9. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members and Providers.

POLICY:

A. All applicable Practitioners including Primary Care Physicians (PCPs), PCP/ OB/GYNs, and Specialists must meet the access standards delineated below to participate in the IEHP network.

B. IEHP monitors Practitioner access to care through IEHP and IPA performed access studies, review of grievances and other methods.

C. All Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

D. IEHP requires IPAs to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in C above.

1. All IPAs are required to provide or ensure that twenty-four (24)-hour, seven (7) days a week access to medical care for Members is available, including after business hours telephone access to a PCP or a triage system utilizing specific licensed personnel.

2. For medical triage, licensed and trained screening or triage personnel include Registered Nurses (RN), Nurse Practitioners (NP) or Physician Assistants (PA). Physician backup must be available.

3. For behavioral health triage, licensed and trained screening or triage personnel include RNs or Master’s level Behavioral Health Practitioners. Supervision must be provided by a licensed Behavioral Health Care Practitioner with a minimum of a Master’s degree and five (5) years of post-master’s clinical experience.

PROCEDURES:

A. Access Standards for Clinical Services - The following information delineates the access standards for availability of services to Members including primary care, specialty care, after hours emergency services, waiting times for appointments, and proximity of Specialists and Hospitals to primary care.

1. Appointment Standards:
## 9. ACCESS STANDARDS

A. Access Standards

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Type of Visit</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td></td>
<td>Immediate disposition of Member to appropriate care setting</td>
</tr>
<tr>
<td>Urgent Visit</td>
<td></td>
<td>Forty-eight (48) hours</td>
</tr>
<tr>
<td>Urgent Visit, requiring authorization</td>
<td></td>
<td>Ninety-six (96) hours</td>
</tr>
<tr>
<td>Non-urgent, acute illness visit</td>
<td></td>
<td>Three (3) business days, or as directed by Physician</td>
</tr>
<tr>
<td>Routine non-urgent visit</td>
<td></td>
<td>Within ten (10) business days of request</td>
</tr>
<tr>
<td>Well Child Visit</td>
<td></td>
<td>Two (2) weeks</td>
</tr>
<tr>
<td>Routine physical (complete)</td>
<td></td>
<td>Thirty (30) Days</td>
</tr>
<tr>
<td>Initial health assessment</td>
<td></td>
<td>Within one hundred twenty (120) days of enrollment</td>
</tr>
<tr>
<td>Initial health assessment (under 18 month of age only)</td>
<td></td>
<td>Within sixty (60) days of enrollment</td>
</tr>
<tr>
<td>Routine pelvic, Pap and breast exam</td>
<td></td>
<td>Thirty (30) Days</td>
</tr>
<tr>
<td>Follow up exam</td>
<td></td>
<td>As directed by Physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Type of Visit</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td></td>
<td>Immediate disposition of Member to appropriate care setting</td>
</tr>
<tr>
<td>Urgent Visit</td>
<td></td>
<td>Forty-eight (48) hours</td>
</tr>
<tr>
<td>Urgent prenatal Visit</td>
<td></td>
<td>Forty-eight (48) hours</td>
</tr>
<tr>
<td>Urgent Visit, requiring authorization</td>
<td></td>
<td>Ninety-six (96) hours</td>
</tr>
<tr>
<td>Non-urgent, acute illness visit</td>
<td></td>
<td>Three (3) business days, or as directed by Physician</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist Physician</td>
<td></td>
<td>Within fifteen (15) business days of request</td>
</tr>
<tr>
<td>Non-urgent with a non-Physician Behavioral Health Provider</td>
<td></td>
<td>Within ten (10) business days of request</td>
</tr>
<tr>
<td>Non-urgent ancillary services (for diagnosis and treatment)</td>
<td></td>
<td>Within fifteen (15) business days of request</td>
</tr>
<tr>
<td>Initial Prenatal Visit</td>
<td></td>
<td>One (1) week</td>
</tr>
<tr>
<td>Routine prenatal care</td>
<td></td>
<td>Two (2) weeks or as directed by Physician</td>
</tr>
<tr>
<td>Routine pelvic, Pap and breast exam</td>
<td></td>
<td>Thirty (30) Days</td>
</tr>
<tr>
<td>Follow up exam</td>
<td></td>
<td>As directed by Physician</td>
</tr>
</tbody>
</table>

2. 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 and other conditions, lab 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.
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3. **Practitioner Office Waiting Time** - For primary or specialist care, the waiting time for a scheduled appointment must be no longer than sixty (60) minutes. Waiting times for Members that are advised to “walk-in” to be seen must be no longer than four (4) hours.

   a. Waiting time at Primary Care Physicians and Specialists’ offices will be collected by Provider Services Representatives (PSRs) at every in-service. On a semi-annual basis, all Practitioners will be asked to verify waiting time as part of the Provider Directory verification. The waiting time information collected will be analyzed and presented at a minimum annually at the Quality Improvement (QI) Subcommittee. The QI Subcommittee will make recommendations on actions to take if Practitioners are not complying with the waiting time standards.

4. **Urgent Care Center Waiting Time** – Urgent Care Centers are designed to serve Members with non-emergency conditions who are unable to make an appointment with their PCP or Specialist. Urgent Care Centers accept unscheduled walk-in patients, therefore waiting time in Urgent Care Centers can vary depending on the number of Members waiting to be seen.

5. 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.

6. **Proximity of PCPs to Members** – IEHP network PCPs must be located within ten (10) miles or thirty (30) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. This proximity standard must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink transportation.

7. **Proximity of Specialists, OB/GYNs, Behavioral Health, and other Providers** – IEHP network Specialists, OB/GYNs, Behavioral Health and other Providers must be located within thirty (30) miles or sixty (60) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink train transportation. On an annual basis, IEHP conducts a Provider Network Status Study for all Network Providers (see policy PRO_GEN 13 “Reporting - Annual Network Status Board Report”, page 1, Procedures B.3) to monitor compliance. IEHP ensures that network Specialists, OB/GYN, Behavioral Health and other Providers are compliant with the Department of Managed Health Care (DMHC) Network Adequacy Standards and meets the reasonable accessibility/availability standards required under the Knox-Keene Act.

8. **Proximity of Hospital** - IEHP network hospitals must be located within fifteen (15) miles or thirty (30) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car,
9. ACCESS STANDARDS

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public bus, hospital van, dial-a-ride, or Metrolink train transportation.

9. Proximity of Pharmacy - IEHP network pharmacies must be located within ten (10) miles or thirty (30) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink train transportation.

10. Minimum Hours On-Site - The PCP must be on site and available for Member care a minimum of sixteen (16) hours per week, or meet the criteria identified in Policies 6D, “Residency Teaching Clinics” and 6E, “Rural Health Clinics.”

11. Telephone Answer Time - All telephone calls to a PCP or Specialist must be answered within six (6) rings. Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person.

12. Telephone Hold Time - A Member must not be kept on hold for more than ten (10) minutes. If a Member is placed on hold, an employee should let the Member know the reason for the delay and offer the Member the choice to either wait or have his/her call returned within the timeframe specified in this policy.

13. Telephone Access Standards - When a Member leaves a message with the office of a PCP or Specialist, requesting a return call, an employee of the office must attempt to return the Member’s call within the following timeframes and log that attempt:

   a. Within three (3) working days for a non-urgent matter (e.g. refills for medications that have not run out; requests for paperwork or medical records; requests for appointments for non-acute conditions)

   b. No later than the same day for an urgent (non-emergency) matter (e.g. refills of critical medications which have run out; acute illness or acute complaint not already dealt with at the Provider’s office)

   c. A minimum of three (3) attempts must be made to return the Member’s call. It is understood that the same staff member or Physician with whom the Member wishes to speak with, may or may not be the party available to return the Member’s call. It is also understood that the staff member returning the call may or may not be able to definitively address the Member’s issue during that call. However, it will be expected that the staff member returning the Member’s call be prepared to do at least one of the following during that return phone call:

      1) Determine the urgency of the Member’s request, solicit more information from the Member if needed, and act accordingly;

      2) Reassure the Member if appropriate;

      3) Agree to pass a message to the Member’s Physician or to another relevant staff member if appropriate; and/or

      4) Provide the Member with a timeline or expectation of when the request can be definitively addressed.
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d. This time requirement and policy for attempting to return Member phone calls (three (3) business days for non-urgent, same day for urgent non-emergency, with a minimum of three (3) attempts) is understood to be a minimal guideline; i.e. this policy is not meant to over-ride more rigorous internal office policy, if one is already in place.

e. Members who reach voice mail must receive detailed instructions on how to proceed.

14. All PCP offices must have an active and working fax machine twenty-four (24) hours per day, seven (7) days per week.

B. Emergency Services - IEHP has continuous availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and supportive paramedical personnel to provide covered services including the provision of all medical care necessary under emergency circumstances. IEHP network Physicians and Hospitals must provide access to appropriate triage personnel and emergency services twenty-four (24) hours a day, seven (7) days a week.

1. IEHP evaluates inappropriate use of Emergency Room services, issues regarding Member access to health care, and under- or over-utilization of services through assessment of encounter data, special studies, claims information, and medical record audits with oversight of the Quality Management (QM) Committee.

C. Emergency Medical Condition – This is a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

D. Urgent Care Services – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity that care is needed within forty-eight (48) hours, but are not emergency medical conditions.

E. Urgent Visit – These are referrals to health care professionals who have advance education and training in a specific area but are not emergency medical conditions. Visit requires prior authorization within ninety-six (96) hours.

F. Follow-up of Emergency Department (ED) or Urgent Care Visits – IPAs are responsible for informing PCPs of Members that receive an ED or Urgent Care visit, including information regarding needed follow-up, if any. PCPs are responsible for obtaining any necessary medical records from such a visit, and arranging any needed follow-up care.

G. Routine Non-Urgent Visit – These are health care services needed to diagnose and/or treat...
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medical conditions that do not need urgent care or non-emergent attention. These visits are used for routine check-ups and can be scheduled within ten (10) business days of request.

H. Non-urgent, Acute Illness Visit – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity to be addressed within three (3) days, however, they do not warrant an urgent care visit.

I. Initial Health Assessment – See Policy 10A, “Initial Health Assessment.

J. Physical Exam – This is a routine preventive exam occurring every one to three (1-3) years. These visits must be scheduled within thirty (30) days.

K. Well Child Visit – These are periodic health care services needed to provide preventive health services for Members under the age of 21 years. These visits must be scheduled within two (2) weeks.

L. Walk-In Clinic Visits – If an IEHP Member is informed by the PCP or the PCP’s office staff that they may “walk-in” on a particular day for routine, non-urgent or non-urgent acute visits, the IEHP Member must be seen at that office on the same day in which the Member was advised to come in, and must not have a wait time in excess of four (4) hours.

M. Urgent Prenatal – These are health care services needed to diagnose and/or treat actual or perceived prenatal conditions that are of sufficient severity that care is needed within forty-eight (48) hours, but are not emergency medical conditions.

N. Initial Prenatal – These are health care services needed to determine potential risk factors and the care plan for a woman during the period of pregnancy. This exam must take place within one (1) week of confirmation of pregnancy.

O. Routine Prenatal Care – These are routine medical visits throughout the period of pregnancy. These visits consist of periodic exams and monitoring for the determination of the condition of both the fetus and the mother. These visits should be scheduled within two (2) weeks or as directed by the Physician in order to detect any untoward changes in the condition of the fetus or mother so that necessary treatment may be initiated.

P. Non-urgent Specialist Appointment – These are referrals to a health care professional who has advanced education and training in a specific area. The appointment to the Specialist is to be scheduled within fifteen (15) days of request unless otherwise indicated by the referring Physician.

Q. Medical Triage Screening and Advice During Business Hours – The IEHP Nurse Advice Line (NAL) provides access to licensed triage personnel including RNs, NPs, and PAs 24 hours a day 7 days a week. By calling the NAL, Members are able to receive assistance with access to urgent or emergency services from a PCP, an on-call Physician, or licensed triage personnel. Licensed triage personnel use appropriate protocols and sound medical judgment in determining the disposition of the Member (e.g., refer to Urgent Care, Emergency Department). Triage and screening wait time must not exceed thirty (30) minutes. On a monthly basis, IEHP’s Family & Community Health Department monitors the triage and screening wait time by reviewing the NAL reports. All PCP sites must have licensed staff
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available for telephone or on-site triage for Members during normal business hours. For in-office triage services, approved licensed triage personnel include RNs, NPs, or PAs. IEHP has not developed specific in-office triage protocols; it is expected that all licensed triage personnel use appropriate medical judgment in determining the disposition of the patient (e.g., treat at office, refer to Urgent Care, Emergency Department, or call 911). There must be sufficient information on how to proceed for Members who reach voice mail.

R. After Hours PCP Access – IEHP provides Members with twenty-four (24) hours, seven (7) days a week direct access to a licensed triage person through the IEHP Nurse Advice Line. IEHP also requires that PCPs and IPAs have arrangements in place for telephone access twenty-four (24) hours a day, seven (7) days per week. Availability of the IEHP Nurse Advice Line does not supplant the requirement for PCPs and IPAs to maintain 24/7 telephone access. Members can access the IEHP Nurse Advice Line by calling the toll-free phone number listed on the Member’s ID card. The IEHP Nurse Advice Line provides access to licensed triage personnel including RNs, NPs, and PAs. By calling the Nurse Advice Line, Members are able to receive assistance with access to urgent or emergency services from the assigned PCP, an on-call Physician, or licensed triage personnel. Licensed triage personnel use appropriate protocols and sound medical judgment in determining the disposition of the Member (e.g., refer to Urgent Care, Emergency Department). When a Member accesses service through the IEHP Nurse Advice Line, the Member’s PCP receives a faxed copy of the encounter including the Member’s medical situation and the disposition of the call. In the event that a Member calls a Physician’s office after hours, there must be sufficient access to information on how to proceed, either through an answering service or phone message instructions.

S. Missed Appointments – When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member’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. Policy 9B, “Missed Appointments.” Missed and/or rescheduled appointments must be scheduled appropriate to the health care and continuity of care and needs of the Member.

T. Hospital Standards – All contracted hospitals must provide timely access for IEHP Members accessing Emergency Departments, being admitted for an inpatient stay, or utilizing hospital based diagnostic or treatment services. Hospital based clinics must meet all the primary care and specialty access standards delineated above.

U. Provider Shortage - If timely appointments within the time or distance standards required are not available, then the IPA shall refer the Member to or assist in locating available and accessible contracted Provider to obtain the necessary health care services in a timely manner appropriate for the Member’s needs.

Special Access Standards

A. The following information outlines the standards for special access needs for Members including sensitive services and access for the disabled and hearing impaired, as well as dental,
9. ACCESS STANDARDS

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behavioral health, and special programs:

1. **Sensitive Services for Minors and Adults** - Providers and Practitioners must have procedures to ensure that minors and adults have access to sensitive and confidential services as outlined in Policy 9E, “Access to Sensitive Services.” Minors and adolescents have the right of access to treatment and/or referral for sensitive services without parental consent. Sensitive services include: access to family planning, STI and HIV testing, and counseling services from qualified family planning Providers or the Local Health Department (LHD). Sensitive services for minors include sexual assault, drug or alcohol abuse, pregnancy, family planning, sexually transmitted infections, and behavioral health care.

2. **Access for People with Disabilities** - All IEHP facilities and Practitioners are required to maintain access in accordance with the requirements of Title II of the Americans with Disabilities Act of 1990. Each PCP’s office is assessed to identify if barriers to Member care exist during the site reviews. Areas audited include but are not limited to: designated parking spaces, wheelchair access, and restroom access for wheelchair users, handrails near toilets, and appropriate signage. If a Provider/Practitioner’s office or building is not accessible to Members with disabilities, an alternative access to care must be provided. See Policy 9D, “Access to Care for People with Disabilities.”

3. **Access and Interpretation Services for People with Hearing Impairments and/or Limited English Proficiency** - All IEHP network Providers, including network Pharmacy and Vision Practitioners, must provide services to limited English proficient Members in the Member’s primary language. For face-to-face interpretation services, including sign language, practitioners must provide interpreters, as needed, for Members’ appointments. IEHP is responsible for the cost of interpretation services. See Policies 9I2, “Cultural and Linguistic Services – Foreign Language Capabilities” and 9D1, “Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing.”

4. **Interpretation Services** - All Providers must provide services to limited English proficient Members in the Member’s primary language.
   a. These linguistic capabilities must be available to Members twenty-four (24) hours a day, seven (7) days a week.
   b. During the process of adding a Physician to IEHP’s network, all Physicians are asked to indicate their foreign language abilities as well as their clinical and non-clinical office staff’s foreign language abilities. Assignment of Members to PCPs able to communicate in the Member’s preferred spoken language is done whenever possible.
   c. Providers are encouraged to have bilingual Practitioners and staff.
   d. Providers may use face-to-face interpreters or telephonic interpretation services to meet the requirement of providing linguistic services to Members.
   e. IEHP contracts with Pacific Interpreters to provide telephone interpretation services to Members. Providers access these services by contacting IEHP Member Services.
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at (800) 440-4347. Pacific Interpreters offers interpretation services twenty-four (24) hours a day, seven (7) days a week.

f. Members or Providers must contact IEHP Member Services at least five (5) working days before the medical appointment to arrange for face-to-face interpreter service. IEHP will attempt to accommodate interpreter requests with less than (5) working days’ notice. If accommodation is not available, telephonic interpreter services are available.

5. Access Standards for Behavioral Health Services – The following information delineates the access standards for availability of services to Medi-Cal Members for Behavioral Health care and after-hours emergency services.

a. The PCP is responsible for behavioral health/substance abuse care within his/her scope of practice, otherwise referrals are coordinated through IEHP at (800) 440-4347 or the designated Behavioral Health Plan:

1) Medi-Cal – Behavioral Health treatment services are provided by the IEHP BH Program as well as County Mental Health and County Drug and Alcohol treatment programs. Medi-Cal Members who meet specialty mental health criteria will be referred to the appropriate county for assessment and treatment. Medi-Cal Members will receive annual alcohol misuse screening from their PCP and if screened positive, the Member will receive brief intervention and full screening by the PCP or appropriately qualified Provider. Members needing treatment for alcohol dependence or drug addiction will be referred for assessment and treatment by the appropriate County Drug and Alcohol treatment program. During normal business hours referral assistance is available through IEHP or directly through the Mental Health Department in the county where the Member resides. After hours, weekends and holidays, referrals must be coordinated through the County Mental Health Departments.

Riverside County Residents
Community Access, Referrals, Evaluation and Support (CARES) Line
(800) 706-7500

San Bernardino County Residents
San Bernardino County Access Unit
(888) 743-1478

b. Appointment standards:

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Type of Visit</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life-threatening emergency</td>
<td>Immediate disposition of Member to appropriate care setting</td>
</tr>
<tr>
<td></td>
<td>Non-life-threatening emergency</td>
<td>Six (6) hours</td>
</tr>
</tbody>
</table>
9. ACCESS STANDARDS

A. Access Standards

<table>
<thead>
<tr>
<th>Urgent behavioral health needs</th>
<th>Within forty-eight (48) hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent behavioral health visit, requiring authorization</td>
<td>Within forty-eight (48) hours</td>
</tr>
<tr>
<td>Initial routine (non-urgent) visit with a Behavioral Health Care Provider</td>
<td>Within ten (10) business days of request</td>
</tr>
<tr>
<td>Follow-up routine (non-urgent)</td>
<td>Within ten (10) business days of request</td>
</tr>
</tbody>
</table>

c. After Hours Access for Behavioral Health Care:

1) All Behavioral Health Providers are required to have an automated answering system twenty-four (24) hours a day, seven (7) days a week, to direct Members to call 911 or go the nearest Emergency Room for any life threatening medical or psychiatric emergencies.

Monitoring

A. IEHP will annually assess the access standards of PCPs, high volume Specialists, Behavioral Health, and Ancillary Providers using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey Methodology. This methodology includes the use of the DMHC Provider Appointment Availability Survey for PCPs, Specialty Care Physicians and Non-Physician Mental Health Providers. The annual assessment is conducted to monitor the network for Providers that are not meeting access standards in order to take action to bring the Providers into compliance. For PCPs, the Plan will not perform a sampling of the Providers. Instead, the Plan will survey all active PCPs. IEHP will follow the sampling methodology as outlined by the DMHC for Specialty Care and Ancillary Care Providers. IEHP will separately report a rate of compliance for each of the time elapsed standards for each IPA located in each county of IEHP’s service area annually using the DMHC Provider Appointment Availability Survey Methodology and the DMHC Provider Appointment Availability Survey tools for PCPs, Non-Physician Behavioral Health Providers, Specialty and Ancillary Care Providers (See Attachments, “DMHC Provider Appointment Availability Survey Methodology” and “DMHC Appointment Availability Survey Tools in Section 9). IEHP may utilize a 3rd party survey vendor to implement all or part of the DMHC Provider appointment Availability Survey methodology.

B. The Quality Management Department monitors missed appointments and in office wait times through the Facility Site and Medical Record Review process. The Provider Services team monitors office wait times by collecting wait time information during the Provider in-service to confirm compliance with access standards.

C. Additional monitoring is performed through the Potential Quality Incident (PQI) review process for individually identified Providers.

D. Monitoring of access and Interpretation Services occurs during the Medical Record Review (MRR) and Facility Site Review (FSR) processes. (See Policy 6A, “Facility Site Review and Medical records Review Survey Requirements and Monitoring”).
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1. Facility Site Review Questions
   a. There is twenty-four (24)-hour access to interpreter services for non or Limited-English Proficient (LEP) Members.
      1) Interpreter services are made available in identified threshold languages specified for location of site.
      2) Persons providing language interpreter services on site are trained in medical interpretation.

2. Medical Record Review Question
   a. Primary language and linguistic service needs of non or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.

Corrective Action Plan

A. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.

B. For Delegates, IEHP requests that Delegates submit their annual study results, corrective actions and proof of Provider training given to remediate any identified deficiencies to IEHP within thirty (30) calendar days of written notification by IEHP of the audit or annual study results.

C. For Direct Providers, IEHP Provider Services submits CAPs to Delegation Oversight addressing deficiencies. The CAP must be submitted to IEHP Delegation Oversight within thirty (30) calendar days of written notification by IEHP of the audit results.

D. IEHP will provide advance written notice to contracted Providers affected by a CAP, including 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.

E. Failure to submit CAPs may result in one of the following activities, depending on the seriousness of the deficiency:
   1. Delegate is frozen to new Member enrollment;
   2. Request for cure under contract compliance;
   3. Requirement to subcontract out the deficient activities within MSO or Delegate;
   4. De-delegation of specified functions;
   5. Contract non-renewal; or

F. Delegates can appeal the results of any oversight activity or specialized study or audit in accordance with Policy 16C, “IPA, Hospital and Practitioner Grievance and Appeal Resolution Process.”
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REFERENCES:

A. Title III of the Americans with Disabilities Act of 1990.
B. Final Rule (Mega Reg) is 81 FR 27498 and codified as 42 CFR Part 438.
C. §1300.67.2.2 Timely Access to Non-Emergency Health Care Services.
E. 2018 Joint Audit, Appointment Availability (AA-005) Item #3.
F. Final Rule (Mega Reg) is 81 FR 27497 and codified as 42 CFR Part 438 and Department of Health Care Services (DHCS) All Plan Letter (APL) 19-002 supersedes APL 18-005, “Network Certification Requirements” Attachment A.
G. MY TAR 2018, Rule 1300.51(d)(I)(5).
H. MY TAR 2018, Rule 1300.67.2.2 (c)(8).
9. ACCESS STANDARDS

B. Missed Appointments

APPLIES TO:

A. This policy applies to all IEHP Providers.

POLICY:

A. The responsibility of follow-up for missed appointments is delegated to Primary Care Physicians (PCPs) with oversight by Delegated IPAs and IEHP.

B. Providers must implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, and adult initial health assessments.

C. IEHP PCPs must maintain procedures to identify and follow-up on missed appointments including staff training.

PROCEDURES:

A. PCPs must have a process in place to follow-up on missed appointments that includes at least the following:

1. Notation of the missed appointment in the Member’s medical record.

2. Review of the potential impact of the missed appointment on the Member’s health status including review of the reason for the appointment by a licensed staff member of the PCP’s office (RN, PA, NP, DO or MD).

3. When it is necessary for a Provider or a Member to reschedule an appointment. The appointment shall be promptly rescheduled in a manner that is appropriate for the Member’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 Health and Safety Code and the requirements of this section.

4. Notation in the chart describing follow-up for the missed appointment including one of the following actions:

   a. No action if there is no effect on the Member due to the missed appointment; or
   b. A letter or phone call to the Member as appropriate, given the type of appointment missed and the potential impact on the Member.

5. Three (3) attempts, at least one (1) by phone and one (1) by mail, must be made in attempting to contact a Member if the Member’s health status is potentially at significant risk due to missed appointments. Examples include:

   a. Members with serious chronic illnesses;
   b. Members with test results that are significant (e.g., abnormal cervical cancer
9. ACCESS STANDARDS

B. Missed Appointments

screening); and

c. Members judged by the treating physician to be at risk for other reasons.

6. Documentation of the attempts must be entered in the Member’s medical record and copies of letters retained.

7. Office staff in Provider offices must be trained in, and be familiar with, the missed appointment procedure specific to their site.


B. Monitoring

1. IEHP Quality Management Department monitors missed appointments through the Facility Site and Medical Record Review process, initially and at minimum every three (3) years thereafter. Please see Policy 6A, “Facility Site Review and Medical Record Review Requirements and Monitoring” for more information.

2. Additional monitoring is performed through the Potential Quality Incident (PQI) referral review process for individually identified Providers.

REFERENCE:

A. Department of Managed Health Care (DMHC), §1300.67.2.2 Timely Access to Non-Emergency Health Care Services.


C. Health and Safety Code, Section 1367.03.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. IEHP provides both Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services for all prior authorized services and Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits covered under Medi-Cal Fee For Service (FFS) within the San Bernardino/Riverside Counties.

B. IEHP coordinates with transportation vendors to ensure compliance with regulatory access standards.

C. There are no limits in receiving NEMT/NMT services as long as the trip is validated to meet the guidelines stipulated in the Department of Health Care Services (DHCS) All Plan Letter (APL) 17-010.
   1. All NMT and NEMT services must be arranged by IEHP. IEHP will make its best effort to authorize the lowest cost type of NEMT that is adequate for the Member’s medical needs.
   2. Prior authorization is not required, when NEMT or NMT services are provided to a Member being transferred from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility.

D. Transportation to a Member’s home setting from facility or hospital is also covered when medical transportation by ambulance, litter van or wheelchair transportation are required due to Member’s medical and physical condition.

E. IEHP will provide NEMT/NMT services to:
   1. The Member and one (1) additional passenger;
   2. Unaccompanied minor(s) to seek sensitive services without requiring a written consent of a parent or a guardian; and
   3. Unaccompanied minor(s) to seek non-sensitive services, requiring a written consent of a parent or a guardian.

F. IEHP will not provide transportation services to:
   1. Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) Meetings;
   2. Social Security Income (SSI) evaluations;
   3. Workman’s Compensation Appointments;
9. ACCESS STANDARDS

   C. Non-Emergency Medical and Non-Medical Transportation Services

   4. IEHP Community Resource Center (CRC) unless a class has been scheduled through the Health Education Department;
   5. Any service that is not covered by IEHP or Medi-Cal FFS; and/or
   6. A Medicare Fee For Service (FFS) Member traveling out of San Bernardino/Riverside Counties.

   G. IEHP will provide gas mileage reimbursement consistent with the Internal Revenue Service (IRS) rate for NMT services provided by private conveyance arranged by the Member for medical purposes when:
      1. Member attestation is received by phone, electronically or in-person that:
         a. All other transportation resources available have been exhausted;
         b. The driver can provide proof of a valid driver’s license, valid vehicle registration and valid vehicle insurance; and
         c. Member has a physical, cognitive, mental or developmental limitation.
      2. The trip has been prior authorized by IEHP

   H. Financial responsibility for transportation services are defined in the Division Of Financial Responsibility (DOFR).

   DEFINITIONS:

   A. Non-Emergency Medical Transportation (NEMT) – Transportation to one’s IEHP or Delegate-approved medical appointment and/or Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits delivered through the Medi-Cal FFS by ambulance, litter van, wheelchair van, or air as per DHCS APL 17-010.

   B. Non-Medical Transportation (NMT) – Roundtrip transportation to one’s IEHP or Delegate-approved medical appointment and/or Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits delivered through the Medi-Cal FFS by private car, taxi or bus, when the Member has reasonably exhausted other transportation resources.

   C. Licensed Practitioner – Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwives (CNM), Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health/Substance Use Disorder Providers.

   PURPOSE:

   A. To ensure that Members have transportation access to medical, mental health, substance abuse and dental care services.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

PROCEDURES:

A. Members may only travel between home address on file and the medical/mental health facility, within the San Bernardino/Riverside counties, unless the service is not available within the two (2) counties.

B. NEMT and NMT will be arranged to locations that meet the Member’s needs and that are closest to their home address on file. For example, Pharmacy requests should be no more than five (5) miles away from the address on file and requests to a Laboratory should be no more than ten (10) miles away from the address on file. The only exception is when either service is not available within the mileage range described above.

C. Members may only be transported to the IEHP contracted Urgent Care within their region of residence.

D. Members requiring NEMT or NMT should contact IEHP Member Services Department at (800) 440-4347 for transportation services at least five (5) business days prior to requested service.

1. The exceptions to the above are:
   a. Dialysis;
   b. Pharmacy;
   c. Urgent Care;
   d. Wound Care;
   e. Cancer Treatment (radiation/chemotherapy);
   f. Pre-Op Appointments;
   g. Mental health appointments;
   h. Substance use appointments;
   i. Surgery; and
   j. Follow Up appointment from a recent Hospital Discharge.

   Please note this is not an all-inclusive list. If Member has justification of why we need to transport, please have them call (800) 440-4347.

E. IEHP can direct all non-emergency transportation to contracted vendors within their network. If a contracted vendor is not available within the IEHP network that can accommodate the Member’s transportation needs based on the Member’s medical, physical, or mental condition, arrangements must be made for the Member to receive services from an appropriately qualified vendor outside the IEHP network.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

F. Requests for NEMT or NMT that do not adhere to APL 17-010 may be denied or partially approved:
   1. If the Practitioner’s or Member’s request for Member transportation is denied/partially approved, a formal written notification is sent to the Member and requesting Practitioner. This notification must include rationale for denial, alternative transportation recommendations, and information on how to appeal the decision.

G. Members must contact IEHP within twenty-four (24) hours when transportation services are no longer required or canceled. Members may receive written communication from IEHP UM for failure to notify IEHP UM representative after three (3) incidences.

H. Members who are found to have misused the transportation benefit will receive a formal written warning from IEHP and will be expected to correct their behavior. If the behavior is not corrected, IEHP will report the continued non-compliance as a potential incident of Fraud, Waste or Abuse (FWA) to the Department of Health Care Services Program Integrity Unit (DHCS PIU).

I. (For Non-Emergent Medical Transportation Only) For Members requiring NEMT services, their PCP or Licensed Practitioner must complete and submit the Physician Certification Statement (PCS) form to IEHP (See Attachment, “NEMT Physician Certification Statement Form” in Section 9). Contracted Providers may submit the form electronically through the secure IEHP Provider portal while non-contracted providers may fax the completed and signed form to IEHP at (909) 912-1049. Such statement remains in effect for twelve (12) months from date of the Practitioner’s signature.
   1. IEHP will not modify this form after the PCP or treating Physician has prescribed the form of transportation.
   2. IEHP will develop a process to capture data from the PCS form and report to DHCS, as required.

J. (For Non-Emergent Medical Transportation Only) IEHP will ensure door-to-door assistance to all Members receiving NEMT services.

K. IEHP will make their best effort to coordinate NMT services which may include use of a transportation vendor, issuance of bus passes and/or coordination with a transportation service program within the San Bernardino/Riverside counties.

L. Members may be issued a one (1) day pass for transportation if the following criteria are met:
   1. Transit was available.
   2. Trip was less than ninety (90) minutes in total duration.
   3. Bus stop is no more than one (1) mile walking distance from the Member’s address on file.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

M. Members who utilize the benefit everyday will be issued a thirty-one (31) day or a thirty (30) day bus pass depending on where they live.

N. With the exclusion of dialysis, standing orders will not be arranged for more than thirty (30) days at a time.

REFERENCES:

A. Title 22, California Code of Regulations §51323.

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-010, “Non-Emergency Medical and Non-Medical Transportation Services”.


INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file
Original Effective Date: September 1, 1996

Chief Title: Chief Medical Officer
Revision Date: January 1, 2019
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. It is IEHP’s goal to ensure that all facilities and services are fully accessible to individuals with disabilities. In accordance with the requirements of Title II and III of the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act and other applicable Federal and State laws and regulations that prohibit discrimination on the basis of disability, all IEHP Providers contracted to provide care to Members are required to provide and maintain access for people with disabilities.

B. Access must be provided, whenever feasible, to service animals, as required by the ADA and pursuant to regulations.

C. IEHP performs a comprehensive access survey for people with disabilities during the initial facility review of Primary Care Physician (PCP) sites, prior to a Practitioner being approved to receive membership, as well as the high-volume specialists, high volume ancillary service Providers and high-volume Community-Based Adult Services (CBAS) Providers. This survey is repeated every three (3) years thereafter (See Policy 6B, Physical Accessibility Review Survey).

D. IEHP consults stakeholders with disabilities to continuously evaluate and maintain accessibility of services for Members with disabilities.

DEFINITIONS:

A. Service animals are:
   1. Guide dogs;
   2. Signal dogs; or
   3. Other dogs individually trained to provide assistance to a person with a disability.

B. Medically qualified personnel include attending or consulting physicians, residents, and supervisory nurses.

PROCEDURES:

A. Office Access Standards (see attachment “DPL 14-004-Facility Site Review-Physical Accessibility Reviews,” in section 6)
   1. Each Provider and Practitioner office must demonstrate the following, but not limited to:
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

a. Accessible parking spaces marked with adequate signage and having appropriate curb cuts within a reasonable distance from the facility’s main entrance;

b. Easy wheelchair access to the main entrance via a ramp or absence of stairs or steps;

c. Inaccessible entrances have signs indicating the location of the nearest accessible entrance;

d. Provide an alternate access to care if the Provider office or building is not accessible to Members with disabilities;

e. Restroom is wide enough to accommodate wheelchair-users or a mobile commode, or a bedpan and urinals are available for use;

f. Adequately secured handrails near toilets are provided in at least one (1) restroom within the facility;

g. Drinking fountains and/or water coolers are accessible to wheelchair-users, if available;

h. If public telephones are available within the facility, at least one (1) is appropriately placed within access for people with disabilities and has teletypewriter (TTY) availability;

i. All features for Members with disabilities are marked by adequate signage;

j. Facility features designed specifically for access by people with disabilities are regularly inspected and repaired or replaced when necessary; and

k. Grievances, complaints, and Member requests for disenrollment mentioning inadequate access for people with disabilities are carefully analyzed and researched to determine areas where improvements can be made.

B. Providers who are anticipating modification to their facilities must meet Americans with Disabilities Act Accessibility Guidelines (ADAAG).

1. The ADA establishes design requirements for the construction and alteration of facilities.

2. The ADA and California’s Code of Regulations Title 24 requires health care Providers to follow specific accessibility standards and codes when constructing new facilities, and when making alterations that could affect access to or use of the facility by people with disabilities.

3. For more information regarding the ADAAG, go to https://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-ada-standards/background/adaag#purpose. For additional assistance, call IEHP’s ADA access line at (909) 890-1916.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

4. For more information on the ADA, go to IEHP’s “ADA and Beyond” web page: https://www.iehp.org/en/providers/special-programs?target=independent-living-and-diversity-resources.

C. Service Animals:

1. Service animals are limited to dogs, under Title II and III of the ADA, that are individually trained to perform tasks for people with disabilities such as guiding people who are blind, alerting individuals who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other special tasks. Miniature horses that have been individually trained to do work or perform tasks for people with disabilities can be covered by IEHP in accordance with ADA regulation standards. Service animals are working animals, not pets.
   a. The ADA prohibits public accommodations from requiring “certification” or proof of an animal’s training, or proof of a person’s disability, for the purposes of access. Staff may ask two (2) questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform? Evidence of current vaccinations, may be requested.
   b. Providers must make reasonable modifications in their policies, practices and procedures when necessary to provide accommodations to Members with disabilities. Generally, this includes modifying any no-pets policy to permit use of a service animal by an individual with a disability.

2. A service animal must be permitted to accompany the Member to all areas of the facility where Members are normally permitted unless a medical justification showing that the presence or use of a service animal would pose a health risk in certain parts of the institution directly involved.

3. Providers may request that the Member be separated from their service animal for short periods of time, if it is necessary to provide a service (i.e. Aqua PT, Audiology testing, or other procedures where there is limited space). The separation should not be any longer than it takes to provide the service.

4. Care and supervision of a service animal are the responsibility of the Member and/or authorized representative.
   a. Neither IEHP nor its Providers are required to supervise or care for the service animal. Members need to make their own arrangements to have someone feed, water and walk the animal during necessary separation in a medical facility.

5. Restrictions on Service Animals
   a. A person with a disability cannot be asked to remove their service animal from the premises unless:
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

1) The nature of the goods and services provided, or accommodations offered at the Provider’s medical facility would be significantly altered.

2) The safe operation of the medical facility would be jeopardized, or the animal poses a direct threat to the health or safety of others, such as preventing what should be a sterile environment (such as a surgical suite) or present a threat to others’ safety (such as an animal being out of control and the owner does not take effective action). Such areas may include, but are not limited to, the following:
   - Operating room suites and post-anesthesia rooms;
   - Burn unit;
   - Coronary care units;
   - Intensive care units;
   - Oncology units;
   - Psychiatric units;
   - Isolation areas;
   - Medication storage areas; and
   - Clean or sterile supply areas.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

REFERENCES:

A. Title 42, United States Code §§ 12181-12189.
B. Title 29, United States Code § 701.
C. Title 28, Code of Federal Regulations Part 36, Appendix A.
D. Title 24, California Code of Regulations Part 2, Volume 1.
E. Title II and III of the Americans with Disabilities Act (ADA) of 1990.
G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004 Supersedes PL 02-002, “Site Reviews: Facility Site Reviews and Medical Record Review”.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities
   1. Members who are Deaf or Hard-of-Hearing

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP requires equal access to its covered services in a non-discriminatory manner required by Title 28 Code of Federal Regulations (CFR) Part 36 and the Americans with Disabilities Act of 1990. All IEHP Providers and Practitioners contracted to provide care to Members are required to provide and maintain access for people with disabilities.

B. All Hospitals must provide interpreters as needed for inpatient and emergency services. The Hospitals are responsible for the cost and arrangement of interpretation services.

C. Requests for interpreter services at Primary Care Physician (PCP) sites, Skilled Nursing Facilities (SNFs), and outpatient visits for Members who are deaf or hard-of-hearing may originate from:
   1. Member;
   2. Family member and/or Authorized Representative;
   3. Member’s PCP or Specialist;
   4. Member’s IPA; or
   5. IEHP.

D. For interpretation services, including American Sign Language (ASL), oral, and signed English, all Practitioners must provide interpreters as requested for Member appointments at no charge to the Member.

E. IEHP and its Providers and Practitioners may not suggest or require that Members provide their own sign language or oral interpreters.

F. Members have the right not to use family members or friends as interpreters. If a Member chooses to use a family or friend in place of a qualified sign language or oral interpreter, documentation that interpreting services were offered and declined must be kept in the Member’s record.

G. It is recommended that the Member or Provider make arrangements for an interpreter at the same time that the medical appointment is being scheduled. Interpreter services can be scheduled by calling IEHP Member Services at (800) 440-IEHP (4347)/ TTY (800) 718-4347.

H. IEHP can better ensure the availability of interpreters for a medical appointment if given at least five (5) working day notice.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities
   1. Members who are Deaf or Hard-of-Hearing

I. Medical appointments may be rescheduled by a Member’s health care Provider upon agreement of both parties if there is no qualified interpreter available for the Member at that time.

J. IEHP is responsible for the cost of the interpretation services for PCP and outpatient visits.

K. IEHP is responsible for the cost of ASL Video Remote Interpreting (VRI) services for Members at contracted Urgent Care Facilities and SNFs.

L. Contracted Urgent Care Providers and SNFs are responsible for the cost, maintenance, and connectivity (Wi-Fi, Cellular, LAN) of IEHP-approved VRI equipment (See Attachment, “Video Remote Interpretation Approved Devices and Technical Specifications” in Section 9).

PROCEDURES:

A. In-person Sign Language Interpreter Requests
   1. Members or Providers who are requesting interpreter services should call IEHP Member Services at (800) 440-IEHP (4347)/ TTY (800) 718-4347 at least five (5) working days in advance of the medical appointment and provide the following information:
      a. Member’s full name;
      b. IEHP Member Identification Number or Social Security Number;
      c. PCP or Specialist’s name;
      d. Date and location of appointment;
      e. Time and expected length of appointment;
      f. Type of interpretation needed (e.g., ASL, oral, or written);
      g. Preferred gender of the interpreter required; and
      h. Single or an on-going appointment.
   2. IEHP must authorize all interpretation service requests. IEHP will call the contracted interpreting services agency to make the arrangements.
   3. IEHP will confirm with the agency the scheduled interpreter’s name and expected arrival time.
   4. IEHP will provide notification of confirmation to Member’s PCP or Specialist via a telephone call. IEHP will provide notification of confirmation to the Member through their preferred method of communication, via telephone or using one of the following methods: TTY, Video Phone Relay, California Relay Services.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities
   1. Members who are Deaf or Hard-of-Hearing

   (Teletypewriter (TTY)/Voice Carry-Over (VCO)/Hearing Carry-Over (HCO)), or e-mail.

B. VRI Requests
   1. VRI is available to IEHP Members who are deaf or hard-of-hearing while accessing health plan services at contracted Urgent Care Facilities and SNFs.
   2. Providers may contact the IEHP Provider Relations Team for VRI set-up and technical assistance at (909) 890-2054.
   3. The following Member information will be collected at the start of the VRI session:
      a. IEHP Member First Name;
      b. IEHP Member Last Name; and
      c. IEHP Member Date of Birth.
   4. VRI services do not require a prior authorization from IEHP.

REFERENCES:

A. Title III of the Americans with Disabilities Act (ADA) of 1990.
D. Section 1557 of the Patient Protection and Affordable Care Act.
9. ACCESS STANDARDS

E. Access to Sensitive Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Members have access to sensitive services through their Primary Care Physician (PCP), or other physicians within the IPA’s network, or, in the case of certain services for Medi-Cal Members, any contracted or non-contracted qualified Practitioner.

B. Sensitive services include the following:
   1. Treatment for sexual assault;
   2. Treatment for rape;
   3. Treatment for intimate partner violence;
   4. Drug or alcohol treatment services;
   5. Pregnancy-related services;
   6. Family planning services;
   7. Sexually transmitted infection preventive care, diagnosis, and/or treatment;
   8. HIV testing;
   9. Behavioral health care; and
   10. Abortion services.

C. Members are bound by the rules or procedures required for the specific services they are accessing.

D. Members are informed of their rights to access sensitive services through the Member Handbook.

E. There are additional regulations that deal specifically with services provided to minors (See Attachment, “California Minor Consent and Confidentiality Law” in Section 9). Prior to any reliance on the information included, please check the citations for a comprehensive understanding of the statutes, as well as any updates and/or changes to the law. Additionally, please refer to your legal counsel for official interpretation or other laws/regulations that may be applicable.

PURPOSE:

A. To ensure that Members have access to sensitive services.

PROCEDURES:

A. Treatment of sensitive services for minors may be obtained without parental consent through a Practitioner other than the PCP if so requested and consistent with other access policies
9. ACCESS STANDARDS

E. Access to Sensitive Services

...and procedures.

B. Members, regardless of age, may obtain information regarding access to care and assistance with appointment scheduling for sensitive services through IEHP Member Services at (800) 440-4347 or their PCP’s office. Assistance is provided with complete confidentiality.

C. Periodic monitoring of Practitioner compliance is performed through chart review and assessment of encounter data.

D. Specific authorization or access requirements include:

1. Sexual Assault/Rape - No prior authorization is required.

2. Drug or Alcohol Treatment Services - Alcohol and substance abuse services are provided by the substance abuse treatment program at the Member’s county of residence of Medi-Cal Fee-For-Service (FFS). See Policy 12K2, “Behavioral Health – Alcohol and Drug Treatment Services” for more information.

3. Pregnancy-Related Services - No prior authorization is required; services can be provided by any credentialed obstetrical Practitioner (OB/GYN or Family Practice) within the IPA’s network.

4. Family Planning - No prior authorization is required; services can be obtained through any contracted or non-contracted qualified Practitioner.

5. Sexually Transmitted Infection Preventive Care, Diagnosis and Treatment - No prior authorization is required; services can be obtained through the PCP, a Local Health Department (LHD) Practitioner, or any qualified Family Planning Practitioner if part of a family planning visit.

6. HIV Testing - No prior authorization is required; services can be obtained through the PCP, LHD testing site, or any qualified Family Planning Practitioner if part of a family planning visit.

7. Behavioral Health Care - The PCP is responsible for behavioral health care within his/her scope of practice, otherwise, the Member may be referred to the appropriate County Behavioral Health Department. Emergent referrals may be made to the IEHP BH Department. Please see Policy 12K1, “Behavioral Health – Behavioral Health Services” for more information.

8. Abortion Services - No prior authorization is required; services can be obtained through any contracted or non-contracted qualified Practitioner.

E. For more specific information regarding authorization requirements and other details, see specific policies related to the particular service or condition as outlined in Sections 10, “Medical Care Standards” and 12, “Coordination of Care”.
9. ACCESS STANDARDS

E. Access to Sensitive Services

REFERENCES:

A. Title 42, Code of Federal Regulations § 2.14(b).
B. California Family Code §§ 6924(b), 6925-6926, 6928-6929.

INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file
Original Effective Date: September 1, 1996

Chief Title: Chief Medical Officer
Revision Date: January 1, 2020
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal Members.

POLICY:
A. In accordance with state law, IEHP and its Delegated IPAs must allow women to directly access, without prior authorization, Obstetrical or Gynecological (OB/GYN) physician services through participating OB/GYNs or Family Practitioners (FP) that meet IEHP credentialing standards to provide obstetrical and gynecological services.
B. Members may only obtain direct access from those OB/GYNs or FPs within the IPA to which they are assigned, and use their assigned Hospital for facility-based services.
C. IEHP requires OB/GYNs and FPs to obtain prior authorization for any specialized procedures or other treatments outside of a “well woman” exam or routine obstetrical or gynecologic care.
D. IEHP requires OB/GYNs and FPs to communicate with the Member’s Primary Care Physician (PCP) regarding the Member’s condition, treatment, and follow-up care.
E. IEHP contracts define OB/GYN services as a delegated responsibility, which includes payment of services accessed by Members under this policy. If it is determined that payment was denied for services rendered under this policy, IEHP will reimburse the Provider and decap the IPA for the cost.
F. Persistent non-compliance related to this policy will result in action against the IPA.

PROCEDURES:
A. IEHP and its Delegated IPAs must allow Members with obstetrical or gynecological conditions to directly access, without prior authorization, OB/GYN physician services through participating OB/GYNs or FPs that meet IEHP credentialing standards to provide obstetrical and gynecological services. Hospital services must be provided through the hospital to which the Member is assigned (See Attachment, “OB/GYN Self-Referral Health and Safety Code 1367.695” in Section 9).
B. FPs participating under this policy must be credentialed by IPAs in accordance with IEHP standards for obstetrical privileges.
C. Typical conditions and procedures for which a woman can directly access an OB/GYN or eligible FP include, but are not limited to, the following:
   1. Abdominal/Pelvic Pain
      a. Salpingo-oophoritis
      b. Endometriosis
      c. Pelvic Inflammatory Disease (PID)
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

2. Abortion
3. Amenorrhea
4. Breast Lump
5. Bartholin Gland Enlargement/Cyst
6. Dysmenorrhea
7. Ectopic Pregnancy
8. Endometriosis
9. Dysuria
10. Estrogen Replacement
   a. Therapy/hormonal changes
11. Family Planning/Birth Control
12. Mastitis
13. Menopause
14. Menorrhagia
15. Premenstrual Syndrome (PMS)
16. Polymenorrhea
17. Pregnancy/Prenatal Care
18. Sexually Transmitted Infection (STI) Testing and/or Treatment
19. Vaginal Bleeding/Vaginal Discharge
20. Vaginitis
21. Well Woman Exam
   a. Cervical Cancer Screening
   b. Breast Exam
22. Colposcopy
23. Endometrial Biopsy

D. The OB/GYN or FP providing care to Members under this policy must obtain prior authorization from IEHP or the IPA for procedures, surgery or other services beyond routine or follow-up office visits. Examples of services requiring prior authorization include, but are not limited to, the following:

1. Diagnostic Procedures
   a. Amniocentesis
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

b. Computer Tomography (CT)
c. Ultrasound
d. Other specialty diagnostic procedures
e. Magnetic Resonance Imaging (MRI)

2. Services
   a. Referrals to other specialists

3. Surgical Intervention
   a. Dilation and Curettage (D & C)
   b. Hysterectomy
   c. Laparoscopy

4. Treatments
   a. Cone biopsy
   b. Cryosurgery

E. Any OB/GYN or FP providing care to Members under this policy is required to communicate to the Member’s PCP, in writing, the Member’s condition, treatment and any need for follow-up care. OB/GYNs or FPs can meet this requirement by providing this information to the Member’s IPA, which then must forward the information to the PCP.

F. OB/GYNs and FPs providing care to Members under this policy are encouraged to either contact their IPA when initiating treatment, or to provide appropriate clinical information when submitting claims to the IPA to ensure timely and appropriate processing of claims.

G. IEHP and its Delegated IPAs are required to reimburse OB/GYNs and FPs providing care to Members under this policy utilizing appropriate claims review and processing standards. Approval types for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.

H. OB/GYNs and FPs providing care to Members under this policy must first appeal denied or disputed claims to the IPA. If the appeal is denied, claims appeal should be directed to IEHP at:

   Inland Empire Health Plan
   Claims Department
   P.O. Box 4349
   Rancho Cucamonga, CA 91729-4349

I. If IEHP determines that the IPA has denied payment for services rendered under this policy, IEHP will reimburse the Provider and decap the IPA.

J. IEHP and its Delegated IPAs should have a structure in place to monitor compliance with
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

this policy. Process should include, but not be limited to, review of denied services for OB/GYN services, review of Member and Provider grievances, and review of Provider appeals and denial of OB/GYN Provider claims.

K. IEHP will perform ongoing monitoring to assure compliance with these requirements. Persistent failure to comply with these requirements will result in negative action against the IPA, up to termination of the IEHP-IPA contract.

L. Information regarding this policy or questions related to it can be obtained by calling the IEHP Provider Relations Team at (909) 890-2054.

REFERENCE:

9. ACCESS STANDARDS

G. Cancer Screening and Treatment Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its Delegated IPAs are required to approve screening tests for cancer by the Member’s Primary Care Physician (PCP) or other treating physician if the request is based on generally medically accepted practice such as, but not limited to, those approved by the Food and Drug Administration (FDA), United States Preventive Services Task Force (USPSTF), scientific evidence or IEHP policies and procedures.

B. IEHP requires Members to obtain all care and services for cancer screening or diagnostic testing only from credentialed IEHP Providers/Practitioners (including Physicians, Surgeons, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, or other Providers of service) within the IPA to which they are assigned, as applicable.

C. IEHP requires Members obtaining care and services for cancer to receive services from the Member’s assigned Hospital, as applicable.

D. If the Member’s treating Physician, who is providing covered health care services, recommends Member participation in a phase I through IV clinical trial for cancer, authorization is requested, and if approved, coverage must be provided for all routine Member care costs related to the clinical trial. The clinical trial endpoint must not be defined exclusively to test toxicity but must have a therapeutic intent.

E. For services related to the treatment of cancer, IEHP and its Delegated IPAs can subject requests from treating physicians to prior authorization process.

F. For reconstructive surgery or prosthetic devices necessary to restore symmetry to a Member after surgical resection of cancer, IEHP and its Delegated IPAs can subject the request to prior authorization process.

G. IEHP contracts define physician and other services as the responsibility of the Delegated IPA. This responsibility includes payment of services accessed by Members under this policy.

PROCEDURES:

A. All cancer screening requests must follow the process outlined in Policy 14D, “Pre-Service Referral Authorization Process” in accordance with community medical standards and IEHP’s policies and procedures:

1. Breast cancer screening;
2. Cervical cancer screening (e.g. cytology and HPV co-testing as appropriate);
9. **ACCESS STANDARDS**

**G. Cancer Screening and Treatment Services**

3. Lung cancer screening (utilizing low dose computed tomography as appropriate);
4. Colorectal cancer screening (e.g. fecal immunochemical tests, fecal occult blood test);
5. Prostate cancer screening; and
6. Other cancer screening tests as appropriate and approved by the FDA.

**B.** In addition, IEHP and its Delegated IPAs must authorize the following services for breast cancer screening and diagnostic testing upon referral from a Member’s treating Physician (either the Member’s PCP, an OB/GYN that the Member is directly accessing per Policy 9F, “Open Access to Obstetrical or Gynecological Services,” or an authorized treating Specialist):

1. Screening Mammography or Ultrasound – The Centers for Disease Control and Prevention (CDC) and USPSTF recommend that women 50-74 years of age should receive biennial mammography screening. Women 40-49 years of age with average risk of breast cancer should receive a biennial or as deemed medically necessary;
2. Diagnostic mammography; and
3. Diagnostic biopsy, as ordered by an appropriate Specialist.

**C.** IEHP and its Delegated IPAs may require prior authorization for the following referral requests related to breast cancer services, but the services must be provided if medically necessary:

1. Surgical treatments – mastectomy, lumpectomy, etc.;
2. Chemotherapy;
3. Radiation therapy; and
4. Treatments for complications related to breast cancer treatments.

**D.** IEHP and its Delegated IPAs may subject the following requests to prior authorization to determine the appropriate Practitioner, but the services must be provided:

1. Prosthetic devices or reconstructive surgery necessary to restore symmetry for the patient after mastectomy.

**E.** A Member’s treating Physician, who is providing covered health care services may determine that participation in a clinical trial has a meaningful potential to benefit the Member diagnosed with cancer. The treating Physician may request for authorization and if approved, coverage must be provided for all routine Member care costs related to a clinical trial for a Member who is accepted into a phase I through IV clinical trial.

1. “Routine Member care costs” include costs associated with the provision of health care services including drugs, items, devices, and services that would be associated with routine care or with care related to the clinical investigation including:
9. ACCESS STANDARDS

G. Cancer Screening and Treatment Services

a. Services typically provided in the absence of a clinical trial;

b. Services required solely for the provision of the investigational drug, item, device, or service;

c. Services required for the clinically appropriate monitoring of the investigational drug, item, device or service;

d. Services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service; and

e. Services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of complications.

2. “Routine Member care costs” do not include the following:

a. Drugs or devices that have not been approved by the FDA and that are associated with the clinical trial;

b. Services other than health care service such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of the treatment being provided for purposes of the clinical trial;

c. Items or services provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member;

d. Services that are otherwise specifically excluded from coverage under the Member’s health plan, except for the fact that they are being provided in a clinical trial; and

e. Services customarily provided by the research sponsors free of charge for any Member in the clinical trial.

3. Treatment shall be provided in a clinical trial that:

a. Involves a drug that is exempt under federal regulations from a new drug application;

b. Is approved by one of the following:

1) One of the National Institutes of Health;

2) The FDA, in the form of an investigational new drug application;

3) The United States Department of Defense; or

4) The United States Veterans’ Administration.

4. The Member’s right to the Independent Medical Review process is not limited.

F. IEHP and its Delegated IPAs can direct all services noted above to contracted in-network Providers/Practitioners whose scope of practice includes these services. If an appropriately
9. ACCESS STANDARDS

G. Cancer Screening and Treatment Services

qualified Practitioner is not available within the IPA network, arrangements must be made for the Member to receive care from an appropriately qualified Providers/Practitioner outside the IPA network.

G. Practitioners rendering breast cancer services to Members are encouraged to either contact their IPA when initiating treatment or to provide appropriate clinical information when submitting claims to the IPA to ensure timely and appropriate processing of claims.

H. IEHP and its Delegated IPAs are required to reimburse Providers/Practitioners rendering care to Members under this policy according to the guidelines above, using appropriate claims review and processing standards. Approvals for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.

I. Providers/Practitioners rendering care to Members must first appeal denied or disputed claims to the IPA. If the appeal is denied, the claims appeal should be directed to IEHP at:

Inland Empire Health Plan
Attention: Claims Appeals
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349
9. **ACCESS STANDARDS**

H.  **Cultural and Linguistic Services**

1.  **Foreign Language Capabilities**

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members who have Limited English Proficiency (LEP).

**POLICY:**

A. The Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) defines threshold language as any primary language of at least 5% of the individuals in a plan’s service area. Spanish and English are designated as the only threshold languages in San Bernardino and Riverside Counties for Medi-Cal Members.

B. All IEHP network Providers and Practitioners, including Delegated IPAs, Hospitals, Primary Care Physicians (PCPs), OB/GYNs, Specialists, Behavioral Health (BH) Providers, Behavioral Health Treatment (BHT) Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Facilities, Pharmacies, other Providers (e.g. Nurse Practitioners, Physician Assistants, Acupuncturists, Midwives, and Dentists), and Long Term Services and Supports (LTSS) Providers must provide services to Members with LEP in the Member’s primary language. Members cannot be required to provide their own interpreters or pay for them.

C. Members have the right to request an interpreter at no charge for discussions of medical information, and at key points of contact.

D. Providers should not require or suggest the use of family members or friends as interpreters. However, a family member or friend may be used as an interpreter if this is requested by the Member after being informed of their right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services or violate the Member’s confidentiality. Minors should not be used as interpreters except for extraordinary circumstances such as medical emergencies.

E. Providers should document the Member’s request for or refusal of interpreter services in their medical record.

F. Providers may use face-to-face interpreters when requested at least five (5) working days before the medical appointment or telephonic interpretation services to meet the language requirement. These interpretation resources are available to Members twenty-four (24) hours a day/seven (7) days a week.

G. IEHP and its network of Providers and Practitioners must provide written materials to Members in designated threshold languages.

H. All Providers and Practitioners, including Vision Practitioners, listed in the IEHP Provider Directory with Spanish-speaking capabilities are required to undergo an annual language competency audit to monitor bilingual Spanish services available to Members.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services
   1. Foreign Language Capabilities

   I. Members who do not select a PCP at the time of enrollment are assigned to a PCP. Language compatibility is one of the factors in the PCP assignment.

   J. Members have the right to file a complaint or grievance if their linguistic needs are not met.

PROCEDURES:

A. Provider Language Capability
   1. IEHP lists all foreign language capabilities of Providers and/or their staff in the Provider Directory.
   2. Any Provider site indicating capability of a threshold language other than English must:
      a. Have staff who speaks that language available during the office’s regular business hours; and
      b. Provide all recorded messages and signage in the designated language.
   3. IEHP verifies the capability of Providers to provide services in the threshold language at the time of entry into the network in accordance with Policy 9H2, “Cultural and Linguistic Services - Spanish Language Competency Audits.”
   4. Members’ concerns about the interpretation capabilities in a Provider’s office are followed up by IEHP, and the IEHP Provider database is corrected as necessary.

B. Interpretation Services
   1. Providers and Practitioners may not require or suggest that Members provide their own interpreters.
   2. All Hospitals must provide interpreters as needed for inpatient and emergency services. The Hospitals are responsible for the cost and arrangement of interpretation services.
   3. Providers must provide interpreters as needed for Member appointments. IEHP covers the costs of the interpretation services for PCP and outpatient visits.
      a. Sign language interpretation must be provided in accordance with Policy 9D1, “Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing.”
   4. When face-to-face interpretation services are required, it is recommended that the Member or Provider schedule an interpreter at the same time or at least five (5) business days in advance of the medical appointment.
      a. Interpreter services are scheduled by calling IEHP Member Services at (800) 440-IEHP (4347), or (800) 718-4347 for TTY users. All requests for interpretation services must be scheduled and authorized by IEHP.
      b. Emergent and urgent interpreter service requests under five (5) business days are
9. ACCESS STANDARDS

H. Cultural and Linguistic Services
   1. Foreign Language Capabilities

subject to interpreter availability.

5. IEHP has contracted with Pacific Interpreters to provide telephonic interpretation services to Members. This company offers interpretation services, twenty-four (24) hours a day, seven (7) days a week. IEHP Members and Providers may access this service at no cost.

   a. Members and Providers can call IEHP Member Services to access this telephone interpretation service during business hours.

   b. After business hours, Members and Providers can call the 24-Hour Nurse Advice Line at (888) 244-IEHP (4347), or (866) 577-8355 for TTY users to access interpretation services.

6. Providers must document all Member requests for and refusal of interpreter services in the Member’s medical record.

REFERENCES:


B. Department of Health Care Services (DHCS) All Plan Letter (APL) 02-003, “Cultural and Linguistic Contractual Requirements: Threshold and Concentration Standard Languages Updates.”


D. Title 42, Code of Federal Regulations §422.112(a)(8).

9. ACCESS STANDARDS

H. Cultural and Linguistic Services

2. Spanish Language Competency Audits

APPLIES TO:

This policy applies to all IEHP Medi-Cal Providers.

POLICY:

A. IEHP verifies the capability of its Providers to provide services in the threshold languages when Providers indicate they have this capability at the time of their entry into the IEHP network. Currently, Spanish and English are the only threshold languages in Riverside and San Bernardino Counties as defined by California Department of Health Care Services (DHCS).

B. IEHP conducts a language competency audit of all Primary Care Physicians (PCPs), Obstetrics/Gynecology (OB/GYNs) and Vision Providers offices that have been designated as having the ability to speak Spanish in the initial credentialing process and on an annual basis. These Providers are listed in the IEHP Provider Directory as having Spanish speaking capabilities.

PROCEDURES:

A. In order to be considered a Spanish speaking office, Providers and/or their staff must be able to converse fluently in Spanish, use and pronounce medical and managed care terminology, and be able to assist Members in completing appropriate forms.

B. On an annual basis IEHP evaluates Spanish-speaking Providers for language competency.

1. The technique utilized for assessing targeted language competency within the Provider site is set up as a monolingual Spanish speaking IEHP Team Member calling into the office to verify that someone in the office speaks Spanish.

   a. The caller immediately begins speaking Spanish and requests to speak to someone that speaks Spanish. The IEHP Team Member introduces oneself as an IEHP employee and begins the audit. The following information is documented from the call:

      1) Who in the office speaks Spanish (Doctor/clinical staff and office staff, doctor/clinical staff only and non-clinical staff only). IEHP Team Member verifies with one Spanish speaking employee in each individual doctor’s office;

      2) How many people in the office speak Spanish; and
9. ACCESS STANDARDS

H. Cultural and Linguistic Services

2. Spanish Language Competency Audits

3) That the use of answering machine or answering service when the office is closed has Spanish options.

b. Providers who do not demonstrate adequate Spanish-speaking capabilities are not listed as a Spanish speaking office in the IEHP Provider Directory and are not assigned Members who express a preference for Spanish-speaking PCPs.

2. Providers receive a letter stating the results of the Spanish audit. The office will pass, fail or have a Corrective Action Plan (CAP).

a. CAPs must be submitted within seven (7) days of receipt of audit results.

   1) The written or telephonic CAP must demonstrate how the office is addressing the deficiencies.

   - Failure to supply a CAP may result in Spanish-speaking capability being removed from the Provider’s information in the IEHP Provider Directory.

3. CAPs are reviewed and evaluated by IEHP Credentialing Manager.

a. For rejected CAPs, IEHP includes the specific reasons for rejecting any CAP.

b. If a CAP is approved, IEHP staff will re-audit that location.

   1) If the re-audit passes, the Provider will keep his/her Spanish-speaking designation in the IEHP Provider Directory.

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   1) If the re-audit passes, the Provider will keep his/her Spanish-speaking designation in the IEHP Provider Directory.

   c. Until such time as an adequate CAP is received by IEHP, the provider will not be listed as a Spanish-speaking Provider in the IEHP Provider Directory and Members requesting a Spanish-speaking Provider will not be assigned.

C. Audit results are reported to DHCS on an annual basis.

D. IEHP conducts annual audits of Provider sites listed in the Provider Directory to confirm ongoing threshold language capabilities.

E. Providers directly contracted with IEHP, wishing to appeal the results of the language competency audit must submit the written appeal to IEHP in accordance with Policy 16C, “IPA, Hospital and Practitioner Grievance and Appeals Resolution Process”.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services

2. Spanish Language Competency Audits
9. ACCESS STANDARDS

H. Cultural and Linguistic Services

3. Non-Discrimination

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In accordance with Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations (CFR), Section 422.110, all Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

B. IEHP establishes methods to promote access and delivery of services in a culturally competent manner to all Members, including those with limited English proficiency (LEP), diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that Members have access to covered services that are delivered in a manner that meets their unique needs.

C. IEHP and contracted Provider organizations must provide covered services to all IEHP Members assigned to them, at an appropriate facility, without imposing restrictions as listed above.

PROCEDURES:

A. IEHP assigns all Members to Providers, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

B. All IEHP contracted Providers and other subcontractors are required to render services to all Members assigned or referred to them. Providers and other subcontractors may not refuse services to any Member based on the criteria listed above.

C. IEHP Providers and other subcontractors must provide covered services to Members in a uniform manner, at non-segregated locations.

D. IEHP investigates all grievances alleging discrimination, and takes appropriate action with Team Members, Provider organizations, and other subcontractors. All discrimination-related grievances are forwarded to the California Department of Health Care Services (DHCS), for review and appropriate action.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services

3. Non-Discrimination

REFERENCES:

A. Title VI of the Civil Rights Act.
D. Title 45 Code of Federal Regulations Part 92.
9. ACCESS STANDARDS

I. Access to Care During a Federal, State or Public Health Emergency

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP monitors the Federal Emergency Management Agency (FEMA) for issuance of Presidential Major Disaster or Emergency Declarations, the Department of Health and Human Services (DHHS) website for public health emergency declarations, the Centers for Medicare and Medicaid Services (CMS) website, the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) for State of Emergency declarations, along with county websites and other non-regulatory entities such as Southern California Edison.

B. IEHP and its Delegates have policies and procedures that ensure Members’ access to medically necessary health care services, equipment and covered drugs is not disrupted in these situations:

1. Members being displaced by a state of emergency;1,2
2. Issuance of a presidential major disaster or emergency declaration;3,4 or
3. Declaration of a public health emergency by the Secretary of Health and Human Services.5,6

C. IEHP informs DMHC and DHCS of the following within 48 hours of a declaration of a State of Emergency that displaces or has the immediate potential to displace Members:7

1. Describing whether the health plan has experienced or expects to experience any disruption to plan operations;
2. Explaining how the plan is communicating with potentially impacted enrollees; and
3. Summarizing actions the plan has taken or is in process of taking to ensure the health care needs of enrollees are met.

PURPOSE:

A. To ensure that Members maintain access to medically necessary health care services,
9. ACCESS STANDARDS

I. Access to Care During a Federal, State or Public Health Emergency

equipment, and covered drugs during a Federal, State or public health emergency.

DEFINITIONS:

A. State of Emergency – Duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions such as but not limited to air pollution, fire, flood, storm, epidemic, riot, drought, cyberterrorism, sudden and severe energy shortage, and plant or animal infestation or disease.\(^8\)

B. Presidential Major Disaster – The United States President can declare a major disaster for any natural event, that the President determines has caused damage of such severity that it is beyond the combined capabilities of state and local government to respond.\(^9\)

C. Presidential Emergency Declarations - The United States President can declare an emergency for any occasion or instance when the President determines federal assistance is needed.\(^10\)

D. Public Health Emergency – The Secretary of DHHS may determine that a disease or disorder presents a public health emergency; or that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. These declarations last for the duration of the emergency or 90 days but may be extended by the Secretary.\(^11\)

E. Delegate – For the purpose of this policy, a Delegate is defined as an organization contracted with IEHP to provide health care and services to IEHP Members.

PROCEDURES:

A. IEHP performs the following to support its Delegates and Providers in ensuring Members continue to have access to medically necessary health care services, equipment and covered drugs during a Federal, State or public health emergency:

1. Upon identification or notification of a Federal, State or public health emergency declaration, IEHP identifies Members affected or at risk of being affected by the declaration.

2. IEHP notifies its Delegates, Providers, and Members of the nature and authority declaring the state of emergency and steps the health plan will complete to support its Members and Provider network:
   a. Members - Communication will be made through, but not limited to, these methods: texts, calls, website banners, social media, web content, etc.

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\(^8\) California Code, Government Code § 8558.

\(^9\) [https://www.fema.gov/disaster-declaration-process](https://www.fema.gov/disaster-declaration-process)

\(^10\) Ibid.

\(^11\) [https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx](https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx)
9. ACCESS STANDARDS

I. Access to Care During a Federal, State or Public Health Emergency

b. Delegates/Providers/Facilities/Pharmacy Network – Communication will be made through, but not limited to, these methods: blast fax, e-mail, website banners, web content, etc.

B. IEHP works with its Delegates to ensure that Members maintain access to medically necessary health care services, equipment and covered drugs by: 12

1. Relaxing prior authorization requirements for medically necessary drugs and services;
2. Extending filing deadlines for claims;
3. Authorizing a Member to replace medical equipment or supplies;
4. Allowing a Member to access an appropriate out-of-network provider if an in-network Provider is unavailable due to the state of emergency or if the Member is out of the area due to displacement;
5. Having a toll-free telephone number that an affected Member may call for answers to questions, including questions about the loss of health insurance identification cards, access to prescription;
6. Suspending prescription refill limitations and allowing an impacted Member to refill their prescriptions at an out-of-network pharmacy; and
7. In case of the issuance of a presidential major disaster or emergency declaration, allowing an affected Member to obtain the maximum extended day supply, if requested and available at the time of refill. 13,14

C. IEHP’s Behavioral Health department coordinates with the Riverside University Health System (RUHS) Behavioral Health and San Bernardino County Behavioral Health Departments to ensure access to behavioral health care for Members during these emergencies.

D. IEHP educates Members proactively on how to access medically necessary health care services, equipment, and covered drugs during a Federal, State or public health emergency.

E. At the request of IEHP, Delegates must provide the following, at minimum, to demonstrate their compliance with these requirements:

1. Identified point(s) of contact to support these efforts;
2. Policies and procedures; and
3. Regular updates on any actions taken to ensure access to care for impacted Members.

12 CA INS § 10112.95.
14 Medicare Managed Care Manual, “Chapter 4: Benefits and Beneficiary Protections,” Section 150.
9. ACCESS STANDARDS

I. Access to Care During a Federal, State or Public Health Emergency
### 9. ACCESS STANDARDS

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MEASUREMENT YEAR 2019
PROVIDER APPOINTMENT AVAILABILITY SURVEY
(PAAS)

METHODOLOGY
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MEASUREMENT YEAR 2019
DEPARTMENT OF MANAGED HEALTH CARE
PROVIDER APPOINTMENT AVAILABILITY SURVEY METHODOLOGY

The Provider Appointment Availability Survey (PAAS) Methodology was developed by the Department of Managed Health Care (Department), pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS Methodology, published under the authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2019 (MY 2019), all reporting health plans shall adhere to the PAAS Methodology when administering the PAAS and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

All health plans that are required to submit an annual Timely Access Compliance Report shall maintain the administrative capacity necessary to gather compliance data in accordance with this mandatory methodology, validate compliance data, and identify and rectify compliance data errors, so that all documents submitted to the Department in connection with Timely Access Compliance Reports are accurate and present appointment availability data regarding the health plan’s in-network providers.

All PAAS data included in the Timely Access Compliance Report shall be submitted using the Department’s PAAS Templates, which include:

- Contact List Template
- Raw Data Template
- Results Template

The health plan’s MY 2019 Timely Access Compliance Report, including the completed PAAS Templates, shall be submitted through the Timely Access Reporting Web Portal no later than April 1, 2020, pursuant to Rule 1300.67.2.2, subd. (g)(2).

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1 California Health and Safety Code sections 1340 et seq. (the “Act”). References herein to “Section” are to Sections of the Act. References to “Rule” refer to the regulations promulgated by the Department at California Code of Regulations, title 28.

2 March 31 is a holiday. As a result, the Timely Access Compliance Report is required to be submitted the following business day. (Cal. Gov. Code section 6707.)
**Step 1: Determine Which Networks to Survey**

Health plans shall report separate rates of compliance with the time elapsed standards for each county in each network (County/Network) for each Provider Survey Type. Health plans shall report rates of compliance for all counties in which contracted providers are located.

Health plans are not currently required to report a rate of compliance for networks serving exclusively Medicare Advantage, CalMediConnect or Employee Assistance Program enrollees, unless that network also serves other lines-of-business that are subject to timely access reporting requirements.

**Plan-to-Plan Arrangements**

Health plans shall report a rate of compliance that is representative of all providers who are a part of the health plan’s network, whether the providers are contracted with the health plan directly, via a plan-to-plan agreement or through another arrangement. How the health plan reports this information depends on whether or not the secondary plan in the plan-to-plan arrangement is required to submit a Timely Access Compliance Report.

**The Secondary Health Plan Also Submits a Timely Access Compliance Report**

Where the health plan contracts with another health plan that also submits a Timely Access Compliance Report, each health plan is required to indicate the relationship in its health plan profile located in the Timely Access Reporting Web Portal. Where the secondary health plan’s approved network is used to provide health care services to the primary health plan’s enrollees, these providers will be incorporated into the primary health plan’s Timely Access Compliance Report through identification of this arrangement in both health plans’ profiles in the Timely Access Reporting Web Portal.

The secondary health plan shall survey and submit separate PAAS Templates to be incorporated into the primary health plan’s Timely Access Compliance Report. The PAAS Templates submitted by the secondary health plan in the Other Plan Network tab of the Timely Access Reporting Web Portal shall only include the relevant providers and data, based on the plan-to-plan arrangement. The primary health plan is responsible for reviewing the relevant plan-to-plan data that will be incorporated into its Timely Access Compliance Report prior to submission by the secondary health plan so that the primary health plan can complete the required affirmation regarding accuracy and completeness.

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3 This methodology requires timely access rates of compliance be reported by county and network, rather than provider group. As a result, this methodology supersedes the provider group reporting requirement set forth in Rule 1300.67.2.2, subd. (g)(2)(B). (Section 1367.03, subd. (f)(3).) Accordingly, this subdivision is amended to require health plans to report “The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each county in which contracted providers are located.”

4 Under Section 1395, health plans are required to affirm, at the time of submission to the Department, that its Timely Access Compliance Report is true, complete, and accurate. This includes portions of the health plan’s Timely Access Compliance Report that have been incorporated from any other health plan submissions.
The profile includes plan-to-plan relationships for the health plan’s Annual Provider Network Report. If a plan-to-plan relationship is created or is terminated and as a result the plan-to-plan relationship(s) reflected in the Timely Access Compliance Report data is not the same as the relationship(s) reflected in the health plan’s profile, the health plan shall submit a narrative in its Timely Access Compliance Report that identifies (1) the name of the health plan it has a plan-to-plan relationship with, (2) the type and scope of services delivered (e.g., full service or mental health services, including both psychiatric and non-physician mental health care provider services), (3) the counties in which the health care services are delivered, (4) the names of the health plan networks that are served through the plan-to-plan arrangement, (5) whether the health plan delivers services to its enrollees through this relationship or whether the health plan maintains a network for use with another health plan and (6) the date the relationship began and/or terminated. This narrative is not required where the relationship(s) reflected in the profile are accurately reflected for both the health plan’s Annual Provider Network Report and its Timely Access Compliance Report.

The Secondary Health Plan Does Not Submit a Timely Access Compliance Report

Where the health plan contracts with another health plan that does not submit a Timely Access Compliance Report, the primary health plan shall include the data for relevant providers contracted through the plan-to-plan arrangement in the primary health plan’s PAAS Templates.

Step 2: Complete the Contact List

The Contact List is used as the source to calculate the required target sample size and select a random sample of the health plan’s network providers to survey for each County/Network. The Contact List shall include providers meeting all of the following requirements:

- The provider is contracted with the health plan as of December 31 of the prior year, including contracted providers located outside of the health plan’s service area.  
- The provider furnishes health care services through enrollee appointments.
- The provider furnishes relevant health care services set forth under at least one of the five Provider Survey Types:

  **Provider Survey Types**

  (1) **Primary Care Providers:** Primary Care Physicians and Non-Physician Medical Practitioners providing primary care

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5 The PAAS Methodology requires that timely access rates of compliance be reported for all contracted providers, regardless of whether the provider is located outside the health plan’s service area. As a result, this methodology supersedes the reference to service area reporting requirement set forth in Rule 1300.67.2.2, subd. (g)(2)(B), (Section 1367.03, subd. (f)(3).) Accordingly, this subdivision is amended as set forth in footnote 3 above.

6 Primary Care Physicians may include Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine Physicians. For other specialty types, health plans shall include only those providers that have agreed to serve as a primary care provider for the health plan. Primary Care Providers include non-physician medical practitioners which are physician assistants and/or nurse practitioners performing primary care.

(Issued 2/28/2019)
(2) **Specialist Physicians**: Cardiovascular Disease, Endocrinology and Gastroenterology
(3) **Psychiatrists**
(4) **Non-Physician Mental Health Care Providers (NPMH)**: Licensed Professional Clinical Counselor (LPCC), Psychologist (PhD-Level), Marriage and Family Therapist/Licensed Marriage and Family Therapist and Master of Social Work/Licensed Clinical Social Worker
(5) **Ancillary Service Providers**: Facilities or entities providing mammogram or physical therapy appointments

If the providers meet all of the applicable requirements to be included in the Contact List the Contact List shall also include:

- Federally Qualified Health Clinics and Rural Health Clinics.
- Providers offering in-person and/or telehealth appointments to enrollees.  
- Primary Care Providers participating in the health plan’s advanced access program.

The Department developed separate Contact Lists for each of the five Provider Survey Types set forth above. Use the Contact List Instructions to complete a separate a Contact List for each of the relevant Provider Survey Types. When completing the Contact List for Specialists, the health plan shall combine all specialists into one single Contact List. Psychiatrists shall be set forth on a separate Contact List. Similarly, the Ancillary Contact List shall include all entities or facilities providing the ancillary services set forth above and shall be combined on one single Contact List.

For further detailed information in the creation of the five required Contact List Templates, please reference the Instructions tab, located within each of the Contact List Templates. Specialties, counties, and other look-up codes are available on the Department’s Timely Access Reporting Web Portal. A copy of each Contact List shall be retained to be submitted to the Department in the health plan’s Timely Access Compliance Report.

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services under the supervision of a primary care physician in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code and/or nurse practitioners performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

7 Ancillary providers in the Contact List shall only include facilities or entities; do not include individual persons providing ancillary services in the Contact List.

8 As with all other providers in the MY 2019 DMHC Provider Appointment Survey Methodology, only those telehealth providers offering appointments shall be included in the Contact List. The Contact List and Raw Data Templates require health plans to create a row for each telehealth provider with "NA" in the Address, City, State, and Zip Code fields. The health plan shall enter “Telehealth” into the County field of this row. Health plans shall treat “Telehealth” as a single virtual county for the purpose of this Methodology and survey providers within each network in the telehealth virtual county in the same manner as all other County/Networks. Providers that offer both in-person appointments and telehealth appointments shall be included in both the physical county they offer in-person appointments and in the telehealth virtual county. Providers that offer only telehealth appointments shall be included only in the telehealth virtual county.
Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) shall be included in the Contact List and surveyed without regard to the availability of any individual provider. The Survey Tool requires that the health plan inquire about the next available appointment at the FQHC/RHC. Only the name of the FQHC/RHC may be used in administering the survey.

The telephone, fax and email address included in the Contact List and used to administer the survey shall be associated with only the FQHC/RHC. In order to avoid surveying individual provider’s to assess availability at each FQHC/RHC, health plans shall not include individual provider telephone numbers, fax numbers and email addresses associated with FQHCs/RHCs in the Contact List.

De-duplicating the Contact List

The goal of identifying duplicate entries in the Contact List is to identify unique providers for the random sample selection process. This ensures that each provider in each county has an equal chance of being selected to be surveyed during the random sample selection process.

Review each Contact List to identify duplicate entries. Duplicate and unique entries must be identified in the “Unique Provider” field of the Contact list and Raw Data Templates. Enter “Y” to identify whether the entry represent a unique provider and “N” to identify duplicate entries. Duplicate entries must be excluded from consideration when selecting a random sample of providers to survey.

Duplicate entries are rows where the same provider appears more than once in a single county for a single network. Any manual corrections that affect the identification of duplicate entries, such as slight name corrections, shall be incorporated into the data set forth on the PAAS Templates submitted to the Department. Unique providers are those providers remaining after all duplicate entries have been identified.

Identify duplicates for each of the five Provider Survey Types using all of the following fields:

- Last Name and First Name (for Ancillary Providers use Other Contracted Provider Facility Name)
- FQHC/RHC Name
- National Provider Identification (NPI)
- County
- Name of Network

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9 Welfare and Institutions Code section 14087.325, subd. (b) requires that enrollees be “assigned directly to the federally qualified health center or rural health clinic … and not to any individual provider performing services on behalf of the federally qualified health center or rural health clinic…”

10 For Ancillary and FQHCs/RHCs, health plans shall use an organizational NPI. For individual providers, health plans shall use the unique NPI number assigned to the provider.
**Step 3: Determine Sample and Oversample Size**

**Determine the Sample Size**

This methodology ensures that an appropriate number of providers for each County/Network are surveyed to produce statistically reliable and comparable results across all health plans, in accordance with Section 1367.03, subd. (f)(2) and Rule 1300.67.2.2, subd. (g)(2)(B). The number of providers that must be surveyed for each County/Network is determined separately for each of the five Provider Survey Types.11 (Section 1367.03, subd. (f)(3) and Rule 1300.67.2.2, subd. (g)(2)(B).)

For each Provider Survey Type in each Network/County, the health plan shall either survey:

- A sample of providers until the target sample size has been met; or
- All providers in the County/Network (census).

Determine the number of unique providers for each of the Provider Survey Types in each County/Network in the de-duplicated Contact List. Use this number and the Sample Size Chart in Appendix 1 to determine the appropriate sample size for each Provider Survey Type in each County/Network.

A health plan may survey a sample larger than what is set forth in the Sample Size Chart (e.g., for internal quality assurance purposes), but it shall only include results in its Raw Data and Results Templates for either all providers in the County/Network (census) or the number of providers identified in the Required Target Sample Size column in the Sample Size Chart. Where census is used, all providers in the Network/County will be surveyed, and no oversample selection is necessary.

**Determine the Oversample Size for Replacements**

The health plan must obtain valid survey responses to reach the target sample size in each County/Network for each of the five Provider Survey Types.12 Ineligible or non-responding providers shall be replaced with another provider, if available in the County/Network, in order to meet the required target sample size and ensure that the health plan’s reported rates of compliance are statistically reliable and comparable. (See Replacements of Non-Responding and Ineligible Providers, below, to ascertain whether a provider may be replaced.)

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11 Combine Specialists to determine the sample size for the Specialist Physicians sample for each County/Network. Combine the entities or facilities providing Ancillary services to determine the sample size for the Ancillary Provider sample for each County/Network.

12 Unless the health plan is unable to meet the target sample size due solely to ineligible providers, it must obtain enough valid survey responses to meet the target sample size regardless of whether a sample or census is surveyed.
The health plan shall select an oversample of each Provider Survey Type for the County/Network using the random sample selection process. The size of the oversample shall be sufficient to replace all non-responders and ineligible providers necessary to meet the target sample size. If the initial oversample is exhausted and additional providers remain in the County/Network, use this same process to add additional providers of that same Provider Survey Type to the oversample. The health plan should continue to add providers to the oversample using the random sample selection process until either the target sample size is reached or all providers have been contacted.

**Step 4: Select Random Samples**

Once the appropriate sample and oversample size for each Provider Survey Type in each County/Network has been determined, use the random sample selection process described below to identify which providers to survey and include in the *Raw Data Template* from the health plan’s working copy of the *Contact List*.

- Assign a random number to each unique provider in the health plan’s de-duplicated *Contact List*.
- Sort each *Contact List* by the random number within each County/Network by each Provider Survey Type.
- Starting with the first unique provider in the randomly sorted de-duplicated *Contact List*, select the required number of providers in the sample and oversample for the largest network in each county. (See Step 3: Determine Sample and Oversample Size for instructions.)
- If there is only one health plan network in the county, move to Step 5.

Health plans may use excel, SAS, or other software to assign a random number and to complete the random sample selection process.

**Counties with Multiple Networks**

The process used to sample multiple networks is designed to sample the smallest number of providers needed to produce results for all networks. For health plans with multiple networks in a single county, use the process described above to select a random sample from the network in the county with the largest number of providers.

Once the first sample is selected, use the first name, last name, FQHC/RHC name, NPI, and County fields to identify whether the provider participates in the other networks in that county. (For Ancillary Providers, use the Other Contracted Provider Facility Name, NPI, and County fields.) Apply the providers sampled from the larger network to all of the smaller networks in which the sampled provider participates. The provider shall be surveyed only once; the response will be applied to the provider for all relevant networks.
Review each network by size to determine whether additional providers need to be sampled to meet the required target sample size. If so, select additional unique providers from that network in the randomly sorted Contact List and apply these providers to all smaller networks in the county. This process will continue until a sufficient sample is identified for each Provider Survey Type in all Counties/Networks. (The oversample for replacement is selected following this same process.)

**Step 5: Engage in Provider Outreach**

In order to accurately report network performance across the time elapsed standards, health plans must obtain survey responses from a meaningful number of providers. Simple, strategic communications with health plan-contracted providers can yield a significant increase in response rates, putting the health plan (and its contracted providers) in the best position to demonstrate compliance with Timely Access appointment availability standards. Special focus for provider groups and Provider Survey Types that had high non-response rates in prior measurement years may be necessary to ensure adequate responses.

Health plans may send outreach communications that inform the provider:

- Who is administering the survey;
- Provide information about the importance of participating in the survey;
- What the survey is, why it is being done, how it is administered and the types of questions that will be asked;
- Identify the date range during which the survey is likely to occur;
- Inform providers that rates of compliance and response rates will be part of publicly available information;
- Offer information on how to participate through the Extraction method to avoid providing this information through another survey mode; and
- Remind providers of any contractual obligations indicating that they shall furnish appointment availability information to the health plan. (See Section 1367.03, subd. (f)(1).)

Outreach communications shall be clear to ensure that providers do not respond directly to the Department. Health plans are required to obtain adequate provider responses to meet the appropriate sample sizes in each County/Network, and where appropriate, to send outreach communications that encourage provider response.
Step 6: Prepare Survey Questions

The Department developed a Survey Tool, to be used with this methodology. Health plans are permitted to make minor adjustments to the Survey Tool introductory language and add language that allows confirmations of the provider’s identifying information. In addition, the Survey Tool may be amended to indicate that the provider is contractually required to furnish this information, if applicable. Any redlined revisions to the Survey Tool are required to be filed as an Exhibit J-13 in eFile within 30 days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

In addition, health plans may incorporate additional survey questions, provider identification verification items and required provider contacts and/or notifications, including those set forth under Section 1367.27, into the Department’s Survey Tool, if all of the following conditions are met:

- All of the Department’s PAAS Methodology is followed.
- The Department’s questions, set forth in the Survey Tool, are included as a block at beginning of the survey. No modifications can be made to Survey Tool’s individual items or the item order.
- In prior years, the DMHC’s Survey Tool included a follow-up question: “Is there another practitioner in the same physical office who could see the patient sooner? (If yes) On what date and time is the earliest appointment?” This question is no longer allowed to be used in connection with the PAAS. If a health plan asks a similar question in relation to assessing compliance and monitoring of other timely access standards, the answers from the question may not be considered in determining the health plan’s rate of compliance submitted to the Department.
- The resulting survey is not too exhaustive (which may decrease willingness to respond or may frustrate providers responding to the survey).
- The data and responses for the Department’s PAAS questions are transferred to the Department’s PAAS Raw Data Template and Results Template.
- The contact and/or notification comply with all other requirements of the Act.
- The redlined revisions are filed as an Exhibit J-13 in eFile within 30 days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

Health plans may use software or a computer program for capturing survey data, if the following requirements are met:

- The survey questions are identical to the survey questions in the Survey Tool.
- The health plan captures the same data fields included in the Survey Tool.
- The health plan populates the Contact List, Raw Data and Results Templates in accordance with the PAAS Methodology and template instructions and submits these documents in its Timely Access Compliance Report submission.
Step 7: Administer Survey

Timeframe and Waves

All surveys shall be completed between April 1, 2019 and December 31, 2019. The surveys shall be conducted in two waves. For each county, approximately 50% (and no more than 60%) of the providers will be surveyed in each wave. The two survey waves may be of any duration necessary to complete the survey of all providers included in the wave, unless Electronic Extraction is used. (See Option 1 in Survey Administration Modality, below, for details related to the duration of the Electronic Extraction waves.) Waves shall be spaced at least three weeks apart, and the second wave shall begin no sooner than three weeks after the final survey of the first wave has been completed. Health plans may sequence the survey administration so that the waves are staggered by Provider Survey Type to avoid periods in which surveys are not being administered.

Survey Administration Modality

All surveys shall be administered using one or a combination of the three survey administration modalities: Extraction (Option 1), the Three Step Protocol (Option 2), or through a Verified Advanced Access Program (Option 3).

Option 1: Manual or Electronic Extraction

Health plans may extract the next available urgent and non-urgent appointments for providers that were selected to be surveyed from the provider’s practice management software. Health plans may manually extract appointment data (e.g., individual urgent and non-urgent appointment queries are ran manually for each provider) or electronically extract appointment data (e.g., the next available urgent and non-urgent appointments are downloaded), if all of the following requirements are met:

- Prior to administering the survey, a reliable method is in place to identify the providers that are able and willing to allow the health plan to access the next available urgent and non-urgent appointment via an Extraction method.
- The method for extracting appointment data from a provider or provider group/IPA’s practice management software is reliable and results in accurate data.
- The method for extracting appointment data from a provider or provider group/IPA’s practice management software allows the health plan to distinguish ineligible and non-responding providers.
- The date and time the extraction of the appointment data occurred (e.g., the date the practice management software is queried or downloaded) is captured and used to populate the “Date Survey Completed” and the “Time Survey Completed” field on the Raw Data Template.
- The Extraction method used by the health plan captures the date and time of the next available urgent and non-urgent appointment for the individual provider sampled. The health plan shall populate this information in the appropriate survey question field on the Raw Data Template.
- The date and time of the extraction and the first available urgent and non-urgent appointment shall accurately represent what would be available to an enrollee if an appointment was requested by an enrollee on the date of the data extraction.
The Department’s Methodology and administration procedures are followed, including selection of the random sample or census of providers. The sample must be randomly selected from all providers in the Contact List, and may not be selected based on whether providers’ scheduling data can be accessed via Extraction and Advance Access Program.

Unless surveying all providers in a County/Network (census), the health plan shall include only those providers who were randomly selected to be sampled on the Raw Data and Results Template, even if Electronic Extraction is available for all providers in a provider group/IPA.

The health plan completes the Contact List, Raw Data and Results Templates in accordance with the instructions set forth in each template and submits these documents as part of its Timely Access Compliance Report submission.

For Electronic Extraction, the health plan shall randomly assign extraction dates to provider groups/IPAs and/or providers with accessible practice management software over a three-week period during each of the survey waves. If the total number of providers in any provider group/IPA selected for appointment data extraction (whether selecting a sample or using census) is less than 50% of the entire sample for the county, the health plan may include all providers in the provider group/IPA that will furnish appointment data by extraction in Wave 1 or Wave 2. (This may allow the health plan to access the provider group/IPA’s practice management software only once.) If a single provider group/IPA constitutes more than 50% of the sample, the health plan shall extract data from the provider group/IPA across both waves.

Option 2: The Three Step Protocol

The Three Step Protocol sets forth a sequence health plans shall follow in administering the survey. The sequence is ordered to reduce disruption to providers.

1. Initiate the Survey via Email, Electronic Communication or Fax\(^\text{13}\): The health plan shall initiate the survey set forth in the Email, Electronic Communication or Fax Survey Tool by sending a survey invitation either by email, electronic communication or fax. (If an email, electronic communication or fax contact is not available, the health plan shall skip to Step 3: Conduct a Telephone Survey.) The survey invitation may be addressed to one or more providers at the same email, electronic communication or fax contact; however, the survey shall require responses from each individual provider to each survey question. The survey invitation shall:

   - Either include the survey or direct the provider to take the survey through a website, internet portal, application or another electronic communication medium.
   - Indicate that the provider has five business days to respond; otherwise, the provider will be contacted by telephone to take the survey.

\(^{13}\) See the Calculating Timeframes section below for further information related to calculating business days.
2. **Send a Survey Reminder:** If the provider has not responded within two business days of sending the initial survey invitation, a reminder notice may be sent. If the health plan elects to send a reminder notice, it shall notify providers who have not responded of the remaining time to respond to the survey. The reminder may not be used to extend the time available to respond.

3. **Conduct a Telephone Survey:** If the provider does not respond to the email or fax survey invitation within five business days, the health plan shall initiate the survey via telephone, using the appropriate *Telephone Survey Tool*. The telephone survey shall be initiated within 6-15 business days of sending the initial survey attempt conducted via email, electronic communication or fax.

   - If a provider responds to the survey prior to initiation of the telephonic survey (e.g., within the 6-15 business day period), the response shall be entered into the Raw Data Template and no phone call shall be made to the provider.
   - Health plans may conduct the survey of several providers during a single telephone call, but survey responses must be individualized to each selected provider.
   - If a provider’s office does not answer the initial call, the surveyor shall call the provider back on or before the next business day to initiate the telephone survey. If possible, the surveyor may also leave a message requesting that the provider complete the survey (via a call-back number and/or email, electronic communication or fax\(^{14}\)) within two business days of the message.
   - If a provider declines to respond to the survey, the surveyor shall offer the provider’s office the option to respond at a later time. If the provider is willing to participate later, the health plan shall offer the provider the option to receive a follow-up call within the next two business days.

If the provider does not complete the telephone survey within two business days of the initial telephone call, the provider shall be recorded on the *Raw Data Template* as a non-responder and replaced with a provider from the oversample. If the health plan was unable to initiate a telephonic survey of the provider within ten business days of sending the initial survey attempt conducted via email, electronic communication or fax, the provider shall be recorded on the *Raw Data Template* as a non-responder and replaced with a provider from the oversample.

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\(^{14}\) If a provider responds multiple times to the survey (e.g., telephone call and via email), the health plan shall enter only the response first received by the provider into the Raw Data Template.
Option 3: Verified Advanced Access Program

Primary Care Providers that are designated by the health plan as providing advanced access in the health plan’s Raw Data do not need to furnish further appointment availability responses through the PAAS. Primary Care Providers that are both part of the random sample (or census) and identified in the Raw Data as participating in the health plan’s advanced access program shall be counted as compliant for all applicable standards in the Raw Data and included in the health plan’s calculations set forth on the Results Template.

If the health plan’s Access and Availability Quality Assurance System verifies the advanced access programs by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1), in accordance with Rule 1300.67.2.2, subd. (d)(2)(E), the health plan shall designate the Primary Care Providers participating in the advanced access program in the Contact List and Raw Data Templates. A health plan may not deem a Primary Care Provider compliant or identify its providers as participating in its advanced access program in the Contact List or Raw Data Templates, if it uses the PAAS to conduct the verification of its advanced access program.

Replacements of Non-Responding and Ineligible Providers

Whether using Extraction or the Three Step Protocol, an ineligible or non-responding provider (defined below) shall be replaced if another provider from the oversample of the same Provider Survey Type and within the same County/Network is available. If a replacement of a provider is necessary, the surveyor will use the next available provider in the oversample as a replacement until the required sample size is reached. The health plan shall continue to replace providers until either the required sample size is reached or all of the providers of that same Provider Survey Type in the County/Network have been exhausted. (This may require the health plan to select additional oversample providers, as set forth in Step 4 above.)

Non-Responding Providers

A non-responding provider is a provider that does not respond to one or more applicable items within the required time-frame or that declines to participate in the survey. If a survey is completed after the end of the measurement year, the health plan shall mark the provider as a non-responder in the Raw Data Template.

Ineligible Providers

A provider is ineligible if he/she meets the definition of one or more of the following outcomes:

- “Provider not in Plan Network” – The provider no longer participates in the health plan’s network at the time the survey is administered or did not participate in the health plan’s network on December 31 of the prior year\(^ {15}\);
• “Provider not in County” – The provider does not practice in the relevant county at the time the survey is administered or on December 31 of the prior year;
• “Provider retired or ceasing to practice” – The provider retired or for other reasons is no longer practicing;
• “Provider Listed under Incorrect Specialty” – Was included in the Contact List under an incorrect Provider Survey Type;
• “Contact Information Issue (Incorrect Phone or Fax Number/Email)” – Was unable to be surveyed because he/she was listed in the database with incorrect contact information that could not be corrected; or
• “Provider does not offer Appointments” – The provider does not offer enrollees appointments (e.g., provides only hospital-based services or peer-to-peer e-consultation services).

The health plan’s discovery that a provider is ineligible may require the health plan to update information in its online provider directory, in accordance with the requirements set forth in Section 1367.27, subd. (e). In addition, health plans shall record the reason the provider is ineligible in its Raw Data Template, and use the information obtained in administering the survey to update health plan records to improve the Contact List for the following measurement year (e.g., update contact information and exclude all ineligible providers that are retired from future Contact Lists).

Survey Administration Notes

• If the provider reports that the date and time of the next available appointment depends upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (the shorter duration time).
• If the provider reports that patients are served on a walk-in or same day basis, ask the provider to provide the date and approximate time that a patient walking in at the time of the call would be seen. Appointments occurring prior to the date and time of the call shall not be deemed compliant.
• Referral of a patient to a different provider (e.g. a provider covering for a provider on vacation or in a separate urgent care center) cannot be recorded as the initially surveyed provider providing an appointment. An appointment offered at a different office in the same county with the same provider can be recorded as an available appointment with the initially surveyed provider. (For FQHCs/RHCs, appointment availability at a separate site with any provider of that Provider Survey Type within the same FQHC/RHC qualifies as an available appointment.)
• If a provider’s office indicates that urgent appointments are not offered, record “NA” on the Raw Data Template in the applicable urgent appointment time, date and compliance calculation fields.

provider was selected to be surveyed, the health plan does not need to send a survey invitation to the provider. The health plan may instead deem that provider ineligible and replace the provider with another provider from the oversample.
• If the provider is not scheduling appointments at the time of the survey because the provider is out of the office (e.g., vacation, maternity leave, etc.), in the Raw Data Template record “NA” in the appointment date and time fields and “N” in the calculation fields to indicate that the provider does not have an urgent and non-urgent appointment available within the applicable standard.

• All survey calls shall be conducted during normal business hours.

**Record the Response and/or Outcome in the Raw Data Template**

Once the health plan has a response to the applicable survey questions (or has identified the provider as being ineligible or non-responsive), record the response and/or outcome to that provider for all applicable networks within the county in the Raw Data Template. The health plan shall record all of the information designated with an asterisk in the Raw Data Template for each provider it surveys or attempts to survey using one of the three survey modalities set forth above.

**Step 8: Calculate the Results**

Health plans shall calculate the rates of compliance, the number of providers surveyed, whether it surveyed a sufficient number of providers to meet the target sample size and the percentage of providers that were ineligible or did not respond. These figures shall be calculated for each County/Network using the responses to the survey questions for each Provider Survey Type. Use the Results Template Instructions, the health plan’s Raw Data Template, and the calculation instructions set forth below to complete these calculations and enter the required information on the Results Template.

**Calculate the Total Number of Providers Surveyed**

The health plan shall ascertain the number of providers that responded to the survey via Three Step Protocol, Extraction and the Advanced Access Program on the Raw Data Template and record these numbers on the Results Template for each Provider Survey Type in each County/Network. The Results Template will calculate the total number of providers that responded to the survey.

• Count the number of providers that responded via the Three Step Protocol. Record this number on the Results Template in the “Number of Providers Responded via Three Step Protocol.”

• Count the number of providers that responded via the Extraction. Record this number in the “Number of Providers Responded via Extraction.”

• For Primary Care Providers only, count the number of providers that responded via the Advanced Access Program. Record this number on the Results Template in the “Number of Providers Responded via Advanced Access Program.”

• The Results Template automatically adds the “Number of Providers Responded via Three Step Protocol,” the “Number of Providers Responded via Extraction” and (for Primary Care Providers only) the “Number of Providers Responded via Advanced Access Program” to calculate the “Total Number of Providers Surveyed.”
Identify Whether the Target Sample Size Was Achieved

Health plans must obtain a sufficient number of valid survey responses in each County/Network for each of the five Provider Survey Types in order to meet the required target sample size and ensure that its reported rates of compliance are statistically reliable and comparable across the industry. The health plan shall ascertain and record on the Results Template whether it was able to successfully survey a sufficient number of providers for each Provider Survey Type in each County/Network, in accordance with the following instructions:

- Identify the number of unique providers in the Contact List. Record this number in the “Number of Providers within County/Network” field.
- Use the “Number of Providers within County/Network” and Appendix 1: County/Network Sample Size Chart to identify the target sample size. Record the target sample size in the “Target Sample Size” field.
- If the health plan was able to successfully survey a sufficient number of providers to reach the target sample size based on the numbers in the "Target Sample Size" and the "Total Number of Providers Responded to Survey" fields, enter "Y" in the “Target Sample Size Achieved” field. Enter “N” if the health plan was unable to meet the target sample size.

If the health plan did not survey a sufficient number of providers in the County/Network to meet the target sample size, the health plan must include an explanation and corrective actions, where necessary, for the failure to meet the target sample size in the health plan’s Quality Assurance Report. Each health plan must report all required information in the Results Template, even if it was unable to meet the target sample size in a County/Network.

Calculating Timeframes

For consistency, timeframes shall be calculated in accordance with the following instructions:

- When calculating timeframes to make a compliance determination use the date and time the provider responded to the survey or extracted the appointment data from the provider’s practice management software as the date of the request for the appointment. Do not use the date of the initial contact for this calculation (e.g., where email is used or a follow-up survey is necessary, use the date the provider responded, not the date the communication was sent).
- Urgent appointments are measured in hours and include weekends and holidays. As a result, health plans shall capture the date and time the provider responded to the questions and the date and time of the first available appointment identified by the provider’s office.
- Non-urgent appointment standards are set forth in the Timely Access regulation in business days. For consistency, all health plans shall use the following rules in calculating timeframes:
  - Count 14 calendar days (including weekends) to calculate the 10 business day standard.
Count 21 calendar days (including weekends) to calculate the 15 business day standard.
When calculating calendar days, exclude the first day (e.g., the day of the request) and include the last day.
The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes and the Three Step Protocol timeframes.

Example: If a Primary Care Provider responds with an appointment date and time on Tuesday the 15th, then the appointment identified shall be on or before Tuesday the 29th in order to meet the 10 business day standard (calculated by counting forward 14 calendar days) for non-urgent primary care appointments.\(^{16}\)

Compliance Determinations
For each response to the question related to the next available appointment (whether obtained through the Three Step Protocol, Extraction or Advanced Access Program), a calculation must be made to determine compliance. All compliance determinations shall be recorded on the *Raw Data Template* in accordance with the following instructions:

Advanced Access Providers
- If the provider is included in the health plan’s advanced access program and is identified as providing advanced access in the *Raw Data Template*, the provider is counted as compliant for the relevant appointment type(s).

Non-Advanced Access Providers
- Record the date and time of the next available urgent care appointment provided in response to Question 1 and the next available non-urgent care appointment provided in response to Question 2. Calculate whether each appointment was available within the applicable timeframe in accordance with the instructions set forth in the Calculating Timeframes section above.

Urgent Appointments
- If the response to Question 1 indicates that: “Yes, there is an available appointment within [48 hours for Primary Care Providers] or [96 hours for Specialist and NPMH]” (as applicable), the provider is counted as compliant for urgent care appointments in Calculation 1.
- If the provider’s response to Question 1 indicates: “No, there is no available appointment within [48 hours for Primary Care Providers] or [96 hours for Specialist and NPMH]” (as applicable), the provider is counted as non-compliant in Calculation 1.

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\(^{16}\) In this example, days would be counted as follows: Tuesday the 15th is not counted (because, as the day of the request, it is excluded), Day 1: Wednesday the 16th, Day 2: Thursday the 17th, Day 3: Friday the 18th, Day 4: Saturday the 19th, Day 5: Sunday the 20th, Day 6: Monday the 21st, Day 7: Tuesday the 22nd, Day 8: Wednesday the 23rd, Day 9: Thursday the 24th, Day 10: Friday the 25th, Day 11: Saturday the 26th, Day 12: Sunday the 27th, Day 13: Monday the 28th, Day 14: Tuesday the 29th.
Non-Urgent Appointments

- If the response to Question 2\(^{17}\) indicates that: “Yes, there is an available appointment within [10 business days for Primary Care Providers and NPMH] or [15 business days for Specialist and Ancillary providers]” (as applicable), the provider is counted as compliant in Calculation 2.
- If the provider’s response to Question 2 indicates: “No, there is no available appointment within [10 business days for Primary Care Providers and NPMH] or [15 business days for Specialist and Ancillary providers]” (as applicable), the provider is counted as non-compliant in Calculation 2.

Calculating the Rate of Compliance

The Results Template includes a formula that automatically divides the total number of compliant providers (the numerator) by the total number of providers that responded (the denominator) and records the result in the “Rate of Compliance with [applicable standard]” field on the Results Template. If a sample was taken, but more providers were surveyed than required to meet the required target sample size for a County/Network, the health plan shall only use the providers in the order they were randomly selected for each network to meet the target sample size when completing the Raw Data Template and calculating the information on the Results Template.

Using the compliance determinations in the calculation fields set forth on the Raw Data Template, the health plan shall record a numerator and denominator for each of the appointment standards. The numerator and denominator shall be calculated and recorded on the Results Template for each County/Network for each Provider Survey Type to develop the percentage of providers with an appointment available, in accordance with the following instructions:

Urgent Appointments

- Add together the total number of compliant providers based on Calculation 1. Record this number in either the “Number of Providers with an Urgent Care Appointment with no Prior Auth within 48 Hours” field or the “Number of Providers with an Urgent Care Appointment with Prior Auth within 96 Hours” field (as applicable). This number is used as the numerator to calculate the percentage of providers with an urgent appointment available.
- Calculate the total number of responding providers, which includes compliant and non-compliant providers. Record this number (the denominator) in the “Number of Providers Responded to an Urgent Care Appointment with no Prior Auth within 48 Hours” field or the “Number of Providers Responded to an Urgent Care Appointment with Prior Auth within 96 Hours” field (as applicable). This number is used as the denominator to calculate the percentage of providers with an urgent appointment available.

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\(^{17}\) For Ancillary Providers the question in the Survey Tool related to the next available non-urgent care appointment is Question 1. For all other Provider Survey Types, the question related to the next available non-urgent care appointment is Question 2. For Ancillary Providers, conduct the compliance calculations using the same instructions for non-urgent appointments but replace “Question 2” with “Question 1” in these instructions.
• Do not count “NA” responses in the denominator or numerator for the 48 or 96 hour standards for urgent care appointments.
• The formula in the Results Template automatically divides the numerator by the denominator to calculate the percentage of providers with an urgent appointment available, which is automatically recorded in the rate of compliance field for urgent appointments.

Non-Urgent Appointments

• Add the total number of compliant providers from Calculation 2. Record this number in either the “Number of Providers with a Non-Urgent Care Appointment within 10 Days” field or the “Number of Providers with a Non-Urgent Care Appointment within 15 Days” field (as applicable). This number is used as the numerator to calculate the percentage of providers with a non-urgent appointment available.
• Calculate the total number of responding providers, which includes compliant and non-compliant providers. Record this number (the denominator) in the “Number of Providers Responded to a Non-Urgent Care Appointment within 10 Days” field or the “Number of Providers Responded to a Non-Urgent Care Appointment within 15 Days” field (as applicable). This number is used as the denominator to calculate the percentage of providers with a non-urgent appointment available.
• Do not count “NA” responses in the denominator or numerator for the 10 or 15 business day standards for non-urgent care appointments.
• The formula in the Results Template automatically divides the numerator by the denominator to calculate the percentage of providers with an urgent appointment available, which is automatically recorded in the rate of compliance field for non-urgent appointments.

The Results Template may also include formulas that calculate a weighted rate of compliance for each of the health plan’s networks for all urgent appointments, non-urgent appointments, and for each of the five Provider Survey Types. The Results Template will include an explanation of how each item is calculated in the Instructions Tab.

Calculating the Percentage of Ineligible and Non-Responding Providers

The health plan shall separately report the percentage of providers that are ineligible and those who do not respond or declined to respond to one or more survey questions for each Provider Survey Type in each County/Network on the Results Template. The Results Template includes a formula to calculate both percentages. To use these formulas, the health plan shall record on the Results Template the numerator for each Provider Survey Type in each County/Network, in accordance with the following instructions:

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18 Ineligible and non-responders may be identified through the Three Step Protocol or through Extraction.
Ineligible Providers

For each County/Network for each Provider Survey Type:

- Count the number of providers identified as ineligible from the sample and any oversample on the Raw Data Template. Record this number on the Results Template in the “Number of Ineligible Providers” field. This field is used as the numerator to calculate the percentage of ineligible providers.
- The Results Template adds the “Total Number of Providers Responded to Survey,” the “Number of Non-Responding Providers” and the “Number of Ineligible Providers” to calculate the denominator.
- The Results Template formula then divides the numerator by the denominator to calculate and record the percentage of ineligible providers on the Results Template in the “Percentage of Ineligible Providers” field.

Non-Responding Providers

For each County/Network for each Provider Survey Type:

- Count the number of providers identified as non-responding in the sample and in the oversample from the Raw Data Template. Record this number on the Results Template in the “Number of Non-Responding Providers” field. This field is used as the numerator to calculate the percentage of non-responding providers.
- The Results Template automatically adds the “Total Number of Providers Responded to Survey” and the “Number of Non-Responding Providers” to calculate the denominator.
- The Results Template formula then automatically divides the numerator by the denominator to calculate and record the percentage of non-responding providers on the Results Template in the “Percentage of Non-Responding Providers” field.

Step 9: Create Quality Assurance Report

Each health plan shall have a quality assurance process to ensure that it followed the PAAS Methodology and PAAS Template Instructions, met all Timely Access Compliance Report statutory and regulatory requirements, and that all information in the Timely Access Compliance Report submitted to the Department is true, complete, and accurate, pursuant to Section 1396.

As part of this quality assurance process, the health plan shall contract with an external vendor to conduct a review to ensure accuracy and completeness of the health plan’s MY 2019 PAAS data and processes. This review and the quality assurance process shall be completed prior to submission of the Timely Access Compliance Report to the Department, on or before April 1, 2020. At a minimum, the external vendor’s review shall ensure all of the following:

- The health plan used the Department-issued PAAS Templates for MY 2019.
- The health plan reported results for all applicable networks, including those networks solely maintained for use by another health plan in a plan-to-plan arrangement.
The health plan identified, surveyed and recorded survey responses in the *Raw Data Template* for unique providers, in accordance with the Methodology.

For any plan-to-plan arrangements, the primary health plan’s line-of-business associated with each network used by a secondary health plan is consistent with the line-of-business reported by the secondary health plan.

The health plan reported survey results for all Provider Survey Types that were required to be surveyed, as applicable, based on the composition of the health plan’s network as of December 31 of the prior year.

The Timely Access Compliance Report (including the Contact List Template, the Raw Data Template, and the Results Template) accurately reflects and reports compliance for providers who were under contract with and part of the health plan’s Department-regulated network(s) on December 31 of the prior year.

All outcomes and calculations, including the rates of compliance and compliance determinations, recorded on the Raw Data Template and the Results Template are accurately calculated and recorded, consistent with, and supported by data entered on the health plan’s *Raw Data Template* (including those calculations embedded on the *Results Templates*).

The administration of the survey followed the Department’s mandatory PAAS Methodology for MY 2019, including, but not limited to, conducting the survey during the appropriate measurement year and ensuring adherence to all target sample sizes and other parameters required under the Methodology, Survey Tool and PAAS Template instructions, in accordance with Section 1367.03, subd. (f)(3).

As part of its *Timely Access Compliance Report*, the health plan shall submit a *Quality Assurance Report*, prepared by an external vendor, outlining the results of the review. The Quality Assurance Report shall at a minimum include:

- Details regarding the review of each verification item identified above.
- A summary of the findings from the review, including completion of the DMHC-issued Addendum to the Quality Assurance Report.
- Identification of any changes and/or corrections made as a result of the data and quality assurance review.
- Any explanations for issues identified, including those determined to be compliant with this Methodology.
- For any identified errors or issues that the health plan did not correct or is unable to correct, the health plan shall explain why it was unable to comply with the MY 2019 PAAS Methodology and identify steps to be taken by the health plan to ensure compliance during future reporting years. (See Section 1367.03, subd. (f)(3).)

The *Quality Assurance Report* and any accompanying health plan explanations shall be submitted in the Comment/Narrative section of the Department’s Timely Access Reporting Web Portal.
Step 10: Submit the Health Plan’s Timely Access Compliance Report

On April 1, 2020, as part of its annual Timely Access Compliance Report, each health plan shall submit the following items to the Department for each of the applicable Provider Survey Types:

- Contact List Template,
- Raw Data Template, and
- Results Template

In addition, each health plan is required to submit all applicable items set forth in the Timely Access Compliance Report Instructions. The health plan’s Timely Access Compliance Report shall be submitted through the Department’s Timely Access Reporting Web Portal. Please refer to the Timely Access Compliance Report Instructions, available on the Department’s Timely Access web page, for further details regarding submission of each required element. Any questions may be sent to the Timely Access email inbox.

Language Assistance Program Assessment Addendum

Health plans shall assess provider perspectives and concerns with the health plan’s language assistance program regarding:

- The coordination of appointments with an interpreter.
- The availability of an appropriate range of interpreters.
- The training and competency of available interpreters.

These additional required questions—designed to elicit providers concerns and perspectives—must be included in the health plan’s Annual Provider Satisfaction Survey. (See Rule 1300.67.2.2, subd. (c)(4) and (d)(2)(C).)

Any redlined revisions to the Provider Satisfaction Survey and policies and procedures to implement these requirements shall be filed as an Exhibit J-13 in eFile within 30 calendar days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

Results for the current year and a comparison of the prior year’s results shall be reported with the health plan’s Timely Access Compliance Report in the Provider Satisfaction Survey Results section of the Timely Access Reporting Web Portal. In addition, health plans are required to utilize information obtained that relates to provider perspectives and concerns in this area in connection with the health plan’s timely access monitoring quality assurance activities and language assistance program compliance monitoring. (See Section 1367.01, Rule 1300.67.2.2, subd. (d), and Rules 1300.67.04, subds. (c)(2)(E) and (c)(4)(A).)
Appendix 1: Sample Size Chart

To determine the required number of completed surveys, identify the target sample size\textsuperscript{19} for each network by identifying the total number of contracted providers in the County/Network in the “Number of Providers in County/Network” column and the corresponding required target sample size.

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\textsuperscript{19} Sample sizes were calculated to produce confidence limits of $\pm$ 5\% for an expected compliance rate of 85\% with a 95\% confidence level. These target sample sizes are expected to produce maximum confidence limits of $\pm$ 5\% for county/networks.
## Sample Size Chart Continued

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<tr>
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<tr>
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<tr>
<td>41650 and above</td>
<td>196</td>
</tr>
</tbody>
</table>
Measurement Year 2019

Provider Appointment Availability Survey (PAAS)

Survey Tool
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</table>
Provider Appointment Availability Survey
Measurement Year 2019

Survey Tool Introduction

The Department of Managed Health Care developed this Survey Tool to conduct the Provider Appointment Availability Survey (PAAS) via the Three Step Protocol. The Survey Tool contains six survey scripts to be used in administering the PAAS. The Email, Electronic Communication or Fax Survey is used to administer the survey to all Provider Survey Types. The remaining five survey scripts are specific to each Provider Survey Type, and are used only to administer the survey telephonically.

Before making any changes to the Survey Tool, the health plan must review the MY 2019 PAAS Methodology for specifications related to allowable changes to the Survey Tool and eFiling requirements.

Instructions in the survey scripts, related to completing specific fields or administering the survey, are in italics. Responses to the survey and compliance calculations must be recorded in the Raw Data Template and submitted to the Department in the health plan’s Timely Access Compliance Report.
Email, Electronic Communication or Fax Survey Script

Please respond to this survey on or before mm/dd/yy; otherwise, (name of survey vendor) will contact you via phone to complete this survey.

Thank you for participating in this survey. Health plans are required by law to obtain information from their contracted providers regarding appointment availability. This survey is designed to assist [insert health plan name(s)] in assessing enrollee access to provider services. Please respond to this survey no later than five business days of this communication. [If sending a reminder, the health plan should change the requested response time to indicate the amount of time remaining to respond.]

The date and time you respond to the survey is used to calculate appointment wait times. Please indicate the date and time of this response:

Date: (mm/dd/yy)
Time: (hh:mm am/pm) PT

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm). If the online software or program used to conduct the survey accurately captures the time and date of the response in Pacific Time, this question must be omitted and this data must be used to populate the response date and time in the Raw Data Template. All fax surveys must include this field.]

[Confirm the provider’s contact information, including name and specialty. (Address, county, telephone number, NPI, etc. are optional fields that may be validated during the survey.) Health plans may allow the provider to update the contact information during the survey or provide information on how to separately report any updates or corrections to the provider’s information. In addition, the health plan should confirm the provider is eligible to take the survey.]

Please indicate whether any of the following items apply to [Provider Name or FQHC/RHC Name]:

__ I do not practice in [County].
__ I am retired or for other reasons am no longer practicing.
__ I am not [insert type of provider being surveyed].
__ [Provider Name or FQHC/RHC Name] is not affiliated with the email or fax number that this survey was sent to.
__ I do not provide [insert type of provider being surveyed] appointments.
__ I am not scheduling appointments because I am out of the office on leave (e.g., maternity leave, vacation, etc.).
[If the provider checked one of the first five items, record the provider as ineligible in the outcome field of the Raw Data Template and replace the provider with another provider from the oversample. If the provider is not scheduling appointments because he or she is on leave, in the Raw Data Template record “NA” in the question fields and “N” in the calculation fields to indicate that the provider does not have an urgent and non-urgent appointment available within the applicable appointment standards.]

If any of the above items apply, the survey is complete. Please submit the survey by [insert directions to submit the survey]. Thank you for your time.

If none of the above items apply, please note the following items and provide a response to the following questions:

- If patients are served on a walk-in or same day basis, provide the date and approximate time that a patient walking in at the time of the call would be seen.
- If appointment wait times depend upon whether the patient is a new or existing patient, use the earlier appointment date and time (shorter duration time).

**Question 1:**

Urgent services are for a condition which requires prompt attention, but does not rise to the level of an emergency. When is [Provider Name or FQHC/RHC Name]’s next available appointment date and time for urgent services? [Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT or indicate that this appointment type is not applicable and provide a brief explanation. ] [Urgent appointments are not measured for Ancillary Providers. Please exclude this question from surveys sent to Ancillary Providers and renumber the questions appropriately.]

**Calculation 1:**

[Record on the Raw Data Template in the urgent calculation field whether an urgent appointment is available within 48 hours (Primary Care Providers) or 96 hours (Specialist Physicians and Non-Physician Mental Health Providers). If NA, insert the explanation in the “Comment 1” field of the Raw Data Template.]

**Question 2:**

When is [Provider Name or FQHC/RHC Name]’s next available appointment date and time for non-urgent services? [Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT or indicate that this appointment type is not applicable and provide a brief explanation.]
Calculation 2:
[Record on the Raw Data Template in the non-urgent calculation field whether a non-urgent appointment is available within 15 business days (calculated as 21 calendar days) for Specialist Physicians, Psychiatrist and Ancillary Providers or within 10 business days (calculated as 14 calendar days) for Primary Care Providers and Non-Physician Mental Health Providers.¹ If NA, insert the explanation in the “Comment 2” field of the Raw Data Template.]

This concludes our survey. [Insert directions to submit the survey.] Thank you very much for your time.

¹ When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends must be included when calculating calendar days. The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes.
Telephonic Survey Introduction

The telephonic survey scripts for each of the five Provider Survey Types are set forth below. The following information is excerpted from the MY 2019 PAAS Methodology and provided here for the Survey Administrator’s convenience. Please note the information excerpted has been modified for use with the telephonic survey. Review the MY 2019 PAAS Methodology for complete information related to administering the survey.

Replacements of Non-Responding and Ineligible Providers

An ineligible or non-responding provider (defined below) shall be replaced if another provider from the oversample of the same Provider Survey Type and within the same County/Network is available. If a replacement of a provider is necessary, use the next available provider in the oversample as a replacement until the required sample size is reached. Continue to replace providers until either the required sample size is reached or all of the providers of that same Provider Survey Type in the County/Network have been exhausted.

Non-Responding Providers

A non-responding provider is a provider that does not respond to one or more applicable items within the required time-frame or that declines to participate in the survey.

Ineligible Providers

A provider is ineligible if he/she meets the definition of one or more of the following outcomes:

- “Provider not in Plan Network” – The provider no longer participates in the health plan’s network at the time the survey is administered or did not participate in the health plan’s network on December 31 of the prior year;
- “Provider not in County” – The provider does not practice in the relevant county at the time the survey is administered or on December 31 of the prior year;
- “Provider retired or ceasing to practice” – The provider retired or for other reasons is no longer practicing;
- “Provider Listed under Incorrect Specialty” – Was included in the Contact List under an incorrect Provider Survey Type;
- “Contact Information Issue (Incorrect Phone or Fax Number/Email)” – Was unable to be surveyed because he/she was listed in the database with incorrect contact information that could not be corrected; or
- “Provider does not offer Appointments” – The provider does not offer enrollees appointments (e.g., provides only hospital-based services or peer-to-peer e-consultation services).
Record the Response and/or Outcome in the Raw Data Template

Once the health plan has a response to the applicable survey questions (or has identified the provider as being ineligible or non-responsive), record the response and/or outcome to that provider for all applicable networks within the county in the Raw Data Template.

Compliance Determinations

For each response to the question related to the next available appointment, a calculation must be made to determine compliance. All compliance determinations shall be recorded on the Raw Data Template in the appropriate calculation field.

Survey Administration Notes

• If the provider reports that the wait time would depend upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (shorter duration time).

• If the provider reports that patients are served on a walk-in or same day basis, ask the provider to provide the date and approximate time that a patient walking in at the time of the call would be seen.

• If the provider is not scheduling appointments at the time of the survey because the provider is out of the office (e.g., vacation, maternity leave, etc.), in the Raw Data Template record “NA” in the appointment date and time fields and “N” in the calculation fields to indicate that the provider does not have an urgent and non-urgent appointment available within the applicable standard.

• If a provider declines to respond to the survey, offer the option to respond at a later time. If the provider is willing to participate later, the health plan shall offer the provider the option to receive a follow-up call within the next two business days. If the provider declines to receive a follow-up call or does not respond within the next two business days, record the provider as a non-responder on the Raw Data Template and replace the provider with another provider from the oversample.

• Referral of a patient to a different provider (e.g., a provider covering for a provider on vacation or in a separate urgent care center) cannot be recorded as the initially surveyed provider providing an appointment. An appointment offered at a different office in the same county with the same provider can be recorded as an available appointment with the initially surveyed provider. (For FQHCs/RHCs, appointment availability at a separate site with any provider of that Provider Survey Type within the same FQHC/RHC qualifies as an available appointment.)

• All survey calls shall be conducted during normal business hours.

(Issued 2/28/2019)
**Telephonic Primary Care Provider Survey Script**

**Introduction:**

"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health plan name(s)] to conduct an appointment availability survey. Health plans are required by law to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC Name]?

- If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]
- If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

**Validate Provider Information**

*If yes, validate the office information above with the person spoken to and conduct the survey. Please ensure that the surveyor has access to the provider’s address located within the appropriate county in case this information is necessary to access appointment data; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.*

---

2 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey, as appropriate.
If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in the Telephonic Survey Introduction, mark the provider as a non-responder or ineligible for the survey in outcome field of the Raw Data Template, then move on to the next provider in the oversample to ensure the required target sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.

**Question 1:**
“Urgent services are for a condition which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for urgent services?”

**Date:** mm/dd/yy
**Time:** hh:mm am/pm PT

- Not applicable. This provider does not offer urgent appointments.
- Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.

**Calculation 1:**
Calculate whether the appointment date and time in Question 1 is within 48 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template in the urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available urgent appointment within 48 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 48 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 48 hours because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent appointments.

(Go to Question 2.)

**Question 2:**
“When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?”

**Date:** mm/dd/yy
**Time:** hh:mm am/pm PT

- Not applicable. This provider does not offer non-urgent appointments.
- Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.
**Calculation 2:**
Calculate whether the appointment date and time in Question 2 is available within 10 business days (14 calendar days) of your request. Indicate in the Raw Data Template in the non-urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 10 business days.
- Mark "N" to indicate no, there is no available non-urgent appointment within 10 business days.
- Mark “N” to indicate no, there is no available urgent appointment within 10 business days because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.

(Conclude survey.)

“This concludes our survey. Thank you very much for your time.”

---

3 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends must be included when calculating calendar days. The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes.
Telephonic Specialist Physicians Survey Script

Date Survey Completed: ______________________________________ [mm/dd/yy]
Time Survey Completed: _________________________________ hh:mm am/pm] PT
Provider First Name: ___________________________________________
Provider Last Name: __________________________________________
FQHC/RHC Name: _________________________________________________
Person Spoken to: ______________________________________________ ___
Health plan creating survey data:___________________________________________
Name of individual conducting survey:_______________________________________
Provider Survey Type: ______Specialist Physicians
Specially/Subspecialty:
   ____ Cardiovascular Disease
   ____ Endocrinology
   ____ Gastroenterology
Address: _____________________________________________ [Optional to validate]
County of this Office Location: ____________________________ [Optional to validate]

Introduction:
"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health plan name(s)] to conduct an appointment availability survey. Health plans are required by law to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC Name]?

- If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

- If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

Validate Provider Information
If yes, validate the office information above with the person spoken to and conduct the survey. Please ensure that the surveyor has access to the provider’s address located within the appropriate county in case this information is necessary to access appointment data; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

__________

4 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey, as appropriate.
If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in the Telephonic Survey Introduction, mark the provider as a non-responder or ineligible for the survey in outcome field of the Raw Data Template, then move on to the next provider in the oversample to ensure the required target sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.

**Question 1:**
“Urgent services are for a condition which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for urgent services?”

<table>
<thead>
<tr>
<th>Date: mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time: hh:mm am/pm PT</td>
</tr>
<tr>
<td>Not applicable. This provider does not offer urgent appointments.</td>
</tr>
<tr>
<td>Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.</td>
</tr>
</tbody>
</table>

**Calculation 1:**
Calculate whether the appointment date and time in Question 1 is within 96 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template in the urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available urgent appointment within 96 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 96 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 96 hours because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent appointments.

(Go to Question 2.)

**Question 2:**
“When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?”

<table>
<thead>
<tr>
<th>Date: mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time: hh:mm am/pm PT</td>
</tr>
<tr>
<td>Not applicable. This provider does not offer non-urgent appointments.</td>
</tr>
</tbody>
</table>
| Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.
Calculation 2:
Calculate whether the appointment date and time in Question 2 is available within 15 business days (21 calendar days) of your request. 5 Indicate in the Raw Data Template in the non-urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 15 business days.
- Mark “N” to indicate no, there is no available non-urgent appointment within 15 business days.
- Mark “N” to indicate no, there is no available urgent appointment within 15 business days because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.

(Conclude survey.)

“This concludes our survey. Thank you very much for your time.”

---

5 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends must be included when calculating calendar days. The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes.
Telephonic Psychiatrists Survey Script

Date Survey Completed:________________________________________ [mm/dd/yy]
Time Survey Completed:________________________ hh:mm am/pm PT
Provider First Name: _____________________________________________
Provider Last Name: _____________________________________________
FQHC/RHC Name: _________________________________________________
Person Spoken to: ________________________________________________
Health plan creating survey data:_____________________________________
Name of individual conducting survey:_____________________________________
Provider Survey Type: ______Psychiatry
Address: _____________________________________________ [Optional to validate]
County of this Office Location: ____________________________ [Optional to validate]

**Introduction:**

"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health plan name(s)] to conduct an appointment availability survey. Health plans are required by law to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC Name]?

- If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

- If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

**Validate Provider Information**

If yes, validate the office information above with the person spoken to and conduct the survey. Please ensure that the surveyor has access to the provider's address located within the appropriate county in case this information is necessary to access appointment data; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

---

6 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey, as appropriate.
If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in the Telephonic Survey Introduction, mark the provider as a non-responder or ineligible for the survey in outcome field of the Raw Data Template, then move on to the next provider in the oversample to ensure the required target sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.

**Question 1:**
“Urgent services are for a condition which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for urgent services?”

<table>
<thead>
<tr>
<th>Date: mm/dd/yy</th>
<th>Time: hh:mm am/pm PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable. This provider does not offer urgent appointments.</td>
<td></td>
</tr>
<tr>
<td>Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.</td>
<td></td>
</tr>
</tbody>
</table>

**Calculation 1:**
Calculate whether the appointment date and time in Question 1 is within 96 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template in the urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available urgent appointment within 96 hours. Mark “N” to indicate no, there is no available urgent appointment within 96 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 96 hours because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent appointments.

(Go to Question 2.)

**Question 2:**
“When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?”

<table>
<thead>
<tr>
<th>Date: mm/dd/yy</th>
<th>Time: hh:mm am/pm PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable. This provider does not offer non-urgent appointments.</td>
<td></td>
</tr>
<tr>
<td>Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.</td>
<td></td>
</tr>
</tbody>
</table>

(Submitted 2/28/2019)
**Calculation 2:**

Calculate whether the appointment date and time in Question 2 is available within 15 business days (21 calendar days) of your request. ⁷ Indicate in the Raw Data Template in the non-urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 15 business days.
- Mark "N" to indicate no, there is no available non-urgent appointment within 15 business days.
- Mark “N” to indicate no, there is no available urgent appointment within 15 business days because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.

(Conclude survey.)

“This concludes our survey. Thank you very much for your time.”

---

⁷ When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends must be included when calculating calendar days. The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes.
Telephonic Non-Physician Mental Health Care Providers Survey Script

Date Survey Completed: _________________________________ [mm/dd/yy]
Time Survey Completed: _________________________________ [hh:mm am/pm] PT
Provider First Name: __________________________________________
Provider Last Name: ____________________________________________
FQHC/RHC Name: ______________________________________________
Person Spoken to: ________________________________________________
Health plan creating survey data: _________________________________
Name of individual conducting survey: _____________________________
Provider Survey Type: ______ Non-Physician Mental Health Provider (NPMH)
License Type: ______________________________________________________
Address: ____________________________________________ [Optional to validate]
County of this Office Location: ___________________________[Optional to validate]

Introduction:
"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health plan name(s)] to conduct an appointment availability survey. Health plans are required by law to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC Name]?

- If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

- If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

Validate Provider Information
If yes, validate the office information above with the person spoken to and conduct the survey. Please ensure that the surveyor has access to the provider's address located within the appropriate county in case this information is necessary to access appointment data; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

8 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey, as appropriate.
If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in the Telephonic Survey Introduction, mark the provider as a non-responder or ineligible for the survey in outcome field of the Raw Data Template, then move on to the next provider in the oversample to ensure the required target sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.

**Question 1:**
“Urgent services are for a condition which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for urgent services?”

<table>
<thead>
<tr>
<th>Date:</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>hh:mm am/pm PT</td>
</tr>
</tbody>
</table>

_____ Not applicable. This provider does not offer urgent appointments.

_____ Not applicable. This provider is out of the office on extended leave.

**Calculation 1:**
Calculate whether the appointment date and time in Question 1 is within 96 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template in the urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available urgent appointment within 96 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 96 hours.
- Mark “N” to indicate no, there is no available urgent appointment within 96 hours because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent appointments.

(Go to Question 2.)
**Question 2:**

“When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?”

<table>
<thead>
<tr>
<th>Date</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>hh:mm am/pm PT</td>
</tr>
</tbody>
</table>

- Not applicable. This provider does not offer non-urgent appointments.
- Not applicable. This provider is out of the office on extended leave.

**Calculation 2:**

Calculate whether the appointment date and time in Question 2 is available within 10 business days (14 calendar days) of your request.  

9 Indicate in the Raw Data Template in the non-urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 10 business days.
- Mark “N” to indicate no, there is no available non-urgent appointment within 10 business days.
- Mark “N” to indicate no, there is no available urgent appointment within 15 business days because the provider is not scheduling appointments while he or she is out of the office on leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.

(Conclude survey.)

“This concludes our survey. Thank you very much for your time.”

---

9 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends must be included when calculating calendar days. The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes.
Telephonic Ancillary Service Providers Survey Script

Date Survey Completed: ______________________________________ [mm/dd/yy]
Time Survey Completed: ______________________________________ [hh:mm am/pm] PT
Provider First Name: ___________________________________________
Provider Last Name: ___________________________________________
FQHC/RHC Name: ______________________________________________
Person Spoken to: ______________________________________________
Health plan creating survey data: ____________________________________
Name of individual conducting survey: ______________________________
Specialty / Subspecialty: __________________________________________
Provider Survey Type: ____________________________________________
[________Mammogram
________Physical Therapy]
Address: ______________________________________________________ [Optional to validate]
County of this Office Location: ________________________________ [Optional to validate]

Introduction:
"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health
plan name(s)] to conduct an appointment availability survey. Health plans are required by law
to obtain information from their contracted providers regarding appointment availability. This
survey should take no more than [five] minutes. Are you the appropriate person to respond
to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC
Name]?

- If no, "May I speak to someone in the office who is able to respond to survey questions
  regarding the scheduling of appointments in your office?" [Repeat introduction when
  transferred to the appropriate person.]

- If no one is available, ask what time would be convenient during the next two business
days to call-back. Schedule and conduct follow-up calls within two business days.

Validate Provider Information
If yes, validate the office information above with the person spoken to and conduct the survey.
Please ensure that the surveyor has access to the provider's address located within the
appropriate county in case this information is necessary to access appointment data;
however, the survey questions relate to the next available appointment at any office in the
county the medical provider delivers services.

---

10 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey, as
appropriate.
If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in the Telephonic Survey Introduction, mark the provider as a non-responder or ineligible for the survey in outcome field of the Raw Data Template, then move on to the next provider in the oversample to ensure the required target sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.

**Question 1:**
“When is the next available appointment date and time with [Provider Facility or Entity Name or FQHC/RHC Name] for non-urgent [Mammogram or Physical Therapy] services?”

<table>
<thead>
<tr>
<th>Date:</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>hh:mm am/pm PT</td>
</tr>
</tbody>
</table>

Not applicable. This provider does not offer non-urgent appointments.

Not applicable. This provider is out of the office on extended leave.

**Calculation 1:**
Calculate whether the appointment date and time in Question 1 is available within 15 business days (21 calendar days) of your request.\(^{11}\) Indicate in the Raw Data Template in the non-urgent calculation field whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 15 business days.
- Mark “N” to indicate no, there is no available non-urgent appointment within 15 business days.
- Mark “N” to indicate no, there is no available non-urgent appointment within 15 business days because the provider is out of the office on extended leave.
- Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.

(Conclude survey.)

“This concludes our survey. Thank you very much for your time.”

---

\(^{11}\) When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends are included in calculating calendar days. The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes.
### CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS*

<table>
<thead>
<tr>
<th>MINORS OF ANY AGE MAY CONSENT</th>
<th>LAW/DETAILS</th>
<th>MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREGNANCY</strong></td>
<td>“A minor may consent to medical care related to the prevention or treatment of pregnancy,” except sterilization. (Cal. Family Code § 6925).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</td>
</tr>
<tr>
<td><strong>CONTRACEPTION</strong></td>
<td>A minor may receive birth control without parental consent. (Cal. Family Code § 6925).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (American Academy of Pediatrics v. Lungren, 16 Cal.4th 307 (1997); Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</td>
</tr>
<tr>
<td><strong>ABORTION</strong></td>
<td>A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; American Academy of Pediatrics v. Lungren, 16 Cal.4th 307 (1997)).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (American Academy of Pediatrics v. Lungren, 16 Cal.4th 307 (1997); Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</td>
</tr>
<tr>
<td><strong>SEXUAL ASSAULT¹ SERVICES</strong></td>
<td>“A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard to the …assault.” (Cal. Family Code § 6928).</td>
<td>The health care provider must attempt to contact the minor’s parent/guardian and note in the minor’s record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928). Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters. The child abuse authorities investigating a child abuse report legally may disclose to parents that a report was made. (See Cal. Penal § 11167 and 11167.5.).</td>
</tr>
<tr>
<td><strong>RAPE² SERVICES FOR MINORS UNDER 12 YRS³</strong></td>
<td>A minor under 12 years of age who may have been raped “may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard” to the rape. (Cal. Family Code § 6928).</td>
<td></td>
</tr>
</tbody>
</table>

¹For the purposes of minor consent health care alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.

²Rape is defined in Cal. Penal Code § 261.

³See also “Rape Services for Minors 12 and Over” on page 3 of this chart.
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>EMERGENCY MEDICAL SERVICES</strong>*</td>
<td>A provider shall not be liable for performing a procedure on a minor if the provider “reasonably believed that [the] procedure should be undertaken immediately and that there was insufficient time to obtain [parental] informed consent.” (Cal. Bus. &amp; Prof. Code § 2397).</td>
<td>The parent or guardian usually has a right to inspect the minor’s records. (Cal. Health &amp; Safety Code §§ 123110(a); Cal. Civ. Code § 56.10. <em>But see exception at endnote (EXC).</em>).</td>
</tr>
<tr>
<td>*An emergency is “a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death” (Cal. Code Bus. &amp; Prof. § 2397(c)(2)).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT</strong></td>
<td>“A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of.” (Cal. Penal Code § 11171.2).</td>
<td>Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.</td>
</tr>
<tr>
<td>* The provider does not need the minor’s or parent’s consent to perform a procedure under this section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT</strong></td>
<td><strong>LAW/DETAILS</strong></td>
<td>MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?</td>
</tr>
<tr>
<td><strong>INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES (DIAGNOSIS, TREATMENT)</strong></td>
<td>“A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease… is one that is required by law…to be reported…” (Cal. Family Code § 6926).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</td>
</tr>
<tr>
<td><strong>SEXUALLY TRANSMITTED DISEASES (PREVENTIVE CARE, DIAGNOSIS, TREATMENT)</strong></td>
<td>A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the prevention, diagnosis or treatment of the disease. (Cal. Family Code § 6926).</td>
<td></td>
</tr>
<tr>
<td><strong>MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT</strong></td>
<td><strong>LAW/DETAILS</strong></td>
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<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td><strong>AIDS/HIV (PREVENTIVE CARE, TESTING, DIAGNOSIS, AND TREATMENT)</strong></td>
<td>A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020). A minor 12 and older may consent to medical care related to the prevention, diagnosis and treatment of HIV/AIDS. (Cal. Family Code § 6926). Services currently available include pre- and post- exposure prophylaxis medication to prevent HIV infection (PrEP and PEP).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</td>
</tr>
<tr>
<td><strong>RAPE SERVICES FOR MINORS 12 and OVER</strong></td>
<td>“A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.” (Cal. Family Code § 6927).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11). Rape of a minor is considered child abuse under California law and mandated reporters, including health care providers, must report it as such. Providers cannot disclose to parents that they have made this report without the adolescent’s authorization. However, adolescent patients should be advised that the child abuse authorities investigating the report may disclose to parents that a report was made.</td>
</tr>
<tr>
<td><strong>INTIMATE PARTNER VIOLENCE</strong></td>
<td>“A minor who is 12 years of age or older and who states he or she is injured as a result of intimate partner violence may consent to medical care related to the diagnosis or treatment of the injury and the collection of medical evidence with regard to the alleged intimate partner violence.” (Cal. Family Code § 6930).</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11). If the health provider providing treatment believes that the injuries require a child abuse report, the health provider shall do both of the following: (1) Inform the minor that the report will be made and (2) Attempt to contact the minor’s parent or guardian and inform them of the report. The health practitioner shall note in the minor’s treatment record the date and time of the attempt to contact the parent or guardian and whether the attempt was successful or unsuccessful. This paragraph does not apply if the health practitioner reasonably believes that the minor’s parent or guardian committed the intimate partner violence on the minor. (Cal. Family Code § 6930(c)).</td>
</tr>
</tbody>
</table>

*For the purposes of minor consent health care alone, “intimate partner violence” means an intentional or reckless infliction of bodily harm that is perpetrated by a person with whom the minor has or has had a sexual, dating, or spousal relationship.” If the minor is seeking services as a result of a rape or sexual assault, minor consent services should be provided under the “sexual assault” or “rape” minor consent laws rather than this law. (Cal. Family Code § 6930(b)).

**THIS LAW GOES INTO EFFECT IN JANUARY 2019:**
<table>
<thead>
<tr>
<th>MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT</th>
<th>LAW/DETAILS</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT MENTAL HEALTH SERVICES</strong> / SHELTER SERVICES</td>
<td>Two statutes give minors the right to consent to mental health treatment. If a minor meets the criteria under either statute, the minor may consent to his or her own treatment. If the minor meets the criteria under both, the provider may decide which statute to apply. There are differences between them. See endnote ** for more on these differences:</td>
<td></td>
</tr>
<tr>
<td>Family Code § 6924</td>
<td>“A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. AND (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.” (Cal. Family Code § 6924.)</td>
<td><strong>MENTAL HEALTH TREATMENT:</strong> The health care provider is required to involve a parent or guardian in the minor’s treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor’s record. (Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii).) For services provided under Health and Safety Code § 124260, providers must consult with the minor before deciding whether to involve parents. (Cal. Health &amp; Saf. Code § 124260(a).)</td>
</tr>
<tr>
<td>Health &amp; Safety Code § 124260</td>
<td>“[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services.” (Cal. Health &amp; Saf. Code § 124260.)</td>
<td>While this exception allows providers to inform and involve parents in treatment when appropriate, it does not give providers a right to disclose medical records to parents without the minor’s authorization. The provider can only share the minor’s medical records with parents with a signed authorization from the minor. (Cal. Health &amp; Saf. Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11, 56.30; Cal. Welf. &amp; Inst. Code § 5328. See also endnote(EXC).)</td>
</tr>
</tbody>
</table>

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**SHELTER:**

Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services.
<table>
<thead>
<tr>
<th>MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT</th>
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<th>MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRUG AND ALCOHOL ABUSE TREATMENT</strong></td>
<td></td>
<td>There are different confidentiality rules under federal and state law.  Providers meeting the criteria listed under ‘federal’ below must follow the federal rule. Providers that don’t meet these criteria follow state law.</td>
</tr>
<tr>
<td>- This section does not authorize a minor to receive replacement narcotic abuse treatment without the consent of the minor's parent or guardian.</td>
<td>“A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem.” (Cal. Family Code §6929(b)).</td>
<td><strong>FEDERAL</strong>: Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria:  1. The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.) (42 C.F.R. §2.12); AND  2. The individual or program:  1) Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; OR  2) Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; OR  3) Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. (42 C.F.R. §2.11; 42 C.F.R. §2.12).  For individuals or programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor’s written consent. One exception, however, is that an individual or program may share with parents if the individual or program director determines the following three conditions are met: (1) that the minor’s situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor’s parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. (42 C.F.R. §2.14).  <strong>STATE RULE</strong>: Cal. Family Code §6929(c). Parallels confidentiality rule described under “Mental Health Treatment” at page 4 above. See also exception at endnote (EXC).</td>
</tr>
<tr>
<td>- This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor’s parent or guardian consents for that treatment. (Cal. Family Code §6929(f)).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MINOR 15 YEARS OF AGE OR OLDER</td>
<td>LAW/DETAILS</td>
<td>MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td><strong>GENERAL MEDICAL CARE</strong></td>
<td>“A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence. (3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.” (Cal. Family Code § 6922(a).)</td>
<td>“A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.” (Cal. Family Code § 6922(c). See also exception at endnote (EXC)).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)</th>
<th>LAW/DETAILS</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL MEDICAL CARE for EMANCIPATED YOUTH</strong></td>
<td>An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). See Cal. Family Code § 7002 for emancipation criteria.</td>
<td>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health &amp; Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</td>
</tr>
</tbody>
</table>

This chart may be reproduced for individual use if accompanied by an acknowledgement.

**Endnotes:**

* There are many confidentiality and consent rules. Different rules apply in different contexts. This chart addresses the rules that apply when minors live with their parents or guardians. It does not address the rules that apply when minors are under court jurisdiction or in other special living situations. Further, the confidentiality section focuses on parent and provider access. It does not address when other people or agencies may have a right to access otherwise confidential information.

** In addition to having slightly different eligibility criteria, there are other small differences between Health and Safety Code §124260 and Family Code § 6924. For example, the two laws both allow “professional persons” to deliver minor consent services but the two laws define “professional person” differently. Also, there is a funding restriction that applies to Health and Safety Code §124260 but not to Family Code § 6924. (See Cal. Family Code 6924, Cal. Health & Saf. Code § 124260 and Cal. Welf. & Inst. Code § 14029.8 and look for more information on www.teenhealthlaw.org.).

**EXC** : Providers may refuse to provide parents access to a minor’s medical records, where a parent normally has a right to them, if “the health care provider determines that access to the patient records requested by the [parent or guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being.” Cal. Health & Safety Code § 123115(a)(2). A provider shall not be liable for any good faith decisions concerning access to a minor’s records. Id.

§ 51323. Medical Transportation Services.
22 CA ADC § 51323
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

(a) Ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.

(1) Ambulance services are covered when the patient's medical condition contraindicates the use of other forms of medical transportation.

(2) Litter van services are covered when the patient's medical and physical condition:

(A) Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport.

(B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.

(3) Wheelchair van services are covered when the patient's medical and physical condition:

(A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

(B) Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation.

(2) LEA specialized medical transportation services shall not be subject to subsection (a)(2)(A)1.

(b) Authorization shall be granted or Medi-Cal reimbursement shall be approved only for the lowest cost type of medical transportation that is adequate for the patient's medical needs, and is available at the time transportation is required.

(1) Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the patient. Each claim for program reimbursement of emergency medical transportation shall be accompanied by a written statement which will support a finding that an emergency existed. Notwithstanding Section 51056 (b), the statement may be made by the provider of the emergency transportation, describing the circumstances necessitating the emergency service. The statement shall include the name of the person or agency requesting the service, the nature and time of the emergency, the facility to which the patient was transported, relevant clinical information about the patient's condition, why the emergency services rendered were considered to be immediately necessary and the name of the physician accepting responsibility for the patient at the facility.
(2) All nonemergency medical transportation, necessary to obtain program covered services, requires a physician’s, dentist’s or podiatrist’s prescription and prior authorization except as provided in (C).

(A) When the service needed is of such an urgent nature that written authorization could not have reasonably been submitted beforehand, the medical transportation provider may request prior authorization by telephone. Such telephone authorization shall be valid only if confirmed by a written request for authorization.

(B) Transportation shall be authorized only to the nearest facility capable of meeting the patient’s medical needs.

(C) Nonemergency transportation services are exempt from prior authorization when provided to a patient being transferred from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility licensed pursuant to Section 1250 of the Health and Safety Code.

(c) Medical transportation by air is covered under the following conditions:

(1) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply:

(A) The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1).

(B) The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1).

(2) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14115.8, 14124.5 and 14132.06, Welfare and Institutions Code. Reference: Sections 14115.8, 14132, 14132.06 and 14136.3, Welfare and Institutions Code.

HISTORY

1. New subsection (d) filed 7-6-82 as an emergency; effective upon filing (Register 82, No. 28). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 11-3-82. For prior history, see Register 82, No. 18.

2. Certificate of Compliance as to 7-6-82 order transmitted to OAL 11-3-82 and filed 12-3-82 (Register 82, No. 49).

3. Amendment of subsection (b) filed 4-11-84; effective thirtieth day thereafter (Register 84, No. 15).

4. Repealer of subsection (d) filed 8-9-85; effective thirtieth day thereafter (Register 85, No. 32).

5. Amendment of subsection (b)(2)(C), designation of portion of subsection (b)(2)(C) as new subsection (b)(2)(C)1. and amendment thereof, new subsections (b)(2)(C)2.-3., and amendment of Note filed 4-1-96 as an emergency; operative 4-1-96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 9-30-96 pursuant to Welfare and Institutions Code section 14132.22 or emergency language will be repealed by operation of law on the following day.

6. Editorial correction of History 5 (Register 96, No. 35).

7. Amendment of subsection (b)(2)(C), designation of portion of subsection (b)(2)(C) as new subsection (b)(2)(C)1. and amendment thereof, new subsections (b)(2)(C)2.-3., and amendment of Note refiled 8-28-96 as an emergency; operative 9-30-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-28-97 or emergency language will be repealed by operation of law on the following day.

8. Editorial correction of subsection (b)(2)(C)3. (Register 97, No. 11).

9. Certificate of Compliance as to 8-28-96 order transmitted to OAL 1-23-97 and filed 3-10-97 (Register 97, No. 11).

10. Change without regulatory effect amending subsection (b)(2)(C), repealing subsections (b)(2)(C)1.-3. and amending Note filed 6-12-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 24).


This database is current through 4/28/17 Register 2017, No. 17

22 CCR § 51323, 22 CA ADC § 51323

END OF DOCUMENT
Non-Emergency Medical Transportation (NEMT)  
Physician Certification Statement

INSTRUCTIONS

1. IEHP requires the submission of this Physician Certification Statement form, signed by the Member’s Primary Care Physician or treating Physician when requesting for Non-Emergent Medical Transportation (NEMT) services. This certification is valid for one (1) year from the date of the physician’s signature.

2. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) do not require the submission of this form. Members requesting NMT services should be directed to call American Logistics Company at (855) 673-3195.

3. Please fax the completed and signed form to IEHP at (909) 912-1049.

MEMBER INFORMATION

Member Name
Member DOB
Member IEHP ID
Date Transportation Needed

Mode of Transportation Needed. Please check (✓) one.

- [ ] Ambulance
- [ ] Litter van/Gurney
- [ ] Wheelchair van
- [ ] Car/Sedan
- [ ] Air
- [ ] Other

Physical and Medical Limitations. Please check (✓) all that applies.

- [ ] Paraplegic
- [ ] Hemiplegic
- [ ] Non-ambulatory
- [ ] High fall risk due to (please specify) _____________________________
- [ ] Poor exercise tolerance
- [ ] Requires oxygen
- [ ] Hemodialysis
- [ ] Requires extensive medical support (e.g., ventilator, IV)
- [ ] Dementia
- [ ] Behavioral issues
- [ ] Blind
- [ ] Other (please specify) _____________________________

CERTIFICATION STATEMENT

I certify and attest that I am the treating Physician/Primary Care Physician for the member and have determined medical necessity for the transportation indicated above.

Physician/Provider Name
NPI #
Physician/Provider Signature
Date
HEALTH AND SAFETY CODE
SECTION 1367.695

1367.695. (a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not be construed to diminish the provisions of Section 1367.69.

(e) The Department of Managed Health Care shall report to the Legislature, on or before January 1, 2000, on the implementation of this section.

11/14/2012
### iPad's Supported

- Running iOS Version 9 or higher.
  - iPad (5th/6th Generation)
  - iPad Pro
  - iPad Air 2/Air
  - iPad Mini 4/3/2
  - iPad (3rd and 4th Generation)
  - iPad 2

**Recommended:** iPad (5th/6th Generation)/iPad Pro/iPad Air2

### Mac Operating System

- Using the latest version of Google Chrome or Firefox.
  - Mac OS X 10.9 or later
  - Processor: 64-bit, 1 gigahertz (GHz) or more
  - 1G of free disk space
  - 2G of RAM

**Recommended:** MacOS 10.12 Sierra

### Windows Operating System

- Using the latest version of Google Chrome or Firefox.
  - Windows 7, Windows 8, or Windows 10
  - Processor: 64-bit, 1 gigahertz (GHz) or more
  - 1G of free disk space
  - 2G of RAM

### Android Devices

Some Android devices are compatible with Interpreting software (InSight) using the latest version of Google Chrome.

### Peripheral Cameras

- Logitech HD Pro C930, C920, C910