Important Information for Physicians Regarding Timely Access Regulations
DMHC Access Standards

DEFINITIONS:

a. "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association 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.

b. "**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)].

c. "Appointment waiting time" means 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 or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.

d. "Health care service plan" or "specialized health care service plan" means either of the following:

- Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.
- Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

e. "Mental Health Care Provider (MHCP)" includes Medical Doctors and Doctors of Osteopathy with specialties in addictionology or psychiatry, clinicians licensed by the state for the independent practice of psychology (including Master's Degree Psychologist, if permitted in the state where the psychologist practices, California requires a PhD in psychology to be licensed for independent practice), and Master's Level Clinicians: counselors, therapists, social workers, licensed professional examiners and nurses who are licensed or certified to practice independently according to state laws in their practice location. Marriage and Family Therapists and Licensed Clinical Social Workers are licensed or certified to practice independently in California.

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

f. "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services [as defined by H&S Code Section 1345(i)].

g. "Provider Group" means a medical group, independent practice association, or any other similar organization (as defined by Section 1373.65(g) of the Act).

h. "Preventive care" means 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.

i. "Specialist" is defined as 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).

j. "Telemedicine" means 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.

k. "Triage" or "screening" means 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.

l. "Triage or screening waiting time" means 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.

m. "Urgent care" means 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).

PROCEDURES:

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

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

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment **within 10 Business Days** of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment **within 15 Business Days** of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment **within 48 hours** of request
Urgent Care appointments that require prior authorization	Must offer the appointment **within 96 hours** of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment **within 15 Business Days** of the request
In-office wait time for scheduled appointments (PCP and SCP)[1]	Not to exceed **30 minutes**

Exceptions to the Appointment Availability Standards

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

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

Advanced Access: The primary care appointment availability standard listed above may be met if the primary care physician office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

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

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment **within 10 business days** of request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment **within 10 business days** of request
Urgent Care appointments	Must offer the appointment **within 48 hours** of request
Access to Care for Non-Life Threatening Emergency	**Within 6 hours**
Access to Life-Threatening Emergency Care	**Immediately**
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: One follow-up encounter with a mental health provider **within 7 calendar days after discharge** Plus One follow-up encounter with a mental health provider **within 30 calendar days after discharge**

Medi-Cal Non-Emergent Medical Appointment Access Standards

Access Measure	Time-Elapsed Standard
Access to PCP or designee	**24 hours a day, 7 days a week**
Non-urgent Care appointments for Primary Care (PCP Regular and Routine, excludes physicals and wellness checks)	Must offer the appointment **within 10 business days** of request
Adult physical exams and wellness checks	Must offer the appointment **within 30 calendar days** of request
Non-urgent appointments with Specialist physicians (SCP Regular and Routine)	Must offer the appointment **within 15 business days** of request
Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	Must offer the appointment **within 48 hours** of request
Urgent Care appointments that require prior authorization (SCP)	Must offer appointment **within 96 hours** of request
First Prenatal Visit	Must offer the appointment **within 5 business days** of request
Child physical exam and wellness checks with PCP	Must offer the appointment **within 10 business days** of request

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

Access Measure	Time-Elapsed Standard
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment **within 15 business days** of request
Initial Health Assessment (enrollees age 18 months and older)	Must be completed **within 120 calendar days** of enrollment
Initial Health Assessment (enrollees age 18 months and younger)	Must be completed **within 60 calendar days** of enrollment

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:

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

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

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

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

Telemedicine
To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established.

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

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

1. The enrollee or the enrollee's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the enrollee or the enrollee's legal representative would otherwise be entitled.
2. A description of the potential risks, consequences, and benefits of telemedicine.
3. All existing confidentiality protections apply.

4. All existing laws regarding enrollee access to medical information and copies of medical records apply.
5. Dissemination of any enrollee identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the enrollee.

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

Other Applicable Requirements:

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

Prior Authorization Processes
Prior authorization processes, are to be completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of the time-elapsed access standards. *Refer to Utilization Management Policy Authorization and Referral Process.*

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

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

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

Triage &/or Screening

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

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

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

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

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

- Answering service/office staff handling enrollee calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the enrollee so that the enrollee can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the enrollee, or to determine when an enrollee needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

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

- The answering service should document all calls.

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