October 11, 2019

Subject: Notification of January 2020 Updates to the Blue Shield Promise Health Plan Medi-Cal Provider Manual

Dear Provider:

We have revised our Blue Shield Promise Health Plan Medi-Cal Provider Manual. The changes listed on the following pages are effective January 1, 2020.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider Portal at https://www.blueshieldca.com/promise/providers/index.asp, click on Providers on the top, then Provider Manual in the drop down list.

The Blue Shield Promise Health Plan Medi-Cal Provider Manual is referenced in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the Blue Shield Promise Health Plan Medi-Cal Provider Manual and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2020 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Hugo Florez
Vice President, Provider Network Management
Promise Health Plan and PPO Specialty Networks
Blue Shield of California

T10634 (10/19)
Section 1: Introduction

**Added** the following definition of Network Provider to comply with APL-19-001.

**Regulatory Requirements for Network Providers**

As defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract (Exhibit E, Attachment 1, Definitions) network providers must:

1. Have an executed written Network Provider Agreement with the managed care plan (MCP) or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of APL 19-001;
2. Be enrolled in accordance with APL 17-019, the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, and any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP’s 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and
4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

Section 3: Benefits

3.1 Covered Benefits

**Added** the following definition of Covered Benefits:

Blue Shield of California Promise Health Plan is contracted with the Local Initiative Health Authority of Los Angeles County (L.A. Care), and the Department of Health Care Services (San Diego) to provide Medi-Cal health benefits to its Medi-Cal recipients.

In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Health Plan Medi-Cal plans are described in the Summary of Benefits and the Evidence of Coverage. Providers can view these documents online by visiting our Provider Portal at [https://www.blueshieldca.com/promise/medi-cal/index.asp](https://www.blueshieldca.com/promise/medi-cal/index.asp). To request printed copies of the publications, please contact the Provider Customer Services Department at (800) 468-9935.
Section 4: Member Rights and Responsibilities

**Added** additional rights and responsibilities to align with Evidence of Coverage (EOC) language.

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

- To wait no more than 10 minutes to speak to a customer service representative during Blue Shield Promise’s normal business hours.
- To get an appointment within a reasonable amount of time.

Section 5: Enrollment

5.1 Eligibility

**Added** language in boldface type below:

Eligible Members must reside within the Blue Shield Promise Health Plan approved service area and meet the requirements for Medi-Cal benefits. The State’s Automated Eligibility Verification System (AEVS) is the ultimate determination of eligibility, while LA Care provides ultimate determination of plan partner assignment for members residing in LA County. Blue Shield Promise Health Plan provides the ultimate determination of eligibility for San Diego Members. As eligibility may change at any time, providers are required to verify member eligibility at time of service. Eligibility may change at any time, so providers are reminded to check Member eligibility at the time of each visit.

Section 7: Utilization Management

7.3: Primary Care Physician (PCP) Scope of Care

**Added** Behavioral Health related services to Gynecology, as below:

Gynecology:

- Screen for prenatal and postpartum mental health conditions and refer for mental health services as appropriate

7.8.3: Early Prevention, Screening, Diagnosis and Treatment

**Added** Behavioral Health related medical necessity criteria, as below:

EPSDT Services:

- Medi-Cal covers all medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This may include children with autism spectrum disorder (ASD) as well as children for whom a physician or psychologist determines it is medically necessary. Consistent with state and federal requirements, a physician or a psychologist must recommend BHT services as medically necessary based on whether BHT services will correct or ameliorate any physical and/or behavioral conditions.
- BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.
- Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.
Section 7: Utilization Management (cont’d.)

7.8.5 Comprehensive Perinatal Services Program (CPSP)

Components of Case Coordination

**Added** Behavioral Health screening to, as follows:

- Screen for prenatal and postpartum mental health conditions and refer for mental health services as appropriate.

7.10 Managed Long-Term Support Services (MLTSS)

**Expanded** upon services offered for managed long-term support services.

Section 8: Encounter Data

8.1: Encounter Data - Medi-Cal

**Added/removed** definition for Policy & Procedures in boldface and strike through type below:

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

All encounters must be submitted electronically using 837 5010 formats. Standardized 5010 EDI Response files will be provided for all encounter files received. Blue Shield Promise Health Plan will provide a report card on a regular basis and will use this report card to evaluate the encounter data quality performance.

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

If you have encounter data submissions questions or if you would like to know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com.

Providers who are contracted with Blue Shield Promise Health Plan through a delegated IPA/Medical Group must submit encounter data to their affiliated IPA/Medical Group in the format and within the timeframes established by the IPA/Medical Group.

Section 9: Quality Improvement

9.1: Quality Improvement Program

This section was **rewritten** for clarification and to align with Blue Shield and Blue Shield Promise policies.

9.2: Policies & Procedures

This section was **rewritten** for clarification and to align with Blue Shield and Blue Shield Promise policies.
Section 9: Quality Improvement (cont’d.)

9.3: Quality of Care Focused Studies

This section was rewritten for clarification and to align with Blue Shield and Blue Shield Promise policies.

9.4: Practitioner/Provider and Member Satisfaction Surveys

Added language in boldface type below:

Practitioner/Provider Satisfaction Survey

Blue Shield Promise will conduct a practitioner satisfaction survey with all contracted Primary Care Providers and specialists at least annually using an NCQA-certified vendor. Results will be summarized and reported to the appropriate departments and committees for follow-up and action.

Member Satisfaction Survey

Blue Shield Promise will conduct a Member Satisfaction Survey at least annually using a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. Results will be summarized and reported to the appropriate departments and committees.

9.5: Clinical Practice Guidelines

Replaced policy to align with Blue Shield and Blue Shield Promise policies, as below:

Blue Shield adopts nationally recognized clinical practice guidelines which are reviewed and approved annually through our committees and is overseen by our Utilization Management department.

9.9.1 Access to Care Standards

Added language to Policy section in boldface type below:

Blue Shield Promise Health Plan will ensure that all primary care, specialty care, behavioral health, ancillary and other practitioners/providers, are in compliance with approved Access to Care Standards (See Appendix 7). Compliance with these standards is monitored through Member complaints and grievances, PQIs, Member Satisfaction Surveys, medical record reviews, disenrollment’s, PCP transfers and annual access surveys.

In Procedure section, noted that attachments B - F were added to Access to Care Standards in Appendix 7 to align with Blue Shield and Blue Shield Promise policies.
Section 9: Quality Improvement (cont’d.)

9.10.1 Broken/Failed Appointment Follow-up

Added language to the Policy section in boldface type below:

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients who fail to keep scheduled appointments. The following is a sample “Broken/Failed Appointment” protocol which may be implemented by practitioner/provider offices if no other protocol is currently in place. Blue Shield Promise Health Plan will monitor its provider network for compliance via oversight activities that may include medical record review, provider surveys and/or review of provider policies.

Added language to the Procedure section in boldface type below.

1. To assure timely and efficient recall of patients who fail to keep scheduled appointments. The primary care and/or specialty care practitioner/provider is responsible to:

9.13 HEDIS Measurements

Added language in boldface type below to comply with NCQA 2020 standards

Use of Practitioners/Providers Performance Data

Practitioners and Providers will allow Blue Shield Promise Health Plan to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). Blue Shield Promise Health Plan will also share Member experience & Clinical Performance data with Practitioners and Providers when requested. Requests should be submitted via email to your delegation coordinator.

9.14 Credentialing Program

Added language to the Policies & Procedures in boldface type below:

Policies and procedures are reviewed annually and revised as needed to meet the NCQA, DHCS, DMHC, CMS, state and federal regulatory agency requirements. Policies and procedures are reviewed by the Chief Medical Officer and submitted to the Credentials Committee and Compliance Department for review and approval.

Added additional activities that delegated PPGs are required to submit on quarterly reports in boldface type below:

3. Delegated PPGs are required to submit a quarterly report for practitioners/providers credentialing, recredentialing, termination and suspension activities.
Section 10: Pharmacy & Medications

10.1: Drug Formulary Policy

**Added** language in boldface type below:

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

**Added** language to the Procedure section in boldface type below:

1. The P&T Committee is responsible for periodically reviewing and amending the drug formularies at least once a year.

15. Non-formulary drugs that are deemed medically necessary are available through the prior authorization or exception review process.

**Removed** language with strike through font below. Therapeutic interchange programs are not reviewed and approved by the Pharmacy & Therapeutic (P&T) Committee. The preferred formulary agents vs. non-preferred/non-formulary agents are approved by the P&T Committee and any substitutions by the pharmacy are based on the P&T-approved formulary.

8. Therapeutic interchange: Is the practice of offering clinically appropriate, cost effective formulary alternatives. This includes generic substitutions when there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates “brand only.” If an FDA-approved generic alternative is available on the Blue Shield Promise Health Plan formulary, the prescribing physician will need to submit medical justification for the use of the brand product. Therapeutic interchange programs are reviewed and approved by the Pharmacy and Therapeutics Committee. Blue Shield Promise Health Plan will work with the prescribing physician to get this accomplished.

10.3: Prior Authorizations and Exceptions

This section was **rewritten** for clarification and to align with Blue Shield and Blue Shield Promise policies.

10.4: Emergency Supply of Drugs Policy

**Removed** language from the Procedure section that was not applicable to Providers.
10.7: Pharmaceutical Utilization Management

**Updated** language to note that the Blue Shield of California Pharmacy & Therapeutics (P&T) Committee **reviews and approves** the utilization management tools.

**Removed** language with strike through font below. Therapeutic interchange programs are not reviewed and approved by the P&T committee. The preferred formulary agents vs. non-preferred/non-formulary agents are approved by the P&T committee and any substitutions by the pharmacy are based on the P&T-approved formulary.

- Therapeutic interchange: Is the practice of offering clinically appropriate, cost-effective formulary alternatives. Therapeutic interchange programs are reviewed and approved by the Pharmacy and Therapeutics Committee. Blue Shield Promise Health Plan will work with the prescribing physicians to get this accomplished.

10.8: Non-Legend/Over the Counter (OTC) Drug Benefit

**Updated** language in the Procedure section regarding how OTC drugs are dispensed, in strike through and boldface type below:

3. The Pharmacy Benefits Manager (“PBM”) is responsible for the implementation and administration of dispensing designated OTC drugs, supplies and devices pursuant to a provider order. **These drugs may be filled at your pharmacy. Certain drugs may need prior approval. Please check your drug formulary.**

10.11: Access to Emergency Contraception Therapy

**Revised** procedures to align with Blue Shield and Blue Shield Promise clinical policies, as below:

1. Blue Shield Promise Health Plan will ensure that all pharmacists providing emergency contraception therapy are acting in accordance with the standards established in SB1169.

2. Blue Shield Promise Health Plan will ensure that authorized pharmacists are permitted to adjudicate claims electronically without requiring submission of a prescribing physician’s identifier.

3. Member access issues related to pharmaceutical care or services are identified through a variety of methods, including but not limited to:
   a. Member grievances
   b. Potential quality issues (PQIs)
   c. Pharmacy credentialing and auditing

4. Access issues will be handled through the same process as other identified grievances or potential quality issues. (Please refer to the Member Services and Quality Management Departments’ policies).

10.12 Access to Pharmaceutical Care and Services

**Removed** language from the Procedure section that was not applicable to Providers.
10.13: Drug Use Review

**Added** language in boldface type and **removed** language with strike through font to align with Blue Shield and Blue Shield Promise policies, as below:

2. **Quarterly Retrospective DURs are submitted performed** to the Blue Shield Promise Health Plan Pharmacy and Therapeutics Committee, any outliers, inappropriate or trends will be presented with proposal of relevant strategies to improve the quality of patient care. **Relevant strategies** to improve the quality of patient care may be created to address significant outliers, including inappropriate or unusual prescribing trends. These proposals will be submitted to the Blue Shield Promise Health Plan Pharmacy and Therapeutics Committee for comment and approval.

4. **The pharmacists may perform retrospective DURs for individual members in prior authorization reviews**, participation in interdisciplinary care teams, and during quarterly utilization reviews. The Clinical Pharmacist performs retrospective DURs daily for individual members in prior authorization reviews, participation in interdisciplinary care teams, and in providing comprehensive medication reviews as part of Blue Shield Promise Health Plan’s Medication Therapy Management Program.

6. Blue Shield Promise Health Plan will provide educational interventions, which include both oral presentations to physicians and pharmacists, and ongoing transfer of information through written materials on clinically important, drug specific therapy problems.

7. **Monthly Quarterly** reports will be reviewed by the Blue Shield Promise Health Plan Clinical Pharmacist to identify drug use problems.

**10.14: Specialty Pharmaceuticals**

**Added** language to the Policy section in boldface type below:

All specialty pharmaceuticals prescribed for Members associated with a non-risk medical group will require prior authorization review that may include requirements for step therapy and place of service. The Blue Shield Promise Health Plan Pharmacy Department will conduct the prior authorization review utilizing criteria and guidelines approved by the Blue Shield Promise Health Plan Pharmacy & Therapeutics Committee.

**Added** language to the Procedure section in boldface type below:

1. In situations where the Member is assigned to a PPG or Blue Shield Promise Health Plan directly contracted physician where Blue Shield Promise Health Plan assumes the risk for providing specialty pharmaceuticals, physicians must obtain a prior authorization approval regardless of whether they utilize office stock, refer patient to a home infusion provider, direct the member to an outpatient facility for administration or require the services of a specialty pharmacy vendor.

12. Approval notices for specialty pharmaceuticals will include the specific medication NDC (National Drug Code). All claims should be billed utilizing the appropriate NDC code. A manual HCFA 1500 claim with NDC and HCPCS may be subsequently submitted to Blue Shield Promise Health Plan for reimbursement.
Section 11: Health Education

11.4: Staying Healthy Assessment (SHA) Tool

Added language about requesting electronic implementation and updated URL, in boldface type below:

All contracted Primary Care Providers must administer the SHA to Medi-Cal managed care members. The goal of the tool is to identify high-risk behaviors of individual plan members, prioritize individual health education needs related to lifestyle, environment, cultural linguistic background, and to assist providers to initiate and document focused health education interventions, referral and follow-up. Contract Medical Groups and PCPs must ensure that the SHA is administered. The tools have been updated. There are nine separate age categories. The tools have been translated into twelve non-English languages. You can access updated Staying Healthy tools at https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-for-providers-medi-cal. To request implementation of the SHA electronically, Providers must call the Health Education Department to request approval.

11.5.3: Departments in Collaboration with Health Education

Cultural and Linguistic Department

Added language indicating that Blue Shield Promise adheres to NCQA Multicultural Distinction Standards and the National CLAS standards. The goal is to support the improvement of CLAS for our members, providers, and employees. For more information, refer to Section 17.

Section 12: Provider Services

Section name has been changed from Provider Network Operations to Provider Services.

Updated contact information throughout this section. Notifications for provider network additions, changes, terminations, directory updates, and changes in PPG affiliation must be sent to Provider Information & Enrollment at the email or address below:

Blue Shield of California
Provider Information & Enrollment
P.O. 629017
El Dorado Hills, CA 95762-9017
Fax: (916) 350-8860
Email: BSCProviderInfo@blueshieldca.com

Updated Provider Service resources to include the following:

- Provider Relations Representative
- Provider In-Services
- Provider Manual
- Provider Bulletin
- Provider Communication

12.2: Provider Orientation

Added ancillary providers to list of providers that orientations are conducted for.
Section 12: Provider Services (cont’d.)

12.4: Provider Affiliations

Removed the hospital affiliation requirement from this section as it is stated in Credentialing Section 9.14.1: Minimum Credentials Criteria.

12.8.1: PCP Terminations

Added language in boldface type below:

Blue Shield Promise retains the right to obligate the PCP/PPG to provide medical services for existing Members until the effective date of transfer. When a PPG fails to designate an appropriate provider, Members will be reassigned according to policy number 70.5.15.0.

12.8.2: Office Relocation

Added email address for 60-day prior notification in boldface type below:

Participating Provider Group “PPG” or Blue Shield Promise direct providers shall send 60-day prior written notification for all office relocations to the BSCProviderInfo@blueshieldca.com inbox. The PCP/PPG is responsible for submitting a coverage plan to Blue Shield Promise, if necessary.

Added mileage standard in boldface type below:

PCP that changes office locations will require a facility site review (FSR). The PCP’s panel will be closed to new Membership until the new location has successfully completed the FSR. Once the site is approved, the provider’s address will be updated and Members will be transferred from the existing site to the new site. If the PCP moves outside of the former office’s geographic area, Blue Shield Promise will coordinate with the PPG to reassign the Members to a new PCP within Blue Shield Promise’s access standard of five (5) miles but no more than ten (10) miles. In transferring Members, the provider’s location, specialty and language are taken into consideration. If the PPG is unable to meet this requirement, Members will be transferred to a provider in the geographic area of the former office location.

12.8.5: Provider Directory Inaccuracies

Removed separate contact information for San Diego providers. All provider inquiries can be directed to the updated contact information for the Provider Information & Enrollment team listed below:

Providers can promptly verify or submit changes to the information listed in the directories through the following:

a. By telephone (800) 258-3091
b. Fax (916) 350-8860
c. Email at: BSCProviderInfo@blueshieldca.com
d. Completing an online interface for providers to submit verification with requested changes generating an acknowledgment of receipt
Section 12: Provider Services (cont’d.)

12.12: Provider Directory

Added language in boldface type below:

The Blue Shield Promise provider directory is updated each month. New enrollees receive a printed copy of the directory as part of the Medi-Cal welcome kit. Any member of the public may download a PDF copy of the directory from blueshieldca.com/promise. A searchable directory is also available online.

The directory lists primary care physicians, specialists, hospitals, vision providers, pharmacies, and Federally Qualified Health Clinics who see Medi-Cal patients. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted PPG and/or Blue Shield Provider Information & Enrollment team department at BSCProviderInfo@blueshieldca.com. Providers may also review their information on the Blue Shield Promise website at www.blueshieldca.com/promise. Blue Shield Promise is committed to ensuring the integrity of the directory.

Section 15: Accounting

15.1: Financial Ratio Analysis (PPG Only)

Added language to align with Blue Shield and Blue Shield Promise policies, in boldface type below:

The Accounting Department is responsible for the accurate financial reporting of capitation and claims expense transactions. The Managed Care Finance Department is responsible for data generation and timely payment of capitation.

PPG must submit year-end financial statements audited by an independent certified public accountant firm within 150 calendar days after the close of the fiscal year to Blue Shield Promise and the Department of Managed Health Care (DMHC) (regulator). On a quarterly basis, financial statements must be submitted to DMHC within 45 calendar days after the quarter ends.

PPG shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability).
- A positive tangible net equity as defined in regulation 1300.76(e).
- A cash to claims ratio as defined in regulation 1300.75(f).
- A claims timeliness requirement as defined in regulation SB260.

15.2: Capitation Payment

Added/removed language to align Blue Shield and Blue Shield Promise policies, in boldface and strike through type below:

The Capitation Department is responsible for sending the monthly capitation payments to its contracted PPGs. Capitation payments are made no later than the 10th of each month for Medi-Cal San Diego and no later than the 14th for Medi-Cal Los Angeles or within 10 days from receipt of revenue from DHCS or L.A. Care or CMS.
Section 15: Accounting (cont’d.)

15.2: Capitation Payment (cont’d.)

Capitation reports and eligibility reports are posted on a secured site or what is widely known as a Secure File Transfer Protocol (“SFTP”) server. These reports are available to the PPGs no later than the 10th of each month. Each PPG is responsible for coordinating with Blue Shield of California Promise Health Plan on how to access the SFTP server. For security measures, only two individuals per PPG are issued a username and password to access this site. Any changes to the PPG’s contact person will require a new password or PGP key. PPGs must request and fill out a new PGP Key Form and submit to their assigned Provider Relations Representative.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.1: Blue Shield Promise Health Plan and Subcontractor’s Responsibility in the Provision of CLAS

Added the following language to CLAS services that Blue Shield Promise is responsible for:

- Developing policies and procedures on CLAS related topics and requirements and ensuring access to members’ CLAS data is protected and only accessible by approved parties.
- Sharing eligible individual member data on language needs with providers.
- Providing information on language patterns of Blue Shield Promise members.
- Sharing providers’ race and/or ethnicity upon member’s request.
- Conducting an annual analysis on the Blue Shield Promise’s provider network capacity and members’ needs. When gaps and/or barriers are identified, develop and implement improvement opportunities to meet member needs.
- Maintaining a committee that oversees Multicultural Distinction and CLAS oversight and approve related documentation. Blue Shield Promise members will serve as active committee members.

Added the following language to CLAS services that PPGs are responsible for:

- Having procedures for handling CLAS-related complaints made at the clinic and PPGs sites and logging grievances with CLAS-related issues.

Appendices

Appendix 4: Social Services Department Referral Form

Replaced the LTSS Referral Form with the Social Services Referral Form. This form can also be found on Blue Shield Promise’s provider portal at https://www.blueshieldca.com/promise/pdfs/providers/Provider_Materials_Forms/Referral_Forms/Social%20Services%20Referral%20Form.pdf
Appendices (cont’d.)

Appendix 7: Blue Shield Promise Health Plan Access to Care Standards

Attachment A: Primary Care Practitioners Access to Care Standards (PCPS)

Added language in boldface type below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
</table>
| Initial Health Assessments and behavioral health screenings if not completed by the County Mental Health Plan or MBHO contracted Behavioral Health Practitioner previously. | Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when member becomes eligible).  
Blue Shield Promise Health Plan encourages that this assessment is completed within the first 90 days of enrollment. Blue Shield Promise Health Plan actively sends reminders to members within this period of time encouraging them to schedule this appointment. 
Blue Shield Promise Health Plan requires that a Staying Healthy Assessment form is completed during this visit. |

The following attachments have been added to Appendix 7 and current Attachment D: Hours of Operation Parity has been moved to Attachment F.

Attachment D: Ancillary Access to Care Standards

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary Providers</td>
<td>Will be seen within fifteen (15) Business Days, for services where prior authorization that has been obtained.</td>
</tr>
</tbody>
</table>

Attachment E: Long Term Services and Support Access to Care Standard

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>Skilled Nursing Facility services will be available within 5 business days of request.</td>
</tr>
<tr>
<td>Intermediate Care Facility/ Developmentally Disabled (ICF-DD)</td>
<td>ICF-DD services will be available within 5 business days of request (These services are provided by Skilled Nursing Facilities and Nursing Facilities (LTC) where 24-hour nursing services are provided.</td>
</tr>
<tr>
<td>Community Based Adult Services (CBAS)</td>
<td>Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for an appointment.</td>
</tr>
</tbody>
</table>

Appendix 10: Health Education State Requirements for Providers

Updated the Health Education Department contact information as follows:

Phone: (323) 827-6036  
Email: BlueShieldofCAHealthEducation@blueshieldca.com