blue california
Promise Health Plan

Policy Title: ACCESS TO CARE STANDARDS AND MONITORING PROCESS		POLICY #: 70.1.1.8 Line of business Medi-Cal, Cal Medi-Connect, Medicare	
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Department Head: Krista Rigatti, RN		Date: 12/9/19	
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PURPOSE

To establish access to care standards for all Blue Shield of California Promise Health Plan (Blue Shield Promise) physician offices, behavioral health provider offices and ancillary providers to ensure health services are available and accessible to members in accordance with Title 22, CCR, Sections 53911 and 53911.5, and Title 28, CCR, Section 1300.67.2.1, Section 1300.67.2.2, The Department of Health Care Services (DHCS) All Plan Letter (APL) 19-002, and all state and federal regulatory agencies.

POLICY

Blue Shield Promise will ensure that all contracted Primary Care Practitioners (PCP) are in compliance with approved access to care standards, as listed in **Attachment A**. Blue Shield Promise will ensure all contracted Specialty Care Practitioners (SCP) are in compliance with approved standards, as listed in **Attachment B;** Managed Behavioral Healthcare Organizations (MBHOs are in compliance with approved access to care standards, as listed in **Attachment C**; Ancillary Providers are in compliance with approved access to care standards, as listed in **Attachment D;** Long Term Services and Support providers are in compliance with approved access to care standards, as listed in **Attachment E**. In addition, Blue Shield Promise will provide or arrange for the provision of access to health care services in a timely manner and establish metrics for measuring and monitoring the adequacy. Compliance with these standards is monitored through member complaints and grievances, PQIs, member satisfaction surveys, medical record reviews, dis-enrollments, PCP transfers, and annual Access Surveys and Studies. Blue Shield Promise will ensure that provider contact lists are generated for all provider groups required to be surveyed for the current MY

Blue Shield Promise shall ensure that its provider network is sufficient to provide accessibility, availability and continuity of covered health care services established by Section 1300.70 of Title 28.

PROCEDURE

DMHC PROVIDER APPOINTMENT AVAILABILITY SURVEY AND METHODOLOGY:

Survey Methodology and Random Sampling
Blue Shield Promise will be using DMHC's Model Provider Appointment Availability Survey & Methodology (Model PAAS) for the current Measurement Year (MY) and beyond, unless the DMHC amends its policy. DMHC's Current MY Model PAAS can be found online at the DMHC web site.

Survey Administration:
The survey will be completed per the current DMHC's Model PAAS methodology, which includes communication modalities such as telephonic, fax, email or an online survey.
Provider office staff will be required to submit the completed responses back to the vendor within the established turnaround time per the current DMHC Model PAAS methodology.

Monitoring and Corrective Action Process:
Blue Shield Promise monitors appointment access through an annual access to care survey conducted by a third-party vendor. The survey questions are based on the tool provided by DMHC. The compliance rates for each question are calculated based on the responses given by the provider offices.

The compliance rate is calculated based on the number of respondents meeting the timeframe thresholds established for individual questions. For example, the threshold for Urgent PCP appointments not requiring authorizations is 48 hours, so to calculate the rate, the vendor will tabulate all the responses and calculate the percentage of providers meeting the criteria. Blue Shield Promise will use this methodology to calculate annual compliance rates for each appointment wait time standard.

Blue Shield Promise will collect a valid sample size utilizing the DMHC's Model Provider Appointment Availability Survey & Methodology, for calculating compliance rate. The vendor will enter all the collected responses into a database and provide a compliance rate for each question in the written report. Vendor will also provide detailed logs of providers not meeting the compliance threshold for any of the appointment wait time standards.

Blue Shield Promise will notify all providers/Primary Provider Groups (PPG) of noncompliance with access to care standards, and will provide the survey results, a request for a corrective action plan (CAP) and access to care standards education/resources. Providers/PPGs will be required to submit a written response to Blue Shield Promise within 30 days of the notification.

The QI Department will annually conduct a report that details compliance by Provider with a drill down by Provider Group and County for Medicaid and Medicare. This will allow the health plan to identify trends that need improvement. Blue Shield Promise will send a request for "corrective action plan" notice to all Groups failing to meet a 95 % compliance threshold on any standard. The Plan will follow the DMHC's current methodology to calculate the compliance rate.

In addition to the annual access surveys, the Facility Site Review Department will assess the provider site as needed to evaluate compliance with access to care standards. This is done in accordance with Blue Shield Promise policy 70.1.4.12 and regulatory requirements.

Appointment Wait Time Standards:
Quality assurance standards requiring that enrollees be offered appointments within the following time-elapsed standards:

- Within 48 hours of a request for an urgent care appointment for services that do not require prior authorization,
- Within 96 hours of a request for an urgent appointment for services that do require prior authorization,
- Within ten (10) business days of a request for non-urgent primary care appointments,

- Within fifteen (15) business days of a request for an appointment with a specialist,
- Within ten (10) business days of a request for an appointment with non-physician mental health care providers, and
- Within fifteen (15) business days of a request for a non-urgent appointment for ancillary services, including LTSS providers, for the diagnosis or treatment of injury, illness, or other health condition.

The annual Provider Network Report Timely Access Report (TAR sections A-F) data is submitted to the Department of Managed Health Care (DMHC) on an annual basis, following the DMHC Timely Access Network Report Form Instructions and utilizing data elements as established by DMHC. Blue Shield Promise will ensure the appropriate staff that are responsible for preparing and filing the DMHC TAR data, operate in accordance with DMHC reporting instructions.

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

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

3. With respect to Behavioral Health Practitioners (including Qualified Autism Service Providers), especially within our Medi-Cal network, Blue Shield Promise recognizes that many members may come to Blue Shield Promise while in treatment with a Behavioral Health Practitioner that is not a participating practitioner in Blue Shield Promise's network (contracted through our contracted MBHO partners). Blue Shield Promise will follow all federal and state rules and regulations for its members to continue care with their current provider. When possible, Blue Shield Promise will make an attempt to allow members to continue with their current provider beyond what may be required. In areas where appropriate licensed Behavioral Health Practitioners are scarce and unwilling to contract, Blue Shield Promise through our contracted MBHOs will use out-of-network Behavioral Health Practitioners as necessary to meet the access standards and needs of our members.

4. Blue Shield Promise Access to Care standards provides that no member is required to travel any unreasonable distance or for any unreasonable period of time in order to receive covered services. For the purposes of these standards, reasonable is determined by analysis of the following factors:
   a. The population density of the geographic area traveled.
   b. Typical patterns of traffic congestion throughout the day.
   c. Established travel patterns in the community.
   d. Established patterns of medical practice in the community.
   e. Natural boundaries and geographic barriers to travel.
   f. Any other relevant factors.

To assure appropriate accessibility of services, these standards must be applied on a case-by-case basis. For Primary Care Practitioner and Specialty Care accessibility requirements, refer to policy 70.1.1,29 Availability of Practitioner (PCP, SPEC, Hospitals, Ancillary) and Provider Network.

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

6. The Practitioner contract also mandates participation in the Blue Shield Promise Quality of Care Review program. Participation in the Quality of Care Review program requires Practitioner cooperation with the assessment of quality of care, accessibility and utilization patterns. The contracted Practitioner agrees to take any appropriate remedial action deemed necessary by Blue Shield Promise.

7. Delegated IPA/PMGs are required to adhere to all Blue Shield Promise Access to Care standards and Blue Shield Promise conducts annual audits of all their high-volume Primary Care Practitioners and Specialists**. Blue Shield Promise defines high volume specialists as those with 60 or more unique member visits per year**. These results are disseminated to all the IPA/PMGs through the Joint Operating Committee (JOC) meetings annually. Blue Shield Promise reviews this information for trends or patterns or quality of care/access issues. Blue Shield Promise will require corrective action plans as appropriate. Blue Shield Promise QI Department has responsibility for conducting the studies, which includes but is not limited to:
    - Development of study and survey tools and methodology
    - Analysis of data results
    - Identification of opportunities for improvements
    - Presenting analysis to Medical Services Committee
    - Development through committee of an improvement action plan
        - Work with individual practitioners on improvement plan
        - Track date of implementation
        - Track department or person responsible for implementation and follow-up
        - Determine date of follow-up and re-measurement to document compliance
    - Provide practitioner, provider and member education
    - Re-assess the interventions put into place
    - Provide feedback to the practitioners and providers, regarding the accessibility of primary care, specialty care and behavioral health services and telephone services.

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

PRIMARY CARE PRACTITIONERS, HIGH VOLUME SPECIALIST, HIGH-IMPACT PROVIDERS, BEHAVIORAL HEALTH AND ANCILLARY PROVIDER ACCESS TO CARE STUDIES:

1. The QI department contracts with a vendor and/or utilizes in-house resources to complete the annual Access to Care Studies including Appointment Availability, After Hours and access to ancillary providers, office wait times, missed/broken appointments.

    1. After Hours
        - The After-Hours Study is conducted assesses the provider phone access, emergency/911 instructions and after-hours provider access., including the provider call back time, as defined in Attachments A-D.

2. Appointment Availability
    - High Volume Specialists, High Impact Providers, OB/GYN providers are surveyed to assess adherence to timely access standards, as defined in Attachments A-E.
3. Office Wait Times and Missed/Broken Appointments
    - Physician offices are surveyed to assess the office wait times members are experiencing as well as the process to document and reschedule missed/broken appointments as defined in Attachments A-B.
4. Timely Access and Appointment Availability per DHCS APL 19-002, or current version
    - Surveys and/or studies are conducted to assess the access and availability of various contracted provider types to include Primary Care and Specialty Care Providers, Behavioral Health Providers, Ancillary Providers, Skilled Nursing Facilities and Long Term Services and Support (LTSS) providers, including Nursing Facilities (includes facilities that provide 24-hour nursing services in lieu of Intermediate Care Facilities) and Community Based Adult Services Providers. Members in need of LTSS services are referred/placed in a facility that provides the level of care most appropriate to the member's medical condition, which will be considered when evaluating access and availability for these provider types.

2. The MBHO provider network is included in the access to care surveys.

3. All practitioners and/or IPAs that fall outside of the access to care requirements must submit a written corrective action plan that addresses the deficiencies within 30 days of the notification date. This monitoring will be completed at least annually. If the practitioner does not submit the required action plan within the required timeframes, he/she will be contacted by QI and further non-compliance will result in additional selected interventions to improve performance. These may include written counseling and/or written corrective action plans. Continued non-compliance may result in referral to the Credentialing and/or Peer Review Committee for action up to and including termination and/or removal from the network. Interventions may also include global education for Practitioners regarding the standards.

4. Practitioners are also surveyed using a current DMHC Appointment Availability survey tool which will be included as part of the annual access study conducted through a vendor. By using this standardized survey tool, it will allow DMHC to compare health plans methodology and compliance rate.

5. Access Survey results are submitted to the Quality Management Committee (QMC) for review by physician and department leadership, where opportunities for improvement are identified and solutioned for. Results and quality activities are reported via the QMC to Blue Shield Quality Improvement Committee (BQIC). Results are communicated to Practitioner network and to delegated IPA/PMGs through the JOC meeting, Practitioner newsletters, provider manuals, online practitioner portals, written update notices, and policy and procedure documents.

6. The effectiveness of the interventions is evaluated or re-measured. Additional telephone or mail surveys may be conducted to further evaluate a particular finding.

7. Access to care is also monitored and tracked through member satisfaction surveys, member complaints and grievances, potential quality of care issues, member requested dis-enrollments and transfers, Emergency Room utilization and facility site reviews. The Quality Improvement Department compares all these areas and submits trending reports to the QMC, at least quarterly.

8. Access to Care standards are included in the Blue Shield Promise *Practitioner Manual*. IPA/PMGs are expected to ensure that each Practitioner in their network receives and complies with Access to Care standards.

9. Blue Shield Promise and all contracted medical groups will ensure that all plan and practitioners maintain processes necessary to obtain covered health care services (i.e., authorizations) are completed in a timely manner appropriate for the member's condition and in compliance with regulatory requirements.

10. When it is necessary for a provider or a member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of Section 1367.03.

11. Interpreter services required by Section 1367.04 of the Timely Access Regulation and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

12. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

13. Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

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

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

Compliance Monitoring:

1. Tracking and documenting network capacity and availability, as described in the above activities.

2. Conducting an annual enrollee experience survey, via the CAHPS survey

3. Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievance and appeals, and triage or screening services.

Corrective Action:

1. Blue Shield Promise shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access, including but not limited to taking all the necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network to compliance.

2. Blue Shield Promise shall give advance written notice to all contracted providers affected by a corrective action and shall include:
    a. Description of the identified deficiencies
    b. Rationale for the corrective action
    c. Name and telephone number of the person authorized to respond to provider concerns regarding Blue Shield Promise's corrective action.

Health Insurance Portability and Accountability Act Requirements:

1. Only authorized personnel can review Member Protected Health Information (PHI). This can include but is not limited to Medical Directors and Quality Improvement staff.

2. All individually identifiable member information, including, but not limited to: names, addresses, dates, telephone numbers, facsimile numbers, e-mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, serial numbers, URLs, internet address, biometric identifiers and photographs is considered PHI as defined by HIPAA. All member information will be de-identified prior to being presented to organizational committees for review.

3. All of the study information containing PHI will be protected as required by applicable Blue Shield Promise Privacy and Information Security Policies and as required by applicable law, including HIPAA. This may include, for example, keeping information in a secured and locked area and ensuring that facsimile machines, printers and copiers used for this information will be kept in a secure location accessible only to authorized personnel.

4. Only the minimum necessary information will be requested for these studies.

MONITORING EFFECTIVENESS

The effectiveness of this policy will be monitored through Access Audits, practitioner office staff surveys, practitioner satisfaction surveys, member satisfaction surveys, member and provider complaints and grievances, emergency room utilization patterns, and after-hours access studies. This process is also monitored through oversight by regulatory agencies.

REFERENCES

Title 22, CCR, Sections 53911 and 53911.5
Title 28, CCR Section 1300.67.2.1; 1300.67.2.2
NCQA Standards
DHCS Standards

ATTACHMENT A

BLUE SHIELD PROMISE HEALTH PLAN
Primary Care Practitioners Access to Care Standards (PCPS)

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

Routine PCP, Non-urgent exam	**Within ten (10) business Days** When a member requests an appointment for a routine, non-urgent condition (i.e., routine follow-up of blood pressure, diabetes or other condition), they must be given an appointment within 10 business days.
Initial prenatal visit to OB/GYN	**Within fourteen (14) Calendar Days** Access to OB/GYN network Practitioner is available without prior authorization.
Well child visits (For child under 2 years of age)	**Within fourteen (14) Calendar Days** When a parent of a member requests an appointment for a Well Child Visit, they must be given the appointment within 14 calendar days, it is acceptable for the member to be scheduled for a covering Practitioner.
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 requires that this assessment is completed within the first 120 days of enrollment. Blue Shield Promise actively sends reminders to members within this period of time encouraging them to schedule this appointment. *Blue Shield Promise requires that a Staying Healthy Assessment form is utilized during this visit.*
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week coverage** to members. The same standards of access and availability are required by physicians "on-call". Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.

Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. Urgent and emergent calls must be handled by the physician or his/her "on-call" coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer (Practitioners Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Waiting Time in office	**Thirty (30) minutes maximum** after time of appointment
Access for Disabled Members	Blue Shield Promise audits facilities as part of the Facility Site Review Process to ensure compliance with Title III of the Americans with Disabilities Act of 1990.
Seldom Used Specialty Services	Blue Shield Promise will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary.
Missed/Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/broken appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments could result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

ATTACHMENT B

Blue Shield Promise Health Plan
Specialist Access to Care Standards

Criteria	Standard
SCPs Defined as:	*Practitioners* providing specialty care to our members, which includes all specialty types listed in Blue Shield Promise Specialist network listing including dental, chiropractic, acupuncture and vision providers.
Emergency Care	**Immediately** When a member calls the Practitioner's office with an emergency medical condition, they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911) If the condition is a non-life-threatening emergency it is still preferable for the member to be given access to care immediately, but no later than six (6) hours.
Urgent Specialist Exam (no auth required)	**Within 48 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is not required the member must be seen within 48 hours or sooner as appropriate from the time the member was referred.
Urgent Specialist Exam (auth required)	**Within 96 hours** When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is required the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized.
Routine specialist visit, Non-urgent exam	**Within fifteen (15) Business Days**
After-hours care	Physicians are required by contract to provide **24 hours, 7 days a week coverage** to members. Physicians "on-call" require the same standards of access and availability. Blue Shield Promise also has a 24-hour, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. The physician or his/her "on-call" coverage must handle urgent and emergent calls within thirty (30) minutes. Appropriately qualified staff can only provide clinical advice (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Blue Shield Promise also has a 24 hours, 7 day a week nurse advice line available through a toll-free phone line to support and assure compliance with coverage and access. Blue Shield Promise also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Our Member Services Department will keep an abandonment rate less than 5%. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.

Criteria	Standard
Speed of Telephone Answer (Practitioners Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Waiting Time in office	**Thirty (30) minutes maximum** after time of appointment
Missed/Broken Appointments (Patient fails to show for a scheduled appointment)	Missed/broken appointments must be documented in the medical record and the member's primary care Practitioner must be notified within 24 hours of the missed appointment. The member must be contacted by mail or phone to reschedule. According to the Practitioner's office's written policy and procedure provisions for a case-by-case review of members with repeated failed appointments can result in referring the member to the Health Plan for case management. Practitioners' offices are responsible for counseling such members.

Blue Shield Promise Health Plan
Behavioral Health Access to Care Standards

Criteria	Standard
Life threatening/Emergency needs	Will be seen immediately
Non-Life-threatening emergency needs	**Will be seen within six (6) hours**
Urgent needs exam	**Within 48 hours**
Routine office visit, Non-urgent exam	**Within ten (10) Business Days**
Non-physician BH Provider: Routine office visit, Non-urgent exam	**Within ten (10) Business Days**
After-hours care	Behavioral Health services for Medi-Cal "Specialty Mental Health Services" and "Alcohol and Other Drug Programs" (AOD) are the responsibility of the appropriate County Mental Health Plan (MHP). Behavioral Health Services for Medi-Cal members with mild and moderate dysfunction outpatient services, and for all other lines of business are carved out to contracted MBHOs The MBHOs each have 24 hour a day, 7 day a week coverage. Blue Shield Promise also has RN's on-call 24 hours a day, 7 days a week to coordinate and arrange behavioral health coverage to members.
Telephone Access	Access by telephone for screening and triage is available 24 hours a day 7 days a week, through our contracted MBHOs and the County MHPs, as appropriate. Blue Shield Promise and its contracted MBHOs require access to a non-recorded voice within thirty (30) seconds and abandonment rate is not to exceed 5%. Blue Shield Promise has RN's on-call at all times to arrange behavioral health coverage to members. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer (Practitioners Office)	The maximum length of time for practitioner office staff to answer the phone is 30 seconds.
Standard for reaching a behavioral health professional	Blue Shield Promise, through our contracted MBHOs, is available to arrange immediate access to a behavioral health professional. The County MHPs also have 24/7 access lines.
Hours of Operation Parity (Medicaid LOB only)	The organization requires the hours of operation that practitioners offer to Medicaid members to be no less than offered to commercial members. Refer to your Provider Medicaid Manual and refer to Appendix 8 and it's available on website at: https://www.Blue_Shield_Promise.com/media/pdf/health-education/providers/Provider_Manual_Med.pdf
Specialty Provider	**Within fifteen (15) Business Days.** (after appropriate PCP visit) Perform comprehensive evaluation and submit to Plan.
Qualified Autism Service (QAS) Provider	**Within fifteen (15) Business Days** after evaluation is approved by the Plan. Perform functional assessment and submit treatment plan to Plan.
QAS Provider (professional or paraprofessional)	**Within fifteen (15) Business Days** after treatment plan approved by Plan. Begin treatment/services.

ATTACHMENT D

Blue Shield Promise Health Plan
Ancillary Access to Care Standards

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

Attachment E

Long Term Services and Support Access to Care Standards

Criteria	Standard
Skilled Nursing Facility	Skilled Nursing Facility services will be available within 5 business days of request
Intermediate Care Facility/ Developmentally Disabled (ICF-DD)	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.
Community Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment