Section 2: Provider Responsibilities

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General Blue Shield Agreement Terms and Conditions

All Blue Shield providers must adhere to the administrative requirements and responsibilities outlined in this section (unless otherwise noted). Any transaction between you, the provider, Blue Shield of California (Blue Shield) and/or any clearinghouse may be subject to federal or state legislation, such as the Health Insurance Portability and Accountability Act (HIPAA).

- Blue Shield provider agreements stipulate that Blue Shield providers agree to accept Blue Shield allowances as payment in full for covered services on all plans administered by Blue Shield. A Blue Shield agreement signed by an individual or group extends to all office locations.

- Blue Shield providers agree to render covered services and manage the health care needs of Blue Shield members.

- Providers must bill Blue Shield directly for covered services and not require full payment from a member at the time of service.

- Blue Shield contracted providers are permitted to collect a specifically identified copayment from a member as described in the *Evidence of Coverage* (EOC) or member's identification card. Contracted providers are allowed to collect an estimated member liability due based on the member's benefits and the contracted rate or agreed to allowance for a specific service that is to apply to the remaining plan deductible and/or out of pocket for the member on the plan.

- All Blue Shield payments are based on our allowances. Once Blue Shield receives and processes a claim, the provider receives payment and an *Explanation of Benefits* (EOB).

- Except as otherwise specified in the agreement, Blue Shield agreements generally encompass all Blue Shield health plans – Traditional Plans, Preferred Provider Organization (PPO) plans, and Health Maintenance Organization (HMO) plans, including the Blue Shield Medicare Advantage plan products (where Blue Shield is licensed to offer this Medicare Advantage Plan in selected California counties).

- Blue Shield will notify providers when they are required to provide direct HMO services in situations where Blue Shield does not have a contracted HMO Independent Provider Association (IPA) or Medical Group.

General Blue Shield Agreement Terms and Conditions *(cont'd.)*

- Providers agree to render services to patients covered under arrangements between Other Payors and Blue Shield or its subsidiaries. (Refer to Appendix 5-B for the Other Payor Summary List). Under such arrangements, providers agree to look only to the applicable Other Payor (and not to Blue Shield or its subsidiaries) for payment for services rendered. In addition, providers agree to render services to persons insured by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). All such entities shall be referred to as "Other Payors."

- Providers agree to have their names, practice locations, phone numbers, and other pertinent information listed in provider directories for use and dissemination by Blue Shield and/or Other Payors.

- Physicians and podiatrists are required to provide and keep current the admitting privileges at hospitals contracted with the insurer.

- Providers must notify Blue Shield within five days of opening or closing their practices to new patients. Providers who close their practices to new patients may only remain closed for a maximum of one year.

- If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

- If you provide authorized covered services in reasonable reliance upon verification of a patient's eligibility provided by Blue Shield, and the patient is subsequently determined not to have been a member at the time services were provided, Blue Shield's compensation for such services will be at the rates set forth in your contract with Blue Shield, less amounts, if any, due to you from any other health care service plan, insurer or third party payor (including Medicare) by which the patient is covered. If the patient was covered by another health plan during the time period involved and the service is covered by that health plan, insurer, or third party payor, you must first bill the other payor for those services. If no payment is received from or the claim is denied by the other carrier, please submit a copy of the other carrier's claim determination (e.g., letter or EOB) to Blue Shield.

  If you fail to verify the patient's eligibility in accordance with this manual, Blue Shield shall have no obligation to compensate you for any services provided to patients who are not members at the time such services are rendered. This provision does not apply to Medicare Advantage, the Federal Employee Program, and self-funded groups.

Blue Shield Provider Standards

Blue Shield provider Agreements stipulate that Blue Shield providers agree to comply with the following standards. Failure to comply with the standards will be cause for termination of the provider's Agreement.

- Providers agree to promote the interest of Blue Shield and its members and, through their own conduct, to uphold the good name of Blue Shield.

- Providers agree to deliver quality medical services that are cost-effective and meet prevailing community standards. In the delivery of health care services, providers do not discriminate against any person because of race, color, national origin, religion, sex, sexual orientation, disability, physical handicap, or available benefits. Providers seek to educate and encourage subscribers to follow health practices that improve their lifestyle and well-being.

- Providers agree not to refer members for non-covered services or perform non-covered services unless the member signs an "Acknowledgement of Financial Responsibility Form" prior to the date of service. To view and download a copy of this form, please log in to Blue Shield's provider portal at blueshieldca.com/provider, click on *Find forms* at the bottom of the page, then *Patient care forms.* The Acknowledgement of Financial Responsibility must include specific information regarding the non-covered service being provided, the date of service, the billed amount and a breakdown of the specific non-covered services being performed. Providers agree to accept Blue Shield allowances as payment in full for covered services on all plans administered by Blue Shield. Providers are permitted to collect specifically identified copayment and estimated member liability due based on the member's benefits and the contracted rate/allowance for a specific service that is to apply to the remaining deductible and/or out-of-pocket for the member on the plan.

- Providers agree to abstain from assessing against members any concierge, boutique or membership fees, or any fees that qualify as surcharges as defined in the Health and Safety Code.

- Providers maintain appropriate licensure for their practice, as well as for any individuals for whom they have direct responsibility, and restrict their practice to the scope of their licensure.

- Physician providers abide by the code of ethics established by the Judicial Council of the American Medical Association and Blue Shield Medical Policy.

- Providers agree to ensure that claims submitted to Blue Shield are coded accurately paying particular attention to the CPT, ICD-10-CM, and ICD-10-PCS descriptors used as well as accurately reflecting the provider of service.

Blue Shield Provider Standards *(cont'd.)*

- Providers who have been disciplined by a professional or governmental body in authority, or who have been placed on review by Blue Shield for an extended period of time for not modifying their practice or billing pattern, understand that they may be expelled from membership. Providers further acknowledge that appropriate discipline may be taken should they be found guilty of fraud, willful misrepresentation, or materially departing from accepted practice standards, including providing medically unnecessary services.

- Providers assure accurate, complete, and timely recording of medical records while observing the requirements for confidentiality.

- Providers cooperate with Blue Shield practices and procedures and honor the terms and conditions of the subscriber's health care service plan. Providers refer subscribers to other Blue Shield contracted providers and admit subscribers to Blue Shield Select or Preferred Hospitals. Providers can confirm participating/contract status by calling Blue Shield at (800) 541-6652. Physician providers actively support appropriate utilization of hospital facilities and ancillary medical services, and abide by review procedures and decisions of professional peer review, as well as Blue Shield Medical and Payment Policies.

- Providers that utilize outside vendors to provide ancillary services (e.g., sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Blue Shield.

Administrative Compliance

The Blue Shield Provider Information & Enrollment Department is charged with administering the Administrative Compliance Review Process. Providers are required to abide by Blue Shield bylaws, rules, and regulations, as well as specific obligations as outlined in their contract. Failure to abide by these requirements could subject the provider to administrative termination.

Note: Quality Issues are addressed by the Credentialing Committee in accordance with California Health and Safety Code Section 1370.

General Administrative Criteria

The following are Blue Shield's general administrative criteria for all providers (unless otherwise noted):

- Accept Blue Shield Bylaws (Physicians only – Refer to a copy in Appendix 2).
- Accept Blue Shield allowances as payment in full for covered services.
- Bill Blue Shield directly for all covered professional services. No "superbills" are to be given to members to submit for payment.
- Ensure that proper industry standards are used when submitting claims to Blue Shield and that correlating clinical records clearly support the use of such codes as well as documenting that the services billed were performed.
- Comply with Blue Shield Medical Policies.
- Comply with Blue Shield Payment Policies.
- Comply with Blue Shield administrative rules and regulations, including the Provider Responsibilities outlined in this section.
- Comply with Blue Shield's Medical Management Program, including QI, Peer Review, and Credentialing processes, which includes sending the requested medical records for audits.
- Allow Blue Shield, or its agents, access to patient medical records within the guidelines of current confidentiality requirements, or as required by the Centers for Medicare & Medicaid (CMS), the Department of Managed Health Care (DMHC), or other regulatory agencies.
- Comply with the policy outlined below for inclusion in the Blue Shield Find a Doctor online directory:

Administrative Compliance *(cont'd.)*

General Administrative Criteria *(cont'd.)*

All providers with a contracted relationship with Blue Shield will display in the Blue Shield Find a Doctor online directory.

Providers have an opportunity to leverage Provider Connection online tools to support the process of attestation and submitting provider directory information updates. Non-responsive providers will be suppressed from the directory until they have attested to their information.

There are two ways to update data:

1) Make changes directly on Provider Connection in the Provider & Practitioner Profiles section.;
2) Download your data via Provider Data Validation Spreadsheet and upload revisions to the site.

To discuss the information shared about your organization in the Blue Shield Find a Doctor online directory, please contact the Provider Information and Enrollment team at **(800) 258-3091**, from 6 a.m. to 6:30 p.m., Monday through Friday.

In order to reduce administrative burden on providers, Blue Shield may delegate some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the provider may work with the vendor in lieu of Blue Shield to complete directory maintenance tasks.

- Have an identifiable practice location to publish in the directory or clearly specify that services are provided in a telehealth setting only Agree to immediately update any change in group/practice affiliation, change in address, billing information, telephone number, or any other provider demographic information required by Blue Shield for use in the directory or claims processes.

  Comply with Blue Shield's processes to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA)Agree to ensure that all medical record entries contain the proper legible signature and licensure of all individuals performing such activity and that services performed are within the scope of practice of the provider and or individuals.
- Provider agrees to bill according to acceptable CPT billing standards.
- Provider agrees to bill using ICD-10 code sets.
- Comply with the Non-Profits' Insurance Alliance of California (NIAC) rules of Coordination of Benefits.
- Comply with CMS Rules & Regulations related to Medicare Beneficiaries.

Administrative Compliance *(cont'd.)*

Administrative Procedure for Non-Compliance

Non-compliance with Blue Shield's general criteria or the administrative requirements of a particular program may result in the initiation of the Administrative Procedure for Non-Compliance. This process can result in the exclusion of the provider from further participation in the applicable program or, ultimately, from Blue Shield. The following is a summary of the Administrative Procedure for Non-Compliance when Blue Shield identifies administrative compliance issues:

- Repeated examples of lack of compliance with non-quality of care driven criteria may result in the immediate administrative cancellation of the provider's contract. (See notation below.)
- The matter is referred to the appropriate Blue Shield department (Provider Compliance Review) for research and contact with the provider. This may include identification of issues, corrective action plans and timeframe for re-reviews, etc.
- If the provider does not agree to comply, the provider would then be subject to administrative cancellation of their contract.
- If the issue remains unresolved and the provider agrees to comply with a corrective action plan, then a corrective action period commences. Further proceedings are suspended for a given period of time, pending re-evaluation.
- If Blue Shield concludes that the provider is not compliant with recommendations, or if follow-up monitoring does not show adequate improvement, the provider is notified that he or she is being administratively terminated from Blue Shield. The provider may be permanently ineligible to re-apply as a Blue Shield provider. Re-application may be considered on a case-by-case basis and subject to probationary conditions.

Note: Documented examples of fraudulent ***or egregious abusive billing*** *behavior, practicing outside the scope of the provider license, as defined by the California Business and Profession Code, California Regulations, or material breach of the provider contract will result in immediate administrative termination of the provider.*

Examples of egregious abusive billing behavior include, but are not limited to: repeated examples of the submission of CPT or ICD-10-CM & ICD-10-PCS codes that inaccurately describes the services performed; submission of claims that inaccurately describes the provider of service; repeated examples of billing for cosmetic services; billing for services not documented; billing for services provided by other entities such as laboratory studies; repeated examples of unbundling billed services; "claim splitting" (submitting separate claims for the same date of service and where the CPT codes are spread over several claims); and where these activities have the effect of enhancing the level of provider reimbursement.

In the event of administrative termination by Blue Shield, providers will be entitled to those due process procedures, which are required of Blue Shield by state or federal law.

Section 2: Provider Responsibilities

Provider Certification

For inclusion in the Blue Shield network, practitioners which include any person licensed or certified to provide member care, must meet Blue Shield's network criteria.

To request a new record for billing and claims purposes, the application forms, or provider profile with equivalent data elements may be submitted to Provider Information & Enrollment by email or postal mail:. Submit the completed application to

Email	BSCProviderInfo@blueshieldca.com
Postal mail	Provider Information & Enrollment P.O. Box 629017 El Dorado Hills, CA 95762-9017

To view, download or complete forms, please log in to Blue Shield's provider portal at blueshieldca.com/provider, click on *Find forms* at the bottom of the page, then *Network and procedure forms.*

Reporting Provider Status Changes

To keep Blue Shield records and directories current, Providers are required to notify Blue Shield of changes to demographic data and any changes to their practice. Upon notification of status changes, Blue Shield will update its provider database and directories accordingly. please contact the Provider Information and Enrollment team at **(800) 258-3091 for questions or guidance regarding the impacts of status changes to claims and the directory.**

The provider group or practice is required to notify Blue Shield of changes to its provider network, as follows:

- **Addition of New Providers**

  The medical group must notify Blue Shield 30 days prior to the date a new provider is added to the IPA/medical group. The medical group is required to send a practitioner profile for all new providers participating with a relationship to the medical group.

  Delegated Medical Groups may send new provider profiles directly to the Provider Information & Enrollment team to be added to the network relationship. Non-delegated Medical Groups must first submit a credentialing application with new provider profiles and receive credentialing approval prior to provider being added to the network.

  Blue Shield will not add a provider who does not meet Blue Shield Network Criteria, including eligibility to participate in any Blue Shield networks the IPA/Medical Group is contracted for.

  Blue Shield will not add a provider whose service location is outside Blue Shield's approved network.

Provider Certification *(cont'd.)*

Reporting Provider Status Changes *(cont'd.)*

- **Demographic/Administrative Changes**

  The provider or medical group must notify Blue Shield of demographic or administrative changes as soon as possible for timely directory updates. Examples of these types of demographic or administrative changes include office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

  The minimum required data for all new providers and provider demographic adds, updates, or termination submissions is as follows.

  - Complete name
  - Primary office locations
  - Telephone number and fax number, if applicable
  - Office hours
  - Specialty
  - California license number or certification identifier as applicable
  - Hospital staff privileges (list hospitals and types of privilege)
  - Languages spoken by practitioner
  - Languages spoken by others in the practice
  - Wheelchair access
  - IRS reporting number
  - NPI identifiers (practitioner and entity as applicable)
  - Designation as PCP or specialist
  - Panel data including gender, age or patient restriction
  - Where required by law, individuals requiring supervision must also provide the name, NPI and license number of the supervising physician.

- **Credential Status Changes**

  - Providers also are required to notify Blue Shield Provider Information & Enrollment whenever there are changes in their individually licensed provider's credentials status (i.e., license status, state probation, liability carrier, accusation, etc.), as well as changes in their practice location and demographic information.

Provider Certification *(cont'd.)*

Reporting Provider Status Changes *(cont'd.)*

Practice changes requiring supporting documentation:

- **IRS reporting number changes**
  - Providers are required to notify Blue Shield Provider whenever there is a change in their Tax reporting information.
  - Blue Shield follows IRS reporting policies using the IRS reporting name and number on file.
  - A new agreement, application materials and supporting certification documents are required when a contracted entity changes the IRS reporting number.

- **Name Changes**
  - Providers are required to provide supporting materials when a name is changed, while the legal entity name and tax reporting number remain the same.
  - Such name supporting materials include:
    - Fictitious Name Permit issued by the applicable California licensing authority
    - County issued Fictitious Name Statement
    - License issued by the applicable California licensing authority
    - Certification issued by the applicable certifying body
    - Legal Entity Name as filed with the California Secretary of State

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Credentialing and Recredentialing

To be accepted as an approved Blue Shield network physician or other health care professional, new credentialing applicants must meet all Blue Shield credentialing standards and must contract with an affiliated IPA/medical group or directly with Blue Shield.

Blue Shield is required to recredential all participating providers and other contracted health care professionals every three years. Blue Shield views the recredentialing program as an important part of our activities in assuring our members have a quality network available to them.

Blue Shield conducts provider credentialing under the direction of the Chief Medical Director and the Credentials Committee. This committee, which is staffed by contracted network physicians, oversees credentialing, recredentialing, and related peer review activities to support Blue Shield's Quality Management and Improvement Program. The Credentials Committee is responsible for credentialing decisions and for the implementation and oversight of the credentialing function.

Blue Shield's credentialing program requires providers to submit all of the following:

1. A completed and signed approved application and attestation to correctness
2. A copy of a current Curriculum Vitae.
3. Evidence of professional liability coverage.
4. Details of any professional liability claims history (if applicable).
5. A valid DEA certificate (except chiropractors).
6. Information verifying the absence of any physical or behavioral impairment, which would interfere with patient care or compliance with the Standards for Blue Shield providers.
7. Practice history for the past five years.
8. Attestation of unrestricted hospital medical staff privileges or admitting coverage arrangements by Blue Shield providers.

Credentialing and Recredentialing *(cont'd.)*

Additionally, Blue Shield verifies the following:

1. Valid, current, and unrestricted California license.
2. No restricted medical license held in any other state.
3. Board certification by a recognized American Board of Medical Specialties (ABMS) if the physician provider states that he/she is board certified.
4. Education and training if not Board Certified by a recognized ABMS Board.
5. Information from the National Practitioner Data Bank.
6. Clinical privileges in good standing at a Blue Shield contracted hospital designated by the practitioner as the primary admitting facility, as appropriate, or a mechanism for another credentialed physician to cover the practitioner's patients when hospitalized; (through appropriate means of primary sources or by attestation from provider).

Blue Shield maintains final authority for the decision to credential and/or re-credential all network providers. Please note that part of the credentialing process may include site visits for any physician or other health professional that receives grievances or complaints against their practice site.

Failure to participate with the initial credentialing or recredentialing process will result in an administrative denial or termination from Blue Shield.

Clinical Laboratory Improvement Amendments (CLIA) Program Requirements

The CLIA mandates that all laboratories, including physician office laboratories, meet applicable Federal requirements and have a CLIA certificate to operate. The CLIA applies to all entities providing clinical laboratory services regardless of whether they or another provider file Medicare claims for the tests. Laboratories billing Medicare have additional responsibilities and requirements.

Blue Shield requires all professional and facility providers to adhere to the CMS and CLIA regulations and maintain a valid CLIA certification for the level of laboratory and/or pathology service they are providing. There are 5 different types of certification. Blue Shield requires any provider billing a laboratory or pathology service to maintain the CLIA certification for the specific test they are performing. For example, if a provider is billing a Q0111 Wet Mount, this provider would be required to have a current Provider Performed Microscopy Procedure (PPMP) certification in order to bill Blue Shield for payment.

Medical Record Review

Consistent and complete documentation in the member's medical record is an essential component of quality patient care.

Providers are required to maintain a medical record for each member that must include patient records of care provided within the provider practice, as well as care referred outside the provider practice.

Blue Shield requires medical record reviews to assess both physician office records and institutional medical records, which are reviewed for quality, content, organization, confidentiality, and completeness of documentation.

Medical records are reviewed annually against Blue Shield's medical record standards. Records are sampled from those submitted for HEDIS review. Blue Shield requires that the physician's office medical records include the following:

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Documentation of preventive health services provided
- Proof that baseline clinical exams were conducted, documented, and pertinent to the patient's presenting complaints
- Current summary sheets of medical history including past surgeries, accidents, illnesses/ past diagnoses and medications, and immunization history
- Consultation reports, hospital summaries, emergency room reports, and test reports that are easily accessible and in a uniform location
- Treatment plan consistent with diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care between primary and specialty physicians
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the patient has not been placed at risk by a diagnostic or therapeutic procedure
- For Medicare Advantage members, evidence on presence or absence of Advance Directives, for adults over age 18 prominently located in the medical record

Medical Record Review *(cont'd.)*

Providers must also comply with all applicable confidentiality requirements for medical records as imposed by federal and state law. This includes the development of specific policies and procedures, when required by Blue Shield, to demonstrate compliance.

To assist Blue Shield in maintaining continuity of care for its members, providers are required to share medical records of services rendered to Blue Shield members. Members may also be entitled to obtain copies of their medical records, including copies of Emergency Department records, x-rays, CT scans, and MRIs. Upon the reassignment or transfer of a member, the provider must provide one copy of these materials, at no charge, to the member's new provider. Upon request, additional copies must be provided to Blue Shield at the provider's reasonable and customary copying costs, as defined by California Health and Safety Code 123110.

Medical Records Tools

Medical Records Tools (Health Maintenance Work Sheets) Make HEDIS Documentation Easier

As part of Blue Shield's commitment to supporting our practitioners, we offer valuable tools to assist you with your medical records documentation as well as HEDIS® compliance efforts. For the busy clinician, specialized flow sheets and quick disease screening tools are essential for timely comprehensive care, as well as meeting extensive HEDIS documentation requirements. For example, the Child and Adolescent Preventive Flow Sheet can help you provide, record, and summarize years of pertinent clinical care. HEDIS audit requirements would be met for a diabetic patient with a photocopy of the Problem List, the Medication List and the Diabetic Care Flow Sheet (to identify most recent test and value: HbA1C, LDL, and Microalbuminuria).

We encourage providers to use these forms. Using these forms and keeping them current can reduce HEDIS record submission to just a few pages. The HEDIS forms can be downloaded from Provider Connection at blueshieldca.com/provider. Once you have logged on, select *Guidelines & Resources, Guidelines and Standards,* and then *Medical Record Standards.*

Access to Records

Physicians and all sub-contracted practitioners and providers must maintain the medical records, books, charts, and papers relating to the provision of health care services and the cost of such services and payments received from members or others on their behalf, as well as make this information available to Blue Shield, the Department of Managed Health Care (DMHC), the Department of Health and Human Services (HHS), any Quality Improvement Organization (QIO) with which CMS contracts, the U.S. Comptroller General, their designees, and other governmental officials as required by law.

Medical Record Review *(cont'd.)*

Access to Records *(cont'd.)*

The above parties, for purposes of utilization management, quality improvement, and other administrative purposes, shall have access to, and copies of, medical records, books, charts, and papers (including claims) at a reasonable time upon request. All such records must be maintained for at least ten years from the final date of the contract period, or from the completion of any audit, whichever is later.

Note: Federal (HIPAA) law allows the plan to charge a reasonable cost-based fee for copying a designated record set. Additionally, it is Blue Shield's policy to not charge a fee for these requests.

Advance Directives

An Advance Directive is a formal document completed by an individual in advance of an incapacitating illness or injury. When individuals are too ill to communicate their wishes concerning their care, providers use the directive as guidance in providing treatment. Blue Shield recommends that all Medicare members and any member 18 years and older, have a signed Advance Directive to communicate their wishes regarding health care decisions to their physician and to their family members as well.

Confidentiality

State and federal laws regulate the release of personal and medical information. Blue Shield supports and maintains all records in keeping with these standards and expects the individual providers to protect and maintain confidentiality on all information related to a Blue Shield member. This means that all records, information, and clinical reports, both personal and medical, are protected from view or contact by anyone not directly responsible for the care provided to the member, or as required by regulatory, law enforcement, or governmental agencies.

Quality Management and Improvement

Blue Shield's Quality Management Department in collaboration with Blue Shield's QI Committees selects and oversees quality measurement and improvement activities that meet corporate 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, Health Risk Appraisal, and Healthcare Effectiveness Data and Information Set (HEDIS®) Measurement.

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

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 but not 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.

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

Provider Responsibilities for Quality Management and Improvement

Blue Shield actively solicits its network providers to participate and partner in Quality Management and Improvement activities as follows:

- QI Committees
- Credentialing, peer review and utilization management determinations
- Clinical QI workgroups
- Focus groups
- QI studies
- Investigation of member grievances and quality of care issues

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

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

HEDIS® Guidelines

To comply with NCQA accreditation requirements, Blue Shield collects and reports HEDIS® data as it relates to Blue Shield members. **Blue Shield contracted physicians are required to provide medical records requested for HEDIS data collection in a timely manner**. HIPAA allows data collection for HEDIS reporting thus no special patient consent or authorization is required to release this information.

HEDIS measurements, identified in Appendix 4-A of this manual, have criteria that is required for your patient's chart or claims review to be considered valid towards HEDIS measurement. When using HEDIS measurements, please use CPT/HCPC codes as well as CPT Category II codes to help your office to meet criteria for HEDIS measures.

Home-Based Palliative Care Program Providers

Enrolling/Disenrolling Members in the Home-Based Palliative Care Program

Member Eligibility

The following plan types are **eligible** for the home-based palliative care program:

HMO, PPO, Medicare Advantage, FEP HMO (Federal Employee Program HMO), IFP (Individual Family Plan), and EPO (Executive Provider Organization).

The following plan types are **not eligible** for the home-based palliative care program:

FEP-PPO (Federal Employee Program PPO), SA (Shared Advantage), and MED SUPP (Supplemental Medicare).

Assessing/Enrolling a Member

Home-based palliative care program providers are responsible for assessing whether a member qualifies for the program after a referral has been made. The assessment must be completed within three (3) business days of the receipt of the referral or, in the case of a hospitalized member, within three (3) days of the member's discharge from the hospital. If the referral is made by a Blue Shield case manager, the provider will receive the referral on a "Home Care Referral Event Form" (see Appendix 2 for a sample form or on Provider Connection at blueshieldca.com/provider under *Forms* then *Patient care forms*), which will be sent via email. Upon receipt, the provider is asked to confirm that the form has been reviewed and the date of the scheduled assessment.

Conducting the Assessment

Blue Shield requires that home-based palliative care providers follow the current version of the *National Consensus Project's (NCP) Clinical Practice Guidelines for Quality Palliative Care, Domain 1: Structure and Processes of Care, Guideline 1.2 criteria*, when conducting the assessment (see Appendix 2).

The provider must notify Blue Shield via email to BSCPalliativeCare@blueshieldca.com within three (3) business days of completing any assessment, whether received from a Blue Shield case manager or another avenue for referral, with the status of the member. If the member was referred by a Blue Shield case manager, an email must also be sent to the referring case manager with the status so that case management can be transitioned to the program provider, as applicable.

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

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

Conducting the Assessment *(cont'd.)*

The status options are as follows:

1. Enrolled (Please use enrollment notification format described in **Enrolling a Member** below)

2. Accepted pending enrollment

3. Enrolled in hospice

4. Not eligible for the program

5. Member declined program

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

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

Enrolling a Member

A notification of enrollment must be emailed to the Blue Shield emails listed below within three (3) days of a member's enrollment, as further described in the agreement.

- BSCPharmacyOperation@blueshieldca.com
- BSCPalliativeCare@blueshieldca.com

Enrollment Notification must contain the following information:

- Member's Blue Shield of California Subscriber ID number
- Member First Name
- Member Last Name
- Member DOB
- Member Diagnosis (ICD-10 Code)
- Date of Enrollment into the program
- Palliative Care treating provider name
- Referral Date
- Referral Source

A provider can recommend a member who they feel may benefit from the Program and/or, fall under the "Other" category on the Eligibility Screening Tool, by submitting supporting clinical documentation for review. Providers should complete an eligibility screening tool and submit, along with any other clinical documentation supporting the members diagnosis to BSCPalliativeCare@blueshieldca.com. The member will be reviewed for eligibility by a Blue Shield Clinical Program Manager.

Submission of Required Documentation Upon Enrollment

Providers are required to submit a copy of the initial clinical assessment, upon member enrollment. Providers are also required to submit monthly clinical notes on all currently enrolled members. Please submit clinical notes to BSCPalliativeCare@blueshieldca.com.

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

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

Home-Based Palliative Care Program Recertification Guidelines

The purpose of the recertification process and required form is to justify the member's ongoing enrollment in the home-based palliative care program.

The Recertification must be completed by an MD, NP or PA involved in the member's care, using the Palliative Care Services Recertification Form (see Appendix 2 for a sample form or on Provider Connection at blueshieldca.com/provider under *Forms* then *Patient care forms*). The member's recertification for the Home-Based Palliative Care Program is required every six months upon admission to the program. The form should be submitted up to 15 days before the end of the six-month enrollment period or no later than 2 business days after the start of the next enrollment period. The form shall be sent to BSCPalliativeCare@blueshieldca.com for review.

Failure to comply with this requirement may result in corrective action, up to and including contract termination.

Disenrolling a Member

Blue Shield must be notified of a member's disenrollment from the program within three (3) days of the member's disenrollment, as specified in the agreement, via email sent to BSCPalliativeCare@blueshieldca.com. In addition to the information submitted upon enrollment, the provider also is required to include the reason for the program member's disenrollment from the palliative care program.

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

Engaging the Palliative Care Team

The palliative care interdisciplinary team includes a physician who provides oversight, as well as a registered nurse (RN), case manager, social worker, home health aide, and chaplain. It may also include a physician assistant (PA), licensed vocational nurse (LVN), pharmacist, dietitian, rehabilitation specialist, physical therapist, etc.

In-person visits must be provided by the palliative care team's prescribing clinician at least once every three (3) months or when goals of care change. Above and beyond this requirement, the number and frequency of in-person and/or phone or video visits to a specific Blue Shield member in the program should be based on the medical, mental, emotional, social and spiritual needs of that patient. At minimum, each member of the palliative care team should contribute to the in-person assessment and the interdisciplinary team meetings. As a best practice, a member of the palliative care team should visit patients monthly. These visits can be completed by, video, phone or face to face.

It is required that a Blue Shield Clinical Program Manager attend monthly IDT meetings to discuss currently enrolled patients. It is the responsibility of the provider to schedule the IDT meetings and send invites to the assigned Blue Shield Clinical Program Manager. You will be required to submit monthly clinical documentation on all currently enrolled members. Please submit the clinical documentation to BSCPalliativeCare@blueshieldca.com.

Interfacing with Member's Treating Providers

The member's treating providers (e.g., PCP, oncologist, etc.) are an integral part of the palliative care team. Therefore, it is required that the palliative care provider executes the following, to ensure adequate team engagement:

- Co-develop and/or share palliative care plan with the treating provider(s),
- Provide chart notes after every visit and advance care planning documents as completed or revised to treating provider(s),
- Collaborate with the treating provider(s) to identify medications that optimally manage symptoms,
- Ensure the treating provider(s) receives results on all outpatient orders,
- Offer to include the treating provider(s) in palliative care conversations via online or phone conferencing, and
- Document and retain records on all interactions with treating provider(s).

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

Participating in Quarterly Meetings

Blue Shield's Palliative Care Program Team will conduct quarterly meetings with each palliative care provider treating Blue Shield members enrolled in the program. During this meeting, Blue Shield will review patient status, discuss issues, answer questions, provide support, and review quality criteria, as shown in the Quality Review Guidelines.

Quality Review Guidelines

The Blue Shield Palliative Care Program will perform a monthly quality review. The review is to ensure an effective and efficient delivery of palliative care services to our members, your patients. It is designed to evaluate the cost and quality of medical services provided by our home-based palliative care providers.

The quality review has the following objectives:

- Assist in the promotion and maintenance of achievable quality of care.
- Ensure patients receive care that is consistent with their preferences.
- Ensure minimum monthly visit frequency expectations are being met.
- Initiate process improvement activities and focus resources on a timely resolution of identified problems.
- Identify patterns of utilization including overutilization, underutilization, and inefficient use of resources.
- Educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.
- Facilitate communication and collaboration among members, providers, and the palliative care team to support cooperation and appropriate utilization of health care benefits.
- Help tell a consistent story of Blue Shield Palliative Care program and the effectiveness of our providers.

The process for the monthly review is:

- Providers will complete the enrollment/disenrollment report. Providers have 7 days to submit the completed report to Blue Shield Palliative Care team.
- Blue Shield Palliative Care team will work with providers to set acceptable targets. Blue Shield will provide feedback through Interdisciplinary Teams (IDTs) and discuss any issues arising from Blue Shield's ongoing and systematic utilization review during the quarterly operation calls.
- Additional quality and performance improvement coaching will be scheduled if needed.

Blue Shield retains the right to audit providers to ensure quality of care at any time and without notice.

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

Quality Review Guidelines *(cont'd.)*

Quality Areas of Focus

1. Enrollment and Disenrollment data: Patient demographics, clinical information, referral information and discharge disposition.
2. Advance Care Planning: Advance directive, confirmation of medical decision maker, POLST and patient's code status decision.
3. Utilization: Emergency Room Visits and Inpatient Hospital Admissions.
4. Patient and family satisfaction surveys.
5. Minimum monthly visit frequency expectations.

Completing the Enrollment and Disenrollment Report

Providers must complete the required report sections using free text or drop-down options when applicable. Completed reports shall be emailed to BSCPalliativeCare@blueshieldca.com.

1. **Documentation of patient demographics**
   Patient's subscriber ID, name, date of birth
2. **Documentation of clinical information**
   ICD-10 code and diagnosis name
3. **Documentation of referral information**
   Referral date and source
4. **Documentation of enrollment and disenrollment information**
   Enrollment date, disenrollment date and reason
5. **Documentation of advance directive**
   Patient's wishes regarding their medical treatment. Providers must have a copy in the patient's medical record to respond yes.
6. **Documentation of POLST**
   Physician Orders for Life Sustaining Treatment (POLST) providing specific medical orders. Providers must have a copy in the patient's medical record to respond yes.
7. **Confirmation of patient's code status decision**
   Patient's wishes on the level of treatment preferred, i.e., Full Code, DNR etc.
8. **Confirmation of medical decision maker**
   Patient's healthcare proxy, i.e., a family member, friend, lawyer, or someone in their social or spiritual community. A person who can make life and medical decisions on patient's behalf. Providers must have the named decision maker in the patient's medical record to respond yes.
9. **Member Email address**
   Current email address for enrolled member.

Submission of Laboratory Results Data

All laboratories 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 the HEDIS Supplemental data team at HEDISSUPPDATA@Blueshieldca.com for additional details and requirements, as well as to initiate required submissions of laboratory results data.

Service Accessibility Standards

Blue Shield requires that contracted providers provide access to health care services within the time periods established by Blue Shield, Title 28 CCR 1300.67.2.2, and Title 10 CCR 2240, where applicable and as specified in this manual.

Blue Shield uses the Consumer Assessment of Health Plans Survey (CAHPS), the Patient Assessment Survey (PAS), Clinician Satisfaction Survey, Provider Appointment Availability Survey results, and member appeals and grievances to measure compliance with the standards for appointment access. All of the above surveys will be used to demonstrate compliance. Providers that are found non-compliant with the access standards may be required to submit a corrective action plan with details on how the providers will achieve and maintain future compliance.

If it is not possible to grant a member an appointment within the designated 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 waiting time will not have a detrimental impact on the health of the member. 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 the Blue Shield Medicare Advantage plan 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 *(cont'd.)*

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, or specialist or 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

Service Accessibility Standards *(cont'd.)*

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

ACCESS TO CARE	STANDARD
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	PCP or covering physician available 24 hours a day, 7 days a week ** Please see "After Hours Requirements" in the section immediately following for more detail on this requirement.*
Emergency Care	Immediate
After Hours Emergency Instructions (telephone answering service or machine)	Specific instructions for obtaining emergency care such as directing the member to call 911 or to go to the nearest emergency room. ** Please see "After Hours Requirements" in section immediately following for more detail on this requirement.*
In-office Wait Time	**Standard**: Member care will not be adversely affected by excessive 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.
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.

Service Accessibility Standards *(cont'd.)*

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

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

ACCESS-TO-CARE	STANDARD
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

Behavioral Health Geographic Access Standards

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health Individual Practitioners including: - Psychologists - Psychiatrists - Master's Level Therapists	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 facilities including: - Inpatient Psychiatric Hospital - 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 and Substance Use practitioner	1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 20,000 members	100%

After Hours Requirements

After Hours Emergency Instructions

Note: Contracted providers musts 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 Access to Care Guidelines

Note: Contracted providers must 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 Commercial and Medicare Advantage members. Please refer to the provider availability standards below.

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

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	90%
Radiology		One Radiology facility in 30 miles	90%
Lab		One lab in 30 miles	90%
Pharmacy		One Pharmacy in 10 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: l in 30 miles	90% 85% 75%
Dialysis		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: l in 30 miles	90% 85% 75%

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

Geographic Distribution *(cont'd.)*

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Acupuncturist and Chiropractor	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/PPO – DMHC/PPO – CDI	One PCP to 2,000 commercial members	100%
Top High-Volume Specialties and High-Impact Specialties to Member Ratio	HMO/POS PPO – DMHC IFP ePPO	1 OB/GYN to 5,000 female members 1 High-Volume Specialty of each type and 1 High-Impact Specialty to 10,000 members	100%
Acupuncturist to Member Ratio	PPO	1 acupuncturist to 5,000 members	100%

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

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

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
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

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 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)

Linguistic and Cultural Requirement

MEASURE	PRODUCT	STANDARD	COMPLIANCE TARGET
Ethnic/ Cultural and Language Needs	HMO/POS *PPO – DMHC*	1 PCP speaking a threshold language to 1,200 members speaking a threshold language	100%

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access and availability 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	10% change	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	70%	Assessed Annually against Standard

Additional Measurements for Multidimensional Analysis for Commercial Products *(cont'd.)*

METRICS	PRODUCT	STANDARD	FREQUENCY
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	10%	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 providers 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 providers 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.

Providers must inform Blue Shield LEP members who have a language preference other than English that they have access to interpretation services at no cost to them.

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

Providing Interpretation Services

Blue Shield provides the following interpretation services when contacted by an enrollee:

- Offers representatives who 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.

- Identifies providers who are bilingual or who employ bilingual staff. Providers who can offer personal bilingual capabilities or staff with bilingual capabilities within their practices are indicated as such in our provider directory, which can be accessed by calling Member Services or by logging on to blueshieldca.com.

Blue Shield provides the following interpretation resources to our contracted providers for assisting our enrollees:

- Access to telephonic interpretation services through Provider Customer Services at (800) 541-6652. The provider will be guided by Voice Response Unit (VRU) menu prompts to request access to spoken interpretation services for a member over the phone (in almost any language) or hear information on how to obtain vital document translation (available in Blue Shield's threshold languages only) on behalf of a member.

  The VRU will also aid in the verification of the enrollee's membership status.

- In-person interpretation services for a member at a provider site. To arrange for in-person interpretation services, the provider must call the Provider Customer Service number at (800) 541-6652 and speak to a Provider Customer Services Agent.

Please refer to the section below on "Timeliness Standards" for information on Blue Shield's response time and expectations from providers who are requesting services on behalf of a member.

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

Contracted providers complete a Record Application Form at the onset of their relationship with Blue Shield. The Record Application Form allows the provider to indicate additional language capability within their practice. Language capability information is included in the provider directory to allow LEP members to select a provider who can speak to them in their preferred language, contingent on the availability of a provider that speaks that language. Providers can update their language capability listing by calling Provider Information & Enrollment at (800) 258-3091. Blue Shield will update its provider directories accordingly and expect updates from providers regarding changes.

If a provider chooses to provide interpretation services to their patients (and Blue Shield members) using their bilingual doctors or staff members, the Language Assistance regulations and Blue Shield's interpreter standards require the bilingual providers and/or bilingual staff meet the following requirements:

- A documented and demonstrated proficiency in both English and the other language(s);
- A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems (or health plan context);
- Education and training in interpreting ethics, conduct and confidentiality.

The Healthcare Industry Collaborative Effort (ICE) has developed a self-assessment tool that can assist providers in identifying language skills and resources existing in their health care setting. This simple tool will provide a basic and subjective idea of the bilingual capabilities of the staff. Once bilingual staff members have been identified, they should be referred to professional assessment agencies to evaluate the level of proficiency. There are many sources that will help assess the bilingual capacity of the staff.

If the provider does not meet these requirements, they should inform the patient that Blue Shield will make an interpreter available to the patient at no charge and inform the patient that he/she can choose to use the bilingual office staff, if they choose, however, if the patient chooses to use the bilingual staff, then the provider should note that decision in the patient's record.

Blue Shield may perform quality assurance audits of its contracted providers to confirm and document the accuracy of provider language capability disclosure forms and attestations of their language capability.

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 providers.

- **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, the provider 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 provider, the provider 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 providers. 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, providers 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 providers 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.

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

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 providers 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.

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).

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

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

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.

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

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): Đểđược 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): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວຟຣີບໍ່ເສຍຄ່າ, 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.)*

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.

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 for standard and non-standard vital documents:

Element	Type of Request	Timeliness Standards
Provider receives a request for translation of a provider's 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 a provider's 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

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

Timeliness Standards for Standard and Non-Standard Vital Documents *(cont'd.)*

The following timeliness standards apply for standard and non-standard vital documents:

Element	Type of Request	Timeliness Standards
Blue Shield member requests a Blue Shield standard vital document from provider.	All: Within one business day	All: 1. Provider informs 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 at Contracted Facilities

Hospitals are required to provide interpretation services. Therefore, when Blue Shield enrollees request assistance directly from hospital staff, the hospital is responsible for making such arrangements. Regulations require that Blue Shield monitor contracted facilities for deficiencies in the delivery of interpretation services.

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.

Several websites provide guidance, tools, and information that may help provider offices treat diverse populations and assist you in compliance with LAP requirements. The topics covered by these websites include bias, cultural competency, diversity, effective communication, equity, inclusion, and providing language services.

- American Academy of Family Physicians Cultural Proficient, Health Care https://www.aafp.org/cme/topic/health-equity.html
- American Medical Association: Delivering Care, Health Equity https://www.ama-assn.org/delivering-care/health-equity
- Health Industry Collaboration Effort (HICE) 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

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

Training and Education *(cont'd.)*

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.

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