CenCal HEALTH
The Regional Health Authority

Policy #:	500-3002-L
Title:	Access to Care
Dept.:	Provider Services
COO Approval:	_____ Date: 9/19/18
Effective Date:	May 2, 2018

I. PURPOSE

To establish standardized access to care parameters for CenCal Health contracted providers to ensure health services are available and accessible to members within a reasonable period of time.

II. POLICY

CenCal Health ensures accessibility of primary care, urgent, specialty health care and continued care consideration for all Plan members, including California Childrens Services (CCS) beneficiaries and newly enrolled Seniors and Persons with Disabilities in compliance with the Medicaid Managed Care Final Rule: Network Adequacy Standards updated March 26, 2018. *Please see Attachment A.*

III. DEFINITIONS

1. "Advanced access" means the provision, by an individual provider, or by the medical group 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.

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 and completing any other condition or requirement of the plan.

4. "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)].

5. "Provider Group" means a medical group.

6. "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.

7. "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) or the equivalent.

8. "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.

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).

IV. PROCEDURE

1. Preventive Care Services and Periodic Follow-Up Care.

   Preventive care services and periodic follow up care include, but are 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. These 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. Appropriate Clinical Timeframes

   CenCal Health ensures that members are offered appointments for covered health services within a time period appropriate for their condition. Attachment A of this policy delineates the timeframe standards by appointment and provider type.

a. First Prenatal Visit: the standard for the first prenatal visit for a pregnant member is within 10 business days upon request
b. Urgent Care: the standard for urgent care appointments is within 24 hours upon request

3. California Childrens Services (CCS)

CenCal Health will ensure that timely preventive, acute, and chronic illness treatment is available to CCS beneficiaries in the appropriate setting though the monitoring processes described in this policy. Plan will utilize only CCS-paneled providers to treat CCS conditions as appropriate for CCS-eligible members, including non-contracted CCS-paneled providers if there are none in the plan's network that have the clinical expertise to treat the CCS condition.

The facilitation of timely access to primary care, specialty care, pharmacy, and other health services provided by CCS providers and facilities with clinical expertise in treating the member's specific CCS conditions, including referrals to address physical or cognitive disabilities, are described in the CenCal Health policy regarding CCS Referral and Case Coordination, #400-2003.

4. Advanced 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 advanced access to primary care appointments as defined herein.

5. 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.

6. 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 that a longer waiting time will not have a detrimental impact on the health of the enrollee. This must be noted within the relevant medical record.

7. 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.

8. Provision of Interpreter Services.

CenCal Health's Cultural and Linguistic Services Program demonstrates compliance with section 130.67.2.2(c) (4) with our cultural and linguistic program. .Please reference CenCal Health's policies concerning access to interpreter services in CenCal Health policy #300-2001, Cultural and Language Access, and #300-2002, Interpreter Services.

9. Staff Education.

Key staff are trained to perform facility site audits, which includes assessing appointment availability to the provider. Certain staff are also trained in the investigation and resolution of member and provider complaints regarding appointment availability if it appears the member's health was put at risk.

Member Services Representatives are trained and responsible for maintaining CenCal Health's telephone access standards, and are responsible for the resolution of member complaints and appeals through the Member Grievance System. The Grievance and QI Manager investigates and resolves member grievance and appeals, analyzes ALL access data relating to grievances with appointment standards and telephone access standards related to responsiveness of the Plan's call center. This data is reported to numerous quality committees that include, Member Support Committee, Network Management Committee, Healthcare Operations Committee, Quality Improvement Committee and to the Board of Directors.

Provider Services Representatives are trained in the appointment availability standards to enable them to assist providers in complying. Designated staff are trained to log, investigate, and resolve provider complaints relating to access (i.e. inability to obtain an appointment with a specialist in a timely fashion), to gather and analyze data on the provider network's compliance with the appointment availability standards, and to gather and analyze provider satisfaction data (see "Monitoring", below).

10. Disclosure of Process to Members and Providers.

Access standards are communicated to members via member newsletters and the Explanation of Coverage (EOC) for each program. Access standards are communicated to providers via several avenues, which may include: the Provider Bulletin, the Provider Manual, and CenCal Health's website: www.cencalhealth.org. Additionally, provider service agreements:

10.1 Require providers to comply with Access to Care Standards adopted by CenCal Health.

10.2 Allow CenCal Health to monitor for compliance with access standards via complaint data analysis, facility audits, and provider audits.

10.3 Require that providers not discriminate against members of CenCal Health programs with respect to accessibility of care, accessibility of emergency services, and provider availability for the provision of health care services.

10.4 Require providers to participate in CenCal Health's Quality Assessment and Improvement Program (QAIP), which includes cooperation with the assessment of quality of care and utilization patterns. Contracted providers agree to take the appropriate corrective action as deemed necessary by CenCal Health. CenCal Health provides advance written notice to contracted providers affected by a corrective action, which includes a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding CenCal Health's corrective action.

11. Confidentiality and Privacy.

CenCal Health has adopted and implemented health plan confidentiality policies and procedures to include the HIPAA Privacy and Security Standards. CenCal Health's Privacy Program is a comprehensive process that addresses all Privacy Standards and interrelating Security Standards. All minimum necessary precautions, as noted in the HIPAA Privacy and Security Standards, have been implemented. Members of the programs under CenCal Health are notified of these standards through the HIPAA Notice of Privacy Practices.

CenCal Health's provider and Business Associate contracts specify expectations regarding the confidentiality of protected member information.

V. MONITORING

Compliance with the Access to Care Standards are reported through CenCal Health's quality committee structure, in which all committees review compliance measures on a quarterly basis. Based on analysis of these monitoring activities, the Healthcare Operations Committee (HOC) sets priorities for opportunities for improvement, and delegates to appropriate committees and departments to implement strategies to improve performance. Evaluating the effectiveness of interventions, reprioritizing opportunities for improvement and oversight of monitoring activities are the ongoing responsibility of the HOC, and the HOC reports to the Quality Improvement Committee (QIC) which reports to the Plan's Board of Directors (BOD). CenCal Health maintains its obligation for monitoring mental health services but fulfills that obligation through a contracted Managed Behavioral Health Organization (MBHO). Oversight of the contracted MBHO is accomplished through CenCal Health's Delegation Oversight Committee, which reports to the Plan's Quality Improvement Committee.

1. The Provider Services Department:

1.1 On a quarterly basis, tracks and trends provider complaints related to access;

1.2 Conducts an annual Provider Survey to monitor compliance with established Access to Care Standards. To conduct this survey, CenCal Health adopts industry standard Provider Appointment Availability Survey & Methodology.

1.2.1 A survey of PCPs, specialists and ancillary providers is conducted via phone or electronically, and includes a sample size as set forth by standard survey methodology for each type of provider.

1.2.2 Methodology: Compliance rates for each time-elapsed standard are calculated using a simple numerator/ denominator calculation, with the numerator equaling all providers with an appointment within the required timeframe and the denominator equaling all providers surveyed for that standard. A mean for each standard is also derived and any outliers (providers without an appointment available within the required timeframe) are noted. Staff calculates overall rates, then sorts the providers by county and recalculated the rates. CenCal Health has set internal benchmarks for these rates at 90%, based on the High Performance Level (HPL) that HEDIS has set for its nationally reported quality measures.

2. The Member Services Department:

2.1 On a quarterly basis, tracks and trends member grievance and appeals and member's request for Primary Care Physician reselection relating to "Access" issues. These data are presented in control charts which utilize a per thousand member per month and per thousand member per month current year (PTMPM/PTMPYCM) calculation. If aggregate totals based upon the numerator/denominator calculation, are above the standard deviation of two for grievances, then interventions are developed. If data suggests there an access issue for a specific provider, the Member Services Quality Improvement Manager forwards the noted trend to the Provider Services Department in order to perform the appropriate barrier analysis and intervention.

Access grievances and PCP reselections are also reviewed through CenCal Health's quality improvement reporting structure. These issues are also reported quarterly to the Department of Health Care Services Managed Care Division, through the completion of required grievance reporting templates.

2.2 Call Center telephone responsiveness and established metrics for Access Standards are reported and trended on a monthly and quarterly basis. These metrics are reported to the Plan's Board of Directors, as well as the Department of Health Care Service's Medi-Cal Managed Care Division, and also quarterly through CenCal Health's quality committee structure, as appropriate.

2.3 The Member Services Quality Improvement Manager conducts an annual Member Access Survey. This survey is administered separately from the routine CAHPS survey, but is designed using CAHPs methodology regarding sample size, questions related directly to access. The population targeted by this survey is 100% of CenCal Health members who are enrolled in the Plan's Knox-Keene regulated programs, thus, the standard methodology used for sample size mailings is not applicable to this population. Every second year, the same methodology regarding sample size used for CAHPS survey, is used to survey the Plan's Medi-Cal population.

3. The Provider Services Department conducts facility audits of all PCPs at the time of initial application to the network, and at least every three years thereafter. These Facility Site Reviews include an appointment availability component, which is scored as part of the outcome of the review. Results are reported to the Quality Improvement Committee (QIC).

Attachment A Network Adequacy Standards					
Provider Type	Timely Access Standard	Time and Distance Standard by County Size			
		Rural	Small	Medium	Dense
Primary Care (Adult and Pediatric)	Within 10 business days to appt. from request	10 miles or 30 minutes from the beneficiary's residence			
Specialty Care (Adult and Pediatric)	Within 15 business days to appt. from request	60 miles or 90 minutes from the beneficiary's residence*	45 miles or 75 minutes from the beneficiary' s residence*	30 miles or 60 minutes from the beneficiary's residence*	15 miles or 30 minutes from the beneficiary's residence*
Obstetrics/ Gynecology (OB/GYN) Primary Care	Within 10 business days to appt. from request	10 miles or 30 minutes from the beneficiary's residence			
Obstetrics/ Gynecology (OB/GYN) Specialty Care	Within 15 business days to appt. from request	60 miles or 90 minutes from the beneficiary's residence*	45 miles or 75 minutes from the beneficiary's residence*	30 miles or 60 minutes from the beneficiary's residence*	15 miles or 30 minutes from the beneficiary's residence*
Hospitals	N/A	15 miles or 30 minutes from the beneficiary's residence			
Pharmacy	Dispensing of at least a 72-hour supply of covered outpatient drug in an emergency situation	10 miles or 30 minutes from the beneficiary's residence*			
Mental Health (non-psychiatry)	Within 10 business days to apt. from request	60 miles or 90 minutes from the	45 miles or 75 minutes from the	30 miles or 60 minutes from the	15 miles or 30 minutes from the

Outpatient Services		beneficiary's residence*	beneficiary's residence*	beneficiary' s residence*	beneficiary's residence*
Long Term Services and Supports	If applicable	Time and distance standards did not need to be established for Multipurpose Senior Services Program (MSSP), Skilled Nursing Facilities (SNF), or Intermediate Care Facilities (ICF) providers as these providers either travel to the beneficiary to provide services or the beneficiary resides at the facility for care.			

Table 1: County Size Categories by Population

Size Category	Population Density	# of Counties	Counties
Rural	<50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 600 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	≥600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

Table 2: DHCS Adult and Pediatric Core Specialists

Cardiology/Interventional Cardiology	Nephrology
Dermatology	Neurology
Endocrinology	Oncology
ENT/Otolaryngology	Ophthalmology
Gastroenterology	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology	Psychiatry
HIV/AIDS Specialists/Infectious Diseases	Pulmonology

Table 3: LTSS Timely Access Network Standards

Provider Type	Timely Access Standard by County Size

	Rural	Small	Medium	Dense
Skilled Nursing Facility (SNF)	Within 14 calendar days of request*	Within 14 calendar days of request*	Within 7 business days of request*	Within 5 business days of request*
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request*	Within 14 calendar days of request*	Within 7 business days of request*	Within 5 business days of request*
Community Based Adult Services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level			

VI. REFERENCE

SBSLORHA-DHCS Contract #08-85212 Section 3- Access Requirements

Medicaid Managed Care Final Rule: Network Adequacy Standards