# Accessibility and Availability Policy and Procedures

| Subject: **Accessibility and Availability of Services** | | Policy #: to be assigned |
|---|---|---|
| **Department:** Health Solutions<br>**Product(s):** Commercial lines of business, including Marketplace, and Medicare<br><br>**Reference Numbers:** 1996-008 and 1997-014, combined: 20191769, DMHC approved: 5/29/2019<br>**Updated:**<br>e-filing #20200323, DMHC Approved: 6/17/2020<br>e-filing #20214232, DMHC Approved: 11/2/2021<br>e-filing #20220914, DMHC Approved: 9/12/2022 | Initial Effective Date: 10/7/1996 | Accessibility Revision Dates:<br>12/03, 9/04, 5/05, 3/06, 1/07, 4/07, 2/08, 4/08, 8/09, 2/11, 2/12, 2/13, 2/14, 9/14, 9/15, 2/16, 6/16, 6/17, 3/18, 5/18, 6/18<br><br>Availability Revision Dates:<br>12/03, 9/04, 5/05, 3/06, 1/07, 4/07, 2/08, 4/08, 8/09, 2/11, 9/11, 2/12, 1/13, 11/13, 2/14, 6/14, 4/15, 2/16, 2/17, 3/17, 4/17, 3/18, 6/18<br><br>Accessibility and Availability Revision Dates: 5/19, updated: 1/20, 7/20, 8/20, 10/21, 3/22 |
| Approved by:<br><br>*Edward Davis*<br>Edward Davis, Ph.D., MHA, CFE, CHC<br>Senior Director, Network Compliance | | *Malaika Stoll, M.D.*<br>Malaika Stoll, MD, MPA<br>Senior Regional Medical Director |

## TOPICS

## POLICY

### INTRODUCTION

Accessibility and Availability (collectively referred to as "Access") to care is fundamental to the Blue Shield of California ("Blue Shield") mission, which is to provide care that is worthy of our family and friends and sustainably affordable. Access to care directly affects:

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

This Policy and Procedure addresses both the accessibility to care and availability of care. Access to care implies that members receive needed care in a timely way, and that members communicate to Blue Shield that they are well cared for. Availability of care refers to the supply and geography of practitioners and assures that Blue Shield complies with regulatory standards.

This Policy and Procedure ensures that Blue Shield has adequate coverage and meets regulatory and accreditation requirements around the provision of healthcare services for primary care, specialty care, acute hospital care, telephone and internet related care services, and ancillary provider care.

The scope of this policy applies to all commercial, health insurance marketplace (public on exchange), off exchange (including private exchanges), non-government business (ASO and fully insured), and Medicare as applicable. This policy includes Federal Employee Programs, but not state-sponsored business, i.e., Medi-Cal (Medicaid) managed care.

### STANDARDS

Blue Shield's accessibility and availability standards are established in compliance with the State of California Knox-Keene Act, § 1300.67.2.1. Geographic Accessibility Standards, for Blue Shield of California enrollees and the California Insurance Code for Blue Shield of California Life & Health Insurance Company insureds, each of which requires that Blue Shield provide members with reasonable access to care. Blue Shield standards meet the availability guidelines set forth in state regulations for geographic proximity of health care providers. In addition, the standards are established in accordance with NCQA guidelines and the Centers for Medicare and Medicaid Services ("CMS") requirements. Blue Shield will continually evaluate and augment standards to reflect the changing environment of how health care services are provided.

### ACCESS TO CARE WORKGROUP

The Access to Care Workgroup is a cross-functional team responsible for execution of this Policy and Procedure. This workgroup meets on a quarterly and ad-hoc basis, and reports to the Blue Shield Quality Management Committee. The workgroup oversees network adequacy, assuring that there is enough volume and type of providers, facilities and ancillary care. The workgroup is tasked with improving access to care using the results of member and provider surveys, and other assessment tools.

### COMMUNICATION

Blue Shield's Accessibility and Availability Standards and Guidelines are distributed annually to participating network providers and practitioners by way of operational manuals, online practitioner and member web portals, written bulletins and update notices, policy and procedure documents, and/or other recognized methods as appropriate. Standards are reviewed and/or

revised annually or more frequently if/when necessary. Staff also communicate standards at routine audits, site visits, joint operating meetings and in other settings. Members receive communication of these standards through Blue Shield's member materials.

## PROCEDURES

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

### METRICS

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

- Medical and behavioral health services including appointments, emergency care, preventative services, inpatient, after-hours care, video visits and RN telephonic triage and screening
- Dental, vision, chiropractic and acupuncture services
- Interpreter services
- Authorizations for necessary care and service
- Cultural needs and preferences for members

Continuity of Care: Blue Shield ensures continuity of care. When it is necessary for a provider or a member to reschedule an appointment, the appointment will 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.

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

1. At least annually, data from CAHPS is evaluated to determine how well the practitioner portion of the networks meets the needs and preferences of members, including cultural. This information is not medical or behavioral health specific. These data sources may include:
    a. Cultural needs and preferences
    b. Gender information
    c. Race/Ethnicity information
2. The U.S. Census – Statistics from the U.S. Census and/or the American Community Survey covering race and languages spoken by the population are reviewed.
3. Interpreter services from Blue Shield's Language Assistance Program ("LAP") – as available.
4. Contracted practitioner gender and spoken language data – if/when available.
5. Member complaints regarding desired cultural availability of practitioners

6. California Medical Board Physician Data – California Business and Professions Code section 2425.3 authorizes the California Medical Board to collect information from physicians at the time of their medical license renewal. A physician may self-report his or her cultural background (i.e., ancestral, ethnic, or national background) and foreign language proficiency (i.e., non-English). This information is aggregated into both statewide totals and by the ZIP Code of the principal practice location. The results are reported on the California Medical Board's website, **http://www.mbc.ca.gov/Survey/**. If a physician does not provide his or her principal practice location, the California Medical Board uses the ZIP Code that appears on record. Blue Shield uses this information as a proxy to determine the networks' practitioners' foreign language proficiency and cultural background and compares that information against members' cultural and linguistic needs.

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

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

Grievances and Appeals: Member grievances related to practitioner availability are tracked quarterly to produce general and detailed trend findings. The grievances are monitored by provider type whenever possible. Blue Shield promptly investigates issues and requests corrective action as appropriate. Implementation of a corrective action plan includes research and direct correspondence with providers as necessary to investigate and resolve issues. Blue Shield also trends recurrent provider issues to ensure a solution is realized. This process includes an analysis of any one-day (i.e., expedited) grievances concerning access to care.

Member Experience Surveys: Member experience surveys provide insight into whether members feel that they received timely care. Member perception of care is measured by validated survey instruments which include:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS). The CAHPS survey assess timely access to care, wait time to appointment, ability to get needed care and cultural needs. On an annual basis, CAHPS survey results are reviewed for Commercial HMO/POS, PPO and Medicare Risk populations according to NCQA specifications and the Centers for Medicare and Medicaid Services requirements. Blue Shield results are compared to the national average. Blue Shield strives to score in the top quartile.
- Patient Assessment Survey (PAS). The Patient Assessment Survey evaluates members' experience with the care they received from their PCPs and specialists. The IPA/medical groups submit their encounter data to an external vendor who then draws a randomized sample, distributes surveys, and analyzes the data. The survey instrument includes questions related to urgent and routine care access to primary and specialty services. The PAS results are reported for each participating IPA/MG. The IPA/MGs that fall below the statewide average are required to submit corrective action plans while the IPA/MGs that

are above the statewide average are informed to continue implementing best practices to improve member experience. Blue Shield uses PAS results to assist delegated IPAs in improving accessibility of services.

Monitoring Mechanisms and Reporting: Delegated medical groups and directly contracted providers are monitored quarterly for compliance through oversight audits for delegated groups and monitoring of surveys and complaints for all providers. Reports are produced, reviewed, and evaluated each quarter using all information available to Blue Shield regarding the ability to meet timely access compliance and network adequacy, the continuation-of-covered-services / continuity-of-care, and network capacity requirements. A determination is then made as to whether corrective actions are appropriate. Spatial analysis availability monitoring and appropriate provider to member ratios are addressed in the Availability and Medical Ratio Guidelines section.

Open Practice Rates: Primary care physicians will be assessed annually for open panels for new patient selection. Blue Shield compares spatial analysis reports against the open practice results and, if needed, develops strategies to address opportunities for improvement. The goal is at least 70 percent of the panels are open for each primary care physician type per network, calculated by (total number of PCP type with open practice panels / total number of contracted PCP's in that type) x 100.

Plan-to-Plan Arrangements: In addition to measuring compliance with clinical appropriateness standards for each member's condition relative to good professional practice, Blue Shield also ensures compliance with the network components offered under plan-to-plan arrangements by monitoring its plan-to-plan partners' networks for adequacy under the Knox-Keene Act. Plan-to-Plan arrangements include all or some behavioral health, dental, vision, chiropractic, and acupuncture provider services. Blue Shield ensures that services covered under a plan-to-plan arrangement provide an adequate network for existing and potential member capacity as well as adequate availability of providers offering members appointments for covered services in accordance with the requirements under the Knox-Keene Act.

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

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

- ER/After-Hours Accessibility and Availability Survey. This survey is conducted annually according to regulatory and accreditation requirements and uses telephone interviews with physician offices to evaluate protocols around after-hours care. Providers with a specialty of family/general practice, pediatric medicine or internal medicine are included in the ER/After-Hours Accessibility and Availability Survey. An analysis of data is conducted, and data aggregated to report annual provider group level performance.
- Provider Appointment Availability Survey ("PAAS"): Timely Access to Care and PAAS – As required by Timely Access to Care Regulations, Blue Shield conducts an annual survey that complies with the PAAS methodology for the measurement year. The survey asks select providers about their availability to treat members for urgent, routine primary care, or specialty care. If the responses are outside the standards, provider groups may be required to submit a corrective action plan (CAP).

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

Additional information concerning provider surveys, specifically, Provider Appointment Availability Survey, Clinician Satisfaction Survey, ER/Afterhours Survey, and Timely Access Reporting and the validation process can be found in Blue Shield's Policy and Procedure: "Timely Access Reporting (TAR) Compliance for Quality Assurance and Validation Reporting."

Spatial Analysis: Spatial analysis software is used to analyze and report information regarding the geographic distribution of PCPs, High Volume and High Impact specialists, and hospitals at a regional level by member and provider practicing ZIP Code.

Substantial Harm: means immobilizing impairment, life threatening damage, or significant or acute injury to a person's physical, sexual, psychological, or mental development or functioning. The measurements outlined in the Additional Network Measurements procedural subsection are applied to identify non-compliance and/or potential incidents of substantial harm. In addition, Blue Shield measures compliance using access related grievances per thousand members ("PTM") to identify patterns of non-compliance and incidents of non-compliance resulting in substantial harm to an enrollee. The threshold is 1.0 PTM; and any IPA/Medical Group with a rate above 1.0 is considered non-compliant. The data is from the Blue Shield's Appeals and Grievances Department, filtered on access and availability related grievances with the IPA's/Medical Group's information included. The reporting timeframe is 12 rolling months. The formula for calculation is: (# of access related grievance / member month) X 12,000. Together with the Grievance Rate, Blue Shield also monitors the networks' PCP turnover rates and open/close panels for network accessibility and availability related indicators.

Triage (Screening) and Provider Offices: Blue Shield provides or arranges for the provision of 24/7 triage or screening services by telephone. Blue Shield ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. Blue Shield provides triage or screening services through a medical advice line pursuant to Section 1348.8 of the Health & Safety Code. Participating providers must maintain a procedure that includes the 24/7 employment of a telephone answering machine, service, or office staff that will inform the caller: (a) Regarding the length of wait for a return call from the provider ; and (b) How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by telephone, or if needed, deliver urgent or emergency care. The provider is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical emergency, the provider is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

## NON-COMPLIANCE/INTERVENTIONS

Providers and/or regions falling significantly below standards are evaluated cross-functionally and appropriate interventions are developed and executed under the guidance of the Access to Care Workgroup. Interventions can include, but are not limited to, continued monitoring, dialogue with the provider group(s) representative(s), any necessary corrective actions, or other network improvement changes. Recommended interventions account for provider group operational

issues, local network characteristics, and effect to membership. A log is maintained to monitor any corrective action plans relative to accessibility and availability. Through periodic reporting, the effectiveness of the interventions is determined.

## PROVIDER SHORTAGE AREAS

Blue Shield assists members in receiving care within the time-elapsed standards by referring members to the closest provider(s) outside the product's network if/when no network contracted provider is available within the time-elapsed standards for medically necessary covered services/procedures. When a medically necessary covered service/procedure is not available or accessible from a participating provider within the network, Blue Shield allows members to receive that service from a larger PPO network or non-participating provider, as appropriate, and applies the policy's in-network benefit levels. Therefore, member costs for medically necessary referrals to non-network providers will not exceed in-network copayments, coinsurance, and deductibles.

Blue Shield requires participating medical groups to ensure adequate practice coverage for members. When a specialist is not available. Providers are required to refer members to available and accessible contracted providers consistent with patterns of practice for obtaining healthcare services in a timely manner appropriate for the member's health needs. Additionally, providers will arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the member's condition. Member costs for medically necessary referrals to non-network providers will not exceed applicable copayments, coinsurance, and deductibles. This requirement does not prohibit Blue Shield or its delegated provider group(s) from accommodating a member's preference to wait for a later appointment from a specific participating provider.

## LANGUAGE LINE AND INTERPRETER SERVICES

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

## APPLICABLE REQUIREMENTS AND EXCEPTIONS

### Accessibility Guidelines:

| Accessibility to Medical Healthcare | Standard | Goal | Mechanism |
|---|---|---|---|
| **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 | The top quarter based on the annual PAS results. | Patient Assessment Survey |
| **Regular and routine care PCP:** Access to a routine, non-urgent symptomatic care appointment 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 | The top quarter based on the annual PAAS results. | PAAS |

| Accessibility to Medical Healthcare | Standard | Goal | Mechanism |
|---|---|---|---|
| **Regular and routine care SCP:** Access to a routine, non-urgent symptomatic care appointment 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 | The top quarter based on the annual PAAS results. | PAAS / Specialty Referral Tracking for non-surveyed subspecialties |
| **Urgent Care Appointment:** Access to urgent symptomatic care **appointments that do not require prior authorization** with the PCP, specialist, covering physician, or urgent care provider. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee. | Within 48 hours | The top quarter based on the annual PAAS results. | PAAS |
| **Urgent Care Appointment:** Access to urgent symptomatic care **appointments requiring prior authorization.** When a Practitioner (e.g., a referral to a specialist by a PCP or another specialist) refers a member for an urgent care need to a specialist 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 | The top quarter based on the annual PAAS results. | PAAS |
| **After Hours PCP Access** | PCP or covering physician available 24 hours a day, 7 days a week | 100% | ER/After Hours Survey |
| **After Hours Emergency Instructions:** (telephone answering service or machine) | Clear instructions for obtaining emergency care | 100% | ER/After Hours Survey |
| **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 waiting time will not have a detrimental result on the enrollee or the appointment request is for preventive care services. | Within 15 business days | The top quarter based on the annual PAAS results. | PAAS |

| Accessibility for Dental Services | Standard | Goal | Mechanism |
|---|---|---|---|
| **Initial Appointment** (Non-urgent) | 14 Business Days | 95% of offices schedule within the standard | DBP calculates using written survey and anonymous calls to |
| **Follow Up Appointment** (Non-urgent) | 14 Business Days | 95% of offices schedule within the standard | |

| Accessibility for Dental Services | Standard | Goal | Mechanism |
|---|---|---|---|
| **Hygiene Appointment** (Non-urgent) | 14 Business Days | 95% of offices schedule within the standard | provider offices on a semi-annual basis. Performance standard to tracked semiannually. |
| **Emergency Care** (Urgent dental services offered within the 72-hour standard or request when it is consistent with the patient's individual needs and as required by professionally recognized standards of dental practice.) | 24 hours / 7 days per week | 95% of offices schedule within the standard | |

| Accessibility for Vision Services | Standard | Goal | Mechanism |
|---|---|---|---|
| **Urgent Care Appointment:** for vision services offered within the standard or request when it is consistent with the patient's individual needs and as required by professionally recognized standards of vision practice. | 7 Calendar Days | 100% of offices schedule within the standard for broken or lost eyewear. | MES calculates using an annual data analysis by various age groups and lines of business to measure performance against standards. |
| **Non-Urgent Routine Care Appointment:** for vision services are offered within the standard of the request for an appointment. | 30 Calendar Days | 100% of offices schedule within the standard | |

| Accessibility for Chiropractic and Acupuncture Services | Standard | Goal | Mechanism |
|---|---|---|---|
| **Urgent Care Appointments:** for chiropractic or acupuncture services offered / rescheduled within 24 hours, as applicable, of request when it is consistent with the patient's individual needs and as required by professionally recognized standards of chiropractic and acupuncture practice. | 24 Hours, as applicable, excluding weekends | The top quarter based on Plan data results. | ASH* calculates using plan data surveys, including: Patient Satisfaction Surveys, Secret Shopper Survey Program, and Member Grievances |
| **Non-Urgent Appointments:** for chiropractic or acupuncture services are offered / rescheduled within seven calendar days of the request for an appointment. | 7 Calendar Days | The top quarter based on Plan data results. | |

*Blue Shield and American Specialty Health ("ASH") have a Plan-to-Plan agreement for chiropractic and acupuncture services. Members have timely appointments and reasonable access to covered services as set forth in the ASH Access & Availability Policy & Procedures, as approved by Blue Shield. ASH conducts an annual assessment for network adequacy and reports the results to Blue Shield's Access to Care Workgroup. ASH ensures members can access services in accordance with the standards set forth in the Knox-Keene Act, including without limitation Health & Safety Code § 1367.03.

| Accessibility for Behavioral Healthcare | Standard | Goal | Mechanism |
|---|---|---|---|
| Care for a Non-life-threatening Emergency | 6 Hours | The top quarter based on Plan data results. | Plan data surveys |

| Accessibility for Behavioral Healthcare | Standard | Goal | Mechanism |
|---|---|---|---|
| Urgent Care | 48 Hours | The top quarter based on the annual PAAS results. | PAAS |
| Routine Office Visit for a non-urgent appointment with Prescriber, including:<br>• Initial visit for routine care<br>• Routine office visit<br>• Non-urgent examination | 15 Business Days | The top quarter based on the annual PAAS results. | PAAS |
| Non-urgent appointments with a non-physician mental health care provider, including:<br>• Initial visit for routine care<br>• Routine office visit<br>• Non-urgent examination | 10 Business Days | The top quarter based on the annual PAAS results. | PAAS |
| Follow Up Routine Care Appointments with Prescriber | 15 Business Days | 50% of members | Plan claims data analysis / PAAS |
| Follow Up Routine Care Appointment with Non-Prescriber | 10 Business Days | 60% of members | Plan claims data analysis / PAAS |

| Accessibility to Telephone Services | Standard | Goal | Mechanism |
|---|---|---|---|
| Blue Shield's 24/7 nurse advice line will be available for all enrollee triage and screening needs. Speed to answer will be: | Within 30 minutes | 100% | Call Statistics |
| Access to customer service to obtain information about how to access clinical care and how to resolve problems during normal business hours. | Within 10 minutes | 100% | Operations Telephone Statistics |
| Average Speed to Answer (ASA) | 45 seconds | 100% | Operations Telephone Statistics |
| Abandonment Rate | ≤ 5% | 100% | Operations Telephone Statistics |

## Availability and Medical Ratio Guidelines[1]:

| ***Availability*** | | |
|---|---|---|
| **Category** | **Standard** | **Goal** |
| PCP: Family Medicine (GP & FP), Internal Medicine, and Pediatrics for non-Medicare | DMHC-Regulated: One PCP of each primary type within 15 miles or 30 minutes (or an approved/pending Alternate Access Standard) from each member's residence or workplace in the approved service area as appropriate by age.<br><br>CDI-Regulated: One PCP of each primary type within 15 miles or 30 minutes of each insured (or an approved/pending alternate access standard Waiver) as appropriate. The number of providers and mileage vary by population. | 100%<br><br>90% |
| OB/GYN: | One OB/GYN within 30 miles of each member | 85% |
| Specialists, including High Volume and High Impact Specialists | One of each type of High-Volume Specialist within 30 miles of each member and one of each type of High Impact Specialist (based on mortality and morbidity) within 30 miles of each member (Addendum A)<br><br>DMHC-Regulated: Specialty care services shall be readily available and reasonably accessible (Rule 1300.51(d)(H)).<br><br>CDI-Regulated: One SCP of each required type within 30 miles or 60 minutes of each insured (or an approved/pending alternate access standard Waiver) as appropriate. The number of providers and mileage vary by population. | 90% |
| Hospitals | DMHC-Regulated: One hospital within 15 miles or 30 minutes (or an approved/pending Alternate Access Standard from each member's residence or workplace (non-Medicare)<br><br>CDI-Regulated: One hospital within 15 miles or 30 minutes (or an approved/pending Waiver Request from each insured's residence or workplace (non-Medicare) | 100%<br><br>90% |
| Radiology/Imaging Center | One Radiology facility within 30 miles of each member | 90% |
| Laboratory | One Laboratory within 30 miles of each member | 90% |
| Pharmacy | One Pharmacy within 15 miles of each member | 90% |
| Durable Medical Equipment (DME) | One DME provider within 15 miles of each member | 85% |
| Ambulatory Surgical Center ("ASC") | One ASC within 30 miles of each member | 95% |
| Skilled Nursing Facility ("SNF") | One SNF within 30 miles of each member | 95% |
| Urgent Care | Urban: 1 within 15 miles of each member<br>Suburban 1 within 20 miles of each member<br>Rural: 1 within 30 miles of each member | 90%<br>85%<br>75% |

[1] The following Availability and Medical Ratio Guidelines apply to non-Medicare lines of business. Refer to the CMS-specific information that follows for Medicare guidelines.

| *Availability* | | |
|---|---|---|
| **Category** | **Standard** | **Goal** |
| Hemodialysis | Urban: 1 within 15 miles of each member<br>Suburban 1 within 20 miles of each member<br>Rural: 1 within 30 miles of each member | 90%<br>85%<br>75% |
| Home Health Agency | Urban: 1 within 15 miles of each member<br>Suburban 1 within 20 miles of each member<br>Rural: 1 within 30 miles of each member | 90%<br>85%<br>75% |
| Dental Services Provider | One Dental Services Provider within 15 miles or 30 minutes (or an approved/pending Alternate Access Standard with DMHC and/or Waiver from CDI) from each member's residence or workplace in the approved service area. | 100% |
| Vision Services Provider | Urban/Suburban: 1 within 15 miles or 30 minutes of each member's home or work address<br>Rural: 1 within 50 miles of each member's home or work address. | MES measures for 100% |
| Acupuncturist and Chiropractor | Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes.<br>Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes. | ASH measures for 90% |

| *Provider to Member Ratio Guidelines* | | |
|---|---|---|
| **Category** | **Standard** | **Goal** |
| Total PCP to Member Availability Ratio: (Family Medicine (GP & FP), Internal Medicine, and Pediatrics) | 1 PCP to 2,000 members[2] | 100% |
| Total SCP to Member Availability Ratio: Specialists | 1 SCP to 1,200 members[2] | 100% |
| High Volume Specialty ("HVS") to Member Ratio (Addendum A) | 1 OB/GYN to 5,000 female members<br>1 HVS of each type to 10,000 members | 100% |
| High Impact Specialty ("HIS") to Member Ratio (Addendum A) | 1 HIS to 10,000 members | 100% |
| A total of four (4) Non-Physician Medical Practitioners in any combination that does not include more than:<br>• Two (2) Physician Assistants per supervising physician.<br>• Four (4) Nurse Practitioners per supervising physician.<br>• Three (3) Nurse Midwives per supervising physician. | Each Non-Physician Medical Practitioner practicing under a physician increases that physician's capacity by 1,000 members to a maximum of 4,000 additional members. However, the following specification cannot be exceeded:<br>• Physician Assistants: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Physician Assistant 1:2.<br>• Nurse Practitioners: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Practitioner 1:4.<br>• Nurse Midwives: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Midwife 1:3. | 100% |
| Dental Services Provider | 1 Dental Services Provider to 2,000 members | 100% |

[2] Each provider extender, such as a nurse practitioner or physician assistant, practicing under a physician, increases that physician's capacity by 1,000 members.

| *Provider to Member Ratio Guidelines* | | |
|---|---|---|
| **Category** | **Standard** | **Goal** |
| Vision Services Provider | 1 Vision Services Provider to 5,000 members | 100% |
| Acupuncture Services Provider | 1 Acupuncture Services Provider to 5,000 members) | 100% |
| Chiropractic Services Provider | 1 Chiropractic Services Provider to 10,000 members | 100% |
| Ethnic / Cultural and Language Needs | 1 PCP speaking a threshold language to 1,200 members speaking a threshold language. Threshold languages are Chinese (traditional), English, Korean, Spanish, and Vietnamese. (Threshold languages are subject to change) | 100% |

| *Behavioral Health Provider to Member Ratio Guidelines* | | |
|---|---|---|
| **Category** | **Standard** | **Goal** |
| Distribution of Behavioral Health Practitioners (commercial) including the following types:<br>• Psychologists<br>• Psychiatrists<br>• Master's Level Therapists | Urban: 1 of each type within 10 miles of each member<br>Suburban: 1 of each type within 20 miles of each member<br>Rural: 1 of each type within 30 miles of each member | Urban: 90%<br>Suburban: 85%<br>Rural: 75% |
| Distribution of Behavioral Health facilities (commercial) including:<br>• Inpatient Psychiatric Hospital<br>• Residential & OP Treatment Facility | Urban: 1 within 15 miles of each member<br>Suburban: 1 within 30 miles of each member<br>Rural: 1 within 60 miles of each member | Urban: 90%<br>Suburban: 85%<br>Rural: 75% |
| Behavioral Health Member Ratio including High Volume Specialties and Substance Abuse practitioners (M.D. + Masters) | 1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 20,000 members | 100% |

| *Additional Network Measurements* | | |
|---|---|---|
| **Category** | **Standard** | **Goal** |
| Access- and Availability-related member complaints / grievances | Rate of complaints / grievances ≤ 1 per thousand members per month | Assessed Quarterly against Standard |
| PCP Turnover (HMO) | Non-Applicable | Assessed Quarterly for 10% change against Standard |
| Open PCP Panels (HMO) | 70% | Assessed Annually |
| Member Satisfaction | Member Satisfaction Survey results reported for the CAHPS survey | Reviewed Annually |

The availability of providers, as established by the Centers for Medicare and Medicaid Services ("CMS"), is measured by the number of required providers, travel distance, and travel time to providers. Blue Shield demonstrates that 90 percent of its provider network meets the established time and distance guidelines and remains fully compliant with the minimum number of providers for each CMS designated specialty. The following tables list the commonly reported provider and facility specialty types required on the CMS HSD tables; however, these provider and facility types are subject to change each year.

blue california

## Medicare Provider Time and Distance Maximum Requirements (subject to annual change)

| Specialty Type | Geographic Type | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Large Metro | | Metro | | Micro | | Rural | | CEAC | |
| | Time (minutes) | Distance (miles) | Time (minutes) | Distance (miles) | Time (minutes) | Distance (miles) | Time (minutes) | Distance (miles) | Time (minutes) | Distance (miles) |
| Primary Care (general and family practice, internal medicine, geriatrics, primary care – physician assistants and nurse practitioners) | 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 |
| General Surgery | 20 | 10 | 30 | 20 | 50 | 35 | 75 | 60 | 95 | 85 |
| Gynecology, OB/GYN | 30 | 15 | 45 | 30 | 80 | 60 | 90 | 75 | 125 | 110 |
| 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, Surgical | 20 | 10 | 45 | 30 | 60 | 45 | 75 | 60 | 110 | 100 |
| Oncology - Radiation/Radiation Oncology | 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 Medicine | 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 |

## Medicare Facility Time and Distance Maximum Requirements (subject to annual change)

| 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 Units (ICU) | 20 | 10 | 45 | 30 | 160 | 120 | 145 | 120 | 155 | 140 |
| 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 |
| Outpatient Infusion/Chemotherapy | 20 | 10 | 45 | 30 | 80 | 60 | 75 | 60 | 110 | 100 |

## Medicare Provider Ratios Minimum Requirements (subject to potential annual change)

| Specialty Type | Geographic Type | | | | |
|---|---|---|---|---|---|
| | Large Metro | Metro | Micro | Rural | CEAC |
| Primary Care (general and family practice, internal medicine, geriatrics, primary care – physician assistants and nurse practitioners) | 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 |
| General Surgery | 0.28 | 0.28 | 0.24 | 0.24 | 0.24 |
| Gynecology, OB/GYN | 0.04 | 0.04 | 0.03 | 0.03 | 0.03 |
| 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 |

Medicare Provider Ratios Minimum Requirements (subject to potential annual change)

| Specialty Type | Geographic Type | | | | |
|---|---|---|---|---|---|
| | Large Metro | Metro | Micro | Rural | CEAC |
| 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 |

## GLOSSARY

Access to Care: A term used to encompass both availability (geographic) and accessibility (appointments) assessment to assist in determining a network's adequacy.

Accessibility: The extent to which a member can obtain available services at the time they are needed. Such services include telephone access and the ease of scheduling an appointment, if applicable.

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

After-hours Coverage: A arrangement used by a healthcare practitioner or other provider type to respond to members' urgent health care needs when the office is closed and/or after normal business hours.

Ancillary Care: Includes, but is not limited to, providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers (per H&S Code Section 1323(e)(1).

Appointment Waiting Time: The time from the initial request for health care services by a member or the member's treating provider, to the earliest date offered for the appointment for the services. This includes the time necessary to obtain any necessary authorization(s) from the delegated provider group or the health plan and completing any other condition(s) or requirement(s) required by the health plan or its delegated provider group.

Availability of Practitioners/Providers: The extent to which members have adequate numbers and types of primary, specialty, acute, behavioral, and ancillary healthcare practitioners and providers available to meet their healthcare needs.

Behavioral Healthcare Practitioners (BHP): Blue Shield's credentialed and contracted psychiatrists, physicians who specialize in addiction medicine, psychologists, and master's level therapists, which includes, but is not limited to, licensed clinical social worker ("LCSW"), licensed marriage

and family therapist ("LMFT"), licensed professional clinical counselor ("LPCC") and psychiatric mental health nurse practitioner.

Behavioral Health/Substance Abuse Facilities: Blue Shield's contracted facilities that are licensed to provide behavioral health services including residential treatment facilities, and inpatient facilities, i.e., acute care hospitals or similar facilities.

CAHPS® (Consumer Assessment of Healthcare Providers and Systems Survey): A standardized annual survey that is used to assess the patients' experiences with healthcare and to improve quality of care. The survey is developed and maintained by AHRQ (Agency for Healthcare Research and Quality), a government agency under the DHHS.

Enrollee Experience Survey ("EES"): A standardized annual survey that is used by Qualified Health Plans to assess exchange patients' experience with healthcare and to improve quality of care.

Geographic Availability: The distribution of Blue Shield's membership, per spatial analysis software, is determined by the number of member home addresses in a ZIP Code compared to the number of providers' physical addresses in that same ZIP Code. The spatial analysis software uses Blue Shield's membership and contracted provider data to calculate a percentage of coverage.

| Definitions of ZIP Code Population Densities | |
|---|---|
| Urban | > 3,000 population |
| Suburban | 1,000 – 3,000 population |
| Rural | <1,000 population |
| Frontier* | <7 population |

*California has six frontier counties with fewer than 7 people per square mile. Frontier Counties are defined by Public Law 94-171. California's Frontier counties are: Alpine, Inyo, Modoc, Mono, Sierra, and Trinity.

High Impact Specialties ("HIS"): are determined by selecting the top specialties (excluding primary care practitioners and hospital-based specialties) that rank highest in-patient mortality and morbidity according to the Centers for Disease Control and Prevention. The typical HIS are found in Addendum A of this Policy.

High Volume Specialists ("HVS"): are determined by selecting credentialed and contracted health professionals identified via claim activity data for unique member occurrences in a 12-month period (excluding primary care practitioners, hospital-based specialties, multi-specialty clinics, and laboratories). The top specialists are assessed for geographic availability and ratio assessment. All OB/GYNs and behavioral health practitioner category types (i.e., Psychologists, Psychiatrists, and Master's Level Therapists) are included in the availability monitoring activities.

Hospitals: A contracting general acute care facility licensed by the State of California, which provides inpatient, outpatient, emergency, diagnostic, or therapeutic services. Behavioral health facilities include inpatient psychiatric hospitals, residential, and outpatient treatment facilities.

Language Assistance Program ("LAP"): In addition to approved legislation regarding access to healthcare (e.g., Title VI of the 1964 U.S. Civil Rights Act; OMH 2000 CLAS Standards; California Department of Health Services Regulations), California Senate Bill 853 (Escutia (D), et. al., amended April 22, 2003) required all healthcare service plans ("Plans") to assess the needs and demographic profiles of their enrollee population and report this information to the

California Department of Managed Health Care and California Department of Insurance in the form of policies and procedures. These policies and procedures were designed to improve "culturally and linguistically appropriate services." The bill also required all Plans to have a LAP for covered individuals who are considered to be limited in English proficiency, or "Limited English Proficient" ("LEP"), when a threshold number of these individuals is reached using the total membership as the population. Blue Shield's LAP includes face-to-face interpreters, TTY and relay services for members with hearing or speech loss, telephonic interpreter services provided at all points of contact, written materials provided in all threshold languages, written materials translated into threshold languages upon request, and oral and written translation of materials provided for all languages. Blue Shield's LAP is designed to meet the growing needs of California's diverse population. Furthermore, Blue Shield is responsible for continually identifying common or "threshold" languages preferred by the individuals for whom coverage is provided. Responsibilities include identifying, tracking, and reporting the written and spoken language preferences of each covered individual. Delegated medical management does not relieve a Plan from identifying, tracking, and reporting language preferences. This information is shared as part of the Eligibility File when an HMO/POS member enrolls with a medical group or transfers from one medical group to another. In addition to a member's written and spoken language preferences, Blue Shield captures the member's race and/or ethnicity. (See Threshold Languages)

Marketplace (public on exchange): Insurance products are available on a government website platform as defined by The Affordable Care Act. State funded, or federally funded and regulated products are available on the government website's Marketplace. Enrollment directly through brokers or Blue Shield sales for private exchange products are referenced as off exchange.

Member: An individual covered under a benefit plan. They may either be the subscriber, enrollee (DMHC), insured (CDI), beneficiary (CMS), or a dependent.

Member Non-Clinical Complaints: Member complaint data regarding geographical availability of contracted primary, specialty, acute, behavioral, and ancillary healthcare practitioners.

NCQA practitioner availability standard: The organization ensures that its network has sufficient numbers and types of practitioners who provide primary, specialty, and behavioral healthcare. Additionally, it monitors how effectively the network meets the cultural needs and preferences of its membership.

Patient Assessment Survey (PAS): A standardized survey that measures patient satisfaction with the experience of care at the provider practice level. The PAS is deployed through a state-wide collaborative and the results to determine compliance or problem areas with specific practitioners, provider groups or geographic areas.

Primary Care Physicians (PCPs): PCPs are family practitioners or general practitioners (Family Medicine), internists (Internal Medicine), or pediatricians (Pediatrics) employed or contracted to provide primary care services to members and to be responsible for coordinating, referring, and managing the delivery of covered services to members. PCPs can also include obstetricians/gynecologists (OB/GYNs) who qualify and have agreed to provide primary care as well as other specialists approved to provide primary care.

Provider: is any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services as defined by Health and Safety Code Section 1353 (i) of the Knox-Keene Health Care Service Plan Act of 1975. Examples of

providers include, but are not limited to, hospitals and home health agencies. Blue Shield's "provider directory" includes both providers and practitioners, and the inclusive definition is the more common usage of "provider."

Provider Appointment Availability Survey (PAAS): Is an annual survey which assesses appointment availability for participating providers, including primary care, certain specialist care and ancillary, and behavioral health. Blue Shield of California contracts directly with an experienced vendor to perform the PAAS. Providers are surveyed according to the DMHC's mandatory methodology; and uses the PAAS tool and reporting templates specific to the measurement year that is under review. This survey includes a compilation and validation of Blue Shield's Timely Access data in preparation for submission of the results to California regulators.

Provider Group: means a medical group, independent practice association, or any other similar organization, as defined by Health and Safety Code Section 1373.65(g) of the Knox-Keene Health Care Service Plan Act of 1975

Preventive care: means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full-service plan includes but is not limited to all of the basic health care services required by Health and Safety Code, subsection (b)(5) of Section 1345 of the Knox-Keene Health Care Service Plan Act, and Section 1300.67(f) of Title 28.

Ratio: Indicates the volume of The Company's members in relationship to a practitioner type. Practitioner availability to members is evaluated as a ratio (i.e. xxx members : 1 practitioner). The ratio is determined by dividing the membership by the number of each contracted practitioner type multiplied by the percentage of time available to Blue Shield patients in each network. The results are rounded to a whole number expressing a practitioner's patient volume. See the example below:

Example for determining ratios:

| A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|
| Provider Type | Measure | Goal | Total Members | Total Practitioners based on FTE | % of Time for Plan | Results Formula D ÷ (E x F) = G (The result will not be a decimal) |
| PCPs | All Members in Network | ≤ 2,000 | 16,350 | 432 | 10% | 16,350 ÷ (432 x 10%) = 378 or 378:1 (representing 378 members to 1 practitioner) |

The ratio of members per practitioner should be a ratio less than or equal to the goal. In this example, the result in cell G is < 2,000, so the goal is met. If it was greater than 2,000, the goal is not met. As an intervention, the actual utilization of the members could be researched to warrant a need for contracting additional practitioners.

Sensitive Services: must be made available to members preferably within 24 hours but not to exceed 48 hours of appointment request. Sensitive services are healthcare services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Specialists or Specialty Care Practitioners (SCPs): is defined as a residency-trained, board-certified or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA). SCPs may include, but are not limited to clinical nurse specialists servicing members.

Telehealth: means the mode of delivering health care services and public health utilizing the combination of HIPAA compliant information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers. Telehealth does not include the use of audio-only telephone, facsimile machine, or e-mail pursuant to the provider and/or the covered individual.

Threshold Languages: Communication with physicians and other healthcare professionals is paramount to ensuring optimum health and wellness. To facilitate communication, Blue Shield offers interpretation services to eligible covered individuals at no cost. In addition, translated documents are provided to covered individuals in the languages required by the language assistance regulations. Specifically, this threshold is defined by section 1367.04(1)(A)(i) as:

> *"A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language."*

Effective January 1, 2009, Blue Shield and all other California Plans regulated by the DMHC were required to implement a LAP to provide language assistance services to their LEP enrollees. In addition, insurers licensed by the CDI were required to comply with similar regulations effective April 1, 2009. Further, on January 1, 2012, Blue Shield and other Plans were required by federal regulators to implement a LAP, which was mandated by the Patient Protection and Affordable Care Act ("PPACA"). Due to previous State legislation, California Plans regulated by the DMHC and CDI already had language assistance programs in place. In addition, Blue Shield includes language assistance to members who are hearing impaired even though SB-853 did not specifically address American Sign Language. Services for hearing impaired enrollees are offered under the American Disabilities Act. Blue Shield assesses threshold languages annually. As of the date of the most recent update to this policy, Blue Shield's threshold languages are: Chinese (traditional), English, Korean, Spanish, and Vietnamese.

Triage or Screening: The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member (patient) who may need care for the purpose of determining the urgency of the member's need for care.

Urgent Care: Health care for a condition that requires prompt attention, such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member's life or health or could

jeopardize the member's ability to regain maximum function. (consistent with subsection (h)(2) of Section 1367.01 of the Act).

## 2022 ADDENDUM A: SPECIALIST GRID

| Specialties (Specialties can vary annually) | High-Volume Specialties | High-Impact Specialties | Behavioral Health (self-Insured) | Other (Required by DMHC) |
|---|---|---|---|---|
| Cardiology/Cardiovascular Disease | X | X | | |
| Endocrinology | | | | X |
| Gastroenterology | X | | | |
| Hematology | | X | | |
| Psychiatry, Psychology, and Master's level therapists, which includes: Licensed Clinical Social Worker ("LCSW"), Licensed Marriage and Family Therapist ("LMFT"), and Licensed Professional Clinical Counselor ("LPCC") in this category type. | X | | X | |
| OB/GYN | X | | | |
| Oncology | | X | | |