Policy:	MA.7007
Title:	**Access and Availability**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/ Michael Hunn 12/26/2023*
Effective Date:	08/01/2005
Revised Date:	12/01/2023
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes required access and availability standards, including Provider Network adequacy, for Members to obtain effective, appropriate, and timely access to care and describes the process which CalOptima Health shall use for monitoring network adequacy.

II. POLICY

A. General Access

1. CalOptima Health shall evaluate CalOptima Health's and its Health Network's compliance with the standards outlined in this Policy. Unless otherwise stated, each access and availability standard outlined herein shall have a minimum performance threshold of eighty percent (80%).

2. CalOptima Health and its Health Networks shall not discriminate against Members or individuals who are eligible to enroll, on the basis of health status or need for health care services, race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental disability.

3. CalOptima Health and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services to accommodate the needs of Members with disabilities, including but not limited to individuals who are institutionalized, disabled or wheelchair bound, or lack transportation.

4. If a Health Network refers a Member to a different Provider pursuant to Section II.A.8 of this Policy, CalOptima Health shall not incur any additional expense as a result of such referral.

5. CalOptima Health shall refer Members to, or assist Members in locating, available and accessible contracted Providers in neighboring service areas or out-of-network providers for obtaining Covered Services in a timely manner appropriate for the Member's needs.

    a. Out-of-network providers shall be made available to Members if CalOptima Health and its Health Networks are unable to arrange for an in-person visit with a contracted Provider.

6. If Covered Services are unavailable to the Member within the Provider Network, CalOptima Health, or a Health Network, shall arrange for the provision of specialty services from Specialty Care Providers outside of the network in a timely manner and, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

7. CalOptima Health and its Health Networks shall ensure that contracting Providers offer CalOptima Health Members hours of operation that are:

    a. Convenient to the population;

    b. Do not discriminate against Medicare Members.

8. Specialist Care: Members shall have access to necessary specialist care, and in particular female Members are given the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

B. Network Providers

1. CalOptima Health and its Health Networks must maintain an appropriate network of specific Provider types to ensure the CalOptima Health's network has the capacity to provide all Medically Necessary Covered Services for current and anticipated membership.

2. CalOptima Health shall take the following into consideration:

    a. Geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.

    b. Members' and Practitioners' language and gender when evaluating adequate access to Covered Services.

    c. The number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.

    d. Anticipated Member enrollment numbers when evaluating adequate access to Covered Services.

    e. Expected utilization of services, considering characteristics and health care needs of CalOptima Health Members.

C. Timely Access

1. CalOptima Health and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this Policy. CalOptima Health shall evaluate CalOptima Health's and Health Network's compliance with the appointment access standards against a minimum performance threshold of eighty percent (80%), unless otherwise indicated.

    a. Emergency Services: Emergency Services shall be available immediately.

    b. Urgent Care Services: Urgent Care Services shall be available immediately.

    c. Appointment Availability for PCPs and Behavioral Health:

APPOINTMENT AVAILABILITY		
Description	**Standard**	**Minimum Performance Level**
Emergency Services	Immediately	80%
Urgent Care Services	Immediately	80%
Services Not Emergent or Urgently Needed but Requires Medical Attention	Within seven (7) business days	80%
Routine and Preventive Care	Within thirty (30) business days	80%

d. Monitoring of appointments, shall include:

i. Primary Care Providers (PCPs);

ii. Specialty Care Providers; and

iii. Mental Health Outpatient Services: Psychologists, Licensed Clinical Social Workers/Social Workers, Psychiatric Nurse Practitioners.

2. Health Risk Assessment (HRA): Appointment for HRA shall be completed in accordance with CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment.

D. Network Adequacy:

1. CalOptima Health and its Health Networks shall contract with a sufficient number of providers and facilities to ensure that at least ninety percent (90%) of Members within the county can access care with specific travel/distance maximums.

a. Standards can be found on the CMS website under 'Network Adequacy Standards' and the attachment to this Policy:

i. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/

E. Telephone Triage or Screening Services:

1. Telephone Triage or Screening Services shall be available twenty-four (24) hours a day, seven (7) days a week. Telephone Triage or Screening Waiting Time shall not exceed thirty (30) minutes.

2. CalOptima Health or a Health Network may provide telephone Triage or Screening Services through:

a. CalOptima Health or Health Network-operated telephone Triage and Screening Services;

b. A telephone medical advice service consistent with Section 1348.8 of the Health and Safety Code;

c. CalOptima Health or the Health Network's contracted Primary Care or Behavioral Health Care provider office; or

d. Other method that provides Triage or Screening Services.

3. If CalOptima Health or a Health Network contracts with a primary care or mental health care Provider for the provision of telephone Triage or Screening Services, such Providers shall maintain a procedure for Triaging or Screening Member telephone calls twenty-four (24) hours a day, seven (7) days a week, with a telephone answering machine and/or answering service, and/or office staff, that informs the Member:

    a. Regarding the length of wait for a return call from the Provider; and

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

4. An unlicensed staff member may perform Triage or Screening on behalf of a licensed staff member in order to assist in determining the Member's condition and refer the Member to a licensed staff member. Such unlicensed staff member shall not use this information obtained from Triage or Screening in an attempt to assess, evaluate, advise, or make any decision regarding the Member's condition, or determine when the Member should see a licensed Provider.

F. Telephone services shall be provided in accordance with CalOptima Health Policy MA.4007: Member Disclosures.

G. Cultural and Linguistic Services shall be provided in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

H. Care During A Federal Disaster or Other State or Public Health Emergency Declaration

1. In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, CalOptima Health shall evaluate whether there is a disruption of access to health care.

2. In the event of disasters or public health emergency declarations that contribute to a disruption in access to health care, CalOptima Health shall:

    a. Allow Members to maintain access to their Part A/B, supplemental Part C and Part D benefits consistent with 42 CFR Sections 422.100(m) and 423.124(a).

    b. Allow the benefits to be furnished at specified non-contracted facilities;

    c. Waive, in full, requirements for gatekeeper referrals, where applicable;

    d. Temporarily reduce plan-approved out-of-network cost sharing to in-network cost-sharing amounts even if enrollee uses out-of-networks providers;

    e. Waive the 30-day notifications to Members as long as all the changes benefit the Member;

    f. Ensure Members have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when Members cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy, and when such access is not routine;

g. Lift their "refill-too-soon" edits; and

i. CalOptima Health may consider extending the implementation of the "refill-to-soon" edits past the expiration of the declaration.

h. Allow an affected Member to obtain the maximum extended day supply, if requested and available at the time of refill.

i. Follow special requirements imposed by 42 CFR Section 422.100(m)(1) for thirty (30) calendar days after the disruption of access to health care ends, while the disaster or emergency is ongoing, and for thirty (30) calendar days after the end of the disaster or emergency if the disruption of access to health care, as defined in 42 CFR Section 422.100(m)(6), continues until the end of the disaster or emergency.

j. Allow a thirty (30) calendar day transition period where special requirements for a disaster or requirement ends, thirty (30) calendar days after the latest of events occurs or end thirty (30) calendar days after the condition ends, where there is no longer a disruption of access to health care.

i. When no end date is identified, the applicability of the special requirements ends thirty (30) calendar days after the expiration of the declared disaster or emergency and any deadline for renewing the state of disaster or emergency.

III. PROCEDURE

A. CalOptima Health shall participate in the validation of network adequacy from the preceding twelve (12) months to comply with requirements set forth in 42 CFR sections 438.68 and 438.14(b)(1).

B. CalOptima Health shall annually conduct the following as a means to collect network adequacy data for monitoring CalOptima Health's Provider Network and health networks, when appropriate:

1. Timely Access Survey;

2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and/or other Member experience surveys;

3. Behavioral Health Member Experience Survey;

4. Geographic Access Mapping; and

5. Facility Site Reviews (FSRs) data collected in accordance with CalOptima Health Policy GG.1608: Full Scope Site Reviews.

C. CalOptima Health shall analyze performance of CalOptima Health's network adequacy at the plan Provider Network and Health Network, against the standards set forth in this Policy, when available and appropriate.

1. Grievances and appeals data;

2. Network Adequacy (Provider/Member ratio and time/distance) report;

3. Encounter/claims data;

4. Potential Quality Issues (PQIs); and

5. Telephone wait times through reports from the call center.

D. Access and availability performance against the standards set forth in this policy shall be reported to the Member Experience Sub-Committee by the Access and Availability Workgroup Chair, or Designee, on a quarterly basis to:

1. Analyze and report results in order to:

a. Prioritize opportunities for improvement identified from analyses.

b. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

i. Non-Behavioral Health Care services and;

ii. Behavioral Health Care services.

c. Evaluate the effectiveness of interventions for improving access to non-behavioral and Behavioral Health Care services.

2. CalOptima Health shall annually develop the following:

a. Accessibility analysis (appointment availability and access during and after business hours) report;

b. Availability analysis (Provider/Member ratio and GeoAccess) report;

E. CalOptima Health shall submit a complete and accurate Health Service Delivery (HSD) report/template that reflects the entire contracted Provider Network and all required supporting documentation to CMS as part of the Triennial Network Adequacy Review.

1. If CalOptima Health is unable to meet time and distance standards, CalOptima Health shall:

a. Allow Members to access services out-of-network, if the services are not available in-network.

2. Notify affected enrollees at least thirty (30) days in advance of the effective date of applicable changes in rules to address the inadequate network.

F. CalOptima Health shall provide the Health Networks and the Member Experience Sub-Committee with access and availability reports of CalOptima Health and Health Networks' performance. These reports shall include CalOptima Health's assessment results against the access and availability standards as set forth in this Policy.

G. If the Member Experience Sub-Committee identifies deficiencies or non-compliance of standards or requirements set for in this policy, the Chair of the Member Experience Sub-Committee, or designee, may take the following steps:

1. Request that the Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant, if applicable.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions, respectively; and

3. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and Compliance Committee, as appropriate.

H. If a Health Network has been identified as having a deficient network component(s) and/or fails to meet network adequacy components:

1. CalOptima Health and the Health Network shall authorize services through out-of-network Providers where Members may utilize any Provider in or out of CalOptima Health's network regardless of Health Network affiliation.

2. The Health Network shall submit a Quality Improvement Plan or PDSA, if requested.

3. The Health Network shall submit a CAP to the CalOptima Health Office of Compliance, if necessary. A Health Network shall take all necessary and appropriate action to identify the causes underlying the access-related deficiencies, including but not limited to a review of whether Provider hours of operation and/or Providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this Policy and CalOptima Health Policy HH.2005: Corrective Action Plan.

I. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

J. The Quality Analytics Department shall annually update CalOptima Health's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

A. Network Adequacy Standards for OneCare

V. REFERENCE(S)

A. Age Discrimination Act of 1975
B. California Civil Code, Section 51
C. California Government Code, Section 11135
D. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Health Policy GG.1122: Follow-up for Emergency Department Care
F. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Care Network Providers
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy GG.1539 Authorization for Out-of-Network and Out-of-Area Services
I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
J. CalOptima Health Policy GG.1619: Delegation Oversight
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. CalOptima Health Policy MA.4007: Member Disclosures

N. CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
O. CalOptima Health Operational Audit Tool
P. CalOptima Health Quality Improvement Plan
Q. National Committee of Quality Assurance (NCQA) standards
R. OneCare Availability Standards: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/
S. Title 28, California Code of Regulations (CCR), §§ 1300.51(H), 1300.67.2, 1300.67.2.2
T. Title 28, Code of Federal Regulations (CFR), Part 36
U. Title 29, United States Code (USC), §794 (Section 504 of the Rehabilitation Act of 1973)
V. Title 42, United States Code (USC), §2000d
W. Title 42, Code of Federal Regulations (CFR), § 422.116
X. Title 45, Code of Federal Regulations (CFR), Part 80, Part 84, and Part 91
Y. Title VI of the Civil rights Act of 1964
Z. Title IX of the Education Amendments of 1973

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2007	MA.7007	Access and Availability Standards	OneCare
Revised	10/01/2008	MA.7007	Access and Availability Standards	OneCare
Revised	07/01/2011	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2013	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2014	MA.7007	Access and Availability Standards	OneCare
Revised	07/01/2015	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	05/10/2016	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	08/01/2016	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	08/01/2017	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	12/01/2017	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	11/01/2018	MA.7007	Access and Availability	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	05/05/2022	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	12/31/2022	MA.7007	Access and Availability	OneCare
Revised	12/01/2023	MA.7007	Access and Availability	OneCare

IX. GLOSSARY

Term	Definition
Ancillary Services that require appointments	Ancillary Services may include, but are not limited to, radiology, physical therapy, occupational therapy, speech therapy, phlebotomy, home health, etc.
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders including specialty mental health services. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some Routine Care of woman.
Complaint	Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Continuity of Care	Continuity of Care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of Ancillary Services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members; 3. Providing translations of informational materials in Threshold Languages, providing oral translation for other language upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Member to culturally and linguistically appropriate community services, as needed.
Disasters	Per CMS, the term disasters refer to disasters and public health emergencies.
Disruption of Access to Health Care	An interruption or interference in access to health care throughout the service area in the service area such that enrollees do not have the ability to access contracted providers or contracted providers do not have the ability to provide needed services causing MA organizations to fail to meet the prevailing patterns of community health care delivery in the service area.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Those covered inpatient and outpatient services required that are (1) furnished by a physician qualified to furnish Emergency Services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall also include the CalOptima Health Community Network.

Term	Definition
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
Member	A beneficiary enrolled in a CalOptima Health program.
Mental Health (Non-Physician) Outpatient Services	For purposes of this Policy, non-specialty mental health services for treatment of mild to moderate impairments provided by psychologists and licensed clinical social workers.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Licensed Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD, a PCP may also be a Specialty Care Provider or clinic.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Provider Network	For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.
Routine Care	Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.
Routine Physical Exams	A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.
Rural Health Clinic	An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.

Term	Definition
Screening	The assessment of a Member's health concerns and symptoms via communication with a qualified health professional acting within his or her scope of practice and who is trained to screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Triage or Screening	The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the Member's need for care.
Triage or Screening Services	Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to perform Triage or Screening Services.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.