

HEALTH PLAN POLICY	
Policy Title: Accessibility of Network	Policy Number: OPND11 Revision: C
Department: Operations	Sub-Department: Network Development
Applies to Product Lines: <input type="checkbox"/> Medicaid <input checked="" type="checkbox"/> USFHP <input type="checkbox"/> Children’s Health Insurance Plan <input checked="" type="checkbox"/> Commercial Insured <input checked="" type="checkbox"/> Health Insurance Exchange <input type="checkbox"/> Non Insured Business <input checked="" type="checkbox"/> Medicare	
Origination/Effective Date: 05/09/2018	
Reviewed Date(s):	Revision Date(s): 07/16/2018, 02/01/2019, 06/01/2020

SCOPE:

To define the standards to assure the accessibility of primary care service, specialty care service and behavioral health services. To establish a process for compliance with regulatory and accreditation agents’ requirements for timely access to care standards and monitoring activities.

DEFINITIONS AND ACRONYMS:

- **Accessibility** - The extent to which a patient can obtain available services from a participating provider at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment
- **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
- **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.
- **Behavioral Health Care Provider (BHCP)** -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 the service areas.
- **National Committee for Quality Assurance (NCQA)** –_Is a non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations
- **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
- **Primary Care Providers** - Licensed practitioners including physicians in General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Pediatric and Family Advanced Practice Nurses, Certified Nurse Midwives and Physician Assistants (practicing under the supervision of a physician), Federally Qualified Health Centers and Rural Health Clinics.

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- **Specialty Care Providers** - All practitioners providing specialty care to enrollees, which includes all specialty types included in the Medicare Specialty Codes including dental, chiropractic, acupuncture and vision providers.
- **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.

POLICY:

All covered services must be available to members on a timely basis in accordance with medically appropriate guidelines that are consistent with generally accepted practice parameters and responsive to the linguistic, cultural and other unique needs of special populations. CHRISTUS Health Plan will ensure that all contracted Primary Care Providers (PCP), Specialty Care Providers (SCP) and Behavioral Healthcare Provides (BHCP) are in compliance with approved standards. The health plan will conduct annual analysis of the available network for its adequacy based on member's availability of practitioners to provide the services.

Methodology:

- A. CHRISTUS Health Plan utilizes certified vendors to conduct the availability study.
- B. The vendor is responsible to conduct survey via phone and. Mail (if needed). The primary mode of administration should be via phone, however if providers request a paper version of the survey, the survey instrument will be faxed to the provider office for completion. Provider office staff will be required to submit the completed responses back to the vendor within 5 business days.
- C. Monitoring and Corrective Action Process- CHP monitors appointment access through an annual access to care survey conducted by a third party vendor. The survey questions are based on the tool evaluated by CHP. The compliance rates for each question are calculated based on the responses given by the provider offices. The compliance rate is calculated based on the number of respondents meeting the timeframe thresholds established for individual questions. The vendor is responsible to enter all the collected responses into a database and provide a compliance rate for each question in the written report. Vendor should also provide detailed logs of providers not meeting the compliance threshold for any of the appointment wait time standards.
- D. CHP will send a request for "corrective action plan" notice to all providers failing on any of the standards. Providers will be required to submit a written response to CHP within 60 days of the CAP notice. All providers failing on any of the thresholds will be included annual survey the following year so that CHP can measure if corrective actions have been implemented and noncompliance issues have been resolved. The Network team is responsible for presenting the identified results via Quality Improvement Committee (QIC) and producing reports.

Standards:

The comparison of performance of providers is based on the following standards:

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A. Primary Care Providers Access to Care Standards (PCPs)

CRITERIA	STANDARD
Emergency exam	<p>Immediately When a member calls the Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911).</p> <p>If the condition is a non-life threatening emergency it is still preferable for the member to be given access to care immediately but no later than six (6) hours.</p>
Urgent PCP Exam	Within 48 hours
Preventive care and physical Exam	Within 30 Calendar days
After-hours care	<p>Physicians are required by contract to provide 24 hours, 7 days a week coverage to members. The same standards of access and availability are required by physicians “on-call”.</p> <p>CHP also has a 24 hour, 7 day a week nurse advice line available through a toll free phone line to support and assure compliance with coverage and access.</p>
Telephone Access	<p>Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member’s call. Urgent and emergent calls must be handled by the physician or his/her “on-call” coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse)</p> <p>Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.</p>
Waiting Time in office	Thirty (30) minutes maximum after time of appointment
Failed Appointments (Patient fails to show for a scheduled appointment)	<p>Failed appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours.</p> <p>According to the Practitioner’s office’s written policy and procedure provisions for a case-by-case review of members with repeated failed appointments could result in referring the member to the Health Plan for case management. Practitioners’ offices are responsible for counseling such members</p>

B. Specialist Care Providers Access to Care Standards (SCPs)

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Emergency Care	<p>Immediately</p> <p>When the Health Plan or Emergency Room contacts a specialty Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately.</p> <p>If a member contacts the specialist's office with an emergency need they must contact the PCP immediately or direct the member to the Emergency Room or call 911</p>
Urgent Specialist Exam (if no auth required)	<p>Within 48 hours</p> <p>When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is not required the member must be seen within 48 hours or sooner as appropriate from the time the member was referred.</p>
Urgent Specialist Exam (auth required)	<p>Within 96 hours</p> <p>When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is required the member must be seen within 96 hours or sooner as appropriate from the time the referral <i>was first authorized</i>.</p>
Routine specialist visit, Non-urgent exam	Within 15 Calendar days
Routine Ancillary visit, Non-urgent exam	Within 15 Calendar days
After Hours Care	Same as PCP standards
Telephone Access	Same as PCP standards
Waiting Time in office	Thirty (30) minutes maximum after time of appointment
Failed Appointments (Patient fails to show for a scheduled appointment)	Same as PCP standards

C. Behavioral Health Care Provider (BHCP) standards

Life threatening/Emergency needs	Immediately
Non-Life threatening emergency needs	Within six (6) hours

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Urgent needs exam	Within 48 hours
Routine office visit, Non-urgent exam	Within ten (10) Business Days
Non-physician BH Provider : Routine office visit, Non-urgent exam	Within ten (10) Business Days
After Hours Care	Same as PCP standards
Telephone Access	Same as PCP standards
Waiting Time in office	Thirty (30) minutes maximum after time of appointment
Failed Appointments (Patient fails to show for a scheduled appointment)	Same as PCP standards

REFERENCES:

- NMSA 1978 § 59A-57-4(B)(2) & (3), 13 NMAC 10.11
- 13.10.22.8 NMAC
- 28 TAC 3.3704
- USFHP TRICARE Operations Manual
- Medicare Advantage Network Adequacy Criteria Guidance – https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf
- NCQA Measurement Standard NET1, NET 2, NET 3, NET 4

RELATED DOCUMENTS:

None

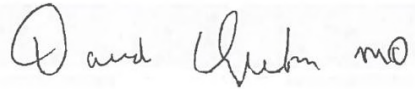
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REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	05/09/2018	Initial release.	Executive Leadership
A	07/16/2018	Added application to Health Insurance Exchange in document header	Executive Leadership
B	02/01/2019	Compliance review. Updated Lines of Business and References.	Executive Leadership
C	06/01/2020	Annual review. Updated References. Made minor formatting correction.	Executive Leadership