9. ACCESS STANDARDS

A. Access Standards

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APPLIES TO:

A. This policy applies to all IEHP DualChoice Members and Providers.

POLICY:

A. All applicable Practitioners including Primary Care Providers (PCPs) and Specialists must meet the access standards delineated below to participate in the IEHP network.

B. IPAs are responsible for monitoring their network to ensure adherence with the access standards described in this policy.

C. IEHP monitors plan-wide adherence to these access standards through IEHP and IPA performed access studies, review of grievances and other methods.

D. IEHP shall not prevent, discourage, or discipline a network Provider or employee for informing a Member about the timely access standards.[1]

E. All Members must receive access to all covered services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code Section 422.56, except as needed to provide equal access to Limited English Proficiency (LEP) Members or Members with disabilities, or as medically indicated. [2,3,4]

DEFINITIONS:

A. **Appointment Waiting Time** – The time from the initial request for health care services by a Member or the Member's treating Provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the Plan or completing any other condition or requirement of the Plan or its contracting Providers.[5] A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.

B. **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:[6]

   1. Placing the health of the individual (or in the case of a pregnant woman, the health of the

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.03(d)
[2] Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Section 10.5.2
[3] Title 42 Code of Federal Regulations (CFR) §438.100 (b)(2)
[4] Medicare Communications and Marketing Guidelines (MCMG), "Anti-Discrimination", Section 30.1
[5] Title 28 California Code of Regulations (CCR) § 1300.67.2.2(b)(2)
[6] Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Section 20.2

9.   ACCESS STANDARDS

A.   Access Standards

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.

C.   **Initial Health Assessment** – See Policy 10C, "Initial Health Assessment."

D.   **Initial Prenatal Visit** – These are health care services needed to determine potential risk factors and the care plan for a woman during the period of pregnancy.

E.   **Network -** A discrete set of network Providers, the Plan has designated to deliver all covered services for a specific network service area.[7]

F.   **Network Adequacy -** The sufficiency of a Plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements.[8]

G.   **Network Provider – A**ny Provider[9] located inside or outside of the network service area of a designated network.[10]

H.   **Network Services Area -** The geographical area, and population points contained therein, where the plan is approved by DMHC to arrange health care services consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by DMHC on the web portal accessible at www.dmhc.ca.gov.[11]

I.   **Non-Urgent (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.

J.   **Non-Urgent (Routine) Specialist Visit** – These are referrals to a health care professional who has advanced education and training in a specific area.

K.   **Non-Urgent (Routine) Visit** – These are health care services needed to diagnose and/or treat medical conditions that do not need urgent care or emergent attention.

L.   **Physical Examination –** This is a routine preventive exam occurring every one to three (1-3) years.

M.   **Preventive Care -** Health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full-service plan includes but is not limited

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[7] 28 CCR § 1300.67.2.2(b)(5)
[8] 28 CCR § 1300.67.2.2(b)(6)
[9] California Health and Safety Code (Health & Saf. Code) § 1345(i)
[10] 28 CCR § 1300.67.2.2(b)(10)
[11] 28 CCR § 1300.67.2.2(b)(11)

to all of the basic health care services.[12,13,14]

N. **Triage or Screening** – This means the assessment of a Member's health concerns and symptoms through communication with a physician, registered nurse (RN), or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who many need care, for the purpose of determining the urgency of the Member's need for care. Other qualified health professionals include nurse practitioners (NP) and physician assistants (PA).

O. **Urgent Care Services** – These are health care services needed to diagnose and/or treat medical conditions that are of enough severity that care is needed urgently but are not emergency medical conditions.

P. **Urgent Prenatal Visit** – 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 urgently but are not emergency medical conditions.

Q. **Urgent Visit** – These are health care services to address an urgent non-emergency medical conditions.

R. **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 urgent or routine visits, the IEHP Member must be seen at that office on the same day in which the Member was advised to visit.

PROCEDURES:

A. **Access Standards for Clinical Services**

1. Appointment Standards – Members must be offered appointments within the following timeframes:

Primary Care Provider (PCP) and Obstetrics/Gynecology (OB/GYN) Primary Care	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do not require prior authorization	Within forty-eight (48) hours of request
Urgent visit for services that do require prior authorization	Within ninety-six (96) hours of request
Non-urgent (routine) visit	Within ten (10) business days of request

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[12] 28 CCR § 1300.67.2.2(b)(3)
[13] CA Health & Saf. Code § 1345(b)(5)
[14] CA Health & Saf. Code § 1367.03(e)(3)

9.   ACCESS STANDARDS

A.   Access Standards

Initial health assessment [15,16]	Within one hundred twenty (120) calendar days of enrollment
Initial Preventive Physical Exam	Thirty (30) days (complete the exam within one hundred twenty (120) days of the Member's enrollment and annually thereafter)
Follow up exam	As directed by Physician

Specialist	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do <u>not</u> require prior authorization	Within forty-eight (48) hours of request
Urgent visit for services that do require prior authorization	Within ninety-six (96) hours of request
Urgent prenatal visit	Within forty-eight (48) hours of request
Non-urgent (routine) visit	Within fifteen (15) business days of request
Non-urgent visit for ancillary services (for diagnosis or treatment of injury or other health condition)	Within fifteen (15) business days of request
Initial Prenatal Visit	Within two (2) weeks of request
Non-Urgent (routine) prenatal care	Within two (2) weeks of request
Follow up exam	As directed by Physician

a. <u>Shortening or Expanding Appointment Times</u> – The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, 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 Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.

b. <u>Preventive Care</u> – Preventive care services and periodic follow -up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care Practitioner acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to Specialists for chronic conditions, periodic office visits to monitor and

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[15] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Member under Twenty-One (21) Years of Age
[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 6, Services for Adults

9.   ACCESS STANDARDS

A.   Access Standards

treat pregnancy and other conditions, laboratory, and radiological monitoring for recurrence of disease.

   c. 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 ensure the Member's timely access to needed health care services. Please see Policy MA_9B, "Missed Appointments."

2. Waiting Times

   a. Practitioner Office – For primary or specialty 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.

   b. Urgent Care Center – Urgent Care Centers are designed to serve Members, who are unable to make an appointment with their PCP or Specialist for their urgent non-emergent conditions. 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.

   c. Health Plan Call Center – During normal business hours, the waiting time for a Member to speak by telephone with a plan representative knowledgeable and competent regarding the Member's questions and concerns must limit average wait time to two (2) minutes. Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person. Calls received after normal business hours (Monday-Friday, 8am-8pm and Saturday-Sunday, 8am-5pm) are returned within one (1) business day. Calls received after midnight are responded to the same business day.

   d. Triage, Screening and Advice – The waiting time to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care, must not exceed thirty (30) minutes.

3. Time or Distance Standards – Time or distance standards apply to OB/GYN primary care services only if a Member elects to use the OB/GYN as a PCP. IEHP does not require OB/GYNs to act as PCPs, regardless of how they are utilized.

   a. Proximity of PCPs and OB/GYN Primary Care to Members – IEHP network PCPs must be located within ten (10) miles or fifteen (15) minutes travel time from assigned their Members' residence, as applicable, based on geographic regions.[17]

   b. Proximity of Specialists, OB/GYNs, Behavioral Health, and other Providers – IEHP network Specialists, OB/GYNs, Behavioral Health and other Providers must be

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[17] CMS Medicare-Medicaid Plan (MMP) Application & Annual Requirements, CY 2020 MMP Health Service Delivery Network Adequacy Standards Criteria Reference Table

9. ACCESS STANDARDS

A. Access Standards

        located within thirty (30) miles or sixty (60) minutes travel time from assigned Members residence, as applicable, based on geographic regions.

  c. <u>Proximity of Hospital</u> – IEHP network hospitals must be located within thirty (30) miles or forty-five (45) minutes travel time from their assigned Members' residence.[18]

  d. <u>Proximity of Pharmacy</u> – IEHP network pharmacies must be located within ten (10) miles or thirty (30) minutes travel time from the Members' residence, as applicable, based on geographic regions.

4. Provider Shortage

  a. 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 in neighboring service areas to obtain the necessary health care services in a timely manner appropriate for the Member's needs. The IPA shall arrange and authorize as appropriate specialty services from specialists outside IEHP's contracted network if unavailable within the network, when medically necessary for the Member's condition or when time or distance standards as established by regulators are not met and at no cost to the Member. It is important to note that IEHP or its IPAs may not meet Time or Distance Standards and are not utilizing Telehealth to meet compliance for certain zip codes or specialties due to a lack of available Providers with whom to contract in those specific areas; or when a significant change occurs in the Network and no longer meet time or distance standards, but must have Alternative Access Standards as approved by DHCS. Please see Policy MA_14D, "Pre-Service Referral Authorization Process" for more information.

5. Telehealth Services[19]

  a. IEHP utilized Telehealth Providers to meet time or distance standards, as well as to provide Members with access to necessary health care services, except for General Surgery, Orthopedic Surgery, Physical Medicine, Rehabilitation, and Hospital services. IEHP must submit documentation to the Department of Health Care Services (DHCS) before using these Telehealth Providers.

  b. The use of Telehealth Providers to meet time or distance standards does not absolve IEHP's responsibility to provide Members with access to in-person services if the Member prefers.[20,21,22]

  c. IEHP must provide transportation to a network Provider and meet timely access

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[18] CMS Medicare-Medicaid Plan (MMP) Application & Annual Requirements, CY 2020 MMP Health Service Delivery Network Adequacy Standards Criteria Reference Table
[19] Welf. & Inst. Code § 14197 (f)(1-2)
[20] Welf. & Inst. Code § 14197 (e)(1)(A)
[21] Welf. & Inst. Code § 14197 (e)(4)
[22] Welf. & Inst. Code § 14132.72 (f)

9. ACCESS STANDARDS

A.   Access Standards

standards for medically necessary services when a Member is offered a Telehealth visit but request an in-person visit.

d.   If IEHP is unable to arrange for an in-person visit with a network Provider, IEHP must authorize OON services and provide transportation to the appointment as needed.

e.   IEHP may use third-party corporate Telehealth Providers due to a Member's choice to use Telehealth or in-person services, IEHP cannot auto-assign a Member to a third party corporate Telehealth Providers.[23]

f.   Telehealth services must be consistent with the criteria outlined in the state and federal laws and regulations and contractual requirements. Please see Policy MA_18P, "Virtual Care" for more information.

1.   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 MA_6D, "Residency Teaching Clinics" and MA_6E, "Rural Health Clinics."

2.   Triage, Screening and Advice Services

a.   PCP Offices – All PCP sites must maintain a procedure for triaging or screening Member calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

1)   Regarding the length of wait for a return call from the provider; and

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

Triage services must be provided by a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage a Member who may need care. Examples of qualified health professional may include but not be limited to nurse practitioners (NPs) or physician assistants (PA).

b.   After Hours – IEHP provides triage, screening and advice services by telephone twenty-four (24) hours a day, seven (7) days a week through its Nurse Advice Line (NAL). By calling the NAL, Members are able to receive assistance with access to urgent or emergency services from 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). In the event that a Member calls a Physician's office after hours, there must be enough access to information on how to proceed, either through an answering service or phone message instructions.

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[23] Health and Safety Code § 1374.141 (a)

9.   ACCESS STANDARDS

A.   Access Standards

c.   <u>Follow-Up After Accessing the Nurse Advice Line (NAL)</u> – IEHP informs PCPs through the secure Provider portal, when their assigned Member accesses service through the IEHP NAL, including the Member's medical situation and the disposition of the call.

3.   Telephone Procedures

a.   All PCP offices must have an answering machine and/or answering service during and after business hours. Members who reach voicemail must receive detailed instructions on how to proceed, including but not limited to how to obtain urgent or emergency care.

b.   All PCP offices must have an active and working fax machine twenty-four (24) hours per day, seven (7) days per week. PCP offices that do not have an active and working fax machine should call the Provider Relations Team at (909) 890-2054.

c.   <u>Returning Calls</u> – Provider offices must have a process in place to return Member phone calls.   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. Consequently, the staff member returning the call may or may not be able to definitively address the Member's issue during the call. However, it is 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.

d.   <u>Standards for Returning Calls</u> – Provider offices must, at minimum, perform and document three (3) attempts to return Member phone calls within three (3) business days for non-urgent calls and within twenty-four (24) hours for urgent non-emergency calls.

4.   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. Please see Policy 14C, "Emergency Services" for more information.

a.   <u>Follow-up of Emergency Department (ED) Visits</u> – IEHP is responsible for

9.   ACCESS STANDARDS

A.   Access Standards

informing PCPs of their assigned Members that receive emergency care, 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.

B. **Hospital Standards –** All contracted Hospitals must provide access for Members that need to be admitted for emergency care, inpatient stay, or to utilize hospital-based diagnostic or treatment services.

C. **Special Access Standards**

1. Sensitive Services for Adults – Providers and Practitioners must have procedures to ensure that minors and adults have access to sensitive and confidential services as outlined in Policy 9D, "Access to Sensitive Services."

2. Access for People with Disabilities – All IEHP facilities and Practitioners are required to maintain access in accordance with the requirements of Title III of the Americans with Disabilities Act of 1990. Each PCP office is assessed to identify if barriers to Member care exist during facility 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 MA_9C, "Access to Care for People with Disabilities."

3. Access and Interpretation Services for People are Deaf or Hard-of-Hearing and/or with Limited English Proficiency – All IEHP network Providers, including network Pharmacy and Vision Practitioners, must provide services to Members with limited English proficiency in the Member's primary language. See Policies MA_9H1, "Cultural and Linguistic Services – Foreign Language Capabilities" and MA_9D1, "Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing."

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

   a. Appointment standards:

Behavioral Health	
Type of Visit	**Timeframe**
Life-threatening emergency	Immediate disposition of Member to appropriate care setting
Non-life-threatening emergency	Six (6) hours, or go to the ER
Urgent visit for behavioral health needs that do not require an authorization	Within forty-eight (48) hours of request
Urgent visit for behavioral health need that do require authorization	Within forty-eight (48) hours of request

9.   ACCESS STANDARDS

A.   Access Standards

Behavioral Health	
Type of Visit	**Timeframe**
Initial routine (non-urgent) visit with a Behavioral Health Care Provider	Within ten (10) business days of request
Follow-up routine (non-urgent) visit with a Behavioral Health Provider	Within ten (10) business days of request
Follow-up routine (non-urgent) visit with a Non-Physician Mental Health Care or Substance Use Disorder Provider[24]	Within ten (10) business days of the prior appointment or at the clinical judgment of the treating Provider regarding the speed and frequency of medically necessary care

b.   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 and Corrective Action Plan Process

A.   On a quarterly basis, IEHP reviews and evaluates the Quarterly Monitoring Report Template (QMRT) regarding our ability to meet timely access surveys and network adequacy requirements, including accessibility, availability, continuity of care, and network capacity requirements, investigation of complaints, grievances and Appeals, issues of non-compliance with contractual requirements and policy guidance; IEHP network monitoring and oversight assessments, quality of care indicators, data reviews for utilization capacity, and Provider-to-Member rations; authorization of OON requests, and the provision of transportation services. IEHP's quarterly compliance monitoring process pertaining to network adequacy shall ensure that Members have access to the full range of covered services through an adequate network.[25]

B.   IEHP monitors network adherence to these access standards through various methods, including but not limited to:

1.   On an annual basis, IEHP conducts the Assessment of PCP Network Adequacy Study to assess IEHP's Provider network in areas of Member Experience related to access, access to Providers, and Provider availability such as distribution and ratios. This study uses various sources of data, including but not limited to grievance and appeals data, CAHPS survey data, Annual Behavioral Health Member Experience Survey, Appointment Availability Survey results, and out-of-network data.

2.   **Appointment Availability Standards** – On an annual basis, IEHP assesses the network's adherence to appointment availability standards for PCPs, high volume

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[24] 28 CCR § 1300.67.2.2
[25] 28 CCR § 1300.67.2.2(d)(2)(D)

9. ACCESS STANDARDS

A. Access Standards

Specialists, Behavioral Health, and Ancillary Providers using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey (PAAS) 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 and take action on Providers that are not meeting access standards to bring them into compliance.

    a. For PCPs, the Plan will not perform a sampling of the Providers. Instead, the Plan will survey all active PCPs.

    b. For Specialty Care and Ancillary Care Providers, IEHP will follow the sampling methodology as outlined by the DMHC for.

Using the DMHC PAAS methodology and tools, IEHP reports on the health plan's overall rate of compliance for each of the time elapsed standards, and that of each IPA in Riverside and San Bernardino Counties (See Attachments, "DMHC Provider Appointment Availability Survey Methodology" and "DMHC Appointment Availability Survey Tools in Section 9). IEHP may utilize a third-party survey vendor to implement all or part of the DMHC PAAS Survey methodology.

3. **Missed Appointments** – The Quality Management Department monitors missed appointments, follow-up, and documentation efforts through the Facility Site Review (FSR) and Medical Record Review (MRR) survey process.

4. **Waiting Times** – The Quality Management Department monitors office wait times through the FSR/MRR survey process. The Provider Relations Team also monitors office wait times by collecting wait time information during the Provider in-service. On a semi-annual basis, all Practitioners are asked to verify office wait time as part of the Provider Directory verification process. On at least an annual basis, the Quality Improvement (QI) Subcommittee reviews the information collected and makes recommendations on actions to take if Practitioners are found to be non-compliant with the office wait time standards.

5. **Time or Distance Standards** – On an annual basis, IEHP conducts the Provider Network Status Study to ensure that the health plan is compliant with time, distance, and Provider to Member ratio standards established by the Centers for Medicare and Medicaid Services (CMS) and the Department of Managed Health Care (DMHC).

6. **Triage, Screening and Advice** – On a monthly basis, IEHP's Family & Community Health Department monitors the Nurse Advice Line's performance and adherence to afterhours triage, screening, and advice standards by reviewing triage call center reports. On at least an annual basis, the QI Subcommittee reviews and makes recommendations on actions to take if the NAL provider is found to be non-compliant with triage, screening, and advice standards.

7. **Telephone Procedures** – IEHP ensures PCPs have an established and maintained process for answering and returning Member calls through the Facility Site Review (FSR) and Medical Record Review (MRR) survey process.

Additionally, all network Providers submit their telephone procedures via the Provider Information Verification Form as part of the semi-annual Provider Directory verification process. The QI Subcommittee reviews the information collected and makes recommendations on actions to take if Practitioners are found to be non-compliant with telephone answer and return call wait time standards.

8. **Access for People with Disabilities –** IEHP conducts the Physical Accessibility Review Survey (PARS) assessment on PCP, identified high volume Specialist, identified high volume Ancillary sites and all contracted Community Based Adult Services (CBAS) Providers as part of the FSR and MRR process. Information gathered from the PARS assessment are made available to IEHP Members through the IEHP Provider Director and the IEHP website. Please see Policy 6B, "Physical Accessibility Review Survey" for more information.

9. **Access and Interpretation Services for People are Deaf or Hard-of-Hearing and/or with Limited English Proficiency** – The Quality Management Department monitors compliance with these standards through these FSR/MRR survey questions:

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.

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.

C. Additional monitoring is performed through the review of grievances and Potential Quality Incidents (PQIs) review process for individually identified Providers.

D. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures. Please see Policy MA_25A3, "Delegation Oversight – Corrective Action Plan Requirements" for more information regarding the CAP process.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Operating Officer	**Revision Date:**	November 7, 2023

9. ACCESS STANDARDS

B. Missed Appointments

APPLIES TO:

A. This policy applies to all IEHP DualChoice Providers.

POLICY:

A. Providers must implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, and initial health assessments, which include procedures for follow-up on missed appointments.[1]

PROCEDURES:

A. PCPs must have a process in place to follow-up on missed appointments. Appointments must be promptly rescheduled, when necessary, in a manner that is appropriate for the Member's health care needs, ensures continuity of care[2] and 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) as appropriate.

3. 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.

4. At least one (1) attempt must be made to contact a Member due to a missed appointment.

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

6. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.

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

8. Providers cannot charge Members for any missed appointments. Please see Policy 18L, "Provider Charging Members."

B. Monitoring

1. IEHP Quality Management Department monitors missed appointments through the Facility Site Review (FSR) and Medical Record Review (MRR) process, initially and at

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[1] Title 28 California Code of Regulations (CCR), § 1300.67.2.2
[2] KKA, § 1300.67.2.2(c)(3)

9.   ACCESS STANDARDS

B.   Missed Appointments

minimum every three (3) years thereafter. Please see Policy 6A, "Facility Site Review and Medical Record Review Requirements and Monitoring" for more information.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

9.   ACCESS STANDARDS

C.   Access to Care for Members with Access and Functional Needs

APPLIES TO:

A.   This policy applies to all IEHP DualChoice Members.

POLICY:

A.   IEHP prohibits discrimination against Members on the basis of disability or Limited English Proficiency (LEP).[1,2] All IEHP Providers contracted to provide care to Members are required to provide and maintain access to facilities and services to individuals with disabilities.[3]

DEFINITIONS:

A.   Service animals – any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability.[4,5]

   1.   Service animal activities include but are not limited to: 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.

   2.   Service animals include: Guide dogs; signal dogs; or other dogs individually trained to provide assistance to a person with a disability.

   3.   Miniature horses that have been individually trained to do work or perform tasks for people with disabilities by IEHP in accordance with ADA regulation standards. Service animals are working animals, not pets.[6]

PROCEDURES:

A.   Prior to a Primary Care Provider (PCP) being approved to be assigned Members, IEHP performs a comprehensive access survey for people with disabilities during the initial facility site review of PCP sites. This survey is repeated every three (3) years thereafter. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements" for more information.

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[1] Title 42 United States Code (USC) § 12132
[2] 42 USC § 18116 et. seq
[3] 42 USC § 12182
[4] Title 28 Code of Federal Regulations (CFR) § 35.104
[5] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Service Animals, 2/24/20
[6] Ibid.

B. **Providers who are anticipating modification to their facilities must meet Americans with Disabilities Act Accessibility Guidelines (ADAAG).**[7]

1. The ADA and California's Code of Regulations Title 24 require 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.[8,9]

2. Providers that need additional assistance in regards to ADAAG can reach out to IEHP's ADA access line at (909) 890-1916 or view the ADAAG online: http://www.access-board.gov/adaag/html/adaag.htmhttps://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-ada-standards/background/adaag#purpose.   For more information on the ADA, Providers can visit IEHP's "ADA and Beyond" web page: https://www.iehp.org/en/providers/special-programs?target=independent-living-and-diversity-resources

C. **Service Animals**[10]

1. Access must be provided, whenever feasible, to service animals.

    a. Providers are prohibited 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. [11]

    b. Providers must make reasonable modifications in their policies, practices and procedures when necessary to accommodate Members with disabilities. Generally, this includes modifying any no-pet policies to permit use of a service animal by an individual with a disability.[12]

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 demonstrates that the presence or use of a service animal would pose a health risk in certain parts of the institution directly involved.[13]

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,

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[7] 28 CFR part 36, subpart D, "New Construction and Alterations"
[8] 42 USC § 12101
[9] 24 CFR § 570.614
[10] 28 CFR § 35.136
[11] 28 CFR § 35.136(f)
[12] 28 CFR § 35.136(a)
[13] 28 CFR § 35.136(g)

or other procedures where there is limited space). The separation should not be any longer than it takes to provide the service.[14]

4.   Care and supervision of a service animal are the responsibility of the Member and/or authorized representative. 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.[15]

5.   A service animal shall be under the control of its handler. A service animal shall have a harness, leash, or other tether, unless either the handler is unable because of a disability to use a harness, leash, or other tether, or the use of a harness, leash, or other tether would interfere with the service animal´s safe, effective performance of work or tasks, in which case the service animal must be otherwise under the handler´s control (e.g., voice control, signals, or other effective means).[16]

6.   Restrictions on Service Animals

   a.   A person with a disability cannot be asked by Providers to remove their service animal from the premises unless:[17]

      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

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[14] Americans with Disabilities Act (ADA), 2010 Revised Requirements, Service Animals
[15] 28 CFR § 35.136(e)
[16] 28 CFR § 35.136(d)
[17] ADA, 2010 Revised Requirements, Service Animals

- Clean or sterile supply areas.

D. Access to Care for Deaf or Hard-of-Hearing

1. IEHP provides appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills upon request.

2. Requests for interpreter services at PCP sites, Skilled Nursing Facilities (SNFs), and outpatient visits for Members who are deaf or hard-of-hearing may originate from:
    a. Member;

    b. Family member and/or Authorized Representative;

    c. Member's PCP or Specialist;

    d. Member's IPA; or

    e. IEHP.

3. IEHP can better ensure the availability of interpreters for a medical appointment if given at least five (5) working days' notice. As such, those 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.

4. It is recommended that the Member or Provider make arrangements for an interpreter at the same time that the medical appointment is being scheduled.

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

6.   Video Remote Interpreting (VRI) services do not require a prior authorization from IEHP. VRI is available to Members who are deaf or hard-of-hearing while accessing health plan services at contracted Urgent Care Facilities and SNFs.

a.   Providers may contact the IEHP Provider Relations Team for VRI set-up and technical assistance at (909) 890-2054.

b.   The following Member information will be collected by the VRI vendor at the start of the VRI session:

1.   IEHP Member First Name;

2.   IEHP Member Last Name; and

3.   IEHP Member Date of Birth.

7.   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.

8.   Members have the right to file a grievance if their access accommodations are unjustifiably denied.

9.   Grievances 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.

E.   **IEHP and Provider Responsibilities**

1.   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.

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.[18]

3.   IEHP is responsible for the cost of the interpretation services for PCP and outpatient visits.[19]

4.   IEHP authorizes all interpretation service requests and will make the arrangements, which include, but are not limited to:

a.   Confirming with the agency the scheduled interpreter's name and expected arrival time;

b.   Providing a telephonic confirmation to the health care Provider; and

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[18] 28 CCR § 1300.67.04
[19] Ibid.

9.   ACCESS STANDARDS

C.   Access to Care for Members with Access and Functional Needs

      c. Providing confirmation to the Member through their preferred method of communication, e.g., telephone, TTY, Video Phone Relay, California Relay Services (Teletypewriter (TTY)/Voice Carry-Over (VCO)/Hearing Carry-Over (HCO)), or e-mail.

5. IEHP is responsible for the cost of ASL VRI services for Members at contracted Urgent Care Facilities and SNFs.[20,21] Contracted Urgent Care Facilities 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).

6. Members and their family members, friends, associates, and/or authorized representatives may make standing requests to receive all written Member information, including clinical Member information, in a specified threshold language and/or in an alternative format (such as braille, large-size print, secure electronic, or audio formats) by contacting IEHP Member Services.[22]

7. IEHP consults with stakeholders with disabilities to continuously evaluate and maintain accessibility of services for Members with disabilities. See Policy 2H – "Persons with Disabilities Workgroup (PDW)."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

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[20] 28 CCR § 1300.67.04
[21] Ibid.
[22] Health Plan Management System (HPMS) Memo, "California MMPs: Application of APL 22-002 to Final Contract Year 2022 Marketing Guidance for California Medicare-Medicaid Plans"

9.   ACCESS STANDARDS

D.   Access to Services with Special Arrangements

APPLIES TO*:*

A.   This policy applies to all IEHP DualChoice Members.

POLICY:

A.   IEHP and IPAs ensure that Members have access to medically necessary covered services, including but not limited to services with special arrangements.

PURPOSE:

A.   To ensure that Members have access to services with special arrangements.

DEFINITION:

A.   Sensitive Services – All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.[1]

PROCEDURES:

A.   Services with special arrangements include the following:

   1. **Family Planning** – Members may access family planning services through any contracted or non-contracted family planning Provider without prior authorization. Please see Policy 10K, "Family Planning Services."

   2. **Sexually Transmitted Infection (STI) Prevention Care, Diagnosis and/or Treatment** – Members may access STI services without prior authorization both within IEHP's Provider network and from an out-of-network Local Health Department (LHD), any qualified family planning Provider, or any other Provider who treats STI within his or her scope of practice. Please see Policy 10G, "Sexually Transmitted Infection Services."

   3. **HIV Testing and Counseling** – Members may access confidential HIV testing and counseling services without prior authorization within IEHP's network and from an out-of-network LHD or any qualified family planning Provider.[2] Please see Policy 10H, "HIV Testing and Counseling."

   4. **Immunization** – Immunizations are preventive services not subject to prior authorization requirements.[3] Please see Policy 10B, "Adult Preventive Services."

   5. **American Indian Health Services Programs –** American Indian Members may access contracted and non-contracted American Indian Health Service Programs.

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[1] California Civil Code (Civ. Code) § 56.05(n)
[2] Ibid.
[3] Ibid.

B. Other authorization or access requirements include:

   1. **Pregnancy-Related Services** – Services do not require prior authorization and can be provided by any credentialed obstetrical Practitioner within the IPA's network.

   2. **Abortion Services** - Abortions are not a covered Medicare procedure except when:[4]

      a. The pregnancy is the result of an act of rape or incest; or,

      b. The woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

      c. Prior authorization is required for non-emergency abortions.

      No Physician or other Health Care Provider who objects to performing abortion services is required to do so, and no person refusing to perform an abortion is to be subject to retaliation in any form for such a choice.[5]

   3. **Behavioral Health Care -** The PCP is responsible for behavioral health care within his/her scope of practice; otherwise, the Member may be referred or may self-refer to the IEHP Behavioral Health Program. Please see Policy 12D1, "Behavioral Health – Behavioral Health Services."

   4. **Substance Use (Drug or Alcohol) Disorder Treatment Services**:

      a. Hospitalization is covered for medically necessary detoxification for alcoholism or other drug use. Authorization must be obtained prior to admission.

      b. Medicare covers substance use disorder treatment in outpatient treatment centers that have agreed to participate in the Medicare program.

   5. For more specific information regarding authorization requirements and other details, see Sections 10, "Medical Care Standards" and 14, "Utilization Management."

C. Medical information related to sensitive services must only be disclosed to the Member receiving care, absent an express authorization of the Member.

D. Members are informed of their right to access sensitive services and services with special arrangements through the Member Handbook.

E. Members may obtain information regarding access to care and assistance with scheduling appointments for sensitive services through IEHP Member Services at (877) 273-4347 or their PCP's office. Assistance is provided with complete confidentiality.

F. Periodic monitoring of Provider compliance is performed through review of encounter data and medical record review. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring," for more information.

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[4] Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD), Abortion, 6/19/06
[5] California Health & Safety Code § 123420

9. ACCESS STANDARDS

D.   Access to Services with Special Arrangements

INLAND EMPIRE HEALTH PLAN			
Chief Approval: *Signature on file*		**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer		**Revision Date:**	January 1, 2023

9.   ACCESS STANDARDS

E.   Open Access to Obstetrical or Gynecological Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its 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.[1]

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.[2]

PROCEDURES:

A. FPs participating under this policy must be credentialed by IPAs in accordance with IEHP standards for obstetrical privileges.

B. 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. Please see Section 10, "Medical Care Standards" for services that may be obtained from contracted and non-contracted providers.

   1. Abdominal/Pelvic Pain
       a. Salpingo-oophoritis
       b. Endometriosis
       c. Pelvic Inflammatory Disease (PID)
   2. Abortion
   3. Abnormal uterine bleeding
   4. Breast Mass
   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

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.695
[2] Ibid.

13. Menopause
14. Premenstrual Syndrome (PMS)
15. Pregnancy/Perinatal Care
16. Sexually Transmitted Infection (STI) Testing and/or Treatment
17. Vaginitis
18. Well Woman Exam
    a. Cervical Cancer Screening
    b. Breast Exam
19. Colposcopy
20. Endometrial Biopsy

C. The OB/GYN or FP providing care to Members under this policy must obtain prior authorization from their IPA for procedures, surgery or other services beyond a well woman" exam, 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
    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

D. Any OB/GYN or FP providing care to Members under this policy is required to communicate to the Member's PCP the Member's condition, treatment and any need for follow-up care. See Policy 14D, "Pre-Service Referral Authorization Process". OB/GYNs or FPs can meet this requirement by providing this information to the Member's IPA, which will then be forwarded to the PCP.[3]

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[3] CA Health & Saf. Code § 1367.695

9.   ACCESS STANDARDS

E.   Open Access to Obstetrical or Gynecological Services

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

F.   IEHP and its 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.

G.   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

H.   If IEHP determines that the IPA has denied payment for services rendered under this policy, IEHP will reimburse the Provider and adjust capitation to the IPA.

I.   IEHP and its IPAs should have a structure in place to monitor compliance with this policy. Processes should include, but not limited to, review of denied OB/GYN services, review of Member and Provider grievances, review of Provider appeals and denial of OB/GYN Provider claims.

J.   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.

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

9. ACCESS STANDARDS

F. Cancer Treatment Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs ensure Members access to medically necessary screening and treatment services for cancer according to nationally recognized clinical criteria.[1]

B. IEHP does not require prior authorization for preventive services. This includes cancer screenings that are United States Preventive Services Task Force (USPSTF) Part A and B recommendations.

PROCEDURES:

Cancer Treatment

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

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

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

1. Surgical treatments;

2. Chemotherapy;

3. Radiation therapy; and

4. Treatments for complications related to cancer treatments.

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

E. IEHP requires Members obtaining care and services for cancer to receive services from the Member's assigned Hospital.

Clinical Trials

A. 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

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.665

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 clinical trial. The clinical trial endpoint must not be defined exclusively to test toxicity but must have a therapeutic intent.[2]

1.   Routine costs in clinical trials include:[3]

   a.   Health care services typically provided in the absence of a clinical trial;

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

   c.   Health care services required for the clinically appropriate monitoring of cancer treatment;

   d.   Health care services provided for the prevention of complications arising from the cancer clinical trial; and

   e.   Health care services needed for the reasonable and necessary care arising from the complications of the cancer clinical trial.

2.   Routine costs of a clinical trial 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 not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the clinical trial;

   c.   Items or services provided solely for data collection and analysis needs and that are not used in the clinical management of the Member;[4]

   d.   Health services associated with the cancer clinical trial that are otherwise specifically excluded from coverage under the Member's health plan;[5] and

   e.   Health services customarily provided by the research sponsors free of charge for the Member in the clinical trial.[6]

B.   IEHP and its IPAs can direct all services noted above to contracted in-network Providers whose scope of practice includes these services. If an appropriately qualified Provider is not available within the IPA network, arrangements must be made for the Member to receive care from an appropriately qualified Provider outside the IPA network.

C.   IEHP and its IPAs are required to reimburse Providers rendering care to Members under this policy according to the guidelines above using appropriate claims review and processing standards. Please see Policy 20A, "Claims Processing" for more information.

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[2] CA Health & Saf. Code § 1370.6(a)
[3] CA Health & Saf. Code § 1370.6(d)(4)
[4] CA Health & Saf. Code § 1370.6(d)(5)
[5] Ibid.
[6] Ibid.

F.   Cancer Treatment Services

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

9.   ACCESS STANDARDS

G.   Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP provides both Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services for all prior authorized services and Medicare and/or Medi-Cal covered services within San Bernardino and Riverside counties.[1] Transportation services for IEHP DualChoice Members are covered by Medi-Cal.

DEFINITIONS:

A. Non-Emergency Medical Transportation (NEMT) – Transportation to one's IEHP or Delegate-approved medical appointment by ambulance, litter van, wheelchair van, or air.

B. Non-Medical Transportation (NMT) – Roundtrip transportation to one's IEHP or Delegate approved medical appointment by private car, taxi or bus, when the Member has reasonably exhausted other transportation resources.

PURPOSE:

A. To ensure that Members have transportation access to necessary medical and behavioral health services.

PROCEDURES:

General Information

Member Rights and Responsibilities

A. Members requiring NEMT or NMT should contact IEHP Member Services Department (877) 273-4347 or IEHP's Transportation Broker at (855) 673-3195 for transportation services at least five (5) business days prior to requested service. The exceptions to the above are:

   1. Dialysis;

   2. Pharmacy;

   3. Urgent Care;

   4. Wound Care;

   5. Cancer Treatment (radiation/chemotherapy);

   6. Pre-Op Appointments;

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[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008, Supersedes APL 17-010, "Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses"

7.   Surgery;

8.   Follow Up appointment from a recent Hospital Discharge;

9.   Transplant; and

10.   Fracture.

Please note this is not an all-inclusive list. If a Member has justification of why IEHP needs to transport them, the Member may call IEHP's Member Services Department at (877) 273-4347.

C.   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 after three (3) incidences.

IEHP Responsibilities

A.   IEHP or its Delegate coordinates with transportation Provider to ensure we meet timely access standards when providing NEMT and NMT.[2] See Policy 9A, "Access Standards" for more information.

B.   IEHP makes its best effort to provide and coordinate NEMT and NMT for services not covered by the health plan, including but not limited to specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal Fee-For-Service (FFS) delivery system.[3]

C.   IEHP has designated its Manager of Transportation Services as the Plan's transportation liaison, who ensures that authorizations are processed during and after business hours. Providers and Members may call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides through the following avenues. Calls and requests will be routed directly to the Plan's transportation liaison, as appropriate:

1.   For Providers - Provider Call Center at (866) 223-4347; and

2.   For Members - Member Services Department at (877) 273-4347/(800) 718-4347 (TTY).

3.   Neither IEHP nor the Transportation Broker modify the PCS form after the PCP or treating Physician has prescribed the form of transportation, unless multiple modalities were selected.[4]

D.   IEHP bears authorization and financial responsibility for transportation services.

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[2] DHCS APL 22-008
[3] Ibid.
[4] Ibid.

9. ACCESS STANDARDS

G. Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

E. IEHP shares the PCS form or communicates the approved mode of NEMT and dates of service to the Transportation Broker.[5]

Coverage and Limitations

A. IEHP will provide NEMT/NMT services to the Member and one (1) attendant.[6]

B. 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) 22-008.

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

   1. Transportation will be provided to Members whose access to medically necessary services are beyond the required time and distance standards. Please see Policy 9A, "Access Standards" for more information.

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. 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 home 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.

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

G. 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;

   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; and/or

   6. A Medicare Fee For Services (FFS) Member traveling out of San Bernardino/Riverside Counties.

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[5] DHCS APL 22-008
[6] Ibid.

9.   ACCESS STANDARDS

G.   Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

H.   IEHP can direct all NEMT and NMT requests to in-network transportation providers. If no in-network provider can accommodate the Member's transportation needs based on their medical, physical, or mental condition, arrangements are made for the Member to receive services from an appropriately qualified vendor outside the IEHP network.

I.   Requests for NEMT or NMT that do not adhere to APL 22-008 may be denied or partially approved. In this event, a Notice of Action 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.[7]

Travel Expenses

A.   IEHP covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for Members receiving medically necessary covered services and their accompanying attendant, including living MOT donors.[8]

B.   IEHP covers the salary of the accompanying attendant determined to be necessary, as well as if the attendance is not a family member.[9]

C.   IEHP will provide retroactive reimbursement for transportation-related travel expenses. The Plan may also consider to pre-payment, as appropriate.[10]

Enrollment of NEMT/NMT Providers

A.   All NEMT and NMT Providers must comply with Medi-Cal enrollment requirements.[11]Providers that continue to be non-compliant with these requirements may be subject to disciplinary action, including the issuance of corrective action plan, leading up to termination of contract.

B.   IEHP will allow NEMT and NMT Providers to participate in its network for up to one hundred twenty (120) days, pending the outcome of the enrollment process. IEHP will track the 120-day timeframe and will terminate its contract with the Provider upon notification from DHCS that the Provider has been denied enrollment in the Medi-Cal program, or upon expiration of the one 120-day period.[12]

Major Organ Transplants

A.   IEHP provides NEMT or NMT services to individuals, who may not be enrolled in IEHP Medi-Cal but serve as living organ donor for an IEHP Member.[13]

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[7] Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.11
[8] DHCS APL 22-008
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Ibid.

9.   ACCESS STANDARDS

G.   Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

1.   PCS forms are not required for MOT donors requesting NEMT services to ensure the donor has the ability to get to the hospital for the MOT.

2.   IEHP allows an attendant for the donor if the Plan determines than an attendant to accompany the donor is necessary.

Non-Emergency Medical Transportation (NEMT)

Prior Authorization

A.   NEMT services are a covered Medi-Cal benefit when a Member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider or a physician extender, for purposes of enabling a Member to obtain medically necessary covered services or pharmacy prescriptions prescribed by the Member's Provider and those authorized by Medi-Cal Rx.[14]

B.   NEMT services are subject to prior authorization. IEHP will authorize the appropriate modality prescribed by the Member's PCP or treating Provider on the Physician Certification Statement (PCS) form to IEHP (See Attachment, "NEMT Physician Certification Statement Form" in Section 9).[15] This PCS form has been approved by DHCS and includes components required by DHCS to arrange for NEMT services.[16]

   1.   This certification statement remains in effect for twelve (12) months from date of the Practitioner's signature.[17]

   2.   The PCS form must be completed before NEMT can be provided. Contracted Providers may submit the form electronically through the secure IEHP Provider portal.

   3.   Non-contracted providers may fax the completed and signed form to IEHP at (909) 912-1049.

   4.   IEHP can authorize NEMT requests telephonically when the Member requires a covered medically necessary service of urgent nature and a PCS Form could not have reasonably been submitted beforehand. The Member's Provider however, must submit a PCS Form post-service for the telephone authorization to be valid.[18]

   5.   IEHP ensures that a copy of the PCS form is on file for all Members receiving NEMT services and that all fields are filled out by the Provider. Additionally, IEHP has developed a process to capture data from the PCS form and report to DHCS, as required.[19]

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[14] DHCS APL 22-008
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Title 22 California Code of Regulations (CCR) § 51323(b)(2)(A)
[19] DHCS APL 22-008

9.   ACCESS STANDARDS

G.   Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

C. For covered services requiring recurring appointments, IEHP authorizes NEMT for the duration of the recurring appointments, not to exceed twelve (12) months).[20]

D. Prior authorization is not required, when NEMT services are provided to a Member being transferred from an emergency room to an inpatient setting, or an acute care hospital immediately following a stay as an inpatient at the acute level of 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 or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.[21]

   1. To ensure timely transfer following an inpatient stay at the acute level of care, NEMT services must be provided within three (3) hours of the Member or Provider's request. If NEMT services are not provided within the three (3) hour timeframe, the acute care hospital may arrange, and IEHP will cover, out-of-network NEMT services.[22]

E. IEHP authorizes the lowest cost type of NEMT that is adequate for the Member's medical needs if multiple modalities are selected by the Member's Provider in the PCS form.[23]

F. IEHP ensures door-to-door assistance is being provided for all Members receiving NEMT services.[24]

G. IEHP informs Members that they must arrive within fifteen (15) minutes of their scheduled appointment. If the NEMT Provider is late or does not arrive at the scheduled pick-up time, the Member is asked to call IEHP so an urgent NEMT ride may be authorized to ensure the Member does not miss their appointment.

Non-Medical Transportation (NMT)

A. IEHP does not require prior authorization for NMT services. These services are a covered Medi-Cal benefit when a Member needs to obtain medically necessary services, including those not covered by the health plan, such as, but not limited to, specialty mental health, substance use disorder, dental, and other benefits delivered through the Medi-Cal FFS delivery system, including pharmacy services provided to Members through Medi-Cal Rx. Therefore, IEHP will not apply utilization controls or time or distance standards for NMT to carved-out services not authorized or arranged by the Plan.[25]

B. IEHP informs Members that they must arrive within fifteen (15) minutes of their scheduled appointment. If the NMT Provider is late or does not arrive at the scheduled pick-up time, the

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[20] DHCS APL 22-008
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.

9. ACCESS STANDARDS

G. Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

Member is asked to call IEHP so the health plan may provide alternate NMT or allow the Member to schedule alternate out-of-network NMT and reimburse for out-of-network NMT.[26]

C. Members may be issued a bus pass for transportation if the following criteria are met:

   1. Transit is available;

   2. Trip is less than one hundred and fifty (150) minutes in total duration (roundtrip);

   3. Bus stop is no more than one (1) mile walking distance from the Member's address on file.

D. 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.

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

F. 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:[27]

   1. Member attestation is received by phone, electronically or in-person that all other transportation resources available have been exhausted;

   2. The driver can provide proof of a valid driver's license, valid vehicle registration and valid vehicle insurance; and

   3. The trip has been prior authorized by IEHP.

Monitoring

A. IEHP does not delegate the following responsibilities to its Transportation Broker:[28]

   1. Review and approval of the PCS form;

   2. Monitoring and oversight of network Providers and subcontractors;

   3. Grievance and appeals resolution;

   4. Enrollment of NEMT or NMT Providers as Medi-Cal providers; or

   5. Utilization management functions, including the review of PCS forms.

B. IEHP ensures its Transportation Broker and Providers meet regulatory and contractual requirements. Monitoring activities are performed no less than quarterly and may include but not be limited to:[29]

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[26] California Welfare & Institutions Code § 14132(ad)(2)(A)(i)
[27] DHCS APL 22-008
[28] Ibid.
[29] Ibid.

9.   ACCESS STANDARDS

G.   Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

1. Enrollment status of NEMT and NMT Providers;

2. Non-modification of the level of transportation service outlined in the PCS form; and

3. Providing door-to-door assistance for Members receiving NEMT services;

4. NEMT and NMT Providers arriving within 15 minutes of scheduled time for appointments;

5. No show rates for NEMT and NMT Providers.

Continued non-compliance will result in intervention, including but not limited to Broker/Provider education, issuance of a corrective action, freezing to new authorizations, leading up to termination of contract.

C. Transportation Brokers are required to have a process that identifies specific NEMT or NMT Providers, including the name of drivers based on service date, time, pick-up/drop-off location, and Member name, including a process for Members to be able to identify specific drivers in a grievance.[30]

D. 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).

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

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[30] DHCS APL 22-008

9. ACCESS STANDARDS

H. Cultural and Linguistic Services
1. Language Assistance Capabilities

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP ensures effective communication with individuals with disabilities and provides meaningful access to Members and potential Members with limited English proficiency (LEP) through the administration of the Cultural and Linguistics Program and Disability Program.

B. IEHP provides oral and written Member information in the threshold languages designated by the Centers for Medicare and Medicaid Services (CMS), in accordance with federal and state regulations.[1]

DEFINITIONS:

A. Threshold Language - The Centers for Medicare and Medicaid Services (CMS) defines threshold language as any primary language of at least 5% of the individuals in a plan's service area.[2]

B. Point of contact - An instance in which an enrollee accesses the services covered under the Plan contract, including administrative and clinical services, and telephonic and in-person contacts.[3]

PROCEDURES:

A. IEHP and its network of Providers must provide written materials to Members in designated threshold languages.[4]

B. **Provider Language Capability**

1. All IEHP network Providers including, but not limited to, IPAs, Hospitals, Pharmacies, and Long Term Services and Supports (LTSS) Providers must provide equal access to health care services, both clinical and non-clinical, in a linguistically competent manner for Members who are Limited English Proficient (LEP) or non-English speaking.[5]

2. IEHP lists all language capabilities of Providers and/or their staff in the Provider Directory.

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[1] Title 42 Code of Federal Regulations (CFR) §438.10(d)
[2] Title 42, Code of Federal Regulations (CFR) § 422.2267(a)(2)
[3] Title 28, California Code of Regulations (CCR) § 1300.67.04(c)(2)(A)
[4] 42 CFR § 422.2267(a)(2)
[5] California Health and Safety Code (Health & Saf. Code) § 1367.04

9.   ACCESS STANDARDS

H.   Cultural and Linguistic Services
1.   Language Assistance Capabilities

3. IEHP verifies the capability of Providers to provide services in the threshold language at the time of entry into the network. IEHP continues to monitor Provider language capabilities through an annual language competency audit.[6] See Policy 9H2, "Cultural and Linguistic Services - Language Competency Audits" for more information.

4. Providers must provide written materials to Members in designated threshold languages.[7]

C.   Interpretation Services

1. All Hospitals must provide interpreters as needed for inpatient and emergency services. The Hospitals are responsible for the cost and arrangement of interpretation services.[8]

2. Providers must be able to facilitate interpreter services as needed for Member appointments. IEHP covers the costs of the interpretation services for Primary Care Provider (PCP) and outpatient visits.

    a. Sign language interpretation must be provided in accordance with Policy 9C1, "Access to Care for People with Disabilities - Members Who Are Deaf or Hard of Hearing."

3. IEHP arranges interpreter services requested by Members and Providers for face-to-face interpretation services. 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.[9,10]

    a. Interpreter services are scheduled by calling IEHP Member Services at (877) 273-IEHP (4347), or (800) 718-4347 for TTY users.

    b. Emergent and urgent interpreter service requests under five (5) business days are subject to interpreter availability.

4. IEHP has contracted with Pacific Interpreters to provide telephonic interpretation services to Members twenty-four (24) hours a day, seven (7) days a week. IEHP Members and Providers may access these services 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 twenty-four (24) hour Nurse Advice Line at (888) 244-IEHP (4347), or (866) 577-8355 for TTY users to

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[6] 28 CCR § 1300.67.04(d)(9)(C)

[7] 42 CFR §438.10(d)(3)

[8] 28 CCR § 1300.67.04(c)(2)(G)(iv)

[9] 22 CCR § 53853(c)

[10] 28 CCR § 1300.67.04

access interpretation services.

D. Members have the right to request an interpreter at no charge for discussions of medical information and behavioral health information at key points of contact.[11]

E. Providers must 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.[12]

F. Providers should document the Member's requests for or refusal of interpreter services in their medical record.[13]

G. Members have the right to file a complaint or grievance if their linguistic needs are not met. Members' concerns about the linguistic capabilities in a Provider's office are followed up by IEHP, and the IEHP Provider database is corrected as necessary.

H. 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. See Policy 3B, "Primary Care Provider Assignment" for more information.

INLAND EMPIRE HEALTH PLAN			
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[11] 28 CCR § 1300.67.04(c)(1)(G)
[12] CA Health & Saf. Code § 1367.04
[13] 28 CCR § 1300.67.04(c)(1)(C)

9.   ACCESS STANDARDS

H.   Cultural and Linguistic Services
2.   Language Competency Study

APPLIES TO:

A. This policy applies to all IEHP DualChoice Providers.

POLICY:

A. IEHP surveys the capability of its Providers to provide services in threshold languages. Threshold languages for Riverside and San Bernardino Counties, as defined by the California Department of Health Care Services (DHCS) are English, Spanish, Chinese (including Mandarin and Cantonese), and Vietnamese.

B. IEHP surveys on an annual basis all Primary Care Providers (PCPs), and High-volume Specialist offices that have been identified as having the ability to speak Spanish, Chinese (including Mandarin and Cantonese), and Vietnamese. These Providers are listed in the IEHP Provider Directory as having threshold language speaking capabilities.

PROCEDURES:

A. On an annual basis, IEHP surveys threshold language-speaking Providers for language capability. The technique utilized for assessing targeted language competency within the Provider site includes, but is not limited to the following steps:

1. The survey will be sent to all PCP and High-Volume Specialist offices via fax and/or email, with return response due within ten (10) business days. The survey will inquire about:

    a. Who in the office speaks the threshold language (Doctor/clinical staff and office staff, doctor/clinical staff only and non-clinical staff only);

    b. How many staff in the office speak the threshold language; and

    c. Confirmation that answering machine or answering service used when the office is closed include threshold language-speaking options.

2. If IEHP does not receive a response from the Provider regarding the threshold language inquiry, the Provider will be included in the second round of faxes/emails, with a response due date of ten (10) business days.

3. If the Provider still does not respond, IEHP will conduct phone calls to the Provider offices to conduct the survey telephonically. The telephones surveys will be conducted within a two (2) week period.

    a. Providers who do not demonstrate adequate threshold language-speaking capabilities are listed in the Provider Directory and portals as not meeting the language capability requirements and are provided resources to expand and improve language assistance

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services for individuals with limited English proficiency (LEP), to ensure compliance with State and Federal law.[1]

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023

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[1] Health and Safety Code § 1367.04

9. ACCESS STANDARDS

H. Cultural and Linguistic Services
3. Non-Discrimination

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APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. All Members must receive access to all covered services without restriction based on sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental or physical disability or medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in California Penal Code Section 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.[1]

B. IEHP and its Delegates may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in IEHP DualChoice on the basis of any factor that is related to health status, including but not limited to medical condition, including mental as well as physical illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.[2,3]

C. IEHP will not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. IEHP will not terminate the enrollment of an eligible individual based on an adverse change in their health.[4]

DEFINITION:

A. Discrimination – For the purpose of this policy, discrimination may include but is not limited to the following:

1. Denying any Member any covered services;

2. Providing the Member any covered service which is different, or is provided in a different manner or at a different time from that provided to other Members, except where medically indicated;

3. Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any covered service;

4. Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed

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[1] Department of Health Care Services (DHCS) State Medicaid Agency Contract (SMAC), Exhibit E, Attachment 2, Provision 25, Discrimination Prohibitions
[2] Title 42 Code of Federal Regulations (CFR) § 422.110(a)
[3] California Government Code (Gov. Code) § 11135(a)
[4] DHCS SMAC, Exhibit E, Attachment 2, Provision 25, Discrimination Prohibitions

by others receiving any covered service, treating a Member or a beneficiary eligible for enrollment into IEHP DualChoice differently from others in determining whether they satisfy any admission, enrollment, quote eligibility, membership, or other requirement or condition, which individuals must meet in order to be provided any covered service;

5.   The assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identify, sexual orientation, or identification with any other persons or groups defined in California Penal Code Section 422.56;

6.   Failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

7.   Failing to ensure meaningful access to programs and activities for LEP Members and potential Members.

PROCEDURES:

A.   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 in this policy.[5]

B.   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 Department of Health Care Services (DHCS) for review and appropriate action.[6] See Policy 16A, "Member Grievance Resolution Process" for more information.

C.   IEHP posts Notice of Non-Discrimination on all publications and communications targeted to Members, potential Members, and the public. Notice is posted in a conspicuously visible font size in physical locations where IEHP interacts with the public, as well as in a conspicuous location on the IEHP website that is accessible on the home page.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

[5] Title 45 CFR Part 92
[6] DHCS SMAC, Exhibit E, Attachment 2, Provision 27, Discrimination Grievances

9. ACCESS STANDARDS

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs maintain 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]

PURPOSE:

A. To ensure that Members maintain access to medically necessary health care services, 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.[7]

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.[8]

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.[9]

D. Public Health Emergency – The Secretary of DHHS may determine that a disease or disorder

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[1] California Health and Safety Code (Health & Saf. Code) § 1368.7(a)
[2] CA Insurance Code (Ins. Code) § 10112.95
[3] Medicare Prescription Drug Benefit Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.12
[4] Medicare Managed Care Manual, "Chapter 4: Benefits and Beneficiary Protections," Section 150
[5] Medicare Prescription Drug Benefit Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.12
[6] Medicare Managed Care Manual, "Chapter 4: Benefits and Beneficiary Protections," Section 150
[7] CA Government Code (Gov. Code) § 8558
[8] https://www.fema.gov/disaster-declaration-process
[9] Ibid.

9.   ACCESS STANDARDS

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

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 ninety (90) days but may be extended by the Secretary.[10]

PROCEDURES:

A. 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.

B. 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.

C. IEHP informs DMHC and DHCS of the following within forty-eight (48) hours of a declaration of a State of Emergency that displaces or has the immediate potential to displace Members:[11,12]

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.

D. IEHP performs the following to support its IPAs 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 IPAs, 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:

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[10] https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx
[11] Department of Managed Health Care (DMHC) All Plan Letter (APL) 19-007 (OPL), "Governor's Declarations of Emergency
[12] CA Health & Saf. Code § 1368.7(b)

9. ACCESS STANDARDS

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

      a. Members - Communication will be made through, but not limited to, these methods: texts, calls, website banners, social media, web content, etc.

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

E. IEHP works with its IPAs to ensure that Members maintain access to medically necessary health care services, equipment, and covered drugs by:[13],[14]

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.[15],[16]

F. IEHP's Behavioral Health and Care Management (BH & CM) 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.

G. At the request of IEHP, IPAs 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

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[13] CA Health & Saf. Code § 1368.7(b)
[14] CA Ins. Code § 10112.95
[15] Medicare Prescription Drug Benefit Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.12
[16] Medicare Managed Care Manual, "Chapter 4: Benefits and Beneficiary Protections," Section 150

3.   Regular updates on any actions taken to ensure access to care for impacted Members.

INLAND EMPIRE HEALTH PLAN		
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9.   ACCESS STANDARDS

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
DMHC Provider Appointment Availability Survey Methodology	9A
DMHC Provider Appointment Availability Survey Tools	9A
NEMT Physicians Certification Statement Form	9G
Video Remote Interpretation Approved Devices and Technical Specifications	9C1

**MEASUREMENT YEAR 2019
PROVIDER APPOINTMENT AVAILABILITY SURVEY
(PAAS)**

METHODOLOGY

Table of Contents

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.[1] 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[2], 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.[3] 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.[4]

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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. [5]
- 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[6]

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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

(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[7]: 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.[8]
- 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 Template*s, please reference the Instructions tab, located within each of the *Contact List Template*s. 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.[9] 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 Template*s. 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)[10]
- 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 <u>first name</u>, <u>last name</u>, <u>FQHC/RHC name</u>, <u>NPI</u>, and <u>County</u> fields to identify whether the provider participates in the other networks in that county. (For Ancillary Providers, use the <u>Other Contracted Provider Facility Name</u>, <u>NPI</u>, and <u>County</u> 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. <u>Initiate the Survey via Email, Electronic Communication or Fax</u>[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.

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[13] See the Calculating Timeframes section below for further information related to calculating business days.

2. <u>Send a Survey Reminder</u>: 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. <u>Conduct a Telephone Survey</u>: 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];

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[15] Providers that were selected to be surveyed, but were subsequently identified by the health plan, independent of the survey, as ineligible may be deemed ineligible and replaced with a provider from the oversample. Thus, if a provider is terminated from a network, retires or moves out of the county and that

- "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.

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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 <u>hours</u> and include weekends and holidays. As a result, health plans shall capture the <u>date and time</u> the provider responded to the questions and the <u>date and time</u> 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.

- o Count 21 calendar days (including weekends) to calculate the 15 business day standard.
- o When calculating calendar days, exclude the first day (e.g., the day of the request) and include the last day.
- o 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*.[18] 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.

<u>Step 9: Create Quality Assurance Report</u>

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 <u>health plan shall contract with an external vendor</u> 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[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.

Number of Contracted Providers in County/Network	Required Target Sample Size	Number of Contracted Providers in County / Network	Required Target Sample Size
1	1	26	24
2	2	27	24
3	3	28	25
4	4	29	26
5	5	30	27
6	6	31	27
7	7	32	28
8	8	33	29
9	9	34	30
10	10	35	30
11	11	36 - 40	34
12	12	41 - 45	37
13	13	46 - 50	40
14	14	51 - 55	44
15	14	56 - 60	47
16	15	61 - 65	49
17	16	66 - 70	52
18	17	71 - 75	55
19	18	76 - 80	58
20	19	81 - 85	60
21	20	86 - 90	62
22	20	91 - 95	65
23	21	96 - 100	67
24	22	101 - 105	69
25	23	106 - 110	71

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[19] Sample sizes were calculated to produce confidence limits of +- 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 +- 5% for county/networks.

Sample Size Chart Continued

Number of Contracted Providers in County / Network	Required Target Sample Size	Number of Contracted Providers in County / Network	Required Target Sample Size
111 – 115	73	326 - 330	124
116 – 120	75	331 - 340	125
121 – 125	77	341 - 345	126
126 – 130	79	346 - 355	127
131 – 135	81	356 - 360	128
136 – 140	82	361 - 370	129
141 – 145	84	371 - 380	130
146 – 150	86	381 - 385	131
151 – 155	87	386 - 395	132
156 – 160	89	396 - 405	133
161 – 165	90	406 - 415	134
166 – 170	92	416 - 425	135
171 – 175	93	426 - 435	136
176 – 180	95	436 - 445	137
181 – 185	96	446 - 455	138
186 – 190	97	456 - 465	139
191 – 195	98	466 - 480	140
196 – 200	100	481 - 490	141
201 – 205	101	491 - 505	142
206 – 210	102	506 - 515	143
211 – 215	103	516 - 530	144
216 – 220	104	531 - 545	145
221 – 225	105	546 - 560	146
226 – 230	107	561 - 575	147
231 – 235	108	576 - 590	148
236 – 240	109	591 - 605	149
241 – 245	110	606 - 620	150
246 – 250	111	621 - 640	151
251 – 255	112	641 - 660	152
256 – 265	113	661 - 675	153
266 – 270	114	676 - 695	154
271 – 275	115	696 - 720	155
276 – 280	116	721 - 740	156
281 – 285	117	741 - 765	157
286 – 290	118	766 - 790	158
291 – 300	119	791 - 815	159
301 – 305	120	816 - 840	160
306 – 310	121	841 - 870	161
311 – 315	122	871 - 900	162
316 – 325	123	901 - 935	163

Sample Size Chart Continued

Number of Contracted Providers in County / Network	Required Target Sample Size
936 - 970	164
971 - 1005	165
1006 - 1045	166
1046 - 1085	167
1086 - 1130	168
1131 - 1175	169
1176 - 1225	170
1226 - 1280	171
1281 - 1340	172
1341 - 1405	173
1406 - 1475	174
1476 - 1550	175
1551 - 1635	176
1636 - 1725	177
1726 - 1825	178
1826 - 1940	179
1941 - 2065	180
2066 - 2205	181
2206 - 2370	182
2371 - 2550	183
2551 - 2765	184
2766 - 3015	185
3016 - 3305	186
3306 - 3660	187
3661 - 4090	188
4091 - 4635	189
4636 - 5330	190
5331 - 6265	191
6266 - 7580	192
7581 - 9565	193
9566 - 12920	194
12921 - 41649	195
41650 and above	196

Measurement Year 2019

Provider Appointment Availability Survey (PAAS)

Survey Tool

Table of Contents

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 <u>mm/dd/yy</u>; 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.

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[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 a 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.

Telephonic Primary Care Provider 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: _____Primary Care Provider
Specialty / Subspecialty: _____
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.[2] 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.

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[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. [3] *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."

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[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
Specialty/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.[4] 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.

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[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?"

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 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?"

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 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."

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[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.[6] 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.

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[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?"

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 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?"

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 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."

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[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.[8] 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.

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[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?"

Date: mm/dd/yy
Time: hh:mm am/pm PT
_____   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?"

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 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."

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[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.[10] 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.

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[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?"

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 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."

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[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.*

IE♥HP

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 Provider or treating Provider when requesting for Non-Emergent Medical Transportation (NEMT) services. **All fields must be completed**. This certification will **only be valid for twelve (12) months from the Transportation Start Date** and is valid for all NEMT requests during this 12-month period. The Transportation End Date must be 12 months after the Transportation Start Date.

2. Neither IEHP nor the Transportation Broker may modify the PCS form after the Member's PCP or treating Provider has prescribed the form of transportation, unless multiple modes of transportation were selected below, or a new PCS form is received from the Provider.

3. 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 contact Call the Car at (855) 673-3195.

4. **Please fax the completed and signed form to IEHP at (909) 912-1049. We strongly encourage submission of this form online through IEHP's secure Provider Portal. For any questions, please call (800) 440-4347 x2 for Transportation Information.**

MEMBER INFORMATION

Member Name	

Member DOB		Member IEHP ID	

Transportation Start Date *(Member's Appointment Date Requiring Transportation – e.g., 6/1/23)*		Transportation End Date *(12 months from Transportation Start Date – e.g., 6/1/24)*	

Mode of Transportation Needed. *Please check (✓) all modes that are appropriate for the Member's physical and medical limitation(s).*

☐ Ambulance ☐ Litter van/ Gurney ☐ Wheelchair van ☐ Car/Sedan ☐ Air

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 Provider/Primary Care Provider for the Member and have determined medical necessity for the transportation indicated above.

Physician/Provider Name		NPI #	
Physician/Provider Signature		Date	

DHCS Approval: 09/13/23

Video Remote Interpretation
(VRI) Approved Devices and Technical Specifications

VRI Application Requirements
• The required "Outbound Only" ports for each used product must be opened on the firewall. • Each concurrent video interpreted call requires a minimum bandwidth of 384kbps. • Language Line requires the Urgent Care Facility to have a non-saturated internet connection. • For the Stratus Video App software, the Urgent Care Facility must provide a wireless network with enough coverage, capacity, and security for connectivity over the network. The network should be designed and structured to provide 384k of bandwidth for each simultaneous video call.

IEHP Approved Devices		
iPad and iPhone Supported	**Mac Operating System**	**Windows Operating System**
Any iPad or iPhone model capable of running IOS 14 or higher.	*macOS Catalina, Big Sur, or newer running the latest version of Google Chrome or Firefox, or Microsoft Edge..* ▪ Processor: 64-bit, 1gigahertz(GHz) or higher ▪ 1G of free disk space ▪ 2G of RAM	*Windows 7 or higher running the latest version of Google Chrome or Firefox, or* Microsoft Edge. ▪ Processor: 64-bit, 1gigahertz(GHz) or higher ▪ 1G of free disk space ▪ 2G of RAM
Android Devices		**Peripheral Cameras**
Android smartphones or tablets running Android 9 or higher		Logitech HD Pro C930/C920/C910