectal Cancer Screening (COL)	Blue Shield of California Promise Health Plan will audit Members that are age 50 – 75 who had appropriate screening for colorectal cancer.	Members should have one or more following screenings for colorectal cancer: • Fecal occult blood test (FOBT) during measurement year • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year • CT colonography during the measurement year or the four years to the measurement year • FIT-DNA test during the measurement year or the two years prior to the measurement year
7. Medication Reconciliation Post-Discharge (MRP)	Blue Shield of California Promise Health Plan will audit Members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge	Members who were discharged from an acute or nonacute inpatient on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: • Identify all acute and nonacute inpatient stays • Identify the discharge date for the stay

Measure	Criteria	Description
8. Osteoporosis Management in Women who had a Fracture (OMW)	Blue Shield of California Promise Health Plan will audit female Members that are age 67-85 during the measurement year and suffered a fracture. There must not be more than a one-month gap in enrollment during the measurement year.	Female Members who suffered a fracture must have had either a bone mineral density (BMD) test or prescribed a drug to treat or prevent osteoporosis within six months after the fracture.
9. Plan All-Cause Readmissions (PCR)	Blue Shield of California Promise Health Plan will audit Members 18 years of age and older that have acute inpatient stays that were followed by an unplanned acute readmission	Members that have had an acute inpatient stay that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
10. Transitions of Care (TRC)	Blue Shield of California Promise Health Plan will audit Members that are 18 years of age and older who have had a notifi of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, medication reconciliation post-discharge	The Member must have each of the following during the measurement year: • Notifi of inpatient admission o Documentation of receipt of notifi of inpatient admission on the day of admission or the following day • Receipt of discharge information o Documentation of receipt of discharge information on the day of discharge or the following day • Patient engagement after inpatient discharge o Documentation of patient engagement provided within 30 days after discharge • Medication reconciliation post-discharge o Documentation of medication reconciliation on the date of discharge through 30 days after discharge

SECTION 8: ENCOUNTER DATA

8.1 : Encounter Data - Medicare

Policy & Procedures

Encounters include all services for which Medical Group is responsible. Medical Groups shall submit encounter data at least once monthly but more frequently is preferred. Medical Group shall submit complete and accurate data in 837P, 837I & 837D formats using the national standard codes acceptable by Blue Shield of California Promise Health Plan within thirty (30) calendar days from the Date of Service ("DOS") in which care was rendered. The Medical Group must meet all data quality measurements established by Blue Shield of California Promise Health Plan and is responsible for correcting and re-submitting all rejections to Blue Shield of California Promise Health Plan within 10 days of notice received.

All encounters must be submitted electronically using 837 5010 format. Standardized 5010 EDI Response files will be provided for all encounter files received. If you have encounter data submissions questions or if you would like know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com.

Encounter Data submissions must meet all requirements outlined in the Companion Guides and are exchanged through the established secure server.

Blue Shield of California Promise Health Plan will provide a report card to the Medical Group on a regular basis and will use this report card to evaluate the encounter data quality performance.

Providers who are contracted with Blue Shield of California Promise Health Plan 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.

COMPLIANCE GUIDELINES

Volume of the data

The Centers for Medicare and Medicaid Services' (CMS) payment methodology is a risk- adjusted payment rate based on the reporting of encounter data. Therefore, it is important to comply with encounter submission requirements and to report all services appropriately to meet established Encounter data Quantity targets.

Quality of the data

The Blue Shield of California Promise Health Plan collects information regarding the utilization of primary care, hospital inpatient and outpatient, specialty and ancillary services by its Members. Data acceptance rate shall not be less than 90% of all data submitted. Medical Group is responsible to correct the rejections and re-submit the corrections to Blue Shield of California Promise Health Plan within 10 days of notice received.

Timeliness of the data

Encounter records shall be submitted within thirty (30) calendar days from Date of Service ("DOS") in which care was rendered.

8.2: Encounter Data Contact Requirement

Blue Shield Promise Health Plan requires that anyone responsible for submitting encounter data provide primary and secondary contact information to Encounter_Ops@blueshieldca.com. Contact information includes the following:

- Office Telephone #
- Business Cell #
- Fax #
- Email

SECTION 9: CLAIMS

9.1: Claim Submission

Blue Shield of California Promise Health Plan applies the appropriate regulatory requirements related to claims processing.

A. Blue Shield of California Promise Health Plan accepts claims submitted electronically or using papers. Refer to Blue Shield of California Promise Health Plan website for updated list of electronic claims vendors. We encourage each provider to submit claims electronically as it can speed claims processing and avoid delays.

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:

Excela- BSCPHP
P.O. Box 272660
Chico, CA 95926

B. Providers must ensure all claims submitted to Blue Shield of California Promise Health Plan are clean and accurate. Clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

When submitting paper claims, all required/mandatory fields in the current CMS- 1450 or UB format adopted by the National Uniform Billing Committee and CMS- 1500 adopted by the National Uniform Claim Committee (NUCC).

When submitting claims electronically, claims must be HIPAA compliant and meet all requirements for EDI transactions. If you have electronic claim submission questions or if you would like to know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com

Claim Data submissions must meet all requirements outlined in the Companion Guides and are exchanged through the established secure server.

C. Claim Filing Limits
Providers must submit clean claims to Blue Shield of California Promise Health Plan within one calendar year from the date of service. For contracted provider, claims must be submitted within the specified timeframe as stated in your contract.

9.2: Claims Processing Overview

A. Blue Shield of California Promise Health Plan makes every effort to ensure clean claims that are Blue Shield of California Promise Health Plan financial responsibility are processed (paid or denied) within 30 calendar days of receipt from non-contracted providers. All other claims are processed (paid or denied) within 60 calendar days of receipt.

B. Misdirected Claims
   a. Claims that are financial responsibility of the Participating Provider Group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.
   b. Billing Providers receive notices from Blue Shield of California Promise Health Plan identifying the responsible payers.

C. Reimbursement Rates
   a. To be eligible for payment, the claim must be clean and accurate.
   b. Contracted providers are paid at contracted rate;
   c. Non-contracted providers are paid at Medicare established rates

D. Interest payments are applied to clean claims from non-contracted providers that are not paid within 30 calendar days. Interest is paid for the period of the time that the payment is late. Interest rate is based on rate published by the Treasury Department.

E. Balance Billing
Beneficiaries are only responsible for plan allowed cost-sharing (copay/coinsurance). Members shall not be balance billed for any covered/authorized or approved services.

F. Overpayment Recovery
Blue Shield of California Promise Health Plan notifies provider of service in writing within three calendar year of the last claim payment when an overpayment is discovered. If the provider does not respond to the overpayment request within 41 calendar days from the first demand letter, Blue Shield of California Promise Health Plan will begin offsetting payments of future claims equivalent to the overpayment amount.

G. Emergency claims
Emergency claims are paid without prior authorization. Legible emergency department reports must be submitted when billing with ER level 5. ER level 5 are forwarded and reviewed by a physician. Physician Reviewer determines whether or not service meets the requirements of emergency level 5.

H. 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.

I. 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. Claims for these services without prior authorization will result in payment denials.

J. Outpatient and other claims
Ambulatory services, outpatient surgeries, ancillary and specialty services require prior authorization. Claims for these services without prior authorization will result in payment denials with the exception of services established as no prior authorization required under the direct referral process. Please refer to **APPENDIX 7** for the listing of services.

9.3: Claims Status Inquiry

Providers may verify a claims status within 15 days of submission to Blue Shield of California Promise Health Plan by calling 1- 800-468-9935 ext. 3 or by checking the Blue Shield of California Promise Health Plan web portal at https://www.blueshieldca.com/promise.

9.4: Claims Oversight and Monitoring – Participating Provider Groups

Blue Shield of California Promise Health Plan is dedicated to ensuring that claim functions delegated to Participating Provider Groups ("PPG") are processed in accordance to regulatory requirements and contractual provisions. Blue Shield of California Promise Health Plan monitors PPG's claims monthly claims processing timeliness and performs at the minimum annual claims audits. Blue Shield of California Promise Health Plan audits include review of PPG's claims processing timeliness and accuracy.

SECTION 10: ACCOUNTING

10.1: Financial Ratio Analysis (PPG Only)

The Accounting Department is responsible for all facets of financial reporting and data generation, timely payment of capitation, and claims.

A random financial audit will be conducted by Blue Shield of California Promise Health Plan consultants at least once a year. PPG must submit year-end financial statements audited by an independent certified public accountant firm within 120 calendar days after the close of the fiscal year. On a quarterly basis, financial statements must be submitted to DMHC (regulator) within 45 calendar days after the quarter ends.

PPG 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.

PPG 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).

10.2: Capitation Payment

The Capitation Department is responsible for sending the monthly capitation payments to its contracted PPGs. Capitation payments are made on the late of the 10th of each month or within 10 days from receipt of revenue from DHCS, LA Care or CMS.

Cap 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 PPGs on the 10th of each month. Each PPG is responsible for coordinating with Blue Shield of California Promise Health Plan on how to access the SFTP server. For security measures, only two individuals per PPG are issued a login to access this site. Any changes to the PPG's keyholder will require a new password or PGP key. PPGs must request and fill out a new PGP Key Form and return the form back to the Provider Relations Department.

SECTION 11: HEALTH EDUCATION

11.1: Health Education Program

Purpose

The Health Education (HE) Program is committed to improving and maintaining the health and wellness of Blue Shield of California Promise Health Plan Members through health education, health promotion, skill training, interventions and disease management provided in a culturally sensitive and linguistically appropriate manner.

Goals

- Promote appropriate use of health services.
- Promote health education services.
- Encourage Member involvement with their Primary Care Physician 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.

11.2 : Scope of Health Education Program

The Blue Shield of California Promise Health Plan 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 diseases as well as maintain optimum health. Members and providers may obtain more information about these programs and services by calling the Health Education Department.

11.2.1 : Health Education Classes

Care1s provides health education classes at various locations in Los Angeles and San Diego Counties. Frequency of these classes varies depending on requests from providers and members. These classes are for all Blue Shield of California Promise Health Plan members. These classes are implemented in English and Spanish. Additionally, Blue Shield of California Promise Health Plan provides individual counseling in English, Spanish, Cantonese and Mandarin. Counseling topics include Hypertension, Hyperlipidemia, Diabetes and Weight Management. Blue Shield of California Promise Health Plan also implements The Stanford Healthier Living Program and the Diabetes Empowerment Education program in English, Spanish, Cantonese and Mandarin.

11.2.2 : Community Outreach

The Health Education Department works with the Outreach Department to coordinate activities for

Blue Shield of California Promise Health Plan involvement in community outreach efforts and health fairs.

1123 : Health Education Materials

A variety of brochures and handouts are available on the Blue Shield of California Promise Health Plan website (https://www.blueshieldca.com/promise/provider/health-education/health-education-materials.asp). All materials are culturally sensitive and linguistically appropriate, and do not exceed the 6th grade reading level.

Blue Shield of California Promise Health Plan is highly committed to the delivery of quality health promotion and education activities. Before materials are purchased or created for the Member population, they are carefully reviewed to meet certain standards. The standards evaluate the content/style, layout/appearance, visuals/graphics, medical accuracy, cultural competency and readability of all materials.

For providers contracted with a PPG

Please contact the health education coordinator at your affiliated PPG to order health education materials.

1124 : Member Resources

The HE Department informs Members of available health education services through provider referrals, the Customer Service phone line, targeted mailings, Blue Shield of California Promise Health Plan Health and Wellness portal and community outreach events. 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 also available for Members requiring interpretation. Members can call the Customer Service Department and request to speak to the Health Education Department for information on cholesterol, weight management, exercise, general nutrition guidelines, and diabetes.

Blue Shield of California Promise Health Plan develops Preventive Health Guidelines for Members. These guidelines represent a compilation of recommendations from the Centers for Medicare and Medicaid Services, U.S. Preventive Services Task Force and Centers for Control and Disease Prevention. Preventive Health Guidelines are available on the Blue Shield of California Promise Health Plan Website at

https://www.blueshieldca.com/promise/members/health-education/health-education-materials.asp?hed=PreventiveHealthGuidelines. 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 provider newsletter, provider visits or blast fax. Members are notified about updates to the guidelines via member newsletters.

1125 : Provider Education

The HE Department Health Educators are available to talk to providers and their staff on health

education services if the provider office requests this service.

Blue Shield of California Promise Health Plan providers may contact the Health Education Department to request an in- service or more information on health education services.

11.3 : Program Resources

11.3.1: Health Education Staff

Health Education Director

The Health Education Director reports to the Divisional Vice President of Medical Services. The Health Education Director works in conjunction with the DVP of Medical Services, the Chief Medical Officer, and other departments to implement health education programs appropriate to identified needs of members and providers. The Health Education Director is responsible for developing, implementing, managing and evaluating member education programs and provider education programs related to Health Education. The Health Education Director ensures that materials and programs are culturally sensitive and linguistically appropriate to the member population under standards created CMS.

Responsibilities of the Health Education Director 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 Procedure.
- 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 CMS, DMHC and other regulatory agencies as appropriate.

The Health and Wellness Program Manager

The Health and Wellness Program Manager reports to the Health Education Director. The Health & Wellness Program Manager leads and manages health education initiatives and ensures compliance with NCQA and CMS requirements. Additionally, the Health & Wellness Program Manager manages the health and wellness portal.

This position collaborates with a number of external clients such as vendors, consultants, regulators and internal teams such as case managers, customer services staff, and QI staff.

Health Educator

The Health Educator reports to the Health Education Director and the Health & Wellness Program Manager. The Health Educator works in conjunction with the Health Education Director and Health & Wellness Program Manager to ensure that health education services and materials are appropriate to identified needs of providers and members.

The Health Educator assists in all aspects of program development and implementation as designated by the HE Director and the Health and Wellness Program Manager. The Health Educator also assists the HE Director in the development and review of member health education materials.

1132 : Health and Wellness Portal

The health and wellness portal is an on-line resource available to members. The goal of the portal is to increase members' ability to manage their health by helping them identify their risks 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 health workshops, meal plans, exercise plans, recipes, health trackers (blood pressure, cholesterol, blood glucose, nutrition) and e-mail access to a Register Dietitian and a Fitness Trainer. Members can also sign up for on-line or telephonic health coaching. To access the portal, members can create and account at www.blueshieldpromise.cernerwellness.com.

1133 : Departments in Collaboration with Health Education

Cultural and Linguistic Department

The HE Department collaborates with the Cultural and Linguistics Department to develop and implement training sessions for staff, providers and PPG's. These units also work together to ensure proper translation of the materials into threshold languages and in alternative formats.

Quality Improvement

The Health Education Department works in conjunction with Quality Improvement 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 Service Department refers all health education related phone calls to the Health Education Department. The Customer Service Department provides 24-hour interpretation services to Blue Shield of California Promise Health Plan 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 materials and services. The Provider Relations Department also assists in the delivery of materials and information as well as in the coordination of provider education seminars.

Utilization Management Department

The Health Education Department works with Utilization Management to direct appropriate health education interventions for patients identified through the UM/HE referral process.

Additionally, the Health Education Department assists the UM Department in educational efforts by identifying and supplying appropriate materials for UM to send to members.

SECTION 12: 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 of California Promise Health Plan has adopted policies & procedures that are consistent with the National Standards (i.e. CMS) for CLAS. Contracts between Blue Shield of California Promise Health Plan and 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.

All providers must ensure that services are provided in a culturally competent manner to all members. This means you should provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical and mental disabilities.

12.1: Provider Responsibility in the Provision of CLAS

I. ***Identification of limited English Proficient (LEP) members:***

Cultural competency and linguistic capability in managed care is critically important to allow Blue Shield of California Promise Health Plan 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.

Blue Shield of California Promise Health Plan 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.

Definition: ***"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.

II. ***Access to 24 Hours & 7 Days Interpretation Services:***

It is Blue Shield of California Promise Health Plan's responsibility to provide 24 hours & 7 days language assistance necessary to afford Limited English Proficient (LEP) members meaningful access to health care services, free of charge.

Blue Shield of California Promise Health Plan and its providers must not require or suggest that LEP or 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.

III. ***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 of California Promise Health Plan is responsible for on-going distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural & Linguistic Department.

IV. ***Cultural Competency Training:***

Blue Shield of California Promise Health Plan values diversity as an integral component of our organization and will promote the achievement of a culturally competent organization. Blue Shield of California Promise Health Plan views cultural competency as a responsibility at both the organizational and individual level. Blue Shield of California Promise Health Plan will foster an environment of respect and dignity in the treatment of each other and our members actively address the issue of barriers and disparities in health, using multiple strategies to reach providers, members, and staff.

Cultural competency 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).

V. ***Translation of Member-Informing and Health Education Materials:***

Blue Shield of California Promise Health Plan makes specific materials available in any language that is the primary language of more than ten percent of its geographic service area. Such materials may include but are not limited to:

- Summary of Benefits
- Annual Notice of Change
- Evidence of Coverage
- Appeals and Grievance letters

VI. ***CLAS Related Grievances:***

Blue Shield of California Promise Health Plan Medicare Members have the right to file a grievance if their cultural and/or linguistics needs are not met. Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office.

(See Section VI Grievances and Appeals)

Blue Shield of California Promise Health Plan CLAS Department is available to provide further explanation on CLAS requirements as well as offer provider and staff education.

SECTION 13: PROVIDER MEDICARE MARKETING GUIDELINES

13.1: Compliance with Laws and Regulations CMS-4131-F

Practitioners and providers and (your) subcontractors must agree to comply with rules and regulations that are applicable to federal contracts. These laws and regulations include Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the American Disabilities Act, and all other laws applicable to recipients of federal funds. This also includes the general rules that might apply and the policies, procedures and manual provisions, as well as other program requirements, issued by the Centers for Medicare & Medicaid Services (CMS). These also include Blue Shield of California Promise Health Plan's policies and procedures.

13.2: Specific Guidance about Provider Promotional Activities

CMS is concerned with provider activities for the following reason:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as agent of the Plan versus acting as the beneficiary's provider.

13.3: Adherence to CMS Marketing Provisions

13.3.1: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Marketing Reforms

The MIPPA became a law on July 15, 2008. Effective January 1, 2009, MIPPA included a number of prohibitions and limitations on sales and marketing activities by Medicare Advantage (MA) and Prescription Drug (PDP) Plan Sponsors and their agents, brokers or other third parties that represent them. Beginning September 18th, 2008, the prohibition on door to door solicitation has been extended to other instances of unsolicited contact that may occur outside of sales and education events.

Providers cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

Providers can refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, http://www.medicare.gov/, or 1-800- MEDICARE.

Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates. Providers may also answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information. These discussions may occur in areas where care is delivered. They may also provide information and assistance in applying for the Low Income Subsidy (LIS)

13.3.2 : Plan Activities and Materials in the Health Care Setting

While providers are prohibited from accepting enrollment applications in the health care setting, plans or plan agents may conduct sales presentations and distribute and accept enrollment applications in health care setting as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.

Prohibited Areas

Providers are prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, exam rooms, hospital patient rooms, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

Provider Affiliation Information

Providers may announce new affiliations and repeat affiliation. Communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Provider affiliation banners, displays, brochures, and/or posters located on the premises of the provider must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has as affiliation with certain plans and only lists plan names and/or contact information do not require CMS approval.

Comparative and Descriptive Plan Information

Providers may display benefit information for all contracted plans. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution.

CMS continues to hold the plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers may not conduct health screening or other like activities that could give the impression of “cherry picking” when distributing information to their patients, as health screening is a prohibited marketing activity.

Providers/Provider Group Websites

Providers may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

Providers’ Do’s and Don’ts

Providers should remain neutral parties in assisting plans with marketing to beneficiaries or assisting

with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accept or collect scope of appointment forms.
- Accepting enrollment applications for Medicare Advantage (MA)
- /MA- Prescription Drug plans or PDPs.
- Directing, urging, offer inducement or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any otherinterests.
- Mailing marketing materials on behalf of plans.
- Offering anything of value to induce plan enrollees to select them as their provider. Offering inducements to persuade beneficiaries to enroll in aparticular plan or organization.
- Conduct health screenings and distributing information to patients as a marketing activity.
- Accepting compensation directly or indirectly from the planfor beneficiary enrollment activities.

Providers contracted with plans (and their contractors) **are permitted** to do the following:

- Provide the names of plans with which they contract and/or participate.
- Provide information and assistance in applying for the Low Income Subsidy.
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contract all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plans with which it participates. To that end, providers are permitted to:
    - Provide objective information on plans' specific plan formularies, based on a particular patient's medications and health care needs. Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.
    - Make available and/or distribute plan marketing materials including PDP enrollment applications, but not MA or MA-PDenrollment applications for all plans with which the providerparticipates.
- To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
- Refer their patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/.or1-800-MEDICARE.
- Print out and share information with patients from CMS' website.

Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing

marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and /or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plans with which it participates.

The "Medicare and You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries.

NOTE: Plans may not use providers to distribute printed information comparing the benefits of different plans unless providers accept and display materials from all plans in the service area and contract with the provider.

Important: CMS conducts its regular marketing oversight and surveillance activities throughout the year. These oversight activities increase significantly during Annual Election and Disenrollment Periods. Blue Shield Promise Health Plan is confident that the release of this information will help you implement CMS policies and procedures and comply with critical program requirements.

To contact the Blue Shield Promise Health Plan Medicare Marketing Department, please call 1-800-847-1222.

SECTION 14: REGULATORY, COMPLIANCE, AND ANTI-FRAUD

14.1: Overview

All providers who render services to Blue Shield Promise Health Plan Members must be informed of their responsibilities through their provider contract or through a provider manual or other provider communication. As a Medicare Advantage provider, you must comply with certain requirements as described in this section.

Blue Shield Promise Health Plan is responsible for maintaining written agreements with practitioners and providers to provide adequate access to covered services.

Blue Shield Promise Health Plan is also required to comply with National Coverage Determinations (NCD) issued by CMS. An NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a specific medical item or service. If the new NCD or legislative change in benefits meets the "significant costs" threshold, Blue Shield Promise Health Plan is not required to assume the risk for the costs of the service until CMS has included the cost of the NCD in Blue Shield Promise Health Plan capitation payment. Coverage of the services will be provided under the Medicare Fee-for-Service program. Medicare fiscal intermediaries and carriers will make payments on behalf of Medicare Advantage organization directly to providers and practitioners for costs associated with an NCD. Medicare Advantage enrollees may be liable for any applicable coinsurance amounts under Original Medicare. For more information on NCDs go the CMS web site at http://cms.hhs.gov/coverage/default.asp.

14.2: Medicare Part D

Beginning January 1, 2006, the new Medicare Prescription Drug Plan was available to all people with Medicare. Medicare Advantage Members were automatically enrolled in the Medicare Part D. These Members receive their medical care and prescription drug coverage from the Blue Shield Promise Health Plan contracted Pharmacy network.

An important requirement of the Medicare Prescription Drug Improvement and Modernization Act (MMA) is the responsibility of the MA-PD to ensure the integrity of the prescription drug program. Blue Shield Promise Health Plan works closely with CMS and CMS' contractors to prevent fraud, waste and abuse of the prescription drug program. If you have questions or want to report suspected or potential fraud, waste and abuse problems, please call our Hotline at 1-800-221-2367 or you may e-mail to stopfraud@blueshieldca.com.

If you have any questions about Blue Shield Promise Health Plan's coverage of Medicare Part D, please call our Member Services Department at 1-800-544-0088

14.3: Compliance with Laws and Regulations

Providers and their subcontractors must agree to comply with all the rules and regulations that are applicable to federal contracts. These include all laws and regulations applicable to federal contracts including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the

Americans with Disabilities Act, and all other laws applicable to recipients of federal funds. This also includes general rules that might apply, and the policies, procedures and manual provisions, as well as other program requirements, issued by CMS. These also include Blue Shield Promise Health Plan's policies and procedures.

14.4: Compliance with Policies and Program

All practitioners and providers must comply with the medical policy and management program and quality assurance / quality improvement program. This includes reviewing and participating in the programs as required.

14.5: Prohibition against Contracting with Excluded Individuals and Entities and Opt-Out-Providers

Blue Shield Promise Health Plan is prohibited from employing or contracting with practitioners and providers excluded from participation in federal health care programs or who have opted out of Medicare. Affiliated practitioners are also prohibited from employing or contracting with such providers. Contracts are terminable for these reasons. Affiliated practitioners and providers must certify to Blue Shield Promise Health Plan that its contractors are eligible to participate in Medicare and/or provisions would be included in the written agreements. Monthly screening of employees, providers, and contracted entities against the Office of Inspector General (OIG) / List of Excluded Individuals and Entities (LEIE) and the General Service Administration (GSA) / System for Award Management (SAM) / Excluded Parties List Systems (EPLS) is essential to prevent inappropriate payment to providers and other individuals or contractors that may have been added to exclusion lists. The link for OIG/LEIE can be found at http://exclusions.oig.hhs.gov/ and the GSA/SAM/EPLS at https://www.sam.gov/.

14.6: Prompt Payment

The amount of payment and the period in which payment should be made must be set forth in the contract. Any subcontracts that you have with practitioners or provider to render services to Blue Shield Promise Health Plan Medicare Advantage Members must likewise contain a prompt provision.

14.7: Disclosure of Information to CMS

Providers must provide Blue Shield Promise Health Plan or CMS with all information that is necessary for CMS to administer and evaluate the Medicare Advantage program. Simultaneously, practitioners and providers must cooperate with Blue Shield Promise Health Plan in providing CMS with the information CMS needs to establish and facilitate a process to enable current and potential beneficiaries to get the information they need to make informed decisions with respect to available choices for the Medicare coverage.

14.8: Maintenance and Audit of Record

The purpose of this requirement is to allow CMS to evaluate the quality, appropriateness and timeliness of services, the facilities used to deliver the services and other functions and transactions

related to CMS requirements. It applies to all parties in relation to service performed, reconciliation of benefit liabilities and determination of amounts payable. All parties are required to have their records available for a 10-year period after Blue Shield Promise Health Plan terminates its contract with CMS or the completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS). You must have books and records (including, but not limited to, financial, accounting, administrative and patient medical records and prescription drug files) available to support any activity with Blue Shield Promise Health Plan.

14.9: Confidentiality

All providers must ensure the confidentiality and accuracy of the medical records or other health and enrollment information of Members and must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records or other health or Membership information. The provider shall not sell, release or otherwise disclose the name or address of any Member to any third party for any purpose, including scientific study.

Practitioners and providers must maintain records in accurate and timely manner and ensure timely access to Members who wish to examine their records. Confidential patient information that is protected against disclosure by federal or state laws and regulations may only be released to authorized individuals.

14.10 Fraud, Waste, and Abuse (FWA) Training Requirements

Employees and contractors who are involved in the administration or delivery of the Medicare benefits must, at a minimum, receive FWA training within 90 days of initial hiring (or contracting for contractors) and annually thereafter. Blue Shield Promise Health Plan will provide training materials to assist in fulfilling this requirement.

Important Note: Providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the FWA training and education requirements. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or contractor is deemed.

SECTION 15: APPENDICES

Credentialing

Appendix 1: Standardized Audit Tool

(go to www.iceforhealth.org/library.asp?sf=&scid=4066#scid4066 to see the audit tool)

Member Services

Appendix 2: Grievance Forms (go to https://www.blueshieldca.com/promise to see forms)

Utilization Management

Pharmaceutical Management

Quality Improvement

Direct Referral

Appendix 7: Direct Referral Form for Blue Shield Promise Health Plan Direct Members (go to https://www.blueshieldca.com/promise/provider/materials-and-form.asp to see form)

Utilization Management Timeliness Standards

		Notification Timeframe	
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. Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.

Routine (Non-urgent) Pre-Service – Extension Needed • Addition-al clinical information required. • Require con-sultation by an Expert Review-er. • Additional examination or tests to be performed (AKA: Defer-ral).	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request. • The decision may be deferred, and the time limit extended an addi-tional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provid-er Group can provide justification upon request by the State for the need for additional information and how it is in the Mem-ber's interest. • Notify Member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 cal-endar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional in-formation needed to ren-der the decision, the type of expert reviewed, and/ or the additional exam-inations or tests required and the anticipated date on which a decision will be rendered.	Practitioner: Within 24 hours of making the decision. Member: None Spec-ified. Practitioner: Within 24 hours of making the decision. Member: None Spec-ified.	Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the re-quest for service. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

		Notification Timeframe	
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 after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the Member notice of denial.	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. 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. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
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 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modifi to Practitioner and Member**
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes 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 timeframe, 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 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	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. Member: Within 2 working days of making the decision. Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modifi 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 timeframe 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.
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 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Member & Practitioner: Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, then written/ electronic notification must be given no later than 3 calendar days after the oral notification.

		Notification Timeframe	
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.
Post-Service - Extension Needed • Additional clinical information required.	**Additional clinical information required (AKA: deferral).** •Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request. **Additional information received** •If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information. **Additional information incomplete or not received** •If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information.	Member & Practitioner: None specified. Member & Practitioner: None Required.	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination. Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination.
Hospice - 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.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: Blue Shield of CA Promise Health Plan **Plan/Medical Group Phone#: (800) 468-9935**
Plan/Medical Group Fax#: (866) 712-2731 **Non-Urgent ☐ Exigent Circumstances ☐**

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 Name:_____ Prior Auth Number (if known):_____ ☐ Other (explain):					
Dose/Strength:	Frequency:		Length of Therapy/#Refills:	Quantity:	
Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:					
Administration Location: ☐ Physician's Office ☐ Ambulatory Infusion Center	☐ Patient's Home ☐ Home Care Agency ☐ Outpatient Hospital Care		☐ Long Term Care ☐ Other (explain):_____		

Revised 12/2016 Form 61-211

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. Required clinical information - 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: _____

Revised 12/2016 Form 61-211

blue california | Promise Health Plan

blue california
Promise Health Plan

Provider Request to Terminate: Patient/Provider Relationship

PROVIDER INFORMATION

Name (First and Last): _____

Address: _____

Phone: _____ **License #:** _____

IPA/Medical Group: _____

PATIENT INFORMATION

Name (First and Last): _____

DOB: _____ **SSN:** _____

Member ID#

Reasons for terminating patient/doctor relationship:

_____

_____

_____

_____

Please give specific dates and instances of the issues you have had with this member:

_____

What actions have you taken to resolve the issues between the member and you?

Currently identified medical conditions requiring immediate or ongoing treatment:

It is very important to document any non-compliant behavior by the member in the member's medical records. Please provide Blue Shield of California Promise Health Plan with all the documentation from the member's medical records which supports your claims. You must document your actions taken to attempt to resolve these issues with the member.

Please **provide the completed form and supporting documentation** to Elizabeth Garcia, Quality Improvement Coordinator **323-827-6141** by the following options:

- **Email to – Quality.Review@blueshieldca.com**
- **FAX # (323) 323-765-2702**
- **If submitting Compact Disc (CD); please note CD must be encrypted.**
- **Mail to - 601 Potrero Grande Drive, 3rd Floor Saturn Building**
  Monterey Park, CA 91755
  Quality Improvement Department – Elizabeth Garcia

I hereby attest that the above information is true and accurate to the best of my knowledge at this time. I also hereby attest that this request is based solely on my concern that I cannot effectively and appropriately treat the medical needs of this patient because of the above given reasons and that this request is not based on any financial motives.

Signed:_____ **Date:** _____

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN
Primary Care Practitioners Access to Care Standards (PCPS)
ATTACHMENT A

Criteria	Standard
PCPs Defined as:	All practitioners providing primary care to our members which includes: General Practice, Internal Medicine, Family Practice, Pediatrics, NPs, PAs, select OB/GYNs and other specialists assigned member for primary care services.
Emergency exam	**Immediately** When a member calls the Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911) If the condition is a non-life-threatening emergency, it is still preferable for the member to be given access to care immediately but no later than six (6) hours.
Urgent PCP exam	**Within 48 hours if no authorization is required** **Within 96 hours if an authorization is required** When a member contacts the Practitioners office with an urgent medical condition we require the member to be seen within above mentioned timeframes. We strongly encourage the Practitioner to work the member in on a walk-in basis the same day. If a situation arises where a Practitioner is not available (i.e., the Practitioner is attending to an emergency or member calls late on a Friday), the member can be seen by a covering Practitioner or directed to an urgent care, covering office or emergency room.
Sensitive Services	Sensitive services must be made available to members **preferably within 24 hours** but not to exceed 48 hours of appointment request. Sensitive services are services related to: Sexual Assault Drug or alcohol abuse for children 12 years of age or older Pregnancy Family Planning Sexually Transmitted Diseases, for children 12 years of age or older Outpatient mental health treatment and counseling, for children 12 years of age or older who are mature enough to participate intelligently and where either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims, of incest or child abuse. Minors under 21 years of age may receive these services without parental consent. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Routine PCP, Non-urgent exam	**Within ten (10) business Days** When a member requests an appointment for a routine, non-urgent condition (i.e., routine follow-up of blood pressure, diabetes or other condition), they must be given an appointment within 10 business days.
Initial prenatal visit to OB/GYN	**Within fourteen (14) Calendar Days** Access to OB/GYN network Practitioners is available without prior authorization.

Criteria	Standard
Well child visits (For child under 2 years of age)	**Within fourteen (14) Calendar Days** When a parent of a member requests an appointment for a Well Child Visit they must be given the appointment within 14 calendar days, it is acceptable for the member to be scheduled for a covering Practitioner.
Preventive care and physical exam	**Within thirty (30) Calendar Days**
Initial Health Assessments and behavioral health screenings if not completed by the County Mental Health Plan or MBHO contracted Behavioral Health Practitioner previously.	**Within thirty (30) calendar days upon request (must be completed within 90 calendar days from when member becomes eligible)** Blue Shield of California Promise Health Plan encourages that this assessment is completed within the first 90 days of enrollment. Blue Shield of California Promise Health Plan actively sends reminders to members within this period of time encouraging them to schedule this appointment. Blue Shield of California Promise Health Plan requires that a Staying Healthy Assessment form is utilized during this visit.
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week coverage** to members. The same standards of access and availability are required by physicians "on-call". Blue Shield of California Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield of California Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. Urgent and emergent calls must be handled by the physician or his/her "on-call" coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Blue Shield of California Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield of California Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Waiting Time when contacting Blue Shield of California Promise Health Plan	**During normal business hours members will not wait more than 10 minutes to speak to a plan representative**
Waiting Time in office	**Thirty (30) minutes maximum** after time of appointment
Access for Disabled Members	Blue Shield of California Promise Health Plan audits facilities as part of the Facility Site Review Process to ensure compliance with Title III of the Americans with Disabilities Act of 1990.

Criteria	Standard
Seldom Used Specialty Services	Blue Shield of California Promise Health Plan will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary.
Failed Appointments (Patient fails to show for a scheduled appointment)	Failed appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments could result in referring the member to the Health Plan for case management. Practitioners' officers are responsible for counseling such members.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN
Specialist Access to Care Standards
ATTACHMENT B

Criteria	Standard
SCPs Defined as:	**All practitioners providing specialty care to our members, which includes all specialty types listed in Blue Shield of California Promise Health Plan Specialist network listing including dental, chiropractic, acupuncture and vision providers.**
Emergency Care	**Immediately** When the Health Plan or Emergency Room contacts a specialty Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately. If a member contacts the specialist's office with an emergency need they must contact the PCP immediately or direct the member to the Emergency Room or call 911.
Urgent Specialist Exam (no auth required)	**Within 48 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is not required the member must be seen within 48 hours or sooner as appropriate from the time the member was referred.
Urgent Specialist Exam (auth required)	**Within 96 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is required the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized.
Routine specialist visit, Non-urgent exam	**Within fifteen (15) Business Days**
Routine Ancillary visit, Non-urgent exam	**Within fifteen (15) Calendar Days**
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week coverage** to members. Physicians "on-call" require the same standards of access and availability. Blue Shield of California Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield of California Promise Health Plan also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.

Criteria	Standard
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. The physician or his/her "on-call" coverage must handle urgent and emergent calls within thirty (30) minutes. Appropriately qualified staff can only provide clinical advice (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Blue Shield of California Promise Health Plan also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield of California Promise Health Plan also has nurse on- call 24 hours a day, 7 days a week to support coordination of care issues. Our Member Services Department will keep an abandonment rate less than 5%. Any practitioner that has an answering machine or answer-ing service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by call-ing 911 or going to the nearest emergency room.
Waiting Time when contacting Blue Shield of California Prom-ise Health Plan	**During normal business hours members will not wait more than 10 min-utes to speak to a plan representative**
Waiting Time in office	**Thirty (30) minutes maximum** after time of appointment
Failed Appointments (Patient fails to show for a scheduled appointment)	Failed appointments must be documented in the medical record and the member's primary care Practitioner must be notified within 24 hours of the missed appointment. The member must be contact-ed by mail or phone to reschedule. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments can result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

Blue Shield of California Promise Health Plan

Behavioral Health Access to Care Standards

ATTACHMENT C

Criteria	Standard
Life threatening/Emergency needs	Will be seen immediately
Non-Life-threatening emergency needs	Will be seen within six (6) hours
Urgent needs exam	Within 48 hours
Routine office visit, Non-urgent exam	Within ten (10) Business Days
Non-physician BH Provider: Routine office visit, Non-urgent exam	Within ten (10) Business Days
After-hours care	Behavioral Health services for Medi-Cal "Specialty Mental Health Services" and "Alcohol and Other Drug Programs" (AOD) are the responsibility of the appropriate County Mental Health Plan (MHP). Behavioral Health Services for Medi-Cal members with mild and moderate dysfunction outpatient services, and for all other lines of business are carved out to contracted MBHOs The MBHOs each have 24 hour a day, 7 day a week coverage. Blue Shield of California Promise Health Plan also has RN's on-call 24 hours a day, 7 days a week to coordinate and arrange behavioral health coverage to members.
Telephone Access	Access by telephone for screening and triage is available 24 hours a day 7 days a week, through our contracted MBHOs and the County MHPs, as appropriate. Blue Shield of California Promise Health Plan and its contracted MBHOs require access to a non-recorded voice within thirty (30) seconds and abandonment rate is not to exceed 5%. Blue Shield of California Promise Health Plan has RN's on-call at all times to arrange behavioral health coverage to members. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Standard for reaching a behavioral health professional	Blue Shield of California Promise Health Plan through our contracted MBHOs is available to arrange immediate access to a behavioral health professional. The County MHPs also have 24/7 access lines.