

POLICIES AND PROCEDURES

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Scope: Facey-wide Approval/s: on file

I. PURPOSE

To define the standards to assure the accessibility of primary care service, specialty care service, behavioral health services and member services. 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, and NCQA accreditation requirements, to assist in improved availability and accessibility to practitioners, providers, and health care services, meeting regulatory, accreditation, and licensing requirements

II. POLICY STATEMENT:

It is the policy of Facey Medical Group to adhere to the access standards established by the Industry Collaboration Effort (ICE), the Health Plans and the DMHC Time-elapsd Access Regulations. 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 and National Committee for Quality Assurance (NCQA) accreditation requirements.

III. SCOPE:

This policy applies to all DMHC licensed health care service plan contracted practitioners (e.g. HMO, POS, PPO, Medi-Cal, Healthy Families, Healthy Kids, and Access for Infants and Mothers).

IV. RESPONSIBILITY:

Quality Management Department and Clinical Operations

V. DEFINITIONS:

- a. "Advanced access" means the provision, by an individual provider, or by the medical group to which an enrollee is assigned (Facey Medical Group), 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:
 - o 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.
 - o 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.
- 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.

- 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).

VI. PROCEDURES:

Primary Care

- a. Patients with life threatening emergencies shall be instructed to call 911 or go to the nearest emergency department.
- b. Patients with urgent medical conditions will be seen as soon as possible within 24 hours.
- c. Patients with an emergent condition have access to emergency care at any emergency department.
- d. Patients requesting a physical examination shall be scheduled within 30 calendar days.
- e. Patients requesting a preventive care appointment shall be scheduled within 30 days.
- f. Specialty appointments shall be scheduled within 15 business days unless there is a suspected malignancy.
- g. Suspected malignancies shall be scheduled within 7 days.
- h. Access to after hours care will be available 24 hours per day / 7 days a week.

Telephone Standards

- a. Access to telephone service is available 24 hours a day / 7 days a week.
- b. The abandonment rate shall not exceed 5.5% percent.
- c. The telephone exchange is available after hours 7 days a week with information about how to access clinical care. The expectation is to receive a call back within 4 hours.

Behavioral Health

- a. A member with a life-threatening emergency shall be directed to call 911 or go to the nearest emergency room.
- b. A member with a non-life-threatening emergency has access within 6 hours.
- c. A member with urgent needs is seen within 48 hours.
- d. A member who needs a routine office visit is seen within 10 business days.

Monitoring

- a. Access to After-Hours care is available 24 hours a day/ 7 days a week. Members to reach
- b. a live voice or recorded message providing emergency care instructions & for non-emergency (urgent) matters a mechanism to reach a Behavioral Health provider (non-MD) within the next business day; and for Psychiatrist, the expectation to receive a call back within 4 hours.
- c. Adherence to the above standards will be monitored by a system generated report on a monthly basis and reviewed by the QI Department, Administrative Director of Operations, Medical Director and President of the Group and CEO of the Foundation.
- d. Intervention will be initiated as indicated to improve performance.

This section summarizes the access to care standards and monitoring requirements. The following information delineates the non-emergency access standards for appointment and telephonic access to health care services and the monitoring activities to ensure compliance.

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
In-office wait time for scheduled appointments (PCP and SCP) ¹	Not to exceed 15 minutes

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Care for Non-Life Threatening Emergency	Within 6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	<p><u>Must Provide Both:</u> One follow-up encounter with a mental health provider within 7 calendar days after discharge</p> <p><u>Plus:</u> One follow-up encounter with a mental health provider within 30 calendar days after discharge</p>

¹ As per DMHC Access & Availability Technical Assistance Guide Section AA-05, 1.5, and T28 CCR §1300.67.2 (f) & 1300.67.2.1(c)(13)

EXCEPTIONS:

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

Advance Access:

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.

Appointment Rescheduling:

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.

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 impact on the health of the enrollee.

Other Applicable Requirements:

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.

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. Refer to Utilization Management Policy UM047 – Service requests – decisions and documentation (Med, chiro, dental, pharma).

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, Facey Medical Group is 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 Facey Medical Group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

Triage &/or Screening

Enrollee’s Health plan provides or arranges for the provision of 24/7 triage or screening services by telephone. The Health Plan ensures 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. The Health Plan provides triage or screening services through medical advice lines pursuant to section 1348.8 of the Health & Safety Code as follows:

Health Plan 24/7 Nurse Advice Lines

Health Plan	Member Telephone Number
Aetna	1 (800) 435-8742
Anthem Blue Cross of California	1 (888) 220-3891
Blue Shield of California	1 (877) 304-0504
CIGNA	1 (800) 244-6224
Health Net	1 (800) 893-5597
PacifiCare	1 (800) 624-8822
SCAN	1 (800) 793-1717
United Health	1 (800) 357-0978

Communication of Guidelines

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

COMPLIANCE MONITORING:

Facey Medical Group will refer to the Plan’s Compliance Monitoring Policy(ies) and Procedure(s) and/or Provider’s Operations Manuals for specific compliance monitoring and reporting processes.