KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 4.30-P Accessibility Standards has been updated and is provided here for your review and approval. The policy was reviewed and approved by DMHC 5/27/2021.

Reviewer	Date	Comment/Signature
Emily Duran Chief Executive Officer	9/13/2022	
Dr. Tasinga Chief Medical Officer	9/9/2022	M Tasinga
Alan Avery Chief Operating Officer	7/20/21	**Alan Avery**
Deb Murr Chief Health Services Officer	6/9/2021	**Deborah Murr RN, CHSO**
Emily Duran Chief Network Administration Officer	4/2/2021	Emily Duran

(CEO decision(s))

Board approval required: Yes ___ No ___ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Accessibility Standards				POLICY #: 4.30-P	
DEPARTMENT: Provider Relations					
Effective Date: 01/1996	Review/Revised Date: 9/13/2022	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Emily Duran
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date_____
Chief Operating Officer

_____ Date_____
Chief Health Services Officer

_____ Date_____
Chief Network Administration Officer

POLICY:
Kern Health Systems (KHS) monitors the accessibility of contracted providers to members to obtain covered services and implements corrective measures when necessary.

Contracted providers are made aware of and accountable for these accessibility standards. This policy will be included in the *KHS Provider Manual*. Provider contracts contain provisions pertaining to member access to medical care, the monitoring of the standards, and KHS right to implement actions to provide sufficient health care access.

Accessibility standards will be monitored in accordance with the following regulatory and contractual requirements:

California Code of Regulations Title 28 §1300.67.2.2

DEFINITIONS:

1.0 ADVANCED ACCESS:
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.

2.0 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.

3.0 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 or its contracting providers.

4.0 PREVENTIVE CARE:
Health care provided for prevention and early detection of disease, illness, injury or other health condition.

5.0 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.

6.0 TRIAGE OR SCREENING:
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.

7.0 TRIAGE OR SCREENING 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.

8.0 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 other health or could jeopardize the enrollee's ability to regain maximum function.

PROCEDURES:

1.0 SCOPE

These standards apply to contracted providers.

2.0 RESPONSIBILITY

KHS has ultimate responsibility for facilitating timely access to covered health care services. The monitoring of these standards has been delegated to the KHS Provider Relations Department. The Director of Provider Relations, with assistance from other KHS departments as needed, shall monitor all areas related to members' access to medical care and shall submit related reports as outlined in §5.0 Reporting.

Limited English Proficient (LEP) and hearing impaired members will be provided equal access to health services in accordance with *KHS Policy and Procedure 3.70-I Cultural and Linguistic Services.*

3.0 STANDARDS

Contracted providers are held to the following accessibility standards concerning their patient facilities and provision of care to members:

3.1 Facility Characteristics

The facility must be clean, adequately-lighted, maintained and project professionalism and quality of care.

3.1.1 Waiting Area

The waiting area must be of sufficient size to accommodate patients and wheelchairs. The seating shall be adequately constructed to support patients of varying physical stature. The waiting area's proximity to the reception areas should be arranged to allow visual and verbal contact. Providers must have a plan or process in place to accommodate patients with a contagious condition as described in *KHS Policy and Procedure #2.20-P: Infection Control Program.*

3.1.2 Parking

Each facility must have access to nearby parking and be free of barriers. Parking must be provided at no charge to KHS members.

3.1.3 Restrooms

Restrooms must be equipped to accommodate patients with and without a disability. The restrooms must be close to waiting and treatment areas.

3.1.4 Treatment Areas

All treatment areas must be appropriately equipped and arranged in a manner that provides for patient privacy, dignity, comfort and safety. The treatment areas must be within easy reach of the waiting and reception areas.

3.1.5 Barriers

Patient areas must be free of barriers that would restrict access to person with or without a disability. This includes the provision of ramps and elevators to access patient care areas and drinking water.

3.1.6 Disability Accommodations

Contracted providers are required to comply with the Americans with Disabilities Act (ADA). Questions regarding the ADA can be directed to Region IX - Disability and Business Technical Center at 1-800-949-4232 or www.ADATA.org

3.2 Staffing

Contracted providers must be staffed with personnel who possess the ability to assist patients who have physical impairments or who have difficulty with the English language.

3.3 Location

All regularly used facilities must be within the KHS service area and connected by roads, streets, and freeways that are easily accessible from all point of the KHS service area. Facilities that provide specialized seldom used services that are not available within the KHS service area must be located as near as possible to the service area and within the reach of members by public and private transportation.

3.4 Transportation

Facilities must have adequate access to public or private transportation.

3.5 Driving Time/Miles

KHS shall maintain a network of providers to ensure compliance with geographic access standards as outlined by applicable regulatory requirements. KHS shall maintain a network of Primary Care Providers and Hospitals located within thirty (30) minutes or ten (miles) of a Member's residence.

Additionally, KHS shall ensure its network of providers meets compliance with time and distance standards as required by the Department Health Care Services' (DHCS) annual network certification.

For geographic service areas (zip codes) found to not meet the above standards, KHS shall maintain alternative access standards, to be filed and approved with the DHCS and DMHC.

3.5.1 Member Assistance (AB 1642)

For zip code/specialty combinations in which KHS maintains an approved alternative access standard from the DHCS, the Member Services Department will assist members with obtaining appointments with applicable specialists within time and distance standards. KHS will make best effort to establish member-specific case agreement for an appointment with a specialist within time and distance standards, in-line with ad-hoc contracting procedures outlined in 4.25-P *Provider Network and Contracting*; member-specific case agreement will be offered at no less than the Medi-Cal FFS rate, agreed upon by the Plan and provider, and must be made within the most recent year. KHS will arrange transportation to appointments within time and distance and timely access standards if a member-specific case agreement cannot be made; transportation services will be arranged in line with 5.15-I *Member Transportation Assistance.*

3.6 Appointment Waiting Time and Scheduling:

The "appointment waiting time" means 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 the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers. KHS shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental	Must offer the appointment within 10 business

health care provider	days of request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

Exceptions to Appointment Waiting Time and Scheduling:

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 Member's medical record that a longer waiting time will not have a detrimental impact on the Member's health.

Telemedicine:
To the extent that telemedicine services are appropriately provided as defined per §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. 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.

OB/GYN PCP

KHS will contract with OB/GYNs as either PCP, Specialty Care, or dual providers. OB/GYN's contracting with the plan are not required to be PCPs. OB/GYN providers that contract with KHS as a primary care provider are subject to the primary care timely access standards outlined in this policy

3.7 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 members to available and accessible contracted providers in neighboring service areas consistent with patterns or practice for obtaining health care services in a timely manner appropriate for the member'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 member's condition. This requirement does not prohibit a plan from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

3.8 Office Waiting Time – Maximum

Service	Required Care	
	Urgent	Routine
Primary Care Services (including OB/GYN)	1 hour	1 hour
Specialty Care Services	1 hour	1 hour
Diagnostic Testing	1 hour	1 hour
Mental Health Services	1 hour	1 hour
Ancillary Providers	1 hour	1 hour

Physicians are not held to the office waiting time standards for unscheduled, non-emergent, walk-in patients.

3.9 Facility Hours

Type of Service	Standard
Emergency Care	24 hours per day, 7 days per week
After Hours Urgent and Emergency Care	Primary and specialty care providers must provide or arrange after hours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered by the contracted provider to other patients. If the contracted provider only serves Medi-Cal beneficiaries, the hours of operation should be comparable to the hours offered to Medi-Call FFS.

Office hours, including after hours availability, should be posted on the outside entrance of the office with the office daytime and after hours phone numbers.

3.10 Telephone Accessibility

Providers and administrative personnel must maintain a reasonable level of telephone accessibility to KHS members. At minimum, the following response times are required:

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or 661-868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-Urgent Mental Health	By close of following business day
Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Contracted providers must answer or design phone systems that answer phone calls within six rings. Providers should address each telephone call regarding medical advice or issues promptly and efficiently and must ensure that non-medical personnel do not give medical advice. Only PAs, NPs, RNs and MDs may provide medical advice. A sample policy that providers may incorporate into their own body of policies is included as Attachment A.

KHS provides or arranges for the provision of 24/7 triage screening services by telephone. KHS ensures that telephone triage or screening are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. KHS provides triage or screening services through medical advice lines pursuant to §1348.8 of the Health & Safety Code. Refer to *KHS Policy and Procedure 3.15-I 24-hour Telephone Triage Service*.

3.11 Full-time equivalent (FTE) Provider to Member Ratios

KHS shall maintain a provider network capacity of the following full-time equivalent provider to member ratios:

Primary Care Physicians	1:2,000
Total Physicians	1:1,200

4.0 MONITORING

The Provider Relations Department shall be responsible for monitoring Plan compliance with access standards.

4.1 Quarterly Access Review

On a quarterly basis KHS will conduct a review of Plan's compliance with after hours and appointment availability access standards. This will include, but is not limited to after hours survey calls, appointment availability survey, a review of access grievances, and a review of data received from the 24-Hour Telephone Triage Service employed by KHS (as outlined in *KHS Policy and Procedure 3.15-I 24-hour Telephone Triage Service).* Based on this review, KHS will take action as applicable including appropriate provider education; if a provider continues to be found out of compliance based on the results of the quarterly review, the provider may be issued a corrective action plan (CAP) as described in *KHS Policy and Procedure #4.40-P Corrective Actions Plans*

The appointment availability survey will consist of quarterly calls made to a sample of contracted primary care and specialist providers (included mental health providers) to assess the provider's and the Plan's level of compliance with appointment availability standards.

The after hours survey calls will consist of quarterly calls made to all contracted primary care provider offices to assess the provider's and the Plan's level of compliance with after-hours standards.

As appropriate, results of the annual Member (§4.3) and Provider (§4.4) Satisfaction surveys will be incorporated into KHS' quarterly access review for additional tracking and trending.

Results of the KHS's quarterly access review will be reported to the QI/UM Committee as outlined in §5.0 - Reporting.

4.2 Geographic Accessibility Analysis

As needed, but at least annually, KHS will conduct a geographic accessibility analysis to ensure compliance with Driving Time/Miles standards and applicable regulatory requirements.

4.3 Appointment Rescheduling

As outlined above, 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.

For primary care providers, compliance with the process for the rescheduling of missed appointments shall be monitored via the medical record review survey process, outlined in 2.22-P *Facility Site Review.*

Appointment availability of a rescheduled appointment will be monitored by KHS via the survey process outlined above in § 4.1 *Quarterly Access Review.* The standard and monitoring process for the availability of a rescheduled appointment shall be equal to

the availability of the initial appointment, such that the measure of compliance shall be shared.

4.4 Member Satisfaction Survey

On an annual basis, KHS shall conduct a Member Satisfaction Survey to determine member satisfaction with, but not limited to, customer service, primary care provider services, specialty care provider services, and access to care.

4.5 Provider Satisfaction Survey

On an annual basis, KHS shall conduct a Provider Satisfaction Survey to determine the satisfaction of its network of providers with, but not limited to, Plan utilization and quality management, financial issues, network and access to care, pharmacy/formulary, Plan staff, and overall satisfaction.

4.6 DMHC Annual Timely Access Compliance Report

On an annual basis KHS shall conduct and submit a Timely Access Compliance report to the Department of Managed Health Care (DMHC). KHS will employ the methodology, survey tool, and submission/templates for the appropriate measurement year as instructed by the DMHC.

4.7 Full-time equivalent (FTE) Provider to Member Ratios

On an annual basis, KHS will monitor that its provider network capacity satisfies the following full-time equivalent provider to member ratios:

1) Primary Care Physicians 1:2,000
2) Total Physicians 1:1,200

Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee.

Due to a maximum member assignment of 1,000 mid-level providers serving in the Primary Care capacity, mid-level providers will be counted as .5 of a PCP FTE, prior to percentage calculation.

4.7 Advanced Access

For a primary care provider to demonstrate their office offers Advanced Access to enrollees, provider office must have a walk-in clinic at the same address as the primary care location; if the member does not want to accept the walk-in clinic appointment, the provider office must be able to offer a scheduled non-urgent primary care appointment within the time standards outlined above.

KHS will track provider offices with available walk-in clinics through its credentialing process and applicable software.

5.0 REPORTING

Reporting of access compliance activities is the responsibility of the Provider Relations Supervisor. Reports are submitted as outlined in the following table.

Reported To	Report	Due Date
QI/UM Committee	Quarterly Access Review (§4.1)	Quarterly
QI/UM Committee	Geographic Accessibility Analysis (§4.2)	Annually
QI/UM Committee	Methodology/Results of FTE Network Capacity (§4.6)	Annually

ATTACHMENTS:

- Attachment A – *Telephone Advice Protocol*

REFERENCE:

Revision 2021-04: **A**dditional language added by Chief of Health Services to clarify rescheduling of missed appointments**. Revision 2020-07:** Policy Revised per APL 20-003 (AB 1642, OB/GYN PCP) and DMHC Audit CAP (appointment rescheduling) Revision **2019-08:** Policy revised to comply with DMHC Timely Access Standards. New Section added 4.1 Quarterly Access Review. Policy approved by DMHC June 2019. **Revision 2017-08**: Revised the methodology for the calculation of FTE as directed by DMHC, approved by DMHC and DHCS. Section 4.0 Monitoring updated to remove ICE vendor and to update FTE ratio. FTE ratio removed from policy 5.06 section 2.4. Revision **2015-07:** Section 4.0 Monitoring updated by Provider Relations to reflect current processes. Attachments B and F reflect attachments referenced within the policy. **Revision 2014-11:** References to mental health services included to expand services to members. Requested by DMHC May 6, 2014, eFiling 20140831. **2014-03:** Policy revised to comply with DMHC model provider appointment availability survey methodology. **Revision 2014-03:** Revisions provided to comply with the 1115 SPD Waiver Survey by the Provider Relations Supervisor. **Revision 2011-08:** Policy underwent major revisions due to Timely Access Standards. Revised by COO Becky Davenport and approved by DMHC 3-19-12 and DHCS 12/5/11.

Attachment A

PROVIDER OFFICE POLICY AND PROCEDURES

TELEPHONE ADVICE PROTOCOL

Policy:

This office will address each telephone call requesting advice or medical issues promptly and efficiently.

Procedure:

All telephone calls from patients or patient representatives with requests for advice, problems or medical question will be documented and promptly referred to the physician, mid-level practitioner or RN.

At no time will office personnel other than PAs, NPs, RNs, or the MD provide medical advice. The caller may be placed on hold while the physician is contacted and information may be relayed. IF the physician is unavailable to address the call, the patient may be scheduled an appointment to be seen. A signed advice form shall be maintained in each employee file.

In the event of an emergency, the patient (caller) will be instructed to call **911**.

All prescriptions must be renewed or changed by the provider.