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

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)[1]	Not to exceed 15 minutes

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Care for Non-Life Threatening Emergency	Within 6 hours

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

Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: One follow-up encounter with a mental health provider within 7 calendar days after discharge Plus One follow-up encounter with a mental health provider within 30 calendar days after discharge

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:
Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice

Advance Access:
A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling:
When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time:
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Telemedicine
To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall

be considered in determining compliance with the access standards hereby established.

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

1. The enrollee or the enrollee's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the enrollee or the enrollee's legal representative would otherwise be entitled.
2. A description of the potential risks, consequences, and benefits of telemedicine.
3. All existing confidentiality protections apply.
4. All existing laws regarding enrollee access to medical information and copies of medical records apply.
5. Dissemination of any enrollee identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the enrollee.

A enrollee or the enrollee's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the enrollee or the enrollee's legal representative understands the written information provided and that this information has been discussed with the health care practitioner, or his or her designee. The written consent statement signed by the enrollee or the enrollee's legal representative shall become part of the enrollee's medical record

Other Applicable Requirements:

Interpreter Services
Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Prior Authorization Processes
Prior authorization processes, are to be completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee’s condition and in compliance with the requirements of the time-elapsed access standards. Refer to the Affinity UM Policies on timeliness.

Shortage of Providers
To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer enrollees to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider

Triage &/or Screening
The delegate shall provide or arrange for the provision of 24/7 triage or screening services by telephone. The delegate shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening wait time does not exceed 30 minutes.

The delegate must at a minimum maintain a procedure for triaging or screening enrollee telephone calls, which shall include the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

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

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

The delegate is responsible for the answering service it uses. If an enrollee calls after hours or on a weekend for a possible medical emergency, the delegate is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- Answering service/office staff handling enrollee calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the enrollee so that the enrollee can be referred to licensed staff; however,

they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the enrollee, or to determine when an enrollee needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to an enrollee that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

- The answering service should document all calls.

Communication of Guidelines

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

COMPLIANCE MONITORING:

Please refer to the Plan's Compliance Monitoring Policy(ies) and Procedure(s) and/or Provider's Operations Manuals for specific compliance monitoring and reporting processes.