Section 2: Hospital and Facility Responsibilities

This page intentionally left blank.

Table of Contents

Section 2: Hospital and Facility Responsibilities

This page intentionally left blank.

Quality Management and Improvement

Blue Shield's Clinical Quality Department, in collaboration with Blue Shield's Quality Committees selects and oversees quality measurement and improvement activities according to Blue Shield's strategic goals, accreditation, and regulatory requirements. Activities are conducted in all areas and dimensions of clinical and non-clinical member care and service, such as: Member Satisfaction, Access and Availability, Case Management, Continuity and Coordination of Care, Wellness, Preventive Health, and Healthcare Effectiveness Data and Information Set (HEDIS®) Measurement.

Blue Shield conducts ongoing systematic reviews of the health care and services provided to members. Care and services are coordinated and monitored in accordance with a variety of applicable accrediting standards, regulatory bodies, and statutes, including not but limited to:

- National Committee for Quality Assurance (NCQA)
- California Health and Safety Code
- California Department of Insurance (CDI)
- Department of Managed Health Care (DMHC)
- Department of Labor Employer Retirement Income Security Act (ERISA)
- Centers for Medicare & Medicaid Services (CMS)
- Centers for Disease Control (e.g., ACIP)
- Office of the Patient Advocate
- Covered California

Accreditation

Blue Shield maintains Health Plan Accreditation (HPA) with National Committee for Quality Assurance (NCQA). Blue Shield of California's Commercial HMO/POS, Commercial PPO, Marketplace HMO/POS (Covered CA/Exchange), Marketplace PPO (Covered CA/Exchange), Medicaid, and Medicare HMO hold NCQA Health Plan Accreditation. The NCQA accreditation survey process assesses a health plan's organizational policies and procedures, and performance against NCQA standards every three years.

Provider Responsibilities for Quality Management and Improvement

Blue Shield actively solicits network provider representatives' participation in several quality management and improvement activities, including:

- Participation on QI Committees
- Expert consulting for Peer Review and UM determinations
- Expert advising for clinical QI workgroups
- Participation in Focus groups
- Partnership in QI studies
- Investigation of member grievances and quality of care issues

Quality Management and Improvement *(cont'd.)*

Provider Responsibilities for Quality Management and Improvement *(cont'd.)*

All Blue Shield providers, including hospitals, are required to participate in quality management and improvement activities by providing, to the extent allowed by applicable state and federal laws, member information, medical records, and quality data for review of quality of care and service provided to members.

All affiliated Hospitals are expected to perform higher than 50% of benchmark for CMS Hospital Compare/CAL Hospital Compare. All affiliated hospitals that perform less than 50% of the benchmark for CMS Hospital Compare/CAL Hospital Compare will be required to submit an improvement plan of action for the identified performance year.

To comply with NCQA accreditation requirements, Blue Shield collects and reports HEDIS data as it relates to Blue Shield members. Blue Shield HMO-contracted physicians and hospitals are required to provide medical records requested for HEDIS data collection within the defined time period. HIPAA includes data collection for HEDIS reporting in the category of health care operations, thus no special patient consent or authorization is required to release this information.

Quality management activities are considered privileged communication in conjunction with peer review activities conforming to Evidence Code Section 1157 and Section 1370 of the California Health and Safety Code.

Submission of Laboratory Results Data

All hospitals contracting with Blue Shield are required to submit member-level laboratory results data as part of Blue Shield's quality management and improvement initiatives. These data elements are used for HEDIS, Align Measure Perform (AMP), chronic condition management programs, and other similar activities.

Results for laboratory tests (analyses) must be submitted using the current version of the CALINX lab data standard, which is based on the Health Level 7 (HL7) industry standard for exchange of laboratory results data. This standard can be obtained on the Integrated Healthcare Association's website at http://www.iha.org/calinx_lab_standards.html. Coding for analytes must use the LOINC coding system. Blue Shield subscriber and member IDs must be used in each record. Data must be submitted on a monthly basis using Blue Shield's secure data exchange procedures.

Contact Yuan Hong at (310) 744-2674 or yuan.hong@blueshieldca.com for additional details and requirements, as well as to initiate required submissions of laboratory results data.

Reporting Specified C-Section Rates

To comply with Covered California requirements, hospitals must report quarterly to the Maternal Data Center of the California Maternal Quality Care Collaborative the number of nulliparous women with a term, singleton baby in a vertex position (NTSV) delivered by cesarean section.

- Numerator: uncomplicated c-sections MS-DRG 766
- Denominator: all born MS-DRGs 765, 766, 767, 768, 774, 775
- Exclusions: twins and higher ICD-10s O30091, O30109, O30099, O30041, O30090, O30009

Quality Management and Improvement *(cont'd.)*

Reporting Hospital-Acquired Conditions to CMS

To comply with the Centers for Medicare & Medicaid Services (CMS) and Covered California requirements, hospitals must report to Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) quarterly rates of hospital-acquired conditions (HACs) specified below using CDC's reporting criteria (www.cdc.gov/nhsn/pdfs/validation/2018/pcsmanual_2018-508.pdf):

- Methicillin-resistant Staphylococcus aureus (MRSA)
- Catheter-associated Urinary Tract Infection (CAUTI)
- Central Line-associated Bloodstream Infection (CLABSI)
- Colorectal Surgical Site Infection (SSI Colon)
- Clostridium difficile Infection (CDI)

Blue Shield is actively working towards improvement of Hospital Acquired Conditions for all contracted hospitals. In order to comply with Covered California's requirements that all hospitals achieve infection rates (measured as a standardized infection ration or SIR) of 1.0 or lower, Blue Shield may reserve the right to promote hospital involvement in a performance improvement plan for Hospitals performing in the bottom quartile.

Patient Safety

Blue Shield is committed to improving the safety of clinical practice by fostering an environment in which all parties are attentive to safety issues. Blue Shield supports our network providers by identifying patient safety opportunities. We also endorse statewide collaborative activities and encourage hospitals to participate in the following programs:

- The Blue Distinction® Program
  http://www.bcbs.com/healthcare-partners/blue-distinction-for-providers/
- Cal Hospital Compare
  www.calhospitalcompare.org
- The California Maternal Quality Care Collaborative
  https://www.cmqcc.org/
- The Leapfrog Hospital Survey
  http://www.leapfroggroup.org/survey-materials

Blue Shield has incorporated safety-related information and on-line consumer decision support tools to promote informed consumer decision making at the point of care.

We take an active role in supporting and improving patient safety through a variety of activities including:

- Promoting continuity and coordination of care between practitioners and between care settings.
- Member education regarding preparation for surgery and post-surgical care.
- Designation of centers of excellence for complex, high-risk procedures.
- Comprehensive Case Management program to improve medication treatment plan adherence.

Quality Management and Improvement *(cont'd.)*

Patient Safety *(cont'd.)*

- Focused utilization management to improve readmission rates and bed day utilization.
- Careful evaluation of new medical procedures and medications, utilizing evidence-based literature, and seeking input from academically acknowledged medical authorities.
- "Alert" messages for physicians and patients regarding clinical compliance with well-accepted practice guidelines.

Quality of Care Reviews

Blue Shield has a comprehensive review system to address potential quality of care issues. A potential quality of care issue arising from a member grievance or an internal department is forwarded to the Blue Shield Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including, but not limited to, medical records and a provider written response. The case may then be forwarded to a Blue Shield Medical Director for review and determination of any quality of care issues. A case review may also include a review of the care provided by a like-peer specialist and/or review by the Blue Shield Peer Review Committee.
During the review process, information is obtained from the involved Facility. Upon review completion, dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a request for corrective action or an educational letter outlining opportunities for improvement. Patient safety concerns and/or patterns of poor care are considered during Blue Shield recredentialing activities or reviewed in more detail by the Blue Shield Credentialing Committee.

Contracted facilities are obligated to participate in the quality of care review process and must provide documents upon request. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157. As such, neither the proceedings or record of the review may be disclosed outside of the review process.

Medical Records

To assist us in maintaining continuity of care, hospitals must provide medical records of services rendered to Blue Shield members when it is essential to communicate the documentation of care to other providers and/or Blue Shield for the purpose of delivering further care and/or making further care decisions.

Members are entitled to obtain copies of their own medical records, including copies of emergency department records, X-rays, CT scans, and MRIs. Hospitals must make member medical records available upon request within time requirements established by regulatory agencies, to the member, and to Blue Shield and its designated agents. Additionally, the hospital must, without charge, transmit a member's medical record information to the member's primary care physician and other providers, to government officials, and to Blue Shield for purposes of utilization management, quality improvement, and other Blue Shield administrative purposes. The hospital also must secure from the member on admission a release of medical information, in the event it is required by law.

Hospitals must maintain an individual, continuous unit record for each member and document on an ongoing basis when a member is seen in the facility with all pertinent information recorded in a legible manner. The medical record must document care provided in the facility, as well as referrals and follow-up to referrals for care outside of the hospital. Allergies must be noted in a prominent place in the medical record, as well as the existence or absence of an executed Advance Directive.

Quality Management and Improvement *(cont'd.)*

Medical Records *(cont'd.)*

Hospitals shall maintain the usual and customary records for Blue Shield members in the same manner as for other hospital patients and require that all physicians treating members at the facility establish and maintain, in an accurate and timely manner, an organized medical record. It should contain the demographic and clinical information necessary to document the member's medical problems and the medical services he or she receives.

The medical record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or provided under the direction of, the hospital. The record shall be in a form that allows trained health professionals, other than the hospital, to readily determine the nature and extent of the member's medical condition and which services were provided and that allows peer review of the care provided.

In keeping with regulatory standards, a member's medical records must be kept for at least 10 years after the last member contact.

Advance Directives

An Advance Directive (also known as a Durable Power of Attorney for Healthcare) is a formal document completed by an individual in advance of an incapacitating illness or injury. When the individual becomes too ill to communicate his or her wishes concerning medical care, providers use the directive as guidance in providing treatment. Blue Shield recommends that all Medicare members and any member 18 and older have a signed Advance Directive communicating their wishes regarding health care decisions to their physician and family members.

Section 2: Hospital and Facility Responsibilities

Service Accessibility Standards

Blue Shield requires that IPAs and medical groups, together with their contracted providers, provide access to health care services within the time periods as established by Blue Shield and Title 28 CCR Section 1300.67.2.2 as specified in this manual.

Blue Shield uses the Consumer Assessment of Health Plans Survey (CAHPS), the Patient Assessment Survey (PAS), Provider Satisfaction Survey, Appointment Availability Survey results, and member appeals and grievances to measure compliance with the applicable access standards. While all of the previously mentioned surveys will be used to demonstrate compliance, an overall rate of compliance by the IPA/medical group will also be calculated based solely on the Provider Satisfaction Survey and Appointment Availability Survey results. Groups that are found non-compliant with the access standards may be required to submit a corrective action plan containing details on how the IPA/medical group will achieve and maintain compliance.

If it is not possible to grant a member an appointment within the timeframes indicated in the Access-to-Care table below, the wait time may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined that a longer wait time will not have a detrimental impact on the health of the enrollee. Such provider must note, in the appropriate record, that it is clinically appropriate and within professionally recognized standards to extend the wait time.

If a member is unable to obtain a timely referral to an appropriate provider, the member, member representative, or an attorney or provider on the member's behalf, may file a grievance by contacting Blue Shield's Customer Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield researches and investigates all grievances and, as appropriate, the Blue Shield Medical Director may review a grievance. For commercial members, call (800) 541-6652 and for Blue Shield Medicare Advantage call (800) 776-4466.

Members or providers on the member's behalf may also contact the applicable state regulator to file a complaint at the following toll-free numbers if they are unable to obtain a timely referral to an appropriate provider.

- California Department of Insurance (CDI): (800) 927-HELP (4357) or TTY (800) 482-4833
- Department of Managed Health Care (DMHC): (888) 466-2219 or TDD (877) 688-9891
- The Centers for Medicare & Medicaid Services (CMS): (800)-MEDICARE [(800) 633-4227] or TTY/TTD (877) 486-2048

Service Accessibility Standards for Commercial and Medicare

ACCESS TO CARE	STANDARD
Preventive Care Appointments Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member's assigned PCP.	Within 30 calendar days
Regular and routine care PCP Access to routine, non-urgent symptomatic care appointments with a member's assigned PCP. The time standards must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 10 business days
Regular and routine care SPC Access to routine, non-urgent symptomatic care appointments with a specialist. The time standards must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 15 business days
Urgent Care Appointment Access to urgent symptomatic care appointments that do not require prior authorization with the PCP, specialist, covering physician, or urgent care provider. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.	Within 48 hours
Urgent Care Appointment Access to urgent symptomatic care appointments requiring prior authorization. When a Practitioner refers a member (e.g., a referral to a specialist by a PCP or another specialist) for an urgent care need to a specialist 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. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.	Within 96 hours
Ancillary Care Appointments Access to non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 15 business days
Rescheduling of Appointments and Authorizations When it is necessary to reschedule an appointment or authorization it must be promptly rescheduled, in line with the health care needs of the patient, and consistent with professional standards. Interpreter services will be coordinated with scheduled appointments to ensure the provision of interpreter services at the time of the appointment.	As determined by licensed healthcare professional
After Hours PCP Access *See "After Hours Requirements" below for more details on this requirement.*	PCP or covering physician available 24 hours a day, 7 days a week
Emergency Care	Immediate
After Hours Emergency Instructions (telephone answering service or machine) *See "After Hours Requirements" below for more details on this requirement.*	Specific instructions for obtaining emergency care such as directing the member to call 911 or to go to the nearest emergency room.

Section 2: Hospital and Facility Responsibilities

Service Accessibility Standards for Commercial and Medicare *(cont'd.)*

ACCESS TO CARE	STANDARD
In-office Wait Time **Recommendation**: In the absence of emergencies, medical offices should seek to limit wait time to 15 minutes after patient's scheduled appointment.	Member care will not be adversely affected by excessive in-office wait time.
Hours of Operation	All providers will maintain sufficient hours of operation so as not to cause member-reported access and availability problems with an adverse effect on the quality of care or medical outcome.

ACCESS TO TELEPHONE SERVICE	STANDARD
Average Speed to Answer (ASA)	45 seconds
Abandonment Rate	≤ 5%
Blue Shield's **24/7 Nurse Advice Line** will be available for all enrollee triage and screening needs. The speed to answer will be:	Within 30 minutes
Access to the **Blue Shield Customer Service** line during normal business hours	Within 10 minutes

Behavioral Health Appointment Access Standards

CATEGORY	ACCESS STANDARDS
Routine and follow-up visits with non-physician practitioners	Within 10 business days
Routine and follow-up visits with behavioral health physicians	Within 15 business days
Urgent Care visits	Within 48 hours
Care for an Emergent Non-Life-Threatening Situation	Within 6 hours

Service Accessibility Standards for Commercial and Medicare *(cont'd.)*

Behavioral Health Geographic Access Standards

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health including: Psychiatrists, Psychologists, Licensed Clinical Social Workers, Marriage and Family Therapists, Substance Abuse and Addiction Specialists	Urban: 1 within 10 miles of each member Suburban: 1 within 20 miles of each member Rural: 1 within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Geographic Distribution of Behavioral Health including: Inpatient Facility, Residential & OP Treatment Facility	Urban: 1 within 15 miles of each member Suburban: 1 within 30 miles of each member Rural: 1 within 60 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Behavioral Health Member Ratio including: Top 3 HVS Substance Abuse practitioner	1 provider: 20,000 members	100%

After Hours Requirements for Commercial and Medicare Members

IPA/medical groups should abide by the following standards for after-hours emergency instructions and after-hours access to care guidelines.

After Hours Emergency Instructions

Note: The IPA/medical group must ensure that its contracted physicians leave emergency instructions that are compliant when contacted by telephone. A list of compliant and non-compliant responses is listed below.

COMPLIANT RESPONSES	NON-COMPLIANT RESPONSES
1. Hang up and dial 911 or go to the nearest emergency room.	1. Stay on the line and you will be connected to a PCP.
2. Go to the nearest emergency room.	2. Leave your name and number, someone will call you back.
3. Hang up and dial 911.	3. Given another number to contact physician.
	4. The doctor or on-call physician can be paged.
	5. Automatically transferred to urgent care.
	6. Transfer to an advise/triage nurse.
	7. No emergency instructions given.

After Hours Requirements for Commercial and Medicare Members *(cont'd.)*

After Hours Access-to-Care Guidelines

Note: The IPA/medical group should ensure that its contracted physicians or health care professionals respond to non-emergent After Hours calls within 30 minutes of a patient trying to reach the physician. A list of compliant and non-compliant responses from a physician or a health care professional is furnished below:

COMPLIANT RESPONSES	NON-COMPLIANT RESPONSES
1. Immediately, can cross connect	1. Within the next hour
2. Within 30 minutes	2. Unknown or next business day

Provider Availability Standards for Commercial Products

Blue Shield has provider availability standards to ensure a network of established primary care physicians (PCPs) and high-volume specialty practitioners that is sufficient in number and geographic distribution for applicable commercial products. Please refer to the provider availability standards below.

Geographic Distribution

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO - CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member	100%
PCP **General Practitioner** **Family Practitioner** **Internist** **Pediatrician**		One PCP within 15 miles or 30 minutes of each member	100%
Obstetrician/Gynecologist		One OB/GYN within 30 miles of each member (non-Medicare)	85%
High-Volume Specialists **High-Impact Specialists**		One of each type of Top High-Volume Specialists and High-Impact Specialists within 30 miles of each member	90%
Hospitals		One hospital within 15 miles of each member	100%
Radiology		One Radiology facility in 30 miles	90%
Lab		One lab in 30 miles	90%

Provider Availability Standards for Commercial Products
(cont'd.)

Geographic Distribution *(cont'd.)*

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
Pharmacy		One Pharmacy in 15 miles	90%
DME		One DME in 15 miles	85%
ASC		One ASC in 30 miles	95%
SNF		One SNF in 30 miles	95%
Urgent Care		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Dialysis		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Acupuncturist	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.	90%

Provider-to-Member Ratio

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
PCP Family Practitioner, General Practitioner, Internist Pediatrician	HMO DCHMO	One PCP to 2,000 commercial members	100%
Top High-Volume Specialties and High-Impact Specialties to Member Ratio	HMO PPO-DMHC IFP-ePPO	1 OB/GYN to 10,000 female members. 1 High-Volume Specialty of each type and 1 High-Impact Specialty to 20,000 members.	100%

Provider Availability Standards for Commercial Products
(cont'd.)

Provider-to-Member Ratio *(cont'd.)*

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Acupuncturist to Member Ratio	PPO	One Acupuncturist to 5,000 commercial members	100%
Ethnic/Cultural and Language Needs	HMO/POS PPO – DMHC	1 PCP speaking a threshold language to 1,200 members speaking a threshold language**	100%
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**	HMO/POS PPO-DMHC IFP-ePPO	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%

*PPO plans are both Blue Shield PPO – DMHC and PPO – CDI plans. PPO membership excludes ASO/self-insured business.
** Threshold languages are Spanish, Chinese – Traditional, Korean, and Vietnamese

Provider Availability Standards for Medicare Advantage Products

Linguistic and Cultural Requirements

MEASURE	STANDARDS	COMPLIANCE TARGET
PCP providers with linguistic capacity	1 PCP speaking a threshold language to 1,000 members speaking a threshold language	100%

Facility Time and Distance Requirements as required by CMS

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services – Intensive Care	20	10	45	30	160	120	145	120	155	140
Outpatient Dialysis	20	10	45	30	65	50	55	50	100	90
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Orthotics and Prosthetics	30	15	45	30	160	120	145	120	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

Provider Availability Standards for Medicare Advantage Products *(cont'd.)*

Provider Time and Distance Requirements as required by CMS

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Maximum Time (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology - Medical, Surgi	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation/Radi	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative M	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130

Provider Availability Standards for Medicare Advantage Products *(cont'd.)*

Provider Minimum Number Requirements

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
Primary Care	1.67	1.67	1.42	1.42	1.42
Allergy and Immunology	0.05	0.05	0.04	0.04	0.04
Cardiology	0.27	0.27	0.23	0.23	0.23
Chiropractor	0.10	0.10	0.09	0.09	0.09
Dermatology	0.16	0.16	0.14	0.14	0.14
Endocrinology	0.04	0.04	0.03	0.03	0.03
ENT/Otolaryngology	0.06	0.06	0.05	0.05	0.05
Gastroenterology	0.12	0.12	0.10	0.10	0.10
Infectious Diseases	0.03	0.03	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
Neurology	0.12	0.12	0.10	0.10	0.10
Neurosurgery	0.01	0.01	0.01	0.01	0.01
Oncology - Medical, Surgical	0.19	0.19	0.16	0.16	0.16
Oncology - Radiation/Radiation Oncology	0.06	0.06	0.05	0.05	0.05
Ophthalmology	0.24	0.24	0.20	0.20	0.20
Orthopedic Surgery	0.20	0.20	0.17	0.17	0.17
Physiatry, Rehabilitative Medicine	0.04	0.04	0.03	0.03	0.03
Plastic Surgery	0.01	0.01	0.01	0.01	0.01
Podiatry	0.19	0.19	0.16	0.16	0.16
Psychiatry	0.14	0.14	0.12	0.12	0.12
Pulmonology	0.13	0.13	0.11	0.11	0.11
Rheumatology	0.07	0.07	0.06	0.06	0.06
Urology	0.12	0.12	0.10	0.10	0.10
Vascular Surgery	0.02	0.02	0.02	0.02	0.02
Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01

*Minimum number of providers required is based upon the (minimum provider to beneficiary ratio) multiplied by the (95th percentile of the average health plan market share times the total Medicare beneficiaries residing in a county)

IPA/medical groups are required to be in compliance with the standards stipulated by CMS. If any IPA/medical group is unable to provide primary or specialty care services according to the requirements of CMS outlined above, the IPA/medical group is required to do one of the following to meet compliance:

1. Have a Medicare fee-for-service provider who meets both the driving time and driving distance requirements render services to the member, or
2. Contact Blue Shield and utilize a Blue Shield's PPO provider who is also contracted for the Medicare line of business and meets both the driving time and driving distance requirements render services.

In selecting either one of the options, the financial responsibility for professional services rendered under this circumstance will rest with the IPA/medical group.

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access related member complaints and grievances	HMO/POS/ PPO	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	14%	Assessed Quarterly against Standard
PCP, Specialist, and Hospital Network Change Analysis	IFP ePPO	10% change	Assessed Quarterly against Standard
PCP to Member Ratio	IFP PPO	1:2000	Quarterly
Top HVS Turnover	HMO/PPO/ CDI/ SHOP HMO/PPO	10%	Assessed Quarterly against Standard
Hospital Turnover	HMO/PPO	5%	Ad hoc for Block Transfer Filings and 10% Change Analysis
Open PCP Panel	HMO/POS/ Directly Contracted HMO	85%	Assessed Quarterly against Standard
Member Satisfaction	HMO/POS/PPO	HMO – Patient Assessment Survey at IPA/MG level HMP/PPO – CAHPS at Health Plan level	Annual

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

METRICS	COMPLIANCE TARGET	FREQUENCY
Availability related member complaints and grievances	Rate of complaints and grievances 8.81 PTM	Semi-Annual
Availability related PCP Transfers	Rate of PCP transfers per thousand members 1.68 PTM	Semi-Annual
PCP Turnover Rate	14%	Semi-Annual
Top 10 HVS Turnover Rate	10%	Semi-Annual
Hospital Turnover Rate	5%	Semi-Annual
Open PCP Panels	85%	Semi-Annual
PCP to Member Assignment Ratio	1: 1200	Semi-Annual
High-Volume and High-Impact Specialist to Member Ratio	1:20,000	Annual

Language Assistance for Persons with Limited English Proficiency (LEP)

Blue Shield does not delegate overall responsibility for culturally and linguistically appropriate services to contracted providers unless otherwise noted in their contract with Blue Shield. This section summarizes Blue Shield's Language Assistance Program (LAP) and specifies the roles and responsibilities of Blue Shield and its contracted hospitals in supporting the program.

Blue Shield's Threshold Languages

Blue Shield's threshold languages are:

- Spanish
- Chinese – Traditional
- Korean
- Vietnamese

A threshold language is a language other than English that Blue Shield will use to translate vital documents. Threshold languages are determined based on the language preferences of the largest number of plan enrollees, excluding Medi-Cal, Medicare and Administrative Services Only enrollees.

Blue Shield's Language Assistance Program

Blue Shield is committed to providing quality health care services to all enrollees regardless of their ability to speak English. Access to timely language services is provided through competent, trained interpreters and translators.

Blue Shield and its contracted hospitals must offer timely language assistance services to its LEP enrollees at all points of contact where the need for such services can be reasonably anticipated, and at no charge to the enrollee, even when the enrollee is accompanied by a family member or friend who can interpret.

Identifying LEP Enrollees at Points of Contact

When an enrollee communicates their language preference to Blue Shield, it is added to the enrollee's profile and printed on their member identification card if it is a language other than English.

Hospitals must inform Blue Shield LEP enrollees who have a language preference other than English that the hospital provides access to interpretation services at no cost to the enrollee.

Providing Interpretation Services at Points of Contact

Blue Shield representatives have access to telephonic interpretation services to provide timely interpretive services in other languages. Blue Shield may employ Member Services/Customer Care Representatives who are multi-lingual and demonstrate proficiency in the non-English language to assist non-English-speaking LEP members. Hospitals are required to provide interpretation services. Therefore, when Blue Shield enrollees request assistance directly from hospital staff, the hospital is responsible for making arrangements and for any associated cost. Regulations require that Blue Shield monitor contracted facilities for deficiencies in the delivery of interpretation services. Where language or communication barriers exist between patients and staff of any general acute care hospital or facility, arrangements must be made for professional staff members that are bilingual to ensure adequate and speedy communication between patients and staff.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Timeliness Standards for Interpretation Services at Points of Contact

For purposes of this subsection, "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if they delay results in the effective denial of the service, benefit, or right at issue. Quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, including standards for coordinating interpretation services with appointment scheduling, are:

- **Over-the-Phone Interpretation (OPI):** Immediate – no more than 10 minutes, from time of connection with the interpretation vendor to the time that the interpreter (who speaks the enrollee's language) in present on the telephone line.

  Used for administrative points of contact with Blue Shield, and routine, urgent and emergent services with contracted hospitals.
- **In-Person Interpretation (IPI), or Face-to-Face Routine Visit:** Five (5) business days with advanced notice from the enrollee is preferred in order to make best efforts to accommodate the request for face-to-face interpreters. At the time of the appointment, if a face-to-face interpreter has been scheduled and the interpreter does not show after a 15-minute wait time, hospital staff shall offer the enrollee the choice of using a telephone interpreter or the opportunity to reschedule the appointment.
- **For appointments made within 48 hours/Emergency** (same or next day access for routine or urgent care): Provide services telephonically (see *Over-the-Phone Interpretation* above).

These standards also apply when the enrollee contacts Blue Shield to arrange for an interpreter.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Documenting Enrollee Refusal of Language Assistance

If the enrollee refuses language assistance services offered when contacting Blue Shield, it will be documented in the enrollee's record. If the enrollee declines language assistance services offered by a Blue Shield contracted hospital, the hospital staff is required to document the refusal in the enrollee's medical record.

Documenting that a patient has refused interpretive services in the medical record is a way to protect hospitals. It will ensure consistency when medical records are monitored through site reviews or audits. If the patient insists on using a family member or friend to interpret, hospital staff must also note that in the medical record. It is especially important to document if the interpreter used is a minor. Consider offering a professional telephonic interpreter through the telephonic interpretation service, in addition to a patient's chosen family member or friend, to ensure accuracy of the interpretation.

In emergency situations, a minor may be used as an interpreter if the following conditions are met:

(A) The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation; and,

(B) The insured is fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the minor as the interpreter shall be documented in the medical record file.

It is required that hospital staff document in the patient's medical record an LEP patient's preferred language. Additionally, it is recommended the medical record also contain the name and contact information of any professionally-trained interpreter whose services were used for a medical visit.

Informing Enrollees of their Right to Appeal

Blue Shield provides enrollees with written notices in their language, provided that it is one of Blue Shield's threshold languages, informing them about their right to file an appeal with the plan or seek independent medical review (IMR).

These notices are available for hospitals on Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Patient care resources*, and then *Language Assistance Program*. Members may access appeal and IMR information in their *Evidence of Coverage* or *Certificate of Insurance*, and at blueshieldca.com, as well as the DMHC website at www.dmhc.ca.gov or on the CDI website at www.Insurance.ca.gov. Hard copies of the DMHC notice may also be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Providing Translation Services

Vital Documents

Vital documents are materials deemed critical to accessing the health plan and its benefits. Vital documents may be produced by the plan, a contracted health care service provider, or contracted administrative services provider.

The following documents are the "vital documents" produced by Blue Shield. This category includes documents produced or distributed to enrollees by a delegated IPA or medical group:

- Applications
- Consent forms, including any form by which a member authorizes or consents to any action by Blue Shield
- Letters containing important information regarding eligibility and participation criteria
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Notices advising LEP enrollees of the availability of language assistance at no cost and other outreach materials that are provided to enrollees
- Blue Shield's and delegated IPA/medical group explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee
- Enrollee disclosures (Benefit Matrix or Patient Charge Schedules).

Vital documents are divided into two categories:

- **Standard Vital Documents**
  Most standard documents are translated up front, while other standard vital documents such as Summary of Benefits Coverage, benefit summaries and benefit matrices will be translated upon request by LEP enrollees.
- **Non-Standard Vital Documents**
  Non-standard vital documents contain enrollee-specific information. These documents are not translated into threshold languages. Blue Shield will include with any non-standard vital documents distributed to enrollees the appropriate DMHC/CDI-approved written notice of the availability of interpretation and translation services. If translation or interpretation of any non-standard vital document is requested by the enrollee, Blue Shield will provide the requested translation within 21 calendar days of that request, with the exception of expedited grievances, as noted below.

Blue Shield's Standard Vital Documents

Blue Shield has identified its standard vital documents (i.e., documents that do not contain enrollee-specific information) and has translated these documents into its threshold languages. Examples of standard vital documents include:

- Applications, consent forms
- Notices of the right to file a grievance or appeal
- Notice of language assistance at no cost

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Blue Shield's Non-standard Vital Documents (those containing enrollee-specific information) include:

- Letters containing important information regarding eligibility and participation criteria;
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits.

Notice of the Availability of Language Assistance Services

Blue Shield issues non-standard vital documents to all enrollees and includes brief, alternate instructions in English and our threshold languages, as follows:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合 1-866-346-7198 に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (پنجابی):-پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Notice of the Availability of Language Assistance Services *(cont'd.)*

A copy of Blue Shield's *Notice of Availability of Language Assistance* (that includes both DMHC- and CDI-approved language) is available on Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Patient care resources,* and then *Language Assistance Program.*

The notice states the following in English and in Blue Shield's threshold languages and non-threshold languages:

> "No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357."

Enrollees requiring help to read a Blue Shield-generated non-standard vital document are instructed to call the toll-free telephone number on the back of their member ID card for at no cost interpretation or translation into the plan's threshold languages. When translation of the non-standard vital document is requested, Blue Shield provides the translation within twenty-one (21) calendar days of the request.

An approved notice of language assistance must accompany the provider's non-standard vital documents if those documents are related to IPA/medical group-generated claims/UM non-standard vital documents.

Request for Translation

Providers are not delegated to provide translation of non-standard vital documents and must forward such requests received from Blue Shield enrollees to Blue Shield.

A provider who receives a request for a vital document translation should forward it to Blue Shield within one business day if it is urgent or within two business days if it is not urgent.

To forward the vital document to Blue Shield:

- Complete Blue Shield's "Language Assistance Form" available at Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Patient care resources,* and then *Language Assistance Program*;
- Attach a copy of the document to be translated;
- Fax the request to (248) 733-6331.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Timeliness Standards for Standard and Non-Standard Vital Documents

The following timeliness standards apply to Blue Shield-generated non-standard and standard vital documents or IPA/MG-generated claims/UM non-standard vital documents:

Element	Type of Request	Timeliness Standards
Provider receives a request for translation of an IPA/MG-generated claim/UM non-standardized vital document from a Blue Shield enrollee	Urgent: Response within one business day Non-Urgent: Response within two business days	Urgent: 1. Forward the following to Blue Shield within one business day: a) Request for translation b) Copy of the document 2. Log the following: a) Date request was received from enrollee b) Date request and document were forwarded to Blue Shield Non-Urgent: 1. Forward the following to Blue Shield within two business days: a) Request for translation b) Copy of the document 2. Log the following: a) Date request was received from enrollee b) Date request and document were forwarded to Blue Shield
Blue Shield requests an IPA/MG-generated claim/UM non-standardized vital document	Urgent: Within one business day Non-Urgent: Within two business days	Urgent: 1. Forward the following to Blue Shield within one business day: a) Copy of the requested document 2. Log the following: a) Date request was received from Blue Shield b) Date document was forwarded to Blue Shield Non-Urgent: 1. Forward the following to Blue Shield within two business days: a) Copy of the requested document 2. Log the following: a) Date request was received from Blue Shield b) Date document was forwarded to Blue Shield
Blue Shield enrollee requests a translation of a Blue Shield standard vital document from provider	All: Within one business day	All: 1. Provider informs the member to call the Blue Shield Member/Customer Service number on the back of his/her Member ID card or (866) 346-7198.

Language Assistance for Persons with Limited English Proficiency (LEP) *(cont'd.)*

Training and Education

Providers are expected to ensure that all contracted or employed providers and their staffs who are in contact with LEP members receive education and training regarding Blue Shield's LAP through formal or informal processes.

For additional information on Blue Shield's Language Assistance Program, go to Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Patient care resources,* and then *Language Assistance Program.*

Monitoring Compliance

Blue Shield's LAP annual compliance audit includes:

1. Monitoring internal Blue Shield organizations, contractors, contracted health care providers, and network compliance with regulatory standards for the LAP, including the availability, quality and utilization of language assistance services.
2. Tracking grievances and complaints related to its LAP.
3. Documenting actions taken to correct problems.

References

Several websites provide guidance, tools and information that may be of help to provider offices in treating diverse populations. The following websites will provide you with resources to comply with the requirements of the LAP:

- American Academy of Family Physicians Cultural Proficient, Health Care https://www.aafp.org/about/policies/all/culturally-proficient-health-care.html
- American Medical Association: Delivering Care, Health Equity https://www.ama-assn.org/delivering-care/health-equity
- Industry Collaboration Effort (ICE) Cultural and Linguistics Provider Toolkit https://www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284
- The Georgetown University Center for Child and Human Development – National Center for Cultural Competence Curricula Enhancement Module Series https://nccc.georgetown.edu/curricula/overview/index.html
- U.S. Department of Health and Human Services, Office of Minority Health. https://www.minorityhealth.hhs.gov

Section 2: Hospital and Facility Responsibilities

Use of Non-Preferred/Non-Participating Providers

Blue Shield requires facilities to notify members, in a manner that allows the member the opportunity to act upon such notification, when the proposed treatment includes either: (1) the use of a non-network provider or facility (e.g., non-network facility-based physician or non-network physician group providing services at the facility); or (2) the referral of a member to a non-network provider or facility for proposed non-emergent covered services.

Facility Directory

Blue Shield maintains a directory of Blue Shield Providers that is made available to members. To ensure accuracy of the information listed in the directory, Blue Shield will send to all facilities, except for general acute hospitals, the information that Blue Shield has in its directories on an annual basis. The facility is responsible, within thirty (30) business days from receipt, for confirming that all of the information is current and accurate or for updating any incorrect information.

If no response is received from the facility within the thirty (30)-business-day period, Blue Shield will attempt to contact the facility to validate the information or to get required updates. If Blue Shield is unable to verify the information or obtain updates within fifteen (15) business days following the initial thirty (30)-business-day period, Blue Shield will provide facility with a ten (10)-business-day advance notice that it will be removed from the provider directory unless the facility responds to the request during this time.

In order to reduce administrative burden on providers, Blue Shield delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the facility must work with the vendor in lieu of Blue Shield to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.