Policy Title: Access Standards

Department: Quality Improvement (QI) **Rev. Date(s): 08/27/2020, 06/08/2022**

Policy Number: QI 103 **Effective Date: 05/01/2015**

Product Lines:	☑ All/Other	☐ Gold Coast Medi-Cal	☐ FFS Medi-Cal
	☑ Medicare	☐ Commercial	
Age Limitations:	☑ None	☐ Under 21	☐ Other

Purpose

To establish a process for compliance with DMHC required timely access to care standards and monitoring activities; and where applicable, compliance with the DHCS access standards, to assist in improved availability and accessibility to practitioners, providers, and health care services, meeting regulatory, accreditation, and licensing requirements.

Policy

This policy establishes minimum compliance standards for enrollee accessibility to primary, specialist, behavioral health, and ancillary care providers. It also defines the process to monitor network compliance to the Department of Managed Health Care (DMHC) access standards; and where applicable, compliance with the Department of Health Care Services (DHCS) access standards.

- **SCOPE:** This policy applies to all DMCH licensed health care service plan contracted practitioners. LOB Medi-Cal Managed Care.
- **RESPONSIBILITY:** AmericasHealth Plan (AHP Quality Management (QM) and Utilization Management (UM) Committees shall approve the adoption of the DMHC and DHCS access standards as submitted in this Policy and Procedure. Procedurally AHP BOD will give final approval of this policy. The QM and UM Departments shall monitor that members have adequate access to providers and report access standard compliance to the QM and UM committees for review and action as necessary.
- **DEFINITIONS:**
  - A. "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.
  - B. "Ancillary service" 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" [as defined by H&S Code Section 1323(e)(1)].
  - C. "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.
  - D. "Health care service plan" or "specialized health care service plan" means either of the following:
    - i. Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

ii. Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

E. "Mental Health Care Provider (MHCP)" includes Medical Doctors and Doctors of Osteopathy with specialties in addictionology or psychiatry, clinicians licensed by the state for the independent practice of psychology (including Master's Degree Psychologist, if permitted in the state where the psychologist practices, California requires a PhD in psychology to be licensed for independent practice), and Master's Level Clinicians: counselors, therapists, social workers, licensed professional examiners and nurses who are licensed or certified to practice independently according to state laws in their practice location. Marriage and Family Therapists and Licensed Clinical Social Workers are licensed or certified to practice independently in California.

F. "Provider" means 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 H&S Code Section 1345(i)].

G. "Provider Group" means a medical group, independent practice association, or any other similar organization (as defined by Section 1373.65(g) of the Act).

H. "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 subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

I. "Specialist" 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).

J. "Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and enrollee constitutes telemedicine for the purposes of this policy and procedure.

K. "Triage" or "Screening" means the assessment of an enrollee'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 an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care. Triage and screening is required to be offered 24 hours a day, 7 days a week.

L. "Triage or Screening Waiting Time" means the time waiting to speak by telephone 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 an enrollee who may need care. The waiting time is not to exceed 30 minutes.

M. "Urgent Care" means health care for a condition which requires prompt attention when the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function (consistent with subsection (h)(2) of Section 1367.01 of the Act).

N. "Emergency Services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

1. For purposes of providing treatment of an emergency medical condition to otherwise eligible aliens pursuant to Welfare and Institutions Code Section 14007.5(d), "emergency medical condition" means a medical condition (including emergency labor and delivery or a threat to the safety of the mother and her unborn child) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Placing the patient's health in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

Procedures

1. Emergency Services Do Not Require Authorization
   A. State and Federal regulations state that every person who presents to the ED must receive a medical screening evaluation by a physician or person under the supervision of a physician without prior authorization.
      a. Medical screening must be performed prior to asking about the individual's ability to pay or before verifying health plan eligibility.
      b. Each person who presents to the ED must be stabilized by medical treatment.

Medi-Cal Non-Emergent Medical Appointment Access Standards

Access Measure	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent Care appointments for Primary Care (PCP Regular and Routine, excludes physicals and wellness checks)	Must offer the appointment within 7 business days of request
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of request
Non-urgent appointments with Specialist physicians (SCP Regular and Routine)	Must offer the appointment within 15 business days of request
Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	Must offer the appointment within 24 hours of request
Urgent Care appointments that require prior authorization (SCP)	Must offer appointment within 96 hours of request
First Prenatal Visit	Must offer the appointment within 5 business days of request
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (enrollees age 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (enrollees age 18 months and younger)	Must be completed within 60 calendar days of enrollment

Member Calls		
24/7 Triage Triage and screening is required to be offered 24 hours a day, 7 days a week	When the member calls his/her PCP information shall be provided on 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 phone, or if needed, deliver urgent or emergency care.	Return call by provider not to exceed 30 minutes
Telephone Answer Time	All telephone calls to a PCP or Specialist must be answered within 6 rings or 45 seconds	Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person
Telephone Hold Time	A Member must not be kept on hold for more than five minutes. If a Member is placed on hold, an employee should let the Member know the reason for the delay and offer the Member the choice to either wait or have his/her call returned within the timeframe	
Telephone Access Standards	When a Member leaves a message with the office of a PCP or specialist, requesting a return call, an employee of the office must attempt to return the Member's call within the following timeframes and log that attempt.	
Routine	Within 3 working days for a non-urgent matter (e.g. refills for medications that have not run out; requests for paperwork or medical records; requests for appointments for non-acute conditions)	
	Within 30 minutes urgent (non-emergency) matter (e.g. Refills of critical medications which have run out; acute illness or acute complaint not already dealt with at the Provider's office)	
	A minimum of three attempts must be made and documented to return the Member's call. It is understood that the same staff member or physician with whom the Member wishes to speak with, may or may not be the party available to return the Member's call	

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type Time	Elapsed Standard
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request

Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within 96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 Business Days of the request

- **EXCEPTIONS**
  1. Preventive Care Services and Periodic Follow Up Care:
     a. 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
  2. Advance Access:
     a. A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.
  3. Appointment Rescheduling:
     a. When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.
  4. Extending Appointment Waiting Time:
     a. 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.
        - A description of the potential risks, consequences, and benefits of telemedicine.
        - All existing confidentiality protections apply.
        - All existing laws regarding enrollee access to medical information and copies of medical records apply.
        - Dissemination of any enrollee identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the enrollee.
     b. An enrollee or the enrollee's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the enrollee or the enrollee's legal representative understands the written information provided and that this information has been discussed with the health care practitioner, or his or her designee. The written consent statement signed by the enrollee or the enrollee's legal representative shall become part of the enrollee's medical record.
  5. Other Applicable Requirements:
     a. Interpreter Services
        - Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations 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.

b. Prior Authorization Processes
   - Prior authorization processes, are to be completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of the time-elapsed access standards. Please refer to AHP P&P No., UM 100, Section UM Titled " Pre-Authorization of Services/NOA Timeframes"

c. Shortage of Providers
   - To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer enrollees to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Furthermore, providers shall 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 enrollee's condition.
   - Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider

d. Triage and/or Screening
   - AHP healthcare providers shall provide or arrange for the provision of 24/7 triage or screening services by telephone and shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening wait time does not exceed 30 minutes.
   - AHP healthcare providers must at a minimum maintain a procedure for triaging or screening enrollee telephone calls, which shall include the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:
     - Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and
     - 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 phone, or if needed, deliver urgent or emergency care.
   - Healthcare providers are responsible for the answering service they employ. If an enrollee 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."
     - Answering service/office staff handling enrollee calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the enrollee so that the enrollee can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the enrollee, or to determine when an enrollee needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to an enrollee that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.
- The answering service will be required to document all calls.
- When medical advice is given to a member via telephone, the provider shall thoroughly document the conversation in the patient's electronic health record during or immediately following the discussion. Documentation shall include the date, time, patient's name, name of caller (if different from patient name), description of complaints, concerns, questions, and advice given.

e. Member Geographical Access Standards
- Proximity – Proximity of Specialists, Hospitals, and other Providers to Sources of Primary Care, Hospitals, and other providers must be located within 15 miles or 30 minutes travel time from assigned Members' residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metro- link train transportation.
- Geographical
  - Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.
  - Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan- operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.
  - Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.
  - Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

f. Communication of Guidelines
- Guidelines regarding access standards must be fully distributed by the plan or delegate throughout the contracted provider network via operation manuals, online practitioner portals, written update notices, policy and procedure documents, or other recognized methods. Standards shall be reviewed/revised annually or as necessary.

- **COMPLIANCE MONITORING**

1. AHP will use several methods to ensure that members have adequate access to providers, including, but not limited to:
   a. Provider appointment access surveys to determine the waiting time for appointments and accessibility of emergency and urgently needed services after regular office hours
   b. AmericasHealth Plan shall utilize the DMHC – ICE Office Access Telephone Survey 2012 Methodology.

c. Member satisfaction surveys to determine whether members are satisfied with the accessibility of health care services
d. Provider satisfaction surveys
e. Member grievances about access to care to identify potential trends or problems

2. To monitor and evaluate the provision of medical advice given via telephone, AHP shall:
   a. Randomly select Primary Care Physician (PCP) offices to conduct periodic chart audits.
      i. Electronic health record/patient charts to be reviewed to identify documentation of telephonic medical advice and ensure timely and thorough documentation of all required elements.
      ii. Audits shall be conducted by either AHP's Quality Improvement Department or AHP's Compliance Department.
      iii. If a documentation issue is identified with respect to telephonic medical advice, the Medical Director or CMO will be notified and a corrective action plan shall be requested.
   b. Review Grievance & Appeals log to identify any potential trends that require intervention.
3. To monitor and evaluate member's access to in-person and telephone interpreter services, AHP shall:
   a. Review grievances and complaints regarding interpretation issues including, but not limited to:
      i. Interpreter services are not offered to Members who are LEP.
      ii. Vital documents received by Members are not written in threshold languages.
      iii. Member unable to timely access needed interpreter services.
   b. Track member requests (such as log and electronic monitoring) for translation services to ensure appropriate and timely access to services. The log shall include:
      i. Date and time the request for translation or vital document was received.
      ii. Date and time the member request and/or vital document was forwarded to the specific health plan.
      iii. Date and time the translated materials were made available to the member/requester.
4. AHP will investigate and request corrective action when timely access-to-care standards are not met.
   a. To comply with these requirements, provider corrective action plan (CAP) will be requested by certified mail when the timely access-to-care standards are not met.
   b. The provider is required to respond to a CAP within 45 days. The response must include the interventions that will be implemented to improve access and/or availability.
   c. AHP will follow up on provider CAP interventions to ensure compliance.
   d. All results for the above activities shall be reported to the Quality Improvement Committee.

Regulatory References

1. National Committee for Quality Assurance Standards and Guidelines
2. Specific Health Plan Requirement