DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

1115 WAIVER SURVEY

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this February 11, 2015 Technical Assistance Guide renders all other versions obsolete.

1115 WAIVER ACCESS & AVAILABILITY TAG

Access and Availability of Services Requirements

TABLE OF CONTENTS

1115 WAIVER ACCESS & AVAILABILITY TAG

Requirement AA-001: The Health Plan Ensures the Availability of Primary Care Services

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network

3. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:
   1) Primary Care Physicians 1:2,000
   2) Total Physicians 1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

8. Time and Distance Standard

Contractor shall maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

DHCS COHS Contract, Exhibit A, Attachment 6 – Provider Network

2. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:
   1) Primary Care Physicians 1:2,000
   2) Total Physicians 1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one (1) provider per 1,000 patients.

7. Time and Distance Standard

Contractor shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including

physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments
   Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
B. First Prenatal Visit
   Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
C. Waiting Times
   Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Paragraph A. Appointments, above.

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appropriate Clinical Timeframes
   Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.
B. Standards for Timely Appointments
   Members must be offered appointments within the following timeframes:
   1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
   2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
   3. Non-urgent primary care appointments – within ten (10) business days of request;
   4. Appointment with a specialist – within 15 business days of request;
   5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.
C. Shortening or Expanding Timeframes
   Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended,

it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

D. Provider Shortage
Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.

16. Out-of-Network Providers
A. If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability

1. General Requirement
Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member to the Primary Care Provider. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.
Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with this Contract and applicable law.

3. Access Requirements
Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.
A. Appointments
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
(1) Appropriate Clinical Timeframes:
Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

(2) Standards for Timely Appointments:
Members must be offered appointments within the following timeframes:
a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
b) Urgent appointment for services that do require prior authorization – within 96 hours of a request;
c) Non-urgent primary care appointments – within ten (10) business days of request;
d) Appointment with a specialist – within 15 business days of request;
e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.
(3) Shortening or Expanding Timeframes
Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.
(4) Provider Shortage
Contractor shall be required to arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner.
C. Waiting Times
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A. Appointments, above.

16. Out-of-Network Providers
A. If Contractor's network is unable to provide necessary medical services covered under the contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

DHCS Two-Plan Contract, Exhibit A, Attachment 13 – Member Services
4. Written Member Information
D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall include the following information:

DHCS GMC Contract, Exhibit A, Attachment 13 – Member Services
4. Written Member Information

D. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as provided in 22 CCR 53920.5, 28 CCR 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF). In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code Section 1363, and 28 CCR 1300.63(a), as to print size, readability, and understandability of text, and shall include the following information:

DHCS COHS Contract, Exhibit A, Attachment 13 – Member Services

4. Written Member Information

D. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as provided in Title 28 CCR Sections 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF), if applicable. In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code Section 1363, and Title 28 CCR Section 1300.63(a), as to print size, readability, and understandability of text, and shall include the following information:

28 CCR 1300.67.2(a), (d), and (f)

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.67.2.1(a) and (b)

Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application

or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.
(b) If, in its review of a plan license application or a notice of material modification, the Department believes the accessibility standards set forth in Item H of Section 1300.51 and/or Section 1300.67.2 are insufficiently prescribed or articulated or are inappropriate given the facts and circumstances with regard to a portion of a plan's service area, the Department shall inform the plan that the Department will not allow application of those standards to that portion of the plan's service area. The Department shall also inform the plan of the Department's reasons for rejecting the application of those standards.

28 CCR 1300.67.2.2(a)(1)
(a) Application
1. All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section.

28 CCR 1300.67.2.2(b)(1)-(2)
(b) Definitions. For purposes of this section, the following definitions apply.
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 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. “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 completing any other condition or requirement of the plan or its contracting providers.

28 CCR 1300.67.2.2(c)(1)-(5)
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee’s condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.
(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are 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 this section.

(3) When it is necessary for a provider or an 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 Section 1367.03 of the Act and the requirements of this section.
(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 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. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:
(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);
(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);
(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);
(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);
(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);
(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);
(G) 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;
(H) Preventive care services, as defined at subsection (b)(3), 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; and
(I) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

28 CCR 1300.67.2.2(c)(7)
(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.
(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, 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. Plans shall arrange for the provision of specialty services from specialists outside the plan'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.

28 CCR 1300.67.2.2(d)(2)(A)
(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:
(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:
(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c).

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Contracting or Provider Relations
- QI Director

DOCUMENTS TO BE REVIEWED

- Standards for geographic distribution of Primary Care Providers (PCPs)
  - Include approved alternative standards, if applicable
- Standards for ratio of PCPs to enrollees
  - Include approved alternative standards, if applicable

- DMHC Network Assessment reports, previous four quarters
- Policies and procedures to periodically review and update network adequacy standards
- Policies and procedures for addressing identified network inadequacies
- Minutes of committee meetings where provider network data is reviewed
- Procedures describing how the Plan monitors and ensures compliance with standards and assures contracting providers have capacity to accept new patients
- Member or Customer Service information available to facilitate access to PCP services
- Standards for PCP appointment wait time and in-office wait time

AA-001 - Key Element 1:

1. The Plan has established a standard for geographic distribution of primary care providers.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network, Provision 8; DHCS COHS Contract, Exhibit A, Attachment 6 – Provider Network, Provision 7; DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 9 – Access and Availability, Provision 1; DHCS Two-Plan, GMC, and COHS Contract, Exhibit A, Attachment 13 – Member Services, Provision 4(D); 28 CCR 1300.67.2.1(a)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on geographic distribution of PCPs?			
1.2 Does the Plan have a network of PCPs that are located within 30 minutes or 10 miles of a member's residence? DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6, Provision 8; DHCS COHS Contract, Exhibit A, Attachment 6, Provision 7			
1.3 If the answer to Assessment Question 1.2 is no, then has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, then has this standard been submitted to and approved by the DHCS?			

AA-001 - Key Element 2:

2. The Plan has established a standard for the ratio of PCPs to enrollees within the service area.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network, Provision 3(A); DHCS COHS Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2(A); DHCS Two-Plan, GMC, and COHS Contracts Attachment 9 – Access and Availability Provision 1; 28 CCR 1300.67.2(a) and (d)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard on the ratio of PCPs to enrollees?			
2.2 Does the Plan's standard provide for at least one PCP for each 2,000 enrollees?			
2.3 If the answer to Assessment Question 2.2 is no, then has the Plan established an alternative standard?			
2.4 If the Plan has established an alternative standard, then has this standard been submitted to and approved by the DHCS?			

AA-001 - Key Element 3:

3. The Plan has established a mechanism that ensures that primary health care services are reasonably accessible to all members.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3, 4, and 16(A); DHCS COHS Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3(A)(1)-(4), and 16(A); 28 CCR 1300.67.2.2(a)(1), (c)(5)(C), (c)(7), and (d)(2)(A)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have mechanisms to ensure reasonable access to primary health care services for all members?			
3.2 Does the Plan ensure they have sufficient numbers of contracted providers to maintain compliance with established standards?			
3.3 If the Plan operates in a service area that has a shortage of PCPs, does the Plan refer enrollees to or assist enrollees with locating available and accessible contracted providers in neighboring service areas?			
3.4 Does the Plan develop and distribute materials that explain: • How to obtain primary care services; and • Timely access standards for PCPs?			
3.5 Does the Plan ensure that delegated entities inform enrollees how to obtain primary care services?			
3.6 Does the Plan ensure that delegated entities inform enrollees of the appointment standards for non-urgent primary care services?			
3.7 Does the Plan monitor the delegated entity's accessibility reports regarding primary care services?			

Assessment Questions	Yes	No	N/A
3.8 Does the Plan have a Member Services Guide with the information necessary to accurately assist enrollees in obtaining information about benefits, providers, coverage, and any other relevant information concerning an enrollee's access to primary care services? Attachment 13, Member Services, Provision 4(D)			

AA-001 - Key Element 4:

4. Each health care service plan shall have a documented system for monitoring and evaluating accessibility of primary care, including a system for addressing waiting time, appointment availability and other problems that may develop. DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A) and 4(A)(B); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)-(C); 28 CCR 1300.67.2(f); 28 CCR 1300.67.2.2(b)(2), (c)(1)-(7), and (d)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan rely on systems that provide advanced access to primary care appointments?			
4.2 Does the Plan have a documented system for monitoring and evaluating access to care, including waiting time and appointments?			
4.3 Does the Plan monitor the rescheduling of appointments to: • Assure it is prompt; • Assure it is in a manner appropriate for the member's health care needs; and • To ensure continuity of care?			
4.4 Does the Plan's monitoring program track and document network capacity and availability with respect to timely access regulations?			
4.5 Does the Plan offer its members non-urgent primary care appointments within ten (10) business days of request? DHCS Two-Plan Contract, Exhibit A, Attachment 9, Provision 4(B)(3); DHCS COHS Contract, Exhibit A, Attachment 9, Access and Availability, Provision 3(A)(2)(c); Rule 1300.67.2.2			
4.6 Does the Plan monitor compliance with the requirement that the first pre-natal visit will be available within 10 business days upon request?			
4.7 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed providers to offer enrollees appointments that meet time elapsed standards?			

Assessment Questions	Yes	No	N/A
4.8 When the Plan identifies problems, does it take action to ensure appointment availability?			
4.9 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

End of Requirement AA-001: The Health Plan ensures the availability of Primary Care services.

1115 WAIVER ACCESS & AVAILABILITY TAG

Requirement AA-002: The Health Plan Ensures the Availability of Specialist Services

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network

1. Network Capacity

Contractor shall maintain a provider network adequate to serve sixty percent (60%) of all Eligible Beneficiaries, including SPD beneficiaries, within Contractor's Service Area and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation if Enrollments do not achieve seventy-five percent (75%) of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.

2. Network Composition

Contractor shall ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and service sites within each service area.

3. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:

1) Primary Care Physicians 1:2,000
2) Total Physicians 1:1,200

DHCS COHS Contract, Exhibit A Attachment 6 – Provider Network

1. Network Capacity

Contractor shall submit a complete provider network that is adequate to provide required Covered Services for Eligible Beneficiaries, including SPD beneficiaries, in the Service Area. Contractor will increase the capacity of the network as necessary to accommodate growth.

2. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:

1) Primary Care Physicians 1:2,000
2) Total Physicians 1:1,200

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments
   Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
B. First Prenatal Visit
   Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
C. Waiting Times
   Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Paragraph A. Appointments, above.
F. Unusual Specialty Services
   Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appropriate Clinical Timeframes
   Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.
B. Standards for Timely Appointments
   Members must be offered appointments within the following timeframes:

1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

C. Shortening or Expanding Timeframes
Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

D. Provider Shortage
Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.

16. Out-of-Network Providers

A. If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member to the Primary Care Provider. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with this Contract and applicable law.

3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of

operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

(1) Appropriate Clinical Timeframes:

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

(2) Standards for Timely Appointments:

Members must be offered appointments within the following timeframes:

a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

b) Urgent appointment for services that do require prior authorization – within 96 hours of a request;

c) Non-urgent primary care appointments – within ten (10) business days of request;

d) Appointment with a specialist – within 15 business days of request;

e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

(3) Shortening or Expanding Timeframes

Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

(4) Provider Shortage

Contractor shall be required to arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner.

B. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.

C. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A. Appointments, above.

G. Specialty Services

Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.

16. Out-of-Network Providers

A. If Contractor's network is unable to provide necessary medical services covered under the contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

28 CCR 1300.67.2(d)-(f)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;
(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.67.2.1(a)
Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.
(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

28 CCR 1300.67.2.2(b)(2)
(b) Definitions. For purposes of this section, the following definitions apply.
2. "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 completing any other condition or requirement of the plan or its contracting providers.

28 CCR 1300.67.2.2(c)(1) and (2)
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.
(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are 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 this section.

28 CCR 1300.67.2.2(c)(5)(D), (F), and (G)
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:
(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);
(G) 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.

28 CCR 1300.67.2.2(c)(7)
(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.
(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, 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. Plans shall arrange for the provision of specialty services from specialists outside the plan'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.

28 CCR 1300.67.2.2(d)(1), (2)(A) and (D), and (3)
(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:
(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.
(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:
(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c);
(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and
(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: 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 the plan's corrective action.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Contracting or Provider Relations
- QI Director

DOCUMENTS TO BE REVIEWED

- Standards for geographic distribution of Physicians, (Including approved alternative standards, if relevant)
- Standards for ratio of Physicians to enrollees (Including approved alternative standards, if relevant)
- DMHC Network Assessment Reports, previous four quarters
- Policies and procedures to periodically review and update network adequacy standards
- Policies and procedures for addressing network inadequacies, when identified
- Minutes of committee meetings where provider network data is reviewed
- Procedures describing how the Plan monitors and ensures compliance with standards
- Member or Customer Service information available to facilitate access to specialists/Physicians
- Procedures for referring enrollees outside the network, including approval criteria, applicable co-pays, case management, coordination of care, etc.
- Referral logs showing number and type of in-network and out-of-network specialty referrals
- Standards for specialty referral wait time and in-office wait time

AA-002 - Key Element 1:

1. The Plan has established a standard for the number of Physicians within the service area.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network, Provision 3 and Attachment 9 – Access and Availability, Provisions 1, 3F, and 4(D);
DHCS COHS Contract, Exhibit A, Attachment 6 – Provider Network, Provision 2 and Attachment 9 – Access and Availability, Provisions 1, 3(A)(4), and 3(G); 28 CCR 1300.67.2(d) and (e); 28 CCR 1300.67.2.1(a)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the ratio of Physicians to enrollees?			
1.2 Does the Plan's standard provide for at least one Physician for each 1,200 enrollees?			
1.3 If the answer to 1.2 above is no, then has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, then has this standard been submitted to the DHCS?			

AA-002 - Key Element 2:

2. The Plan has established a standard for the distribution of and accessibility to medically required specialists.
DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3(A)(4), 3(G), and 16(A); 28 CCR 1300.67.2(d) and (e) 28 CCR 1300.67.2.2(c)(2) and (7)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard on the distribution of and accessibility to specialists in its network?			
2.2 Does the Plan have a process to arrange for out-of-network medically necessary specialty services?			
2.3 Does the Plan have a process to ensure enrollee costs for out-of-network referrals are no greater than they would be if the services were furnished within the network?			

AA-002 - Key Element 3:

3. The Plan has established a mechanism that ensures that specialty health care services are reasonably accessible to all members.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 4(D) and 16(A); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(A)(4) and 16(A); 28 CCR 1300.67.2.2(c)(2), CCR 1300.67.2.2 (c)(5)(D), (c)(7), and (G)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have established standards to ensure ready referral, and provision of covered services in a timely manner appropriate for the nature of the member's condition and in a manner consistent with good professional practice?			
3.2 Does the Plan have mechanisms to ensure reasonable access to specialty health care services for all enrollees?			
3.3 Does the Plan have sufficient numbers of contracted specialty providers to maintain compliance with established standards?			
3.4 If the Plan operates in a service area that has a shortage of specialists, does the Plan refer members to or assist enrollees with locating available and accessible contracted providers in neighboring service areas?			
3.5 Does the Plan develop and distribute materials that explain: • How to obtain specialty care services; and • Timely access standards for specialty providers?			
3.6 Does the Plan ensure that delegated entities inform enrollees how to obtain specialty care services?			

Assessment Questions	Yes	No	N/A
3.7 Does the Plan ensure that delegated entities inform enrollees of the appointment standards for urgent and non-urgent primary, specialty, and ancillary care?			
3.8 Does the Plan monitor the delegated entity's accessibility reports regarding specialty care services?			
3.9 Does the Plan have a Member Services Guide with the information necessary to accurately assist enrollees in obtaining information about benefits, providers, coverage, and any other relevant information concerning an enrollee's access to specialty care services? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 13 – Member Services, Provision 4(D)			

AA-002 - Key Element 4:

4. Each health care service plan shall have a documented system for monitoring and evaluating accessibility to specialty care, including a system for addressing waiting time, appointment availability, and other problems that may develop. DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 3 and 4; DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(A)(1)-(3) and 3(C); 28 CCR 1300.67.2(e) and (f); 28 CCR 1300.67.2.2(b)(2), (c)(1), (c)(5)(D), (d)(1), (d)(2)(A), (d)(3), and (D)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have a documented system for monitoring and evaluating specialty care access, including waiting time and appointments?			
4.2 Does the Plan monitor the rescheduling of appointments to: • Assure it is prompt; • Assure it is in a manner appropriate for the member's health care needs; and • To ensure continuity of care?			
4.3 Does the Plan's monitoring program track and document network capacity and availability with respect to timely access regulations?			
4.4 How about: Does the Plan offer its members appointments with specialists within 15 business days of request? DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9, Provision 4(B)(4) and Rule 1300.67.2.2(c)(5)(D); DHCS COHS Contract, Exhibit A, Attachment 9, Access and Availability, Provision 3(A)(2)(d)			
4.5 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed providers to offer members appointments that meet time elapsed standards?			

Assessment Questions	Yes	No	N/A
4.6 When the Plan identifies problems, does it take action to ensure appointment availability?			
4.7 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

End of Requirement AA-002: The Health Plan ensures the availability of Specialist services.

1115 WAIVER ACCESS & AVAILABILITY TAG

Requirement AA-003: The Health Plan Ensures the Availability of Urgent Care Services

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments
   Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

B. First Prenatal Visit
   Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

C. Waiting Times
   Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Paragraph A. Appointments, above.

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appropriate Clinical Timeframes
   Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

B. Standards for Timely Appointments
   Members must be offered appointments within the following timeframes:
   1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
   2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;

3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

C. Shortening or Expanding Timeframes
Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

16. Out-of-Network Providers

A. If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability

3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

(1) Appropriate Clinical Timeframes:

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

(2) Standards for Timely Appointments:

Members must be offered appointments within the following timeframes:

a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

b) Urgent appointment for services that do require prior authorization – within 96 hours of a request;

c) Non-urgent primary care appointments – within ten (10) business days of request;

d) Appointment with a specialist – within 15 business days of request;

e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

(3) Shortening or Expanding Timeframes

Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.
C. Waiting Times
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A. Appointments, above.

16. Out-of-Network Providers
A. If Contractor's network is unable to provide necessary medical services covered under the contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

DHCS Two-Plan and GMC Contracts, Exhibit E, Attachment 1 – Definitions
Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

DHCS COHS Contract, Exhibit E, Attachment 1 – Definitions
Urgent Care means an episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

28 CCR 1300.67.2.2(b)(7)
(b) Definitions. For purposes of this section, the following definitions apply.
7. "Urgent care" means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.

28 CCR 1300.67.2.2(c)(5)(A) and (B)
(c) Standards for Timely Access to Care.
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:
(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);
(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Contracting or Provider Relations
- QI Director

DOCUMENTS TO BE REVIEWED

Please note:

- Standards for geographic distribution of urgent care facilities
- DMHC Network Assessment Reports for SPD and for Rural Expansion counties, previous four quarters
- Policies and procedures to periodically review and update network adequacy standards
- Policies and procedures for addressing network inadequacies, when identified
- Minutes of committee meetings where provider network data is reviewed
- Procedures describing how the Plan monitors and ensures compliance with standards
- Member or Customer Service information available to facilitate access to urgent care
- Procedures for referring members outside the network, including approval criteria, applicable co-pays, case management, coordination of care, etc.
- Standards for urgent care appointments and in-office wait time

AA-003 - Key Element 1:

1. The Plan ensures availability of and timely access to urgent health care services for all members.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(A), 4(B)(1), 4(B)(2), and 16(A); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(A), 3(A)(2)(a), 3(A)(2)(b), and 16(A); DHCS Two-Plan GMC, and COHS Contracts, Exhibit E, Attachment 1; CA Health and Safety Code section 1367(h)(2)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan offer its members appointments for urgent care services that do not require prior authorization within 48 hours of a request? DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provision 4(B)(1); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3(A)(2)(a).			

Assessment Questions	Yes	No	N/A
1.2 Does the Plan offer its members appointments for urgent care services that require prior authorization within 96 hours of a request? DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provision 4(B)(2); DHCS COHS Contract, Exhibit A, Attachment 9, Provision 3(A)(2)(b).			
1.3 Does the Plan have sufficient numbers of contracted urgent care providers to maintain compliance with established standards?			
1.4 If the Plan operates in a service area that has a shortage of urgent care providers, does the Plan refer members to or assist members with locating available and accessible contracted providers in neighboring service areas?			
1.5 Does the Plan develop and distribute materials that explain: • How to obtain urgent care services; and • Timely access standards for urgent care providers?			
1.6 Does the Plan ensure that delegated entities inform members how to obtain urgent care services?			
1.7 Does the Plan ensure that delegated entities inform members of the appointment standards for urgent care?			
1.8 Does the Plan monitor the delegated entity's accessibility reports regarding urgent care services?			
1.9 Does the Plan have a Member Services Guide with the information necessary to accurately assist members in obtaining information about benefits, providers, coverage, and any other relevant information concerning an enrollee's access to urgent care services?			

AA-003 - Key Element 2:

2. Each health care service plan shall have a documented system for monitoring and evaluating accessibility to urgent care, including a system for addressing waiting time, appointment availability, and other problems that may develop. DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(A), 3(C) and 4; DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 3(A) and 3(C); 28 CCR 1300.67.2.2(b)(7); 28 CCR 1300.67.2.2 (c)(5)(A)-(B)

Assessment Questions	Yes	No	N/A
2.1 How about: Does the Plan offer its members appointments for urgent care services that do not require prior authorization within 48 hours of a request? DHCS Two-Plan and GMC Contracts: Attachment 9, Provision 4(B)(1); DHCS COHS Contract: Attachment 9, Provision 3(A)(2)(a)			
2.2 How about: Does the Plan offer its members appointments for urgent care services that require prior authorization within 96 hours of a request? DHCS Two-Plan and GMC Contracts: Attachment 9, Provision 4(B)(2); DHCS COHS Contract: Attachment 9, Provision 3(A)(2)(b)			
2.3 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed providers to offer members appointments that meet time elapsed standards?			
2.4 When the Plan identifies problems, does it take action to ensure appointment availability?			
2.5 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

End of Requirement AA-003: The Health Plan ensures the availability of Urgent Care services

1115 WAIVER ACCESS & AVAILABILITY TAG

Requirement AA-004: The Health Plan Ensures the Availability of After Hours Care.

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

D. Telephone Procedures
   Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

E. After Hours Calls
   At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.

DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member to the Primary Care Provider. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

D. Telephone Procedures
Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.
F. After Hours Calls
At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.

28 CCR 1300.67.2(b) and (f)
(b) Hours of operation and provision for after-hour services shall be reasonable;
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.67.2.2(c)(1)
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- QM Director
- Provider Relations Manager, responsible for compliance oversight of provider groups
- Director of Member Services Department or Call Center

DOCUMENTS TO BE REVIEWED

- Policies and procedures defining standards for hours of operation
- Policies and procedures for monitoring of the standards for hours of operation
- Policies and procedures defining standards for after-hours coverage requirements
- Policies and procedures for monitoring of the standards for after-hours care;
- Plan after-hours coverage and access monitoring reports, after-hours or other types of telephone access studies from the Plan's telephone system or other methodologies (such as random calling at various times and dates)
- Committee meeting minutes, Provider Manual or other methods to communicate standards to providers
- Corrective Action Plans
- Standards for response time for after-hours care and in-office wait time

AA-004 - Key Element AA-004 - 1:

1. The Plan has established a standard defining reasonable hours of operation for provider health care facilities that is sufficient to prevent delays detrimental to the health of members.
DHCS Two Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3(D), and 3(E); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3(D), and 3(F); 28 CCR 1300.67.2(b) and (d)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan require its providers to maintain procedures for: • Triaging members' telephone calls; • Providing telephone medical advice (if available); and • Accessing telephone interpreters? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3(D)			
1.2 Does the Plan have an established standard that defines reasonable hours of operation for provider facilities?			
1.3 Does the Plan ensure that a Physician or an appropriate licensed professional under the Physician's supervision is available for after-hours calls? DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 1 and 3(E); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 1 and 3(F)			
1.4 Does the standard ensure that availability is sufficient to prevent delays detrimental to the health of members?			

AA-004 - Key Element 2:

2. The Plan has established standards that ensure that the availability of and access to after-hours services both at the Plan and provider-level are sufficient to prevent delays detrimental to the health of members.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 1, 3(D) and 3(E); DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provisions 1; 3(D); 3(F); 28 CCR 1300.67.2(b); 28 CCR 1300.67.2.2(c)(1)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have established standards on availability of and access to after-hours services which address availability of providers?			

Assessment Questions	Yes	No	N/A
2.2 Does the Plan have established standards on availability of and access to after-hours services which address provider response to messages left after hours?			
2.3 Does the Plan have established standards on availability of and access to after-hours services which address Plan services (e.g. customer service)?			
2.4 Do the Plan's standards ensure that availability of access to after-hours services is sufficient to prevent delays detrimental to the health of members?			

AA-004 - Key Element 3:

3. The Plan has established and implemented a documented system for monitoring and evaluating providers' adherence to the standards regarding hours of operation and after-hours services.
DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access and Availability, Provisions 3 and 4; DHCS COHS Contract, Exhibit A, Attachment 9 – Access and Availability, Provision 3; 28 CCR 1300.67.2(b) and (f)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan monitor compliance to the screening and triage requirements performed at the provider group level?			
3.2 Does the Plan disseminate its standard to providers? (e.g., via facility contracts, provider manual, etc.)			
3.3 Does the Plan regularly measure providers' performance against its standard?			
3.4 Does the Plan implement corrective action and follow-up review to address any deficiencies?			
3.5 Does the Plan periodically review the appropriateness of its standard and update it when indicated?			

End of Requirement AA-004: The Health Plan ensures the availability of After Hours care

Requirement AA-005: The Health Plan Ensures the Availability of Emergency Services

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 5 – Utilization Management

2. Pre-Authorizations and Review Procedures
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:
G. Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
3. Timeframes for Medical Authorization
A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

DHCS COHS Contract, Exhibit A, Attachment 5 – Utilization Management

2. Pre-Authorizations and Review Procedures
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:
G. Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
3. Timeframes for Medical Authorization
A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

DHCS Two-Plan Contract, Exhibit A, Attachment 6 – Provider Network

5. Emergency Services
Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

DHCS GMC Contract, Exhibit A, Attachment 6 – Provider Network

5. Emergency Services
Contractor shall have, as a minimum, a designated emergency service facility with in the Service Area, providing care on a 24 hours a day, 7 days a week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

DHCS COHS Contract, Exhibit A, Attachment 6 – Provider Network

4. Emergency Services
Contractor shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24-hours a day, 7-days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility at all times.

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 8 – Provider Compensation Arrangements

13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

A. Emergency Services: Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek Emergency Services.

B. Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Provider, the plan, or DHCS of the enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

DHCS COHS Contract, Exhibit A, Attachment 8 – Provider Compensation Arrangements

12. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

A. Emergency Services: Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek emergency services.

B. Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollees primary care provider, the plan, or DHCS of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 9 – Access & Availability

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with 28 CCR 1300.67.2 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall ensure that contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

7. Emergency Care

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

A. Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7, Provider Relations).
B. Contractor shall ensure adequate follow-up care for those Members who have been screened in the emergency room and require non-emergency care.
C. Contractor shall ensure that a plan or contracting physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

DHCS COHS Contract, Exhibit A, Attachment 9 – Access & Availability

3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall ensure that Contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards**.**

6. Emergency Care

Contractor shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24-hours a day, 7-days a week.

A. Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR Section 1300.67(g)(1). Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS approved emergency department protocol (see Exhibit A, Attachment 7, Provider Relations).
B. Contractor shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care.
C. Contractor shall ensure that a plan or contracting Physician is available 24-hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

28 CCR 1300.67(g)(1)
(g)(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

28 CCR 1300.67.2(c)
(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Contracting or Provider Relations
- QI Director

DOCUMENTS TO BE REVIEWED

- Standards for geographic distribution of emergency facilities
- DMHC Network Assessment reports for SPD and for Rural Expansion, previous four quarters
- Policies and procedures to periodically review and update network adequacy standards
- Policies and procedures for addressing network inadequacies, when identified
- Minutes of committee meetings where provider network data is reviewed
- Procedures describing how the Plan monitors and ensures compliance with standards
- Member or Customer Service information available to facilitate access to emergency care
- Description of monitoring activities to identify inappropriate Emergency Room usage for routine primary care or specialty care
- Standards for response time to emergency calls
- Standards for time waiting in the Emergency Room

AA-005 - Key Element 1:

1. **The Plan has established policies and procedures for emergency health care services.**
   DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network, Provision 5; DHCS COHS Contract, Exhibit A, Attachment 6 – Provider Network, Provision 4; 28 CCR 1300.67.2(c)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the geographic distribution of emergency health care services in its network?			
1.2 Does the Plan's designated emergency service facility have at least one Physician and one Nurse on duty at all times?			
1.3 Does the Plan make emergency health care services available and accessible within the service area 24 hours a day, seven days a week? DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 6 – Provider Network, Provision 5**;** COHS Contract, Exhibit A, Attachment 6 – Provider Network, Provision 4; Rule 1300.67.2(c)			

AA-005 - Key Element 2:

2. The Plan ensures the availability of and access to emergency health care services within the service area 24 hours per day, seven days per week.

DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 5 – Utilization Management, Provisions 2(G) and 3(A) and Attachment 9 – Access and Availability, Provisions 3,4, 7(A)-(C); DHCS Two-Plan and GMC Contracts, Exhibit A, Attachment 8 – Provider Compensation, Provisions 13(A) and (B); DHCS COHS Contract, Exhibit A, Attachment 8 – Provider Compensation, Provisions 12(A) and 12(B) and Attachment 9 – Access and Availability, Provisions 3 and 6(A)-(C); 28 CCR 1300.67.1(g); 28 CCR 1300.67.2(c)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have mechanisms to ensure reasonable access to emergency health care services for all members?			
2.2 Does the Plan have sufficient numbers of contracted emergency providers to maintain compliance with established standards?			
2.3 Does the Plan develop and distribute materials that explain: • How to obtain emergency services; and • Timely access standards for emergency services providers?			
2.4 Does the Plan ensure that delegated entities inform members how to obtain emergency services?			
2.5 Does the Plan ensure that delegated entities inform members of the availability of emergency services?			
2.6 Does the Plan monitor the delegated entity's accessibility reports regarding emergency services?			

Assessment Questions	Yes	No	N/A
2.7 Does the Plan have a Member Services Guide with the information necessary to accurately assist members in obtaining information about benefits, providers, coverage, and any other relevant information concerning an enrollee's access to emergency services?			

End of Requirement AA-005: The Health Plan ensures the availability of Emergency Services

1115 WAIVER ACCESS & AVAILABILITY TAG

Requirement AA-006: The Health Plan has Implemented Policies and Procedures for Addressing a Patient's Request for Disability Accommodations

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

10. Site Review

A. General Requirement

Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites in accordance with the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, MMCD Policy Letter 10-016 and W & I Code 14182(b)(9).

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a 5% sample size or a minimum of 30 sites, whichever is greater in number, shall be reviewed six (6) weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of Plan operation. For 30 or fewer sites, reviews shall be completed on all sites six (6) weeks prior to Plan operation.

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing.

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established

guidelines as specified in MMCD Policy Letter 02-02, the Site Review Policy Letter. Primary Care Provider sites that do not correct cited differences are to be terminated from Contractor network.

E. Data Submission

Contractor shall submit the site review data to DHCS by January 31 and July 31 of each year. All data elements defined by DHCS shall be included in the data submission report.

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether carried out by the Contractor, completed by other Medi-Cal Managed Care contractors or delegated to other entities.

DHCS GMC Contract, Exhibit A, Attachment 4 – Quality Improvement System

7. Written Description Contractor shall implement and maintain a written description of its QIS that shall include the following:

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

10. Site Review

A. General Requirement

Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites, in accordance with the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53913. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the MMCD Policy Letter 10-016 and W & I Code 14182(b)(9).

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a 5 percent sample size or a minimum of 30 sites, whichever is greater in number, shall be reviewed 6 weeks prior to plan operation. Reviews shall be completed on all remaining sites within 6 months of Plan operation. For 30 or fewer sites, reviews shall be completed on all sites 6 weeks prior to Plan operation.

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or re-credentialing.

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in MMCD Policy Letter 02-02, the Site Review Policy Letter.

Primary Care Provider sites that do not correct cited deficiencies are to be terminated from Contractor network.

E. Data Submission

Contractor shall submit the site review data to DHCS by January 31 and July 31 of each year. All data elements defined by DHCS in MMCD Policy Letter 02-02 shall be included in the data submission report.

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether carried out by the Contractor, completed by other Medi-Cal Managed Care contractors or delegated to other entities.

DHCS COHS Contract, Exhibit A, Attachment 4 – Quality Improvement System

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

10. Site Review

A. General Requirement

Contractor shall conduct Facility site and Medical Record reviews on all Primary Care Provider sites in accordance with to the Site Review Policy Letter, MMCD Policy Letter 02-02, 12-006, and Title 22, CCR, Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, MMCD Policy Letter 12-006 and W&I Code 14182(b)(9).

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, shall be reviewed six (6) weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of plan operation. For 30 or fewer sites, reviews shall be completed on all sites six (6) weeks prior to plan operation.

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing.

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in MMCD Policy Letter 02-02. Primary Care Provider sites that do not correct cited deficiencies are to be terminated from Contractor network according to guidelines set forth in MMCD Policy Letter 02-02.

E. Data Submission
Contractor shall submit the site review data to DHCS by January 31 and July 31 of each year. All data elements defined by DHCS in MMCD Policy Letter 02-02 shall be included in the data submission report.
F. Continuing Oversight
Contractor shall retain accountability for all site review activities whether carried out by the Contractor, completed by other Medi-Cal Managed Care contractors or delegated to other entities.

DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 13 – Member's Rights and Responsibilities
2. Member Services Staff
C. Contractor shall ensure that Member Services staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with complaint and grievance resolution, access barriers, and disability issues, and referral to appropriate clinical services staff.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Plan Medical Director or designated QA Physician
- Plan staff person responsible for Site Review
- Plan QA Manager

DOCUMENTS TO BE REVIEWED

Please note:

- Related policies and procedures, including those detailing the processes for facility site review, and the procedures for identifying providers who serve a high volume of SPD members
- Site Review tools, forms, and reports/results
- Site review periodic review schedule, including the list of providers for whom the Plan will conduct a Facility Site Physical Accessibility Review within the next 18 months
- Web site section that includes the results of the Facility Site Review Attachment C (see MMCD Policy Letter 11-013)
- Any delegation agreements, policies and procedures if Site Review is delegated
- Facility Site review routine and ad hoc reports

AA-006 - Key Element 1:

1. The Plan conducts Facility Site Physical Accessibility reviews on Primary Care Provider Sites and all provider sites which serve a high volume of SPD beneficiaries, in accordance with MMCD Revised Facility Site Review Policy Letter 11-013.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 7(F) and 10(A)-(F)

Assessment Questions	Yes	No	N/A
1.1 Has the Plan defined policies, procedures and a methodology for determining what constitutes high volume for each category of specialty and ancillary providers?			
1.2 Does the Plan maintain a list of specific high-volume providers for whom a Facility Site Physical Accessibility Review will be administered in the next 18 months?			
1.3 Does the Plan's Web site display the results of the Facility Site Physical Accessibility Review, including the level of access results per provider site?			
1.4 If the Plan delegates Facility Site Physical Accessibility Review, does the Plan have policies, procedures, and agreements that specify the delegated entities responsibilities and FSR requirements?			

End of Requirement AA-006: The Health Plan has implemented policies and procedures for addressing a patient's request for disability accommodations.