| Heritage Provider Network & Affiliated Medical Groups | Program: **QUALITY IMPROVEMENT** | |
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| Title of Policy: **MEMBER ACCESS TO CARE** | | |

**PURPOSE:**

To establish mechanisms to ensure timely member access to primary care, specialist, behavioral health, after-hour, emergency, and member services. To ensure all members have access to a primary care provider after normal business hours, in an emergent, or non-emergent situation. To institute processes which ensure compliance with applicable regulatory, licensing and accreditation access to care standards and requirements.

**POLICY**:

This policy establishes minimum compliance standards for member access to care, and applies to all lines of business of the Heritage Provider Network (HPN) and its affiliates. Heritage Provider Network and its affiliates make sure that all primary care physicians inform their patients of what to do in case of an emergency and be available to their patients after regular hours for non-emergent situations. Heritage Provider Network (HPN) and its affiliates will ensure that the hours of operation of its providers are convenient and do not discriminate against certain members relative to other members.

The HPN and its affiliates will monitor and measure their performance in this area against State, Federal and NCQA access and availability standards. Each primary provider group will make information available about its access standards to all practitioners, providers, and other first-tier and downstream entities with which they contract.

Each primary provider group will monitor member telephone access monthly to ensure that telephone access and availability standards are met. The self-audits, California Cooperative Healthcare Reporting Initiative (CCHRI) and the Patient Assessment Survey (PAS) surveys will completed by each Group and presented to the Quality Improvement (QI) Committee annually for review.

**Definitions**:

1. *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 non –urgent 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.
2. *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)].
3. *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.

4. *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.
5. *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.
6. *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)].
7. *Provider Group* means a medical group, independent practice association, or any other similar organization (as defined by Section 1373.65(g) of the Act).
8. *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).
9. *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.
10. *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.
11. *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).

**PROCEDURES**:
This section summarizes the access to care standards and monitoring requirements.

**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 |

**Behavioral Health Emergent & Non-Emergent Appointment Access Standards**

| Appointment Type | Time-Elapsed Standard |
|---|---|
| Non-urgent appointments with a physician Behavioral Health Care Provider (psychiatrist) | Must offer the appointment within 15 business days of request |
| Non-Urgent Care appointments with a non-physician Behavioral Health Care provider | Must offer the appointment within 10 business days of request |
| Appointment for follow-up routine care with a non-physician behavioral health care provider (i.e. psychologists, Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT)[1] | Members have a follow-up visit with a non-physician behavioral health care provider within twenty (20) calendar days of initial visit for a specific condition. |
| 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 | Must Provide Both: One follow-up encounter with a mental health provider within 7 calendar days after discharge. Plus One follow-up encounter with a mental health provider within 30 calendar days after discharge |

**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 | Must offer the appointment within 10 |

[1] Cal Optima Policy GG. 1600 Access and Availbility 9618

| Access Measure | Time-Elapsed Standard |
|---|---|
| Regular and Routine, excludes physicals and wellness checks) | 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 48 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 2* weeks of request. |
| Well Child Visit | 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 90 calendar days of enrollment |
| Initial Health Assessment (enrollees age 18 months and younger) | Must be completed within 60 calendar days of enrollment |

**Centers for Medicare & Medicaid Services Emergent & Non-Emergent Appointment Access Guidelines**

| Appointment Type | Time-Elapsed Standard |
|---|---|
| Medically necessary services | Must be made available 24 hours a day, 7 days a week |
| Urgently needed services or Emergency | Immediately |
| Services that are not emergency or urgently needed, but in need of medical attention | Within one week |
| Routine and preventive care | Within 30 days |

**EXCEPTIONS**:

**Preventative Care Services and Periodic Follow up Care:**
Preventative care services and periodic follow up care including but not limited to, standing referrals to specialist 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 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 as required by section 1300.67.2.2 (5)(g) of the California Health and Safety Code of Title 28 of the California Code of Regulations.

**Telemedicine:**
To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established.

Prior to the delivery of health care via telemedicine, the provider must obtain verbal and written informed consent from the enrollee or the enrollee's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the enrollee or the enrollee's legal representative verbally and in writing:

1. The enrollee or the enrollee's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the enrollee or the enrollee's legal representative would otherwise be entitled.
2. A description of the potential risks, consequences, and benefits of telemedicine.
3. All existing confidentiality protections apply.
4. All existing laws regarding enrollee access to medical information and copies of medical records apply.
5. 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.

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.

**Other Applicable Requirements:**
***Interpreter Resources***
Interpreter services required by section 1367.04 of the California Health and 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 appointment.

***Prior Authorization Process***
Prior authorization processes, are to be completed in a manner that assures the provision of covered healthcare 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 Authorization and Referral Process.*

***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 timely manner appropriate for the enrollee's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialist outside the provider's contracted network if unavailable within the network, when medically necessary for the enrollees' condition.

Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable copayments, 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 specific contracted provider.

***Triage and/or Screening***

Practitioners, and providers shall provide or arrange for the provision of 24/7 triage or screening services by telephone. The delegate 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.

The practitioners and providers must at a minimum maintain 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:

1. Regarding the length of wait for a return call from a provider (not to exceed 30 minutes); and
2. 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.

***Provider Office Wait Times***

For scheduled appointments. Heritage Provider Network and (Groups) are required to monitor PCP and SCP waiting times.

**After Hour Non-Emergent Care**

1. When the office is closed, it is expected that each physician's office automated message or answering service will provide appropriate emergency instructions and will have a healthcare professional available to return patient calls within 30 minutes for situations where the patient perceives their issue as urgent. Specific guidelines are:
    a. Primary Care physicians need to make provisions so that ***assigned members have access to urgent and emergency care 24 hours a day, seven days a week***.
    b. **Every after-hours caller** is expected to receive emergency instructions, whether a line is answered live or by recording.
2. Callers with an emergency are expected to be told to:
    a. Hang up and dial 911,
    b. Go to the nearest emergency room, or
    c. Hang up and dial 911 or go to the nearest emergency room.
3. After receiving emergency instructions, callers with non-emergency situations that cannot wait until the next business day should receive one of the following options:
    a. When speaking to a person:
        i. Stay on the line to be connected to the doctor on call,
        ii. Leave a name and number and a physician or qualified healthcare professional

will call the person back within specified time frames (not to exceed 30 minutes).

iii. Reach the doctor at another number.

4. When reaching a recording:
    a. Leave a message and have their call returned that same evening or day within 30 minutes of receipt for situations where the patient perceives their issue as urgent.

**Member Services by Telephone**

Each primary provider group will monitor member telephone access logs monthly. A quarterly report shall be tabulated. The report shall contain the following information:

1. Number of Calls Received - This is the total number of member calls received during the month.
2. Call Abandonment Rate - This is the percentage of member calls that abandon from the queue. This should be reported as calls abandoned up to and including 60 seconds. The rate should be less than 5% of all calls.
3. Average Speed to Answer - This is the amount of time that all calls waited in queue before being connected to a customer services representative (CSR). It includes ringing, delay recorder(s), and music. This time begins when the caller enters the queue and includes both calls delayed and those answered immediately. The speed to answer should be less than 30 seconds.
4. Average Talk Time - This is the total average amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.

**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 should be reviewed, and revised annually or as necessary.

**COMPLIANCE MONITORING**:

Using valid methodology, Heritage Provider Network's affiliates will collect and perform an annual quantitative analysis of data against accessibility standards and qualitative analysis of the performance results for access to:

1. Regular and routine care appointments
2. Urgentcare appointments.
3. After-hours care offered 24/7 and a healthcare professional will return the call within 30 minutes
4. Member Services, by telephone – Average Speed to Answer <30 seconds, and Abandonment rate <5%
5. Ancillary non-urgent appointments

Heritage Provider Network's affiliates will draw valid statistically samples to assess performance against access State, and Federal accessibility standards. Member access to care will be evaluated through the following methods:

1. Primary provider group access survey audits.
2. The number of providers who are not accepting new patients.
3. Analysis of member complaints received from the Health Plans, and the primary provider group member services department.
4. Self-reported access data from practitioners, during focus access survey audits.
5. Patient assessment survey, member's experience with accessibility to the practitioner and specialist.
6. Patient Assessment Survey (PAS).
7. Analysis of member services telephone access reports.
8. Analysis of data to measure its performance against its standards for after hour care.

Note: If the primary provider group uses practitioner self-reported information, it must supplement the data with an analysis of complaints regarding access.

**Quality Compliance**

1. A passing score of 95 to 100% must be achieved by the practitioner or provider.
    a. If a score of 95 to100% is not achieved, a corrective action plan must be sent to the practitioner or provider for completion.
    b. The Medical Group must conduct practitioner and provider training to ensure their compliance.
    c. A focus-audit must be conducted upon receipt of the corrective action plan, and until compliance is achieved.
2. The Medical Group will report the results of the survey to their QI Committee and to HPN's QIC at least annually.