Accessibility and Availability Policy and Procedures

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TOPICS

POLICY

INTRODUCTION

Accessibility and Availability (collectively referred to as "Access") to care is fundamental to the Blue Shield of California Promise Health Plan ("Blue Shield Promise") mission, which is to provide

care that is worthy of our family and friends and sustainably affordable. Access to care directly affects:

- Member experience, as measured through patient surveys addressing access to care and access-related grievances and appeals.
- Quality, relative to access to preventative care, such as vaccines and screenings affecting clinical outcomes, including incidence of communicable disease and cancer.
- Cost of Healthcare, relative to when members who cannot access primary or specialty care utilize the emergency department.

This Policy and Procedures addresses both the accessibility to care and availability of care. This Policy and Procedures ensures that Blue Shield Promise offers adequate coverage and meets the regulatory and accreditation requirements around the provision of healthcare services for primary care, specialty care, acute hospital care, long term services and support, behavioral health care, telephone and services provided by telehealth, and ancillary provider care. The scope of this policy applies to state-sponsored business, including Medi-Cal (Medicaid) and Cal Medi-Connect managed care.

ACCESSIBILITY

Blue Shield Promise will ensure that all contracted Primary Care Practitioners (PCP) comply with approved access to care standards, as listed in **Table A.** Blue Shield Promise will ensure all contracted Specialty Care Practitioners (SCP) are in compliance with approved standards, as listed in **Table B;** Managed Behavioral Healthcare Organizations ("MBHO") are in compliance with approved access to care standards, as listed in **Table C;** Ancillary Providers are in compliance with approved access to care standards, as listed in **Table D;** Long Term Services and Support ("LTSS") providers are in compliance with approved access to care standards, as listed in **Table E.** Blue Shield Promise's telephone Accessibility Services are shown in **Table I**. In addition, Blue Shield Promise provides or arranges for the provision of access to healthcare services promptly using establish metrics for measuring and monitoring the adequacy. Compliance with these standards is monitored through member complaints and grievances, Potential Quality Issues ("PQI"), member satisfaction surveys, medical record reviews, dis-enrollments, PCP transfers, and annual access surveys and studies. Blue Shield Promise ensures that accurate provider contact lists are generated for all provider types required to be surveyed for the current Measurement Year ("MY"). Blue Shield Promise ensures that its provider network is sufficient to provide accessibility, availability, and continuity of covered health care services established by Section 1300.70 of Title 28.

AVAILABILITY

Annually, the Blue Shield Promise monitors provider network availability to ensure an adequate provider network, and compliance with regulatory standards for network capacity, provider-member ratios, and geographical distribution. Time and distance standards and provider-member ratios, including provider language and cultural/ethnicity availability, are established per NCQA standards and regulatory requirements as indicated in **Table A** and **Table B.** When patterns of non-compliance are identified via monitoring and oversight procedures, and gaps in the network are present, contracting efforts are made to fill the network gaps. Blue Shield Promise is required to meet or exceed network capacity and ratio requirements as outlined in the Managed Care Plan Contract. Blue Shield Promise's network(s) must meet the full time equivalent (FTE) ratios of one FTE PCP to every 2,000 members and one FTE physician to every 1,200 members. Additional information concerning Medical Ratio Guidelines can be found in **Table G**.

Blue Shield Promise maintains an adequate provider network to ensure the provisions of medical and behavioral healthcare services, for projected enrollment and current utilization patterns.

Health plan data, such as the active membership, number and types of network providers, geographic location of providers (relating to time and distance), provider hours of operation, timely availability of services, physical accessibility and access to out of network providers when services are not available in-network (out-of-network referrals and letters of agreements), are used to assess network adequacy and determine performance, as well as the identification and prioritization of opportunities for improvement.

Emergency health care services are available and accessible within the service area twenty-four hours a day, seven days a week, via Blue Shield Promise's contracted emergency department network, as well as out-of-area and out-of-network emergency department access.

In the event that services are not available within the Blue Shield Promise provider network (including the California Department of Health Care Services ("DHCS") defined "Mandatory Providers") and/or a specific provider type does not meet the access standards (time/distance, network capacity, etc.), Blue Shield Promise has protections in place for members to ensure access to out-of-network services are available within and outside the service area. Blue Shield Promise will offer and arrange for access to an out-of-network provider via a single case letter of agreement. Blue Shield Promise member facing staff are trained to assist members in obtaining access to an out-of-network provider and have all necessary information and resources available to ensure that members have adequate and timely access to appropriate provider types, as well as address any questions or concerns. Additionally, transportation services are available to Blue Shield Promise members to access out-of-network providers that exceed the time/distance guidelines or maybe located outside the approved service area.

Blue Shield Promise ensures that all downstream entities comply with the established network adequacy standards as outlined in this policy. Blue Shield Promise does not delegate network access and/or network adequacy standards to downstream entities, such as contracted Primary Provider Groups (PPGs) or a Managed Behavioral Healthcare Organization (MBHO).

Blue Shield Promise contracts with an NCQA-accredited MBHO and ensures that all behavioral healthcare services are within the availability standards for approved geographic regions and distribution aligns with existing and potential member locations while also considering members with special healthcare needs and preferences. The Blue Shield Promise Provider Network teams, with the support of the Delegation Oversight team, oversees that downstream entities comply with network adequacy standards. Blue Shield Promise annually assesses the provider network adequacy and may impose a Corrective Action Plan ("CAP") on any downstream entity that is non-compliant with established network adequacy standards, including the requirements of DHCS All Plan Letter ("APL") 21-006 and subsequent APLs.

Blue Shield Promise adheres to applicable network certification requirements including the DHCS Annual Network Certification ("ANC") requirements set forth in DHCS APL 21-006 and subsequent APLs, 42 C.F.R., and 42 C.F.R. 438.68 (c)(1). The Blue Shield Promise Network Management unit files the required documentation per established timelines and addresses any identified network gaps. Solutions to address any identified network gaps may include requests for alternative access and/or initiation of contracting efforts to fill the identified gaps when possible.

STANDARDS

Blue Shield Promise's accessibility and availability standards are established in compliance with the State of California Knox-Keene Act, §1300.67.2.1. Geographic Accessibility Standards, for Blue Shield Promise enrollees, which requires that Blue Shield Promise provide members with reasonable access to healthcare services. Blue Shield Promise standards meet the availability guidelines set

forth in state regulations for geographic proximity of health care providers. In addition, the standards are established in accordance with NCQA guidelines, the Centers for Medicare and Medicaid Services ("CMS") regulations, and DHCS requirements. Blue Shield Promise continually evaluates and augments standards to reflect the changing environment of how healthcare services are provided.

Specifically, the purpose for accessibility is to establish and maintain access to care standards for Blue Shield Promise that ensure healthcare services are obtainable to members in accordance with Title 22, CCR, Sections 53911 and 53911.5, and Title 28, CCR, §1300.67.2.1, §1300.67.2.2, DHCS APL 21-006 and subsequent APLs, and all state and federal regulatory agencies. The purpose for the geographic access and provider network adequacy associated with availability ensures compliance with State and Federal laws for time, distance and adequate readiness of network providers for the Medi-Cal and Cal Medi-Connect ("CMC") members in accordance with Title 22, CCR, Sections 53911 and 53911.5, Title 28, CCR §1300.67.2.1 and §1300.67.2.2, DHCS APL 19-002 and subsequent APLs, NCQA guidelines, and the California Department of Managed Health Care ("DMHC") requirements.

ACCESS AND AVAILABILITY SUBCOMMITTEE

The Blue Shield Promise Access and Availability Subcommittee is a cross-functional team responsible for providing a forum for receiving addressing and finding solutions for provider network adequacy issues. The results of any quality activities and initiatives, including access surveys and other forms of monitoring, are reported to the Access and Availability Subcommittee on a routine basis. Execution of this Policy and Procedures is also under the subcommittee's responsibilities. The subcommittee meets regularly and reports to the Blue Shield Promise Quality Management Committee on a quarterly cadence. The subcommittee oversees network adequacy, assuring that there is enough volume and provider types, facilities, and ancillary care. The subcommittee is tasked with improving access to care using the results of member and provider surveys, and other assessment tools, discussed in this document.

COMMUNICATION

Blue Shield Promise's Accessibility and Availability Standards and Guidelines are distributed annually to participating network providers and practitioners by way of operational manuals, online practitioner and member web portals, written bulletins and update notices, policy and procedure documents, and/or other recognized methods as appropriate. Standards are reviewed and/or revised annually or more frequently if/when necessary. Blue Shield Promise staff also communicate standards at routine audits, site visits, Joint Operating Meetings, and in other settings. Members receive communications about these standards through Blue Shield Promise's member materials.

PROCEDURES

Blue Shield Promise provides and arranges for the provision of covered healthcare services in a timely manner appropriate for the nature of each member's condition consistent with good professional practice. Blue Shield Promise establishes and maintains provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standards and network adequacy requirements of the Knox-Keene Act. Blue Shield Promise, through the Access and Availability Subcommittee, as well as within other forums, analyzes access to care information from various sources. Data is assessed at different levels, including overall health plan, geographic area, product line, provider group

and individual practitioner. Instances and patterns of non-compliance are identified and recommendations for corrective action are made by the subcommittee.

METRICS

Blue Shield Promise measures and benchmarks accessibility and availability based on Federal, State, accreditation and regulatory standards. Measurement allows for benchmarking, feedback to provider groups, and targeted improvement activities. Metrics cover timely accessibility and availability of:

- Medical and behavioral health services including appointments, emergency care, preventative services, inpatient, after-hours care, video visits and RN telephonic triage and screening
- Vision, chiropractic, and acupuncture services provided through plan-to-plan arrangements
- Interpreter services
- Authorizations for necessary care and services
- Cultural needs and preferences for members

Spatial Analysis. Spatial analysis software is used to analyze and report information regarding the geographic distribution of PCPs, High Volume and High Impact specialists, and hospitals at a regional level by member and provider practicing ZIP Code. PCPs are assessed annually for open panels for new patient selection. Blue Shield Promise compares spatial analysis reports against the open practice results and, if needed, develops strategies to address opportunities for improvement.

Member Experience Surveys. Access to care is also monitored through a member satisfaction surveys, member complaints and grievances, potential quality of care issues, member requested dis-enrollments and transfers, Emergency Room utilization, facility site reviews, and vendor performance reports. The member experience survey provides insight into whether members feel that they received timely care. Member perception of care is measured by the validated survey instrument, Consumer Assessment of Healthcare Provider and Systems (CAHPS). The CAHPS survey assesses timely access to care, wait time to appointment, ability to get needed care and cultural needs. On an annual basis, CAHPS survey results are reviewed for Medi-Cal and Cal-MediConnect populations according to NCQA specifications and the Centers for Medicare and Medicaid Services requirements. Blue Shield Promise results are compared to the national average. Blue Shield Promise strives to score in the top quartile.

Provider Surveys. Providers are an important source of information about member access to care. Provider surveys include:

- ER/After-Hours Survey. This telephonic survey assesses provider telephone access, emergency/911 instructions and after-hours provider access, including the provider call back time, as defined in Tables A - D. This survey is administered annually according to regulatory and accreditation requirements to evaluate protocols around after-hours care. Providers with a specialty of family medicine (also known as family practice and general practice), pediatrics, or internal medicine are included in the ER/After-Hours Survey as well as behavioral health practitioners. An analysis of the responses is conducted, and data is aggregated to report annual provider group level performance.
- Provider Appointment Availability Survey ("PAAS"). Timely Access Compliance Reporting and PAAS – As required by Timely Access to Care Regulations, Blue Shield Promise administers an annual survey that complies with the PAAS methodology for the MY. The survey asks sampled providers about their availability to treat members for urgent and

routine primary care, certain specialty care, behavioral healthcare, and certain ancillary care. If the responses are outside the standards, provider groups may be required to submit a CAP to Blue Shield Promise.

- Clinician Satisfaction Survey ("CSS"). Timely Access Compliance Reporting and CSS – As required by Timely Access to Care Regulations, Blue Shield Promise administers an annual survey that complies with the Provider and Enrollee Surveys section – Provider Satisfaction Survey Results. Blue Shield Promise's CCS evaluates clinician practices to gauge satisfaction rates and guide process enhancements that are geared toward improved access, care delivery, and quality.

In addition to the annual provider surveys, Blue Shield Promise's Facility Site Review Department assesses the provider site as needed to evaluate compliance with access to care standards. This assessment maybe completed by an onsite review and/or assessment of telephone access. This is done in accordance with Blue Shield Promise's *Member Complaint Site Review policy 70.1.4.12*.

NON-COMPLIANCE/INTERVENTIONS

Providers and/or regions falling significantly below standards are evaluated cross-functionally and appropriate interventions are developed and executed by the Provider Network Department. Interventions can include, but are not limited to, continued monitoring, dialogue with PPGs' representatives, offering additional education and resources to providers, any necessary corrective actions, or other network improvement changes. Recommended interventions account for provider group operational issues, local network characteristics, and the effect to membership. A log is maintained to document outreach and monitor any CAPs relative to accessibility and availability findings. Through periodic reporting, the effectiveness of the interventions is determined.

LANGUAGE LINE AND INTERPRETER SERVICES

Interpreter Services – required under Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations – are coordinated with scheduled appointments for healthcare services in a manner that ensures the provision of interpreter services at the time of the appointment. Blue Shield Promise provides members access to TTY Services and interpreter services through a language assistance line. Blue Shield Promise requires all participating providers to offer our members access to the Blue Shield Promise language assistance services, as appropriate.

ADDITIONAL APPLICABLE REQUIREMENTS AND EXCEPTIONS

Continuity of Care. Blue Shield Promise ensures continuity of care. When it is necessary for a provider or a member to reschedule an appointment, the appointment will be promptly rescheduled per the access standards found in Tables A and B – in a manner that is appropriate for the member's health care needs – to ensure continuity of care consistent with good professional practice and consistency with the objectives of Section 1367.03 of the Knox Keen Act.

Grievance and Appeal. Member grievances, and appeals to those grievances, are reviewed quarterly during the Access and Availability Subcommittee meetings. The grievances are monitored by provider type whenever possible. Blue Shield Promise promptly investigates issues and requests corrective action as appropriate. Implementation of a CAP includes research and direct correspondence with providers as necessary to investigate and resolve issues. Blue Shield Promise also trends recurrent provider issues to ensure a solution is realized. This process includes an analysis of any one-day (i.e., expedited) grievances concerning access to care.

Non-Emergency Medical Transportation (NEMT). NEMT is provided for all members who have no alternative means of transportation to assure access to providers. All members requesting transportation must be eligible with Blue Shield Promise for the month that the transportation is requested. Transportation is offered to and from Blue Shield Promise approved locations. Arrangement is made at least 24 hours before the appointment by calling Blue Shield Promise Customer Care at: (877) 433- 2178 (TTY 711). A Physician Certification Statement (PCS) form must be completed and submitted before NEMT services can be prescribed and provided to the member.

Prior Authorization Processes. The prior authorization process is to be completed in a manner that assures the provision of covered healthcare services to members in a timely manner appropriate for the member's condition and in compliance with the requirements of the time-elapsed access standards.

Triage (Screening) and Provider Offices. Blue Shield Promise provides or arranges for the provision of 24/7 triage or screening services by telephone. Blue Shield Promise ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition. Blue Shield Promise provides triage or screening services through a medical advice line pursuant to Section 1348.8 of the Health & Safety Code. Participating providers must maintain a procedure that includes the 24/7 employment of a telephone answering machine, service, or office staff that will inform the caller: (a) Regarding the length of wait for a return call from the provider ; and (b) How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by telephone, or if needed, deliver urgent or emergency care. The provider is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical emergency, the provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Advance Scheduling. Blue Shield Promise's Medical Care Solutions' policies allow advance scheduling. Preventive care services and periodic follow-up care, including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

Exception for Extending Appointment Waiting Time. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental result on the health of the member. When a practitioner or member must reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for the member's healthcare needs; and ensure continuation of covered services consistent with good professional practice and consistent with the objectives of Section 1367.03 of the Knox Keen Act.

Exception for Preventive Care Services and Periodic Follow Up Care. Preventive care services and periodic follow up care, including but not limited to, standing referrals to, specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health

conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

PROCEDURES FOR ACCESSIBILITY GUIDELINES

Appointment Wait Time Standards. The Appointment Wait Time Standards are quality assurance standards requiring that enrollees be offered appointments within established timely access standards with primary care and specialty practitioners, behavioral health providers, ancillary facilities, and long-term services and support providers. Timely access standards are listed in Tables A, B, C, D, and E.

The annual compliance Timely Access Report (TAR sections A-F) information is submitted annually to the DMHC following the DMHC Timely Access Network Report Form instructions, which includes the data elements established by the DMHC. Blue Shield Promise ensures that the appropriate staff responsible for preparing and filing, operate in accordance with DMHC reporting instructions.

1. Blue Shield Promise PCP Access to Care Standards are listed in **Table A**. Specialty Access to Care standards are listed in **Table B**. Behavioral Health Access to Care standards are listed in **Table C**. Ancillary Access to Care standards are listed in **Table D**. LTSS Access to Care standards are listed in **Table E**.

2. Primary and Specialty Care Practitioners are required to be available to members 24 hours a day, seven days a week, either directly or through arrangements for after hours' coverage with an appropriately qualified practitioner. Practitioners must be available as detailed in **Tables A - E** for emergency and urgent care needs and may provide care in their offices or based on the medical necessity of the case, refer the member to an urgent or emergency care facility. Blue Shield Promise has a nurse on call to arrange for care if a practitioner is unavailable. If a member contacts Blue Shield Promise about an emergency situation, Blue Shield Promise will direct the member to an appropriate urgent or emergency care center for immediate assessment and treatment. After-hours access issues will be referred to Blue Shield Promise's QI Department as a potential quality issue (PQI) and handled in accordance with approved procedures.

   In addition, Blue Shield Promise has a 24-hour a day, 7 days a week telephone nurse advice line available to our members toll-free. Blue Shield Promise also has nurses available 24-hours a day, 7 days a week to handle authorization or coordination of care issues. It is Blue Shield Promise's goal to answer the nurse advice line immediately and adhere to all telephone access requirements, i.e., abandonment rate less than 5 percent and call answered within 30 seconds. Routine reports are monitored daily. The on-call nurses are contacted by the service to arrange for patient transfers, fast track authorizations, address pharmacy issues, or any other coordination of care issues, and all requests are initiated within 30 minutes. Although Blue Shield Promise has the nurse advice line and the on-call nursing support for the coordination of care, practitioners are still required to provide 24 hours a day, 7 days a week coverage for patients. The practitioner or the Blue Shield Promise nurse advice line can provide triage or screening services by telephone. Blue Shield Promise has on-call nurses available 24 hours a day, 7 days a week to support coordination of care (see Utilization Management Nurse Advice Line Policy # 70.2.72)

3. With respect to Behavioral Health Practitioners (including Qualified Autism Service

Providers), especially within the Medi-Cal Managed Care Network, Blue Shield Promise recognizes that members may come to Blue Shield Promise while in treatment with a Behavioral Health Practitioner who may not participate in Blue Shield Promise's network. Blue Shield Promise will follow all federal and state rules and regulations for our members to continue care with their current provider. When possible, Blue Shield Promise will attempt to allow members to continue with their current provider beyond what may be required. In areas where appropriate licensed Behavioral Health Practitioners are scarce and/or unwilling to contract with managed care Plans, Blue Shield Promise will use out-of-network Behavioral Health Practitioners, as necessary, to meet access standards and the needs of our members.

4. Blue Shield Promise Access to Care standards provide that no member is required to travel an unreasonable distance or for an unreasonable length of time to receive covered services. For the purposes of these standards, "reasonable" is determined by analysis of the following factors:
    - The population density of the area traveled.
    - Typical patterns of traffic congestion throughout the day.
    - Established travel patterns for the community.
    - Established patterns of medical practice in the community.
    - Natural boundaries and geomorphic barriers to travel.
    - Any other relevant factors.

5. Blue Shield Promise Customer Care Department has written standards for call timeliness and abandonment rates, which includes the abandonment rate standard of below 5 percent and call timeliness to answer a call within standard timeframes. During normal business hours, a member must not wait more than 10 minutes to speak with a Blue Shield Promise representative. This is monitored daily within the Customer Care Department and reported at least quarterly to the QMC. (refer to Customer Care Telephone Access Standards Policy #70.3.45.)

6. The Blue Shield Promise practitioner contract allows Blue Shield Promise to monitor accessibility and requires contracted practitioners to abide by standards established for accessibility. The practitioner contract also provides that members will not be discriminated against with respect to access to care, reasonable accessibility to emergency services, and minimal weekly availability for the provision of healthcare services.

7. The practitioner contract also mandates participation in the Blue Shield Promise Quality of Care Review Program. Participation in the Quality-of-Care Review program requires practitioner cooperation with the assessment of the quality of care, accessibility, and utilization patterns. Contracted practitioners agree to take any appropriate remedial action deemed necessary by Blue Shield Promise.

8. Delegated IPA/PMGs are required to adhere to all Blue Shield Promise Access to Care standards. Blue Shield Promise and all contracted medical groups maintain necessary processes so that members can promptly obtain covered health care services (i.e., authorizations) in a manner appropriate for a member's condition and in compliance with regulatory requirements. In addition, Blue Shield Promise conducts annual audits of all high-volume PCPs and specialists. Blue Shield Promise defines high-volume specialists by benchmarks dependent on county and percentage of the Plan's SPD (Seniors and Persons with Disabilities) members who have been seen by a specialist within a 12-month timeframe. Criteria are subject to annual change and can be found in the Clinical Training/Auditing – Facility Site Review SOP. These results are distributed annually to all participating IPA/PMGs through the Joint Operating Committee (JOC) meetings. Blue

Shield Promise reviews this information for trends and patterns as well as quality of care and access to care issues. Blue Shield Promise requires CAPs from IPA/PMGs when appropriate. Blue Shield Promise's QI Department is responsibility for conducting studies, which includes:

- Develop the study and survey tools and methodology
- Analysis of data results
- Identification of opportunities for improvement
- Presenting analysis to the Medical Services Committee
- Development of an Improvement Plan through the Medical Services Committee, which includes working with individual practitioners on the Improvement Plan, tracking the implementation date and responsible individual(s) for implementation and follow-up, determination for follow-up and remeasurement to document compliance.
- Provide practitioner and member education
- Reassess the interventions put in place
- Offer feedback to practitioners regarding the accessibility of primary care, specialty care, behavioral health services, and telephone services.

9. Access standards are also measured and monitored through member satisfaction surveys, grievances, and complaints with annual reporting to the Medical Services Committee. Member satisfaction surveys are conducted annually, in compliance with Rule 1300.67.2.2(d)(2) (B), via the CAHPS survey, as described in internal policy (Member Satisfaction Survey – CAHPS #70.1.1.25)

Accessibility Related Health Insurance Portability and Accountability Act Requirements. Only authorized personnel can review Member Protected Health Information (PHI). This can include, but is not limited to, Medical Directors and Quality Improvement staff. All individually identifiable member information, including names, addresses, dates, telephone numbers, facsimile 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 is considered PHI as defined under the HIPAA. All member information is de-identified before being presented to organizational committees for review. All study information containing PHI is protected as required by applicable Blue Shield Promise Privacy and Information Security policies and as required by applicable law, including HIPAA. This may include, for example, keeping the information in a secured and locked area and ensuring that facsimile machines, printers, and copiers used for this information are kept in a secure location accessible only to authorized personnel. Only the minimum necessary information is requested for these studies.

PROCEDURES FOR AVAILABILITY GUIDELINES

Annually, Blue Shield Promise evaluates the provider network performance according to the established network adequacy standards by provider type, by conducting quantitative and qualitative analyses. See **Tables F and G.** Provider types include, but are not limited to: primary care practitioners (PCP), specialty care practitioners (SCP), high-volume/high-impact specialists, behavioral health providers, hospitals and emergency departments, pharmacies, ancillary providers, language accessibility and availability, and public transportation availability.

High-volume and high-impact specialties are determined using the following definitions, see **Table H**. High-volume providers include OB/GYN providers at a minimum, psychiatrists as behavioral health high-volume providers, and the top two specialty types determined by selecting credentialed and contracted healthcare professionals identified by way of claims activity data for unique member occurrences in a 12-month period (excluding primary care

practitioners, hospital-based specialties, multi-specialty clinics, and laboratories). The top specialists are assessed for geographic availability and ratio assessment. All OB/GYNs and behavioral health practitioner category types, e.g., psychiatrists, psychologists, and Master's-level therapists, are included in the availability monitoring activities.

High-impact specialists at a minimum include oncologists. In addition, at least two contracted provider types, excluding primary care practitioners and hospital-based specialties, that rank highest in inpatient mortality and morbidity according to the Centers for Disease Control and Prevention, are selected and considered high-impact specialists. **Table H** is reviewed annually and updated, as needed, to reflect current measurement year high-volume and high-impact specialists.

Member- and provider-specific data/reporting are collected for monitoring and evaluating network availability. The information used to monitor and evaluate the network includes member population figures by line of business; the number of practitioners by specialty and location (including high-volume/impact specialties and behavioral health); ancillary provider types by location; available member ethnicities, language preferences and other cultural identifiers. Blue Shield Promise also evaluates network availability relative to providers' spoken languages and other cultural identifiers, and ethnicity. Additionally, the availability of public transportation, CAHPS results relative to provider availability, access to care member grievances and provider complaints, out-of-network referrals and letters of agreement trends, and timely access to care studies.

The QI Department annually evaluates Blue Shield Promise's performance by comparing the network monitoring results against established access standards/goals and completing an analysis to determine the quality indicators for network access. The network's performance results are compared against the standards/goals; and when they are not met, a barrier analysis is produced to determine whether improvement opportunities exist. When opportunities are identified, they are prioritized for implementation. Considerations to determine whether improvement opportunities exist include:

- Availability of practitioners to contract within the area where a network gap is identified.
- The population density in the area.
- Established patterns of medical practice in the community, including travel patterns.
- The providers' language and the cultural/ethnic needs for existing and potential enrollees.
- Physical (i.e., geographic) barriers and social/economic barriers to travel.
- The existence of out-of-network referrals and Letter of Agreement trends.
- The presence of member access to care grievances (including behavioral health).
- The results of member and provider surveys.

Annual network adequacy reports are reviewed for issues and shared/addressed in collaboration with the Clinical Access Programs, Network Management, Provider Operations, Provider Relations and other departments as needed. When opportunities for improvement are identified, as necessary, a CAP may be implemented, including interventions and process revisions. Follow-up is performed to ensure network adequacy is achieved and maintained in areas where gaps were identified.

Cultural Needs and Assessment. Several sources are used to evaluate access to culturally appropriate care:

1. At least annually, data from CAHPS is evaluated to determine how well the practitioner portion of the networks meet the needs and preferences of members, including cultural needs. This information is not medical or behavioral health specific. These data sources may include cultural needs and preferences, gender information, and race/ethnicity information.

2. The U.S. Census – Statistics from the U.S. Census and/or the American Community Survey covering race and languages spoken by the population are reviewed. This is correlated against members' expressed preferences based on feedback and/or grievances.
3. Interpreter services from Blue Shield Promise's Language Assistance Program ("LAP") – as available.
4. Contracted practitioner gender and spoken language data – if/when available.
5. Member complaints regarding desired cultural availability of practitioners
6. California Medical Board Physician Data – California Business and Professions Code section 2425.3 authorizes the California Medical Board to collect information from physicians at the time of their medical license renewal. A physician may self-report his or her cultural background (i.e., ancestral, ethnic, or national background) and foreign language proficiency (i.e., non-English). This information is aggregated into both statewide totals and by the ZIP Code of the principal practice location. The results are reported on the California Medical Board's website, **http://www.mbc.ca.gov/Survey/.** If a physician does not provide his or her principal practice location, the California Medical Board uses the ZIP Code that appears on record. Blue Shield Promise may use this information as a proxy to determine the networks' practitioners' foreign language proficiency and cultural background and compare that information against members' cultural and linguistic needs.
7. Take action to enhance the practitioner network if/when linguistic or cultural gaps are identified.

Department of Health Care Services Annual Network Certification. As part of the Annual Network Certification ("ANC"), the DHCS performs Quarterly Monitoring to assess continued network adequacy. This is done per DHCS APL 21-006 and subsequent APLs. The DHCS provides Blue Shield Promise with the results. Blue Shield Promise responds to the DHCS monitoring results, as required, and addresses any identified network adequacy issues as needed. Specifically, Blue Shield Promise annually submits an ANC to DHCS with supporting documentation within 105 days before the contract year. This reflects the entire contracted provider network by service area, which includes network capacity and provider to member ratios, network composition, provider types – including mandatory providers (i.e., Federally Qualified Health Centers, free standing birthing centers, certified nurse midwives, licensed midwives and Indian health service facilities), behavioral health therapy, and time and distance standards. In the event network adequacy standards cannot be met, a request for alternate access is requested from the DHCS for any provider types not meeting the network adequacy guidelines. DHCS notifies Blue Shield Promise when a demand for alternate access standards is requested from DHCS. The DHCS notifies Blue Shield Promise if/when an alternate access request(s) is/are approved.

DHCS uses Blue Shield Promise's monthly 274 File submission to verify the compliance with the required provider-to-member ratios, mandatory providers, and timely access to appointment standards. For purposes of annual network compliance, Blue Shield Promise's February 274 File submission is used. Please Note: The DHCS uses the same February 274 File submission to review Blue Shield Promise's resubmissions of errors identified during the preliminary review process. If the DHCS is unable to access Blue Shield Promise's February 274 File submission due to untimely, incomplete, or inaccurate submission, Blue Shield Promise may be subject to imposition of a CAP and/or monetary sanctions.

Blue Shield Promise maintains documentation of the efforts taken to contract with additional nonparticipating providers identified for the Alternative Access Standard requests who are located in the county or bordering counties where network deficiencies are identified. It is

advisable to contract with all available providers, including those outside of time or distance standards, to increase network capacity.

Subcontracted Network Certification Requirement. The DHCS requires Medi-Cal Managed Care Plans to apply a subcontracted annual network certification process. A subcontracted network is a provider network to which Blue Shield Promise delegates various functions, including but not limited to; claims processing, provider credentialing, financial solvency, and utilization management to entities such as participating provider groups, hospitals, and applicable subcontracted vendors. The goal of the subcontracted network certification requirement safeguards that Medi-Cal Managed Care Plans – that delegate the medical management responsibility of providing Medi-Cal covered healthcare services by way of subcontracted networks – meet network adequacy requirements for each subcontracted network. All subcontracted networks are subject to the same network adequacy standards required of the primary Managed Care Plan, as outlined by the DHCS (see APL 21-006 or subsequent APLs), including:

- Provider to member ratios
- Mandatory provider types
- Time and distance standards
- Timely access to care

The following table outlines the provider types included in the Subcontracted Network Certification.

Adult and Pediatric primary care physicians (including non-physician medical practitioners)	Adult and pediatric core specialties: 1. Cardiology/Interventional Cardiology 2. Dermatology 3. Endocrinology 4. ENT/Otolaryngology 5. Gastroenterology 6. General Surgery 7. Hematology 8. HIV/AIDS Specialists/Infectious Diseases 9. Nephrology 10. Neurology 11. Oncology 12. Ophthalmology 13. Orthopedic Surgery 14. Physical Medicine and Rehabilitation 15. Psychiatry 16. Pulmonology
Obstetrics/Gynecology (OB/GYNs)	
Adult and pediatric mental health outpatient providers	
Hospitals	
Pharmacies	
Ancillary Services	

A full list of network adequacy standards is available on the DHCS website in Attachment A of APL 21-006 or subsequent APLs, or **Attachment A** of this policy. Subcontracted networks must meet network adequacy standards for the scope of services they are contracted to provide. If/When Blue Shield Promise determines that a subcontracted network will not or cannot be certified, the reason(s) is/are clearly explained. In addition, Blue Shield Promise works with the subcontracted network to ensure that enrollees within the network continue to access appropriate care.

Monitoring Effectiveness. The effectiveness of this policy is monitored through access to care audits, spatial analyses, practitioner office staff surveys, practitioner and member satisfaction surveys, member and provider complaints and grievances, disenrollment reports, out-of-network referral patterns, PCP transfers, DHCS annual network certification, emergency room utilization

patterns, and after-hours access studies. These processes are also reviewed by regulatory agencies during routine examinations.

Note: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed clinician, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time is appropriate and will not have a detrimental effect on the health of the enrollee.

TABLES

The following tables provide guidelines and standards for accessibility and availability.

- Table A - Primary Care Practitioners Accessibility Guidelines
- Table B - Specialist Accessibility Guidelines
- Table C - Behavioral Health Accessibility Guidelines
- Table D - Ancillary Accessibility Guidelines
- Table E - Long Term Services and Support Accessibility Guidelines
- Table F - Availability Guidelines
- Table G - Medical Ratio Guidelines
- Table H - Specialty Care Physicians – High Volume, High Impact, DHCS Core, and Behavioral Health
- TABLE I **–** Blue Shield Promise Telephone Accessibility Services

TABLE A - Primary Care Practitioners Accessibility Guidelines	
Criteria	**Standard**
Primary Care Practitioners (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 members 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.
Urgent PCP exam	Within 48 hours – When a member contacts the Practitioners office with an urgent medical condition, we require the member to be seen within the 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.

TABLE A - Primary Care Practitioners Accessibility Guidelines	
Criteria	**Standard**
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 healthcare services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Routine PCP, Non-urgent exam (includes Follow-Up and Routine appointments)	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 ten (10) Business Days Access to OB/GYN network Practitioner is available without prior authorization.
Well-child visits (For a child under 2 years of age)	Within ten (10) Business Days When a parent of a member requests an appointment for a Well Child Visit, they must be given the appointment within 10 business days. It is acceptable for the member to be scheduled with a covering Practitioner.
Initial Health Assessments and behavioral health screenings if not completed by the County Mental Health Plan or MBHO contracted Behavioral Health Practitioner previously (Medi-Cal line of business only)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when a member becomes eligible) Blue Shield Promise requires that this assessment is completed within the first 120 days of enrollment. Blue Shield Promise actively sends reminders to members within this period of time encouraging them to schedule this appointment. Blue Shield Promise 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 Promise also has a 24-hour, 7 days a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurses 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 Promise also has a 24-hour, 7 days a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurses 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.

TABLE A - Primary Care Practitioners Accessibility Guidelines	
Criteria	**Standard**
Speed of Telephone Answer (Practitioners' Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Waiting Time in office	Thirty (30) minutes maximum after the time of appointment
Access for Disabled Members	Blue Shield Promise audits facilities as part of the Facility Site Review Process to ensure compliance with Title III of the Americans with Disabilities Act of 1990.
Seldom Used Specialty Services	Blue Shield Promise will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary.
Missed/Broken Appointments (Patient fails to show for scheduled appointment)	Missed/broken 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' offices are responsible for counseling such members.

TABLE B - Specialist Accessibility Guidelines	
Criteria	**Standard**
Specialty Care Practitioners (SCPs) Defined as:	Practitioners providing specialty care to our members, comprised of all specialty types listed in Blue Shield Promise network l including chiropractic, acupuncture, and vision providers, according to the services offered per contracted line of business.
Emergency Care	Immediately - When a member calls the Practitioner's 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.
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 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 (e.g., a referral to a specialist by a PCP or another specialist) 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
Urgent Vision Services	Vision services offered within 72 hours of request when it is consistent with the patient's individual needs and as required by professionally recognized standards of vision practice.
Non-Urgent Vision Services	Vision services are offered within 36 business days of the request for an appointment.
Preventative Care Vision Services	Vision services are offered within 40 business days of the request for an appointment.

TABLE B - Specialist Accessibility Guidelines	
Criteria	**Standard**
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 Promise 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 Promise also has nurses 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. 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 Promise also has 24 hours, 7 days a week nurse advice line available through a toll- free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurses on-call 24 hours a day, 7 days a week to support coordination of care issues. Our Customer Care Department will keep an abandonment rate of less than 5%. 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.
Speed of Telephone Answer (Practitioners Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Waiting Time in office	Thirty (30) minutes maximum after the time of appointment
Missed/Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/broken 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 contacted 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.

TABLE C - Behavioral Health Accessibility Guidelines	
Criteria	**Standard**
Life-threatening/Emergency needs	Will be seen immediately (preferably directing the member to the Emergency Room or calling 911)
Non-Life-threatening emergency needs	Will be seen within six (6) hours
Urgent Visit	Within 48 hours
Non-physician Behavior Health Clinician, including: • Initial visit for routine care, • Routine office visit, • Non-urgent examination	Within ten (10) Business Days

TABLE C - Behavioral Health Accessibility Guidelines	
Criteria	**Standard**
Follow-up Routine Care Appointments	• Within 10 Business Days for non-prescriber mental healthcare clinicians • Within 15 Business Days for prescriber mental healthcare clinicians Follow-up routine care appointments are visits at later, specified dates to evaluate the patient's progress and other changes that have taken place since a previous visit.
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 all other lines of business are carved out to contracted MBHOs The MBHOs each have 24 hours a day, 7 days a week coverage. Blue Shield Promise 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 Promise and its contracted MBHOs require access to a non-recorded voice within thirty (30) seconds and the abandonment rate is not to exceed 5%. Blue Shield Promise 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.
Speed of Telephone Answer (Practitioners Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
The standard for reaching a behavioral health professional	Blue Shield Promise, through our contracted MBHOs, is available to arrange immediate access to a behavioral health professional. The County MHPs also have 24/7 access lines.
Hours of Operation Parity (Medicaid LOB only)	The organization requires the hours of operation that practitioners offer to Medicaid members to be no less than offered to member with a commercial benefit plan. Refer to the Appendix of your Provider Manual available at: **www.blueshieldca.com/promise.**
Specialty Provider	Within fifteen (15) Business Days. (after appropriate PCP visit) Perform comprehensive evaluation and submit to Plan.
Qualified Autism Service (QAS) Provider	Within fifteen (15) Business Days after the evaluation is approved by the Plan. Perform functional assessment and submit a treatment plan to Plan.
QAS Provider (professional or paraprofessional)	Within fifteen (15) Business Days after treatment plan approved by Plan. Begin treatment/services.

TABLE D - Ancillary Accessibility Guidelines	
Criteria	**Standard**
Ancillary Providers	Will be seen within fifteen (15) Business Days, for services where prior authorization has been obtained.

TABLE E - Long Term Services and Support Accessibility Guidelines	
Criteria	**Standard**
Skilled Nursing Facility	Skilled Nursing Facility services will be available within 5 business days of the request
Intermediate Care Facility/ Developmentally Disabled (ICF-DD)	ICF-DD services will be available within 5 business days of the request. *Note, ICF-DD are not included in the Blue Shield Promise Network. Please refer to the standard for Skilled Nursing Facility.* (These services are provided by Skilled Nursing Facilities and Nursing Facilities (LTC) where 24-hour nursing services are provided.
Community-Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for an appointment. *Note, there are no standard requirements for CBAS.*

TABLE F - Availability Guidelines		
Category	**Standard**	**Goal**
Primary Care Practitioners (PCP): Family Medicine (GP & FP), Internal Medicine, Pediatrics, and OB/GYN practicing as a PCP (Medi-Cal only)	One PCP of each primary type within 10 miles or 30 minutes (or an approved/pending Alternate Access Standard) from each member's residence or potential member's residence in the approved service area as appropriate by age.	100%
Specialty Care Practitioners (SCP) (Adult and Pediatric), Including OB/GYNs, Psychiatrists, and high-volume/impact SCP (see **Table H**)	One SCP (per specialty type) within 15 miles or 30 minutes from any member or potential member's residence.	90%
Vision Services Provider	One Vision Service Provider within 15 miles or 30 minutes from any member or potential member's residence.	90%
Non-physician Mental Health (NPMH) Outpatient services, including high-volume behavioral health providers and substance abuse providers (Adult and Pediatric)	One NPMH provider within 15 miles or 30 minutes from any member or potential member's residence.	90%
Hospitals	One hospital within 15 miles or 30 minutes (or an approved/pending Alternate Access Standard) from each member's or potential member's residence.	100%
Emergency Health Care Facility	One facility within 15 miles or 30 minutes from any member or potential member's residence.	90%
In-Patient Psychiatric Facility	One facility within 15 miles or 30 minutes from any member or potential member's residence.	90%
Ancillary Facility, including radiology, dialysis, ambulatory surgical centers ("ASC"), occupational/physical therapy. laboratories, chemotherapy and radiation.	One ancillary facility (per facility type) within 30 miles from any member or potential member's residence.	90%
Skilled Nursing Facility ("SNF")	One SNF within 30 miles from any member or potential member's residence.	90%
Pharmacy	One pharmacy within 10 miles or 30 minutes from any member or potential member's residence.	90%

TABLE G - Medical Ratio Guidelines		
Provider Type	**Provider-Member Ratios**	**Goal**
Total PCP to Member Availability Ratio: (Family Medicine (GP & FP), Internal Medicine, Pediatrics, and OB/GYN practicing as a PCP)	1 PCP to 2,000 members	100%
Specialty Care Practitioners (SCP) Including high volume/impact specialists (see **Table H**)	1 SCP of any type per 1,200 members	100%
	1 SCP of each type per 10,000 members 1 OB/GYN per 5,000 female members	90%
A total of four (4) Non-Physician Medical Practitioners in any combination that does not include more than: • Two (2) Physician Assistants per supervising physician. • Four (4) Nurse Practitioners per supervising physician. • Three (3) Nurse Midwives per supervising physician.	Each Non-Physician Medical Practitioner practicing under a physician increases that physician's capacity by 1,000 members to a maximum of 4,000 additional members. However, the following specification cannot be exceeded: • Physician Assistants: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Physician Assistant 1:2. • Nurse Practitioners: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Practitioner 1:4. • Nurse Midwives: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Midwife 1:3.	100%
Vision Services Provider	1 Vision Services Provider to 5,000 members	90%
Behavioral Health Practitioners, including psychiatry, NPMH, and substance abuse practitioners	1 provider of each category per 10,000 members	90%
Dental Services Provider	Carved out service for Medi-Cal and Cal-MediConnect	N/A
Acupuncture Services Provider	1 Acupuncture Services Provider to 5,000 members)	100%
Chiropractic Services Provider	1 Chiropractic Services Provider to 10,000 members	100%

TABLE H - Specialty Care Physicians (Subject to Change Annually)				
Specialties Specialties apply to adult and pediatrics. This listing can vary annually)	High Volume Specialties	High Impact Specialties	DHCS Core Specialty	Behavioral Health
Cardiology/Intervention Cardiology		X	X	
Dermatology	X		X	
Gastroenterology			X	
OB/GYN	X			
Ophthalmology	X		X	
Endocrinology			X	
ENT/Otolaryngology			X	
General Surgery			X	
Hematology			X	

TABLE H - Specialty Care Physicians (Subject to Change Annually)				
Specialties Specialties apply to adult and pediatrics. This listing can vary annually)	High Volume Specialties	High Impact Specialties	DHCS Core Specialty	Behavioral Health
HIV/AIDS Specialist/ Infectious Disease			X	
Nephrology			X	
Neurology		X	X	
Oncology		X	X	
Orthopedic Surgery			X	
Physical Medicine and Rehabilitation			X	
Pulmonology			X	
Psychiatry	X		X	X

TABLE I – Blue Shield Promise Telephone Accessibility Services			
Accessibility to Telephone Services	**Standard**	**Goal**	**Mechanism**
Blue Shield Promise's 24/7 nurse advice line is available for all enrollee triage and screening needs. Speed to answer expectation:	Within 30 seconds	100%	Call Statistics
Access for a covered individual to speak by telephone with a Customer Service Representative who is knowledgeable and competent regarding the covered individual's questions and concerns during normal business hours.	< 10 minutes or a scheduled callback within 30 minutes.	100%	Operations Telephone Statistics
Average Speed to Answer (ASA)	Within 30 seconds	100%	Operations Telephone Statistics
Call Abandonment Rate	< 5%	100%	Operations Telephone Statistics

DHCS NETWORK ADEQUACY STANDARDS - ATTACHMENT A OF APL 21-006
(Subject to Change)

Network Adequacy Standards

Provider Type	Timely Access Standard	Time and Distance Standard by County Size[1]			
		Rural	Small	Medium	Dense
Primary Care (Adult and Pediatric)	Within 10 business days to appt. from request	10 miles or 30 minutes from any member or anticipated member's residence			
Specialty Care[2] (Adult and Pediatric)	Within 15 business days to appt. from request[3]	60 miles or 90 minutes from any member or anticipated member's residence	45 miles or 75 minutes from any member or anticipated member's residence	30 miles or 60 minutes from any member or anticipated member's residence	15 miles or 30 minutes from any member or anticipated member's residence
Obstetrics/Gynecology (OB/GYN) Primary Care	Within 10 business days to appt. from request	10 miles and 30 minutes from any member or anticipated member's residence			
OB/GYN Specialty Care	Within 15 business days to appt. from request	60 miles or 90 minutes from any member or anticipated member's residence	45 miles or 75 minutes from any member or anticipated member's residence	30 miles or 60 minutes from any member or anticipated member's residence	15 miles or 30 minutes from any member or anticipated member's residence
Hospitals	Not Applicable	15 miles or 30 minutes from any member or anticipated member's residence			
Pharmacy	Dispensing of at least a 72- hour supply of covered outpatient drug in an emergency situation	10 miles or 30 minutes from any member or anticipated member's residence			
Mental Health (non-psychiatry) Outpatient Services[4] (Adult and Pediatric)	Within 10 business days to apt. from request	60 miles or 90 minutes from any member or anticipated member's residence	45 miles or 75 minutes from any member or anticipated member's residence	30 miles or 60 minutes from any member or anticipated member's residence	15 miles or 30 minutes from any member or anticipated member's residence
Ancillary Services	Within 15 business days to appt. from request.	Not Applicable			
Long Term Services and Supports (LTSS)	If applicable[5]	Time and distance standards are not established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the member to provide services or the member resides at the facility for care.			

[1] County Size category by Population defined in Table 1.
[2] Time and Distance Standards apply to the core specialists outlined in Table 2.
[3] Timely Access standards apply to all specialists, not only core specialists.
[4] Non-specialty mental health services for members with mild to moderate impairments
[5] LTSS Timey Access Network Standards defined in Table 3.

Table 1: County Size Categories by Population

Size Category	Population Density	Number of Counties	Counties
Rural	≤50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 599 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	≥600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

Table 2: DHCS Adult and Pediatric Core Specialists

DHCS Adult and Pediatric Core Specialists	
1. Cardiology/Interventional Cardiology	9. Nephrology
2. Dermatology	10. Neurology
3. Endocrinology	11. Oncology
4. ENT/Otolaryngology	12. Ophthalmology
5. Gastroenterology	13. Orthopedic Surgery
6. General Surgery	14. Physical Medicine and Rehabilitation
7. Hematology	15. Psychiatry
8. HIV/AIDS Specialists/Infectious Diseases	16. Pulmonology

Table 3: LTSS Timely Access Network Standards

Provider Type	Timely Access Standard by County Size			
	Rural	Small	Medium	Dense
SNF	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Community Based Adult Services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level.			

Table 4: Call Center Wait Time Standards

Call Center Wait Time Standards	
Medi-Cal Managed Care Health Plan (MCP) Call Center	10 minutes from the time the call is placed.