

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Timely Access to Care Requirements and Ongoing Monitoring	Policy No.: PS-CR04
Department: Provider Services	
Cross Functional Departments: Member Services, Medical Management, Quality	
Effective Date: 05/2018	Last Revised Date: 04/2023
P&P Require DHCS Approval? Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
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I. Purpose:

To describe timely access to care requirements and the process for conducting ongoing monitoring to ensure compliance with applicable timeliness standards.

II. Policy:

- A. CenCal Health ensures timely access to urgent and routine primary care, specialty health care, non-specialty mental health (NSMH), prenatal care, children's periodic routine healthcare assessments, adult initial health appointments, and placement in Long-Term Care (LTC) or Skilled Nursing Facilities (SNFs) for all Members in accordance with applicable timeliness standards. Further, CenCal Health ensures that Network Providers are informed of these timeliness requirements.
- B. CenCal Health Members are offered appointments for Covered Services within a timeframe appropriate for their health condition and no later than those timeliness requirements set forth in 28 California Code of Regulations (CCR) section 1300.67.2.2, unless a later appointment is requested by the Member.
- C. CenCal Health monitors appointment wait times and missed appointments and implements follow-up and corrective action, if and as required.
- D. CenCal Health maintains protocols for triaging Members' phone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven (7) days a week.
- E. Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors are required to participate in CenCal Health's Quality Improvement and Health Equity Transformation Program (QIHETP) which includes but is not limited to participation in and cooperation with CenCal Health's continuous monitoring, review, evaluation, and actions to improve access to and availability of all Covered Services. CenCal Health's oversight includes processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements, and the Welfare and Institutions (W&I) Code sections 14197 and 14197.04. Network Providers, Fully

Delegated Subcontractors, and Downstream Fully Delegated Subcontractors will take the appropriate corrective action as deemed necessary by CenCal Health to improve access to and availability of all Covered Services.

III. Procedure:

A. Timely Access to Routine and Urgent Care.

1. Network Providers must offer hours of operation to CenCal Health Members that are no less than the hours of operation offered to non-Medi-Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries.
2. CenCal Health ensures that appointments for Covered Services are offered to Members within the following timeframes:

Urgent Care Appointments	Timeframe
Urgent Care Appointment that does not require prior authorization	48 hours
Urgent Care Appointment that requires prior authorization	96 hours
Routine Appointments	Timeframe
Routine Primary Care Appointment	10 business days
Routine Specialty Care Appointment	15 business days
Routine Non-Physician Mental Health Care Appointment	10 business days
Routine Ancillary Care Appointment for the diagnosis or treatment of injury or illness	15 business days
Availability of Long-Term Care (LTC), Skilled Nursing Facility (SNF) providers, or Intermediate Care Facilities (ICF)	Within 14 days of request
Community Based Adult Services (CBAS) centers	Capacity cannot decrease in aggregate statewide below April 2012 level

B. Advanced Access

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

C. Extending Appointment Waiting Time

1. The applicable waiting time for a particular appointment may only be extended if:
 - a. The Member’s medical record notes that waiting will not have a detrimental impact on the Member’s health as determined by the treating health care provider;
 - b. The provider’s decision to extend the applicable waiting time is noted in the medical record and is available to DHCS upon request; and

- c. CenCal Health ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a grievance disputing the extension.
- D. Appointment Rescheduling
1. When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.
- E. Telemedicine
1. To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established.
- F. Member Services Call Center, Triage, and Telephone Medical Advice
1. Member Services Representatives undergo all necessary and required trainings and have the knowledge and competency to assist in resolving Members' questions and concerns.
 2. Member calls are triaged for urgency.
 3. A medical director or licensed physician acting on behalf of the medical director is available 24 hours a day, 7 days a week to assist with access issues.
 4. During normal business hours, the waiting time to speak with a Member Services Representative must not exceed 10 minutes.
 5. CenCal Health provides access to a 24/7 Nurse Advice Line to Members seeking urgent telephone medical advice.
- G. Disclosure of Process to Members and Providers
1. Access standards (or appointment time standards) are communicated to Members via Member newsletters and the Explanation of Coverage (EOC) for each program.
 2. Access standards (including appointment time standards) are communicated to Network Providers via several avenues which may include: the Provider Bulletin, the Provider Manual, the Network Provider Agreement, and CenCal Health's website: www.cencalhealth.org.
 3. CenCal Health requires that Providers treat Members equitable and prohibits discrimination against Members of CenCal Health programs with respect to accessibility of care, accessibility of emergency services, and provider availability for the provision of health care services.
- H. Audit and Monitoring Activities for Timely Access
1. Key CenCal Health staff are trained to perform facility site audits which include assessing appointment availability to the Provider. Specified staff are also trained in the investigation and resolution of Member and Provider complaints regarding appointment availability if it appears the Member's health was put at risk.

2. CenCal Health monitors appointment wait times and ensures compliance with requirements for follow-up on missed appointments.
3. Audit and monitoring activities are performed by several departments within CenCal Health as further detailed below.
4. Member Services Department
 - a. Member Services Representatives are trained and responsible for maintaining CenCal Health's telephone access standards, and the Grievance & Appeal Coordinators, within the Member Services Department, are responsible for the resolution of Member grievances and appeals through the Member Grievance System. The Grievance and Quality Improvement Manager investigates and resolves Member grievance and appeals, analyze all access data relating to grievances with appointment standards and telephone access standards related to responsiveness of the Plan's call center. This data is reported to numerous quality committees which include Member Support Committee, Network Management Committee, Customer Experience Committee, Quality Improvement and Health Equity Committee, and to the Board of Directors.
 - b. On a daily, monthly, and quarterly basis, the Member Services Department tracks and analyzes Member grievances and appeals and Members' request for Primary Care Physician (PCP) reselection relating to "access" issues. The data is to be presented in control charts which utilize a per thousand Member per month and per thousand Member per month (PTMPM) calculation. If aggregate totals based upon the numerator/denominator calculation, are outside or approaching the limits of expected deviation from expected averages, then interventions are considered and/or developed. If the data suggests there is an access issue for a specific provider, the Member Services Grievance & Quality Improvement Manager forwards the noted trend to the Provider Services Department to perform the appropriate barrier analysis and intervention. Access grievances and PCP reselections related to access are also reviewed through CenCal Health's Quality Committee structure. These issues are also reported quarterly to DHCS's Managed Care Division, through the completion of required grievance reporting templates.
 - c. Call Center telephone responsiveness and established metrics for Access Standards are reported and analyzed on a monthly and quarterly basis. These metrics are reported to the Plan's Board of Directors, as well as DHCS's Medi-Cal Managed Care Division, and also quarterly through CenCal Health's Quality Committee structure, as appropriate.
 - d. In addition to monitoring Member grievances related to access, the Member Services Department may conduct periodic targeted Member surveys to gauge Member satisfaction with access and appointment availability. Results of any such surveys are reported through CenCal Health's Quality Committee structure. If survey data suggests a gap or opportunity for improvement, this information is forwarded to the Provider Services Quality Liaison for further review.
5. Provider Services Department

- a. Provider Services staff are trained in appointment availability standards to enable them to assist providers in complying with access standards. Designated staff are trained to log, investigate, and resolve Provider complaints relating to access (i.e., inability to obtain an appointment with a specialist in a timely fashion), to gather and analyze data on the Provider network's compliance with the appointment availability standards, and to gather and analyze Provider satisfaction data.
 - b. Provider Services Site Review staff conduct facility audits of all PCPs at the time of initial application to the network, and at least every three years thereafter. These Facility Site Reviews include an appointment availability component and a review of all clinical staff which is scored as part of the outcome of the review. Facility Site Reviews are performed in accordance with CenCal Health policy PS-CR22 Facility Site Review and Medical Record Review Process, and all DHCS tools and standards. Results are reported through the Quality Committee structure.
 - c. On a quarterly basis, the Provider Services Department tracks and analyzes Provider complaints related to access.
 - d. The Provider Services Department conducts Provider Surveys at least annually to monitor compliance with established Access to Care Standards. CenCal Health models its survey methodology after that used by DHCS for quarterly timely access surveys.
 - i. A survey of PCPs, specialists, NSMH and ancillary providers is conducted via phone or electronically. The sample size is set forth by standard survey methodology for each type of provider.
 - ii. Questions include average wait times and number and type of staff on site to ensure the site has sufficient staffing to provide timely access.
 - iii. The survey also includes questions to confirm that the site offers the same appointment availability and the same hours of operation to CenCal Health Members as it offers to patients with other insurance or with fee-for-service Medi-Cal.
 - iv. CenCal Health has set internal benchmarks for timely access compliance rates at 70%, based on DHCS methodology.
6. Medical Management Department
- a. On a monthly basis, the Medical Management Department monitors authorization processing time for all prior authorization requests to ensure a turn-around time (TAT) of five business days. If additional information is needed, that may be extended up to 14 days. This ensures that Medically Necessary care is authorized in a timely manner, including timely access to SNFs and LTC Facilities.
 - b. In the event there is no available SNF/LTC bed, Medical Management staff may authorize placing the Member in an out-of-network facility to ensure timely access to the appropriate level of care.
7. Additional Monitoring and Corrective Action Plans (CAPs):

- a. Compliance with the Access to Care Standards are reported through CenCal Health's QIHETP structure. Based on analysis of these monitoring activities, the Customer Experience Committee and/or the Network Management Committee sets priorities for opportunities for improvement, and delegates to appropriate committees and departments to implement strategies to improve performance.
- b. Network providers found to be noncompliant with access standards, including appointment availability and equitable hours of operation for Plan Members, may be subject to corrective action.
- c. A CAP letter will outline the deficiencies identified and standards the Network Provider shall adhere to.
- d. Network Providers shall provide a written response to CenCal Health, outlining the actions that will take place to address the identified deficiencies and improve compliance. This may include plans to improve appointment availability and the timeline to implement those plans.
- e. An on-site educational meeting and resurvey conducted by Plan Provider Relations staff may occur.
- f. Plan staff may assist the Network Provider in determining whether their practice is efficiently run and whether all Network Provider staff are working at the top of their licensure and training.
- g. Plan staff may also explore whether the Network Provider is able to expand their practice by recruiting additional practitioners.
- h. CenCal Health staff will monitor any Network Provider on a CAP until the provider can demonstrate compliance with access standards.
- i. Plan staff will resurvey the Network Provider monthly until the practice is able to meet appointment availability standards.
- j. If the Network Provider is unable to attain compliance with access standards, Member assignment may be frozen.
- k. CenCal Health will monitor CAP progress until the Network Provider can demonstrate evidence of compliance. Network Provider progress on the CAP shall be reported to internal committees, as appropriate.
- l. If CenCal Health identifies trends in access concerns in a particular specialty, Plan staff will initiate recruitment efforts to support timely access, including but not limited to increasing access to telehealth services.

IV. Definitions:

Advanced Access: the provision, by an individual provider, or by the medical group to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

Ancillary Service: includes, but is not limited to, providers of pharmaceutical,

laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers (as defined by H&S Code Section 1323(e)(1)).

Appointment Waiting Time: the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services, inclusive of time for obtaining authorization from the plan and completing any other condition or requirement of the plan.

Community Based Adult Services (CBAS): means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program.

Covered Services: those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq.* and 14131 *et seq.*, 22 CCR section 51301 *et seq.*, 17 CCR section 6800 *et seq.*, the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, CenCal Health's contract with DHCS, and APLs that are made the responsibility of the CenCal Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Downstream Fully Delegated Subcontractor: a Downstream Subcontractor that contractually assumes all duties and obligations of CenCal Health under the DHCS Medi-Cal Managed Care Agreement, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

Downstream Subcontractor: an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Fully Delegated Subcontractor: a Subcontractor that contractually assumes all duties and obligations of CenCal Health under the DHCS Medi-Cal Managed Care Agreement, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

Intermediate Care Facility (ICF): means a residential facility certified and licensed by the State to provide Medical Services at a lower level of care than is provided at SNFs, and meets the standards specified in 22 CCR section 51212.

Long-Term Care (LTC): means specialized rehabilitative services and care provided in a Skilled Nursing Facility, subacute facility, pediatric subacute facility, or ICF.

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Network Provider: any provider or entity that has a Network Provider Agreement with CenCal Health, CenCal Health's Subcontractor, or CenCal Health's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the contract between CenCal Health and DHCS. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement: a written agreement between a Network Provider and CenCal Health, Subcontractor, or Downstream Subcontractor.

Potential Member: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

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 to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

Quality Improvement and Health Equity Transformation Program (QIHETP): the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care Agreement.

Skilled Nursing Facility (SNF): means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by CDPH or is a distinct part or unit of a hospital, meets the standards specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal Program.

Specialist: a residency-trained, board-certified, or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA) or the equivalent.

Subcontractor: an individual or entity that has a Subcontractor Agreement with CenCal Health that relates directly or indirectly to the performance of CenCal Health's obligations under the contract between CenCal Health and DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement: a written agreement between CenCal Health and a Subcontractor. The Subcontractor Agreement must include a delegation of CenCal Health's duties and obligations under the contract between CenCal Health and DHCS.

Telemedicine: the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and enrollee constitutes telemedicine for the purposes of this policy and procedure.

Triage: the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

Triage Waiting Time: the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.

Urgent Care: health care for a condition which requires prompt attention when the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function (consistent with subsection (h)(2) of Section 1367.01 of the Act).

V. References:

- A. Medicaid Managed Care Final Rule: Network Adequacy Standards updated March 26, 2018 and All Plan Letter 23-001 Attachment A.
- B. California Business and Professions Code, Section 2290 5(a)
- C. DHCS 2024 Contract: Exhibit A Attachment III 5.2.1 Access to Network Providers and Covered Services
- D. DHCS 2024 Contract: Exhibit A Attachment III 5.2.5 Network Adequacy Standards (A)
- E. 22 CCR Section 53853
- F. 28 CCR Section 1300.67.2.2
- G. 22 CCR Section 53853(a)
- H. W&I Code Sections 14182(c)(2) and 14087.3
- I. W&I Code Section 14182(b)(11)
- J. W&I Code Section 14197
- K. W&I Code Section 14197(h)(2)

VI. Cross Reference:

- A. Policy and Procedures (P&P):
 - 1. MS-31: Cultural and Language Access
 - 2. MS-32: Interpreter Services
 - 3. PS-CR06: Network Adequacy Standards
 - 4. PS-CR22: Facility Site Review and Medical Record Review Process

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date	DHCS P&P Approval Date
12/2023	Jordan Turetsky, Chief Operating Officer	2024 Template Migration	01/2024	N/A

06/2023	Jordan Turetsky, Robert Janeway	Updated for R.0183	01/2024	12/2023
04/2023	Jordan Turetsky, Robert Janeway	Policy revised to align with 2024 DHCS Contract Wave 3 requirements (Checklist R.0180).	01/2024	2023
09/2022	Jordan Turetsky, Robert Janeway	Policy revised to align with 2024 DHCS Contract Amendment requirements.	01/2023	2022
05/2021	Terri Howell	Revised per Annual Network Certification to align with APL 21-006: Network Adequacy Standards.	05/2021	N/A