KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 4.30-P

Last approved version: 5/2024

Reason for revision: Policy version 5/2024 was signed and implemented, however during the implementation process the plan received comment letters from the DMHC which resulted in additional revisions that were made on 3/2024. On 8/2024, Compliance reconciled the policy to include the revisions made on 3/2024.

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Date posted to public drive: _____

Date posted to website ("P" policies only): _____

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: 01/28/2025	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Emily Duran
Chief Executive Officer

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POLICY:

Kern Health Systems (KHS) shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. KHS shall establish and maintain appropriate networks, policies,

procedures, monitoring systems, and processes sufficient to ensure compliance with this clinical appropriateness standard. KHS shall ensure that all plan and provider processes necessary to obtain covered health care services are 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. KHS will ensure compliance with applicable regulatory accessibility standards, as set forth by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).
Network providers shall be made aware of, and accountable for, these accessibility standards. The information in this policy will be included in the KHS Provider Manual. Provider contracts will 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.

DEFINITIONS:

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.
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	The time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative, or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.
High Impact Specialties	Specialties that manage conditions with high morbidity/mortality rates and that require significant resources. KHS identifies Oncology as a High Impact Specialty.
High Volume Mental Health Specialties	KHS identifies as Psychiatry, Psychology, Licensed Clinical Social Worker (LCSW), and Licensed Marriage & Family Therapist (LMFT) as High-Volume Mental Health Specialties.
High Volume Specialties	Specialties with a high volume of utilization based on claims data. KHS identifies Obstetrics/Gynecology, Cardiology, Ophthalmology, and Neurology as High-Volume Specialties. As appropriate, KHS will utilize claims data to evaluate and identify High Volume Specialties.
Network	A discrete set of network providers, the Plan has designated to deliver all covered services for a specific network service area.
Network Adequacy	The sufficiency of the Plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements set forth in the Knox-Keene Act, including subsection (a)(5) of section 1371.31, subsections (d) and (e) of section 1367 and section 1375.9 of the California Health and

	Safety Code and Rules and 1300.51, 1300.67.2, and 1300.67.2.1 of the California Code of Regulations
Network Provider	Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services located inside or outside of the network service area of a designated network, meeting all of the following criteria: A. The provider is available to provide covered services to all plan enrollees in the network. B. The provider is one or more of the following: 1. An employee of the plan. 2. An individual health professional or health facility contracted directly with the plan consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.7, 1379 and subsection (d) of section 1351. 3. An individual health professional or health facility contracted with the plan through an association, provider group, or other entity, consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.5, 1379, and subsection (d) of 1351. 4. An individual health professional or health facility designated to deliver covered services to enrollees in the network through a plan-to-plan contract, as defined in subsection (b)(13); or 5. An individual health professional or health facility required to be part of the plan's network under any of the following circumstances: a. a corrective action plan submitted to the Department by the plan or its delegated entity. b. as required by the Department pursuant to section 1373.65 of the Knox-Keene Act; or c. as otherwise required by order of the Department. C. The provider is accessible to enrollees of the designated network without limitations other than established: 1. In-network referral or authorization processes; or 2. Processes for changing provider groups consistent with section 1373.3 of the Knox-Keene Act, in networks where enrollees are assigned to a provider group. D. A network provider shall not include: 1. Providers made available through single-case agreements, letters of intent, or contract agreements that do not include the provider contracting requirements of the Knox-Keene Act as described in subsection (b)(10)(B)(ii) and (iii) of this Rule.

	Noncontracting individual health professionals, as defined in subsection (f)(5) of section 1371.9 of the Knox-Keene Act.
Network Service Area	The geographical area, and population points contained therein, where the Plan is approved by the DMHC and contracted with the DHCS, to arrange health care services consistent with network adequacy requirements. Population points shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data and made available annually by the DMHC on their web portal.
Plan-to-Plan Contract	An arrangement between KHS and another Plan, in which the subcontracted plan makes network providers available to KHS enrollees and may be responsible for other managed-care functions. Plan-to-plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan. The Primary Plan in a Plan-to-Plan contract is a licensed plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services. The Subcontracted Plan in a Plan-to-Plan contract is a licensed plan or specialized plan that is contracted to allow a primary plan's enrollees access to the subcontracted plan's network providers.
Preventive Care	Health care provided for prevention and early detection of disease, illness, injury, or other health condition and includes all of the following health care services required by sections 1345(b)(5), 1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).
Provider Group	A medical group, independent practice association, or any other similar organization.
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/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.
Triage/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.
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.[i]

PROCEDURES:

A. RESPONSIBILITY

KHS has ultimate responsibility for facilitating timely access to covered health care services. The monitoring of these standards shall be conducted by the KHS Provider Network Management Department, with assistance from other KHS departments as needed.

B. STANDARDS

Network Providers are held to the following accessibility standards concerning their patient facilities and provision of care to members, as outlined below. The Plan will not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.

1. Facility Characteristics

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

a. 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.

b. Parking

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

c. Restrooms

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

d. 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.

e. 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.

f. 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

2. Geographic Accessibility

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. Additional information outlined in 3.9 Annual Network Certification

For geographic service areas (Zone Improvement Plan (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.

KHS' geographic accessibility standards do not modify the requirement of the Plan to remain in compliance with Section 1300.51, Rule 1300.67.2, or Rule 1300.67.2.1 of the California Code of Regulations.

a. Primary Care, by Specialty Type

In addition to the above-referenced regulatory standards, Primary Care geographic accessibility will be monitored by Primary Care Specialty, against the established standards below.

Primary Care Geographic Standards		
Specialty	**Geographic Standard**	**Goal**
General Practitioners/ Family Practice	1 Provider within 10 miles	90%
Internal Medicine	1 Provider within 10 miles	90%
Pediatrician	1 Provider within 10 miles	90%

b. High Volume Specialty

In addition to the above-referenced regulatory standards, High Volume Specialty geographic accessibility will be monitored against the established standards below.

High Volume Specialties Geographic Standards		
Specialty	**Geographic Standard**	**Goal**
Obstetrics/Gynecology	1 Provider within 10 miles	90%
Cardiology	1 Provider within 45 miles	90%
Ophthalmology	1 Provider within 45 miles	90%
Neurology	1 Provider within 45 miles	90%

c. High Impact Specialty

In addition to the above-referenced regulatory standards, High Impact Specialties will be monitored against the below established geographic standards.

High Impact Specialties Geographic Standards

Specialty	Geographic Standard	Goal
Oncology	1 Provider within 45 miles	90%

d. High Volume Mental Health Specialty

In addition to the above-referenced regulatory standards, High Volume Mental Health Specialties will be monitored against the below established geographic standards.

High Volume Mental Health Specialties Geographic Standards		
Specialty	**Geographic Standard**	**Goal**
Psychiatry	1 Provider within 45 miles	90%
Psychology	1 Provider within 45 miles	90%
LCSW	1 Provider within 45 miles	90%
LMFT	1 Provider within 45 miles	90%

3. Appointment Waiting Time and Scheduling

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:

Appointment Type	Standard
Urgent care appointment for services that do not require prior authorization	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 non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent follow-up appointment with a non-physician mental health care provider, for those undergoing a course of treatment for an ongoing mental health condition	Within 10 business days from prior appointment date
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

a. Interpreter Services and Appointment Wait Time/Scheduling

Interpreter services shall be coordinated with the scheduled appointment for health services in a manner that ensures the provision of interpreter services at the time of the appointment and does not impose a delay on the scheduling of the appointment. Interpreter services will be scheduled in line with KHS policy and procedure 11.23-I Cultural and Linguistic Services.

b. 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.

c. 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 above.

d. 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 and in line with KHS Policy and Procedure 2.01-P General Exam Guidelines

e. 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. Documentation in the member's medical record regarding the provider's decision to extend the applicable waiting time shall be made available by the provider to KHS and/or the DHCS upon request. Providers shall inform members of their decision to extend applicable wait time standards and include an explanation of the member's right to file a grievance disputing the extension.

f. Referral

A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard unless the requirements of section b or e of this policy are met.

4. Network Adequacy

KHS' network adequacy standards do not modify the requirement of the Plan to remain in compliance with Section 1300.51, Rule 1300.67.2, or Rule 1300.67.2.1 of the California Code of Regulations

a. 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

b. Network Provider Adequacy

KHS will require network providers have adequate staff, including providers, nurses, administrative, and other support staff to ensure that they have sufficient capacity to provide and coordinate care for covered services for KHS enrollees.

c. Primary Care, by Specialty Type

In addition to the above-referenced Primary Care ratio standard, Primary Care network adequacy will be monitored, by specialty type, against the established standards below.

Primary Care Ratio Standards	
Specialty	**Ratio Standard**
General Practitioners/ Family Practice	1 Provider to every 3,000 Members
Internal Medicine	1 Provider to every 5,000 Members
Pediatrician	1 Provider to every 5,000 Members

d. High Volume Specialty

High Volume Specialty network adequacy will be monitored against the established standards below.

High Volume Specialties Geographic Standards	
Specialty	**Ratio Standard**
Obstetrics/Gynecology	1 Provider to every 5,000 Female Members
Cardiology	1 Provider to every 7,500 Members
Ophthalmology	1 Provider to every 7,500 Members
Neurology	1 Provider to every 7,500 Members

e. High Volume Mental Health Specialty

High Volume Mental Health Specialties network adequacy will be monitored against the established standards below.

High Volume Mental Health Specialties Geographic Standards	
Specialty	**Ratio Standard**
Psychiatry	1 Provider to every 7,500 Members
Psychology	1 Provider to every 10,000 Members
LCSW	1 Provider to every 10,000 Members
LMFT	1 Provider to every 15,000 Members

f. Non-Physician Mental Health Accepting New Patients Standard

KHS will ensure within the Plan's network of contracted non-physician mental health providers remains in compliance with the following standards:

Network Compliance Threshold	At least 75% of counseling non-physician mental health professionals in the network are accepting new patients, or At least 80% of non-physician mental health locations in the network are accepting new patients.
County Compliance Threshold	At least 75% of counseling non-physician mental health professionals in the network are accepting new patients, or At least 80% of non-physician mental health locations in the network are accepting new patients.

5. Provider Shortages and Out-of-Network Services

When a shortage of one or more types of providers is identified, the Plan shall ensure timely access to covered health care services, as outlined in this policy, by assisting enrollees to locate available and accessible network providers in neighboring network service areas, consistent with patterns or practice for obtaining health care services in a timely manner appropriate for the member's health needs.

If unavailable within the network, KHS shall arrange for the provision of covered services from providers outside the KHS network if unavailable within the network, and when medically necessary for the member's condition. KHS shall ensure that enrollee costs for medically necessary referrals to out-of-network providers when in-network providers are unavailable, shall not exceed applicable member costs, including co-payments, co-insurance, and/or deductibles. This requirement does not prohibit a plan from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider. Services shall be arranged in accordance with section 2.2.1 of this policy, KHS Policy and Procedure 3.22-P Referral and Authorization and 4.25-P Provider Network and Contracting

6. Office Waiting

Service	Required Care	
	Urgent	**Routine**
Primary Care Services (including Obstetrics and Gynecology (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.

7. Hours of Operation

Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered to non-Medi-Cal patients, or to Medi-Cal fee-for-service beneficiaries if the Network Provider serves only Medi-Cal beneficiaries. Contracted provider compliance with this standard will be monitored during the appointment availability survey as outlined below.

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

a. Afterhours Urgent and Emergency Care
Primary and Specialty care Network Providers must provide or arrange afterhours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

8. 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 maintain 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. A sample policy that providers may incorporate into their own body of policies is included as Attachment A.

a. 24-Hour Telephone Triage Services
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.

9. OB/GYN Primary Care Physician (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.

10. Emergency Services

Emergency Services will be available and accessible to all enrollee, 24-hours a day, seven days a week, and in line with KHS Policy and Procedure 3.31-P Emergency Services.

C. MONITORING AND REPORTING

The Provider Network Management Department shall be responsible for monitoring Plan compliance with accessibility standards.

1. Quarterly Network 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 an afterhours survey, an accessibility standards survey, a review of access grievances, a review of geographic accessibility, and an analysis of network adequacy. Based on this review, KHS will take action as applicable to address specific identified issues; provider action is outlined below in §3.1.1 Instances of Noncompliance.

The accessibility standards survey will consist of quarterly calls made to a sample of contracted primary care, specialist, mental health, ancillary, and OB-GYN providers to assess the provider's and the Plan's level of compliance with standards related to appointment availability, in-office wait time, timeframe to answer and return calls, and hours of operation offered to Plan enrollees.

The afterhours 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 Enrollee Experience and Provider 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 Quality Improvement and Utilization Management (QI/UM) Committee.'

a. Instances of Non-compliance

KHS will conduct outreach and education to providers as instances of noncompliance with above outlined accessibility standards are identified.

i. Instances of Noncompliance – Quarterly Surveys

KHS will take the following action for provider identified as noncompliant during the Plan's quarterly survey and afterhours survey:

Quarter	Action
First Quarter Noncompliant	KHS will send the provider a letter notifying them of their noncompliance and educating them on Plan accessibility standards.
Second Quarter Noncompliant	In addition to a second letter, a Plan Provider Relations Representative and a member of Provider Network

	Management team will make contact with the provider, either in person or via phone, and notify them of their noncompliance and educate them on Plan accessibility standards.
Third Quarter Noncompliant	The Plan will issue a corrective action plan, in line with KHS Policy and Procedure #4.40-P Corrective Action Plan.

ii. Instances of Noncompliance – Other

As provider specific instances of noncompliance are identified via other avenues (access grievance review, other departmental reporting), these issues will be monitored by the Provider Network Management Department for tracking and trending. The Provider Network Management Department will investigate any potential trends and educate providers as appropriate. If a provider continues to occur instances of noncompliance, the provider may be issued a corrective action plan in line with KHS Policy and Procedure #4.40-P Corrective Action Plan.

Trends will be identified as multiple instances occurring amongst a singular timely access standard, network, contracted group or site, provider type, network provider, or region. Trending will consider the number of enrollees affected in comparison to the total enrollees within the Plan's network, and the time span across which the instances occurred – with a twelve-month or four quarter period acting as the typical lookback period. Trending will not be limited to the review categories outlined above.

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. KHS will utilize a representational census population points mapping methodology when conducting geographic accessibility analysis.

On a quarterly basis, KHS will report on the PNM Department's ongoing review of member population changes and provider terminations/additions in regard to their impact on the Plan's ability to meet geographic accessibility standards. This analysis will be included as part of the Plan's Quarterly Network Review, as outlined in §3.1. Additional information outlined in *3.9 Annual Network Certification*

3. 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 and in line with KHS Policy and Procedure 2.01-P General Exam Guidelines.

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 KHS Policy and Procedure 2.71-P Facility Site Review and Medical Record Review.

The 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. **Enrollee Experience/Member Satisfaction Survey**
   On an annual basis, KHS shall conduct an Enrollee Experience (or 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.

   The survey shall be conducted in accordance with statistically valid and reliable survey methodology.

   The survey shall inform enrollees of their right to obtain an appointment within each of the time-elapsed standards above, and then obtain enrollee perspectives and concerns regarding their experience obtaining timely appointments for health care services within the standards set forth above.

   The survey shall evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining enrollees' perspectives and concerns regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services receive. The survey shall be translated into the enrollee's preferred language in those situations where the Plan is aware of the enrollee's language and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by DHCS.

   As part of the DMHC Annual Timely Access Compliance Report, the survey questions, survey methodology, results, a comparison against the results of prior years, and a discussion of changes will be submitted to the DMHC.

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.

   The survey shall be conducted in accordance with statistically valid and reliable survey methodology.

   The survey shall obtain Network Provider perspectives and concerns regarding compliance with the above standards.

The survey shall obtain Network Provider perspectives and concerns regarding the Plan's language assistance program, including coordination of appointments with an interpreter, availability of an interpreter based on the needs of an enrollee, and the ability of the interpreter to effectively communicate with the Network Provider on behalf of the enrollee.

As part of the DMHC Annual Timely Access Compliance Report, the survey questions, survey methodology, results, a comparison against the results of prior years, and a discussion of changes will be submitted to the DMHC.

6. DMHC Annual Timely Access Compliance Report

On an annual basis KHS shall conduct and submit a Timely Access Compliance report, including a Provider Appointment Availability Survey (PAAS), to the DMHC. KHS will employ the methodology, survey tool, submission templates, and any other applicable instructions for the appropriate measurement year to successfully complete and submit its Annual Timely Access Compliance Report and Annual Network Reporting. KHS will include subcontracted plan data in its Timely Access Compliance Report, including subcontract plan's PAAS Report Forms.

Network Providers will be identified and reported in line with definition established above. Provider data for KHS Annual Network Reporting and Provider Appointment Availability Survey report forms will be generated from the plan's credentialing database; data is entered into the credentialing database and verified as outlined in policy 4.01-P Credentialing. The Plan utilizes multiple resources to identify potential provider data inaccuracies, including but not limited to external (member/provider) notification, provider directory verification efforts (12.13-P Provider Directory), and prior survey results (ineligible providers). As applicable, provider data inaccuracies are investigated by the Plan and changes are made to the Plan's credentialing database.

KHS will utilize an external data validator to conduct a quality assurance review of the Plan's reporting and will include the vendors' quality assurance report as part of the Plan submission. Provider Network Management will be responsible for ensuring that staff involved in the KHS Annual Timely Access Compliance Report has appropriate training and skill to verify that the information and data collected for reporting is true and correct and does not contain misstatements or omissions of material fact. For the purposes of this submission, Provider Network Management leadership will act as the Timely Access Compliance Report compliance officer, responsible for reviewing and submitting the required reports and information.

a. Incidents of Non-compliance

Providers who are identified as non-compliant due to the results of the annual DMHC PAAS will receive a letter notifying them of their noncompliance and educating them on Plan accessibility standards.

Additionally, KHS will identify and address incidents of non-compliance with accessibility standards that result in substantial harm. For the purposes of this section, substantial harm shall be considered loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss. These incidents will be identified and reviewed via the Plans established policies 2.70-I Potential

Inappropriate Care (PIC) and 2.72-I Provider Preventable Conditions. Corrective Action will be handled in line with 4.40-P Corrective Action Plans.

b. Patterns of Non-compliance

For purposes of the Provider Appointment Availability Survey, non-compliance will be defined as fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network, having a non-urgent or urgent appointment available within the time-elapsed standards. For non-physician mental health follow-up appointments, the network is required to meet a compliance standard of 80%.

Additionally, a pattern of non-compliance will be identified when the DMHC receives information establishing that the Plan was unable to deliver timely, available, or accessible health care services to enrollees.
The DMHC may consider any of the following factors in evaluating whether each instance identified is part of a pattern of non-compliance that is reasonably related:

i. Each instance is a violation of the same timely access standard.
ii. Each instance involves the same network.
iii. Each instance involves the same provider group, or subcontracted plan.
iv. Each instance involves the same provider type.
v. Each instance involves the same network provider.
vi. Each instance occurs in the same region.
vii. The number of enrollees in the health plan's network and the total number of instances identified as part of a pattern.
viii. Whether each instance occurred within the same twelve-month period.
v. Whether each instance involves the same category of health care services.

c. DMHC Annual Network Reporting

On an annual basis KHS will submit to the DMHC an Annual Network Report in compliance with all applicable reporting requirements. Annual Network Reporting will be submitted no later than May 1 of the reporting year, unless instructed otherwise by the DMHC. KHS will capture and report data from the Annual Network Report according to the network capture date of January 15th of the Annual Network Report Measurement Year, unless a different capture timeframe is applicable.

KHS will identify and report data in accordance with definitions outlined above and as defined in the DMHC provided instruction manual for the appropriate measurement year. KHS will submit the Annual Network Report utilizing DMHC provided report form templates and in accordance with field and reporting instructions outlined in the DMHC provider instruction manual for the appropriate measurement year. The plan will report all data and information in line with the DMHC's standardized terminology and will utilize provided crosswalk tables when appropriate.

As part of the Annual Network Reporting, KHS will complete a Network Access Profile for each applicable network each reporting year. KHS will report and update the Annual Network Report profile in line with DMHC provider instruction manual for the appropriate measurement year. KHS will ensure that it is reporting each approved network consistent with the Plan's licensure documents on file with the DMHC, and if discrepancies are identified, the Plan will take steps to rectify.

If KHS maintains applicable plan-to-plan contracts, KHS will gather and submit all subcontracted plan network data as part of its Annual Network Report.

The Timely Access Compliance Measurement Year will apply to certain report forms within the Annual Network Report, including, but not limited to the Timely Access and Network Adequacy Grievance Report Form.

KHS will ensure all reports and information submitted as part of the Annual Network Report, including the Network Access Profile, is timely, accurate, and complete, and does not contain misstatements or omissions of material fact. KHS retains full responsibility for ensuring the accuracy of all information and data submitted as part of the Annual Network Report, including information provided by delegated provider groups or subcontracted plans. KHS will designate an individual as a compliance officer who shall be responsible for reviewing and submitting the required reports and information. As part of the submission KHS will complete a verification of the accuracy and correctness of the Annual Network report, including the Network Access Profile.

i. Annual Network Reporting – Corrective Action

KHS will maintain appropriate corrective action processes regarding issues identified as part of Annual Network Reporting. KHS will demonstrate it has implemented corrective action through appropriate staffing or other resources needed to bring itself into compliance with reporting requirements outlined above. KHS will implement corrective action when the Plan identifies it has failed to report timely, accurate, or complete information and data for a network service area, in one or more areas of the Annual Network Report submissions. KHS will implement corrective action when the DMHC identifies non-compliance with the data collection, accuracy, or verification requirements outlined above.

7. Network Adequacy

a. Full-time equivalent (FTE) Provider to Member Ratios

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

i. Primary Care Physicians 1:2,000
ii. Total Physicians 1:1,200

This analysis will be included as part of the Plan's Quarterly Network Review, as outlined in §3.1.

Full-time equivalency will be calculated based on the percentage of time allocated to Plan beneficiaries by KHS contracted providers and the Plan's Medi-Cal membership market share. As part of the Plan's Provider Satisfaction survey, the Plan will collect data regarding Plan membership volume for KHS contracted provider. This data will be combined with the most recent available Medi-Cal membership market share data 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.

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.

i. **Accepting New Patients**
As part of KHS's quarterly review of network adequacy, the Plan will review the percentage of provider's that are accepting new patients to ensure it is sufficient. This review will be included as part of the Plan's Quarterly Network Review, as outlined in §3.1

b. Network Provider Adequacy
KHS will ensure that network providers have adequate staff, including providers, nurses, administrative, and other support staff to ensure that they have sufficient capacity to provide and coordinate care for covered services for KHS enrollees. Monitoring activities will include:

i. Requiring providers to notify the plan of changes that may impact their ability to provide covered services.
ii. Identifying potential issues or trends via ongoing accessibility monitoring as outlined above.
iii. As needed review of contracted groups individual provider to member ratios.

8. 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. Appointment availability for these providers shall be monitored through the monitoring processes outlined above. Providers must give written notice to KHS no more than 30 days after provider stops offering advance access appointments.

9. Annual Network Certification
a. Submission Requirements

KHS will submit complete and accurate data and information to the DHCS that reflects the composition of the contracted network of providers subject to Annual Network Certification (ANC) requirements. KHS submission will occur no later than thirty (30) calendar days after the receipt of the DHCS ANC package unless an extension has been granted by the DHCS. KHS submission documents will contain all required ANC exhibits, including alternative access standards (AAS) requests, if applicable. KHS submission will utilize correct file labeling convention through DHCS Secure File Transfer Protocol site. KHS will subject to DHCS corrective action plan (CAP) and/or other enforcement actions if complete and accurate exhibits, data, and information for ANC are not submitted by the regulatory deadline.

b. 274 File Submission

The DHCS will utilize the KHS' monthly 274 file submission to verify compliance with Provider to Member ratios, Mandatory Provider types, and timely access to care standards for PCPs, core specialists, non-specialty mental health providers, hospitals, and ancillary services.

If the DHCS is unable to access the required 274 file submission to the KHS' untimely, incomplete, or inaccurate submission, the submission of KHS' ANC will be considered late, and KHS will be subject to imposition of DHCS CAP and/or other enforcement actions.

c. Contracted Network Requirements

KHS will maintain an appropriate contracted network of specific provider types to ensure capacity to provider all medically necessary services for current and anticipated membership. KHS contracted network of providers will include, at a minimum, adult and pediatric PCPs, non-physician medical practitioners, adult and pediatric core specialists, adult and pediatric non-specialty mental health providers, hospitals, and ancillary services.

In accordance with Women Infant and Children Program (WIC) section 14197.45 KHS will make good faith efforts to contract with at least one cancer center within Kern County for the provision of services to any eligible member diagnosed with a complex cancer diagnosis.

d. Network Capacity and Ratios

KHS will meet or exceed minimum service area capacity and ratio requirements as outlined in §2.4 and §3.7 of this policy.

KHS will also meet provider-to-member ratios for adult and pediatric non-specialty mental health providers to ensure timely access to covered services. The DHCS annually calculates the number of non-specialty mental health providers necessary to cover the projected mental health needs for anticipated members in each county and will provide KHS with the number of non-specialty mental health providers needed to meet the minimum required provider-to-member ratio.

e. Mandatory Providers

Mandatory Provider Types (MPT) are specific provider and facility types that KHS is federally or statutorily required to contract or demonstrate efforts to contract. If KHS does not have a contract with a specific MPT within its service area, KHS will arrange for members to access services that are customarily provided by the MPT, either in or outside of KHS service area, including the provision of transportation services to assist members in accessing needed care. If KHS does not meet minimum contracting requirements with MPTs, as part of the ANC, KHS will submit an attestation or justification, maintain all supporting documentation of the KHS contracting attempts, including failed contracting efforts, and will provide to the DHCS upon request as part of the MPT validation process.

i. **Federally Qualified Health Centers and Rural Health Centers**
As the Local Initiative health plan within our service area, KHS is required to offer to contract will all available Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). KHS will maintain supporting documentation of contracting efforts for non-contracted FQHC and RHCs will provide to the DHCS upon request.

ii. **Freestanding or Alternative Birthing Centers and Midwife Services**
KHS will contract with one Freestanding Birthing Center (FBC), one Certified Nurse Midwife (CNM) and one Licensed Midwife, as available within Kern County, in accordance with state and federal network adequacy requirements.

iii. **Indian Health Care Providers**
KHS will offer to contract with all Indian Health Care Providers (IHCP) available within Kern County. KHS will maintain supporting documentation of contracting efforts and will provide to the DHCS upon request.

IHCPs can voluntarily enter into a contract with KHS at any time. If KHS is unable to contract with an IHCP, KHS will allow eligible to members to obtain services from out-of-network IHCPs.

f. Time or Distance Standards

KHS will meet time or distance standards based on Kern County population density for the designated provider types outlined in Attachment A of DHCS All Plan Letter (APL) 23-001. The DHCS will assess KHS time or distance compliance based on the 274 Provider file for all ZIP codes within KHS service area and accounting for all current and anticipated Members. The DHCS will provide KHS with a time or distance analysis report, utilizing a representational census population points mapping methodology to determine whether the KHS is meeting time or distance standards for anticipated members. The DHCS the methodology will use census data representing population points per ZIP code in habitable areas to account for current members, as well as the farthest points of the ZIP code where an anticipated member could potentially live.

If KHS is meeting the requirement for the AAS delivery system exemption, KHS is not required to submit AAS requests through Attachment C, but instead must file a delivery system AAS justification for DHCS' consideration.

g. Telehealth

KHS is required to cover 100% of the population points in the ZIP code in order to be considered compliant with time or distance standards with any deficiencies accounted for through AAS requests.
However, when medically appropriate, if KHS covers at least 85% of the population points in the ZIP code, DHCS will permits KHS to use the synchronous mode of telehealth instead of submitting an AAS request. If KHS is using telehealth to meet time or distance for 15% of the population points in the ZIP code, it must meet the required telehealth provider-to-member ratio based on the number members in that ZIP code that are not covered by in-person providers.

Telehealth providers can be utilized to meet time or distance standards for any ANC Provider types except for General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation, and Hospitals. If using telehealth to meet time and distance standards KHS will submit documentation as specified in DHCS APL 23-001. The use of telehealth providers to meet time or distance standards does not absolve KHS responsibility to provide members with access to in-person services if the member prefers. KHS will provide transportation to a contracted network provider and meet timely access standards for medically necessary services when a member is offered a telehealth visit but requests an in-person visit. If KHS is unable to arrange for an in-person visit with a contracted network provider, KHS will authorize out-of-network services and provide transportation to the appointment as needed. Telehealth services must be consistent with the criteria outlined in the Medi-Cal Provider Manual and DHCS APL 19-009, APL 23-001 and subsequent revisions. Telehealth service provider must be certified and enrolled in the Medi-Cal Program and credentialed by KHS.

KHS may use third-party corporate telehealth providers; due to a member's choice to use telehealth or in-person services, KHS will not auto-assign a member to a third-party corporate telehealth provider.

h. Alternative Access Standard Requests

KHS will submit AAS requests to the DHCS when it is unable to demonstrate compliance with meeting time or distance standards and are not utilizing Telehealth to meet compliance with time or distance standards; or when a significant change in our contract network of providers and they no longer meet time or distance standards (as outlined in KHS Policy and Procedure 4.39 Provider Termination) occurs.

Before submitting an AAS request, KHS will make good faith efforts to exhaust reasonable contracting options with additional providers within the time or distance standards. KHS will complete outreach attempts with the provider identified in the previous ANC submission prior to the reporting year submission. DHCS will generally not accept ongoing contracting efforts with the same provider as a rationale in order to ensure that KHS is actively outreaching to closest providers.

AAS requests must be submitted every three years. In years in which KHS is not submitted AAS requests, KHS will submit an attestation via a DHCS-supplied AAS analysis report. In order for AAS requests to be considered for ANC purposes, KHS will submit the request with the ANC submission no later than thirty (30) calendar days after receipt of DHCS' ANC documents package, unless an extension is granted by DHCS. DHCS will not accept any AAS requests after the ANC submission deadline.

AAS requests submissions must detail the facts and circumstances for each AAS request and provide supporting details. KHS will utilize the Managed Care Open Data Portal and Fee-For-Service Open Data Portal as resources to identify providers for inclusion in AAS requests.

DHCS may revoke any approved AAS requests if an inaccuracy is discovered or if KHS is unable to provide all required supporting documentation during the validation process. KHS must maintain documentation of all efforts to contract with out-of-network providers that are in their county or boarding counties where network deficiencies have been identified and as identified in their AAS requests. Upon request from the DHCS, KHS must provide all documentation of failed contracting efforts.

KHS will inform members who reside in applicable zip codes where an AAS request has been approved by posting all approved AAS on their website within 30 days after DHCS publishes the statewide results. KHS will also inform affected members where DHCS has approved the use of telehealth to meet time or distance standards in lieu of AAS requests.

i. **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 (in person or via telehealth) 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 Fee for Service (FFS) rate, agreed upon by the Plan and provider, and must be made within the most recent year. If this cannot be arranged, KHS will arrange for an appointment with a contracted network specialist. 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-PMember Transportation Assistance.

ii. **Delivery System Alternative Access Standard**
   In order to be considered for a delivery system AAS, KHS must submit a written request to the DHCS. An approved delivery system AAS is valid for one reporting year. If DHCS approved KHS

delivery system AAS for the previous reporting year, KHS can submit an attestation certifying it is seeking to utilize the previous approved justification for the current ANC.

i. Annual Network Certification Validation and DHCS Review

DHCS may request additional documentation at any time in order to confirm that submitted information is accurate. KHS' failure to provide the requested documentation or a determination by DHCS that the information in the submission is invalid or inaccurate will lead to rescission of the ANC approval, implementation of a CAP, and/or other enforcement actions.

DHCS will provide technical assistance to KHS if a complete ANC submission is submitted by the deadline and may not be able to provide technical assistance if KHS does not meet the submission deadline. Technical assistance will be provided in the form of a preliminary findings worksheet and will contain DHCS' initial review of the quality, accuracy, and completeness of the KHS submission. KHS will have the opportunity to resubmit a corrected submission for identified errors, incompleteness, and inaccuracies within ten business days.

j. Correct Action Plans

KHS must submit a detailed plan of action setting forth all steps KHS will take to correct the ANC deficiencies identified in the CAP notification letter received from the DHCS. KHS will have six months to correct all deficiencies including continually working to improve access in its contract provider networks and comply with all CAP mandates set forth below until the CAP is closed. KHS must close out any deficiencies identified in the CAP in a timely manner to ensure member access is adequate and continue to work to improve access in the contracted provider network. The DHCS may impose sanctions for failure to comply with network adequacy requirements at the end of the CAP period.

i. Corrective Action Plan Mandates

While under an ANC CAP KHS will comply with the following mandates:

1) Provider an initial CAP response no later than (30) days after the issuance of the CAP notification letter;
2) Provide DHCS with monthly status updates that demonstrate action steps KHS is undertaking to correct the CAP deficiency(ies);
3) Authorize Out of Network (OON) access to medically necessary providers within timely access standards and applicable time or distance standards specified in the CAP, regardless of associated transportation or provider costs until the CAP is completed by KHS and closed by DHCS;
4) Demonstrate the ability to effectively provide OON access information to members and ensure that its member services staff, contracted network of providers, and Subcontractors are trained on the mandates, including the right for Members to request OON access for medically necessary services and transportation to providers where KHS is unable to comply with ANC requirements.

ii. Subcontractor Compliance

KHS is required to have processes in place to ensure Subcontractors comply with Network adequacy and access requirements. Members who receive care through subcontractors must have the same access to required providers as they would through the KHS contracted provider network. To ensure access, KHS may permit Subcontractors to supplement their provider networks with KHS contracted provider network. KHS is required to have contractual provisions and policies and procedures in place for identifying when changes in a Subcontractor's network results in KHS being out of compliance with any of the ANC requirements. KHS will report all significant instances of a subcontractor's deficiencies and impositions of CAPs to the DHCS. As applicable, KHS will allow Subcontractors to request Alternative Access Standards (AAS) and will utilize a process mirroring the DHCS' procedures for receiving, reviewing, and approving Subcontractor AAS.

iii. Subcontractor Network Certification

On annual basis, KHS is required to undergo a Subcontractor Network Certification (SNC) that is separate and distinct from the submission process for the Annual Network Certification. An SNC is also required when a Subcontractor Network experiences a significant change (an event that impacts the provision of health care services for 2,000 or more Members, or when a Subcontractor Network change causes KHS to become noncompliant with any of the Network adequacy and access standards), and/or when KHS enters into a new risk-based Subcontractor Agreement with a Subcontractor that expands the KHS' existing Provider Network. If a significant change occurs within the ninety (90) calendar days prior to the SNC annual submission date, KHC can document the change as part of that Reporting Year SNC filing.

As part of the annual SNC submission, KHS will include all Subcontractor Networks reported via the 274 Provider Network data file, unless the Subcontractor Network is exempt and required documentation is submitted supporting the exemption. A Subcontractor Network is considered exempt if:

1) KHS only contracts with one Subcontractor Network in the service area, and no providers contract directly with KHS, or.
2) The Subcontractor Network only provides specialty or ancillary services, or.
3) The Subcontractor Network only provides care through single case agreements and is not available to all MCP's Members upon enrollment.

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KHS will submit the required SNC documentation no later than 45 days following the close of the Reporting Year, or if that day falls on a weekend, the next business day. KHS will submit all required SNC documentation with the correct file naming conventions through the DHCS Secure File Transfer Protocol Site. If KHS fails to submit complete and accurate SNC

documentation by the SNC annual submission date, it will be subject to the imposition of a correct action plan (CAP) and other enforcement actions. KHS SNC Submission will include:

1) Subcontractor Network Exemptions Request Template
2) Network Adequacy and Access Assurances Report (NAAAR)
3) Verification Documents

All Subcontract Network deficiencies impacting member access to care will result in KHS or the Subcontractor authorizing covered services from an out-of-subcontractor-network (OOSN) provider for members within the deficient subcontractor network, regardless of associated transportation or Provider costs, until the deficiency is addressed. KHS or Subcontractor will ensure that the deficient Subcontractor or Downstream Subcontractor informed members that OOSN access to services are available. KHS or Subcontractor will ensure staff are trained a member's right to request OOSN access for covered services and transportation to providers in areas where the Subcontractor or Downstream Subcontractor is unable to comply with Network adequacy or access standards.

If KHS received a CAP, KHS will provide an initial response no later than thirty (30) calendar days after the issuance of the CAP notification letter and will detail the plan of action and set forth steps KHS will take to correct the identified deficiencies. KHS will have six months to correct all deficiencies, during which time, KHS must provider monthly updates to the DHCS that demonstrate activities KHS is undertaking to address the CAP.

iv. Post Network Certification Monitoring Activities

KHS will be subject to quarterly monitoring by the DHCS, which may include requests for additional evidence and information, including, but not limited to:

1) Timely access surveys.
2) Investigation of complaints, Grievances, Appeals, and issues of non-compliance with contractual requirements and policy guidance.
3) Network monitoring and oversight assessments.
4) Quality of care indicators.
5) Data reviews for utilization capacity and provider-to-member ratios.
6) Authorization of OON requests.
7) Provision of transportation services

KHS is responsible for ensuring members obtain medically necessary covered services from an OON provider if the services cannot be provided by a contracted network provider in accordance with contractual requirements**.**

10. DHCS Network Adequacy Validation

KHS will participate in any DHCS network adequacy validation activities, including the DHCS External Quality Review Organization (EQRO) validation of KHS network adequacy representations from the preceding 12 months. As appropriate, KHS will

implement any technical assistance guidance provided by the EQRO at the direction of the DHCS.

11. Significant Network Change Review and Filling (10% Change in Names)

On a quarterly basis the Plan will review its network composition to identify if a 10% change has occurred within its network in comparison to its most recent provider network filing with the DMHC. The results this review will be included as part of the Plan's Quarterly Network Review, as outlined in §3.1.

A 10% change will be considered any change of 10% or greater in the names of physicians, hospitals, or ancillary providers included in the Plan's filed provider rosters within the KHS' approved network, within the Plan's regulatory established service area. This change will be calculated by identifying the sum of unique provider's added to and deleted from the Plan's network and dividing by the total number of unique provider's available within the Plan's network as of the Plan's most recent provider network filing with the DMHC. The percentage change will be calculated separately for reach of the following provider filing types: All Physicians, Hospitals, Other Contracted Providers (mental health and ancillary).

The Plan will utilize the most recent DMHC Provider Network Filing Instruction Manual to submit the required exhibits for review and approval.

D. DELEGATION AND MONITORING

KHS is responsible for ensuring that delegates comply with all applicable state and federal laws and regulations, contract requirements, and other regulatory guidance, including APLs and Dual Plan Letters, in line with KHS' Delegation Oversight Policy. These requirements will be communicated by KHS to all delegated entities and subcontractors.

In line with section 1367.03(c) of the California Health and Safety Code, the obligation of KHS to remain in compliance with applicable regulatory standards, including those outlined in section 1367.03, is not waived if KHS delegates to provider groups or other contracting entities any services or activities that KHS is required to perform.

ATTACHMENTS:

- Attachment A – Telephone Advice Protocol

REFERENCE:

[1] Knox Keene Act, Section 1367.01(h)(2)

Revision 2024-08: Compliance reconciled the policy to include the revisions made on March 3/8/2024 and 3/11/2024. **Revision 2024-05:** Per CEO, The CMO will be included as a signatory on this policy**. Revision 2024-03:** Comment Letter #2 received for DMHC APL 22-026 on 4.18.2024; revisions were submitted on 5/14/2024 The same version was also submitted for DMHC APL 23-023 comment table #1 submitted on 3.15.2024. **Revision: 2024-02:** DMHC Comment Letter #1 received 2.15.2024 for DMHC APL 22-026, Implementation Filings for Amendments to Network Reporting Statues and Regulation, Filing # 20240254. **Revision 2024-02:** Per CMO, updates were made to policy signatories to include Medical Directors and the removal of the CMO. Formatting updates by Compliance. **Revision 2024-01:** DMHC APL 23-023: Amendments to Rules 1300.51 and 1300.67.2, Sections 2.4.7, 3.6.2, and 3.7. **Revision: 2024-01:** Policy revised to comply with DMHC APL 23-023. This version was also sent to the DHCS per CAP, approval

received on 1/25/2024. **Revision 2024-01:** Per DMHC APL 22-026, Timely Access Policies and Procedures, Comment Letter, Filing # 20230632 **Revision 2023-09:** Revised and submitted for DMHC Filing number 20234353 – filing was closed on 10/10/2023. **Revision 2023-09:** Per DMHC APL 23-018, NPMH Provider Follow-Up Appt. **Revision 2023-07:** Per DMHC APL 22-026, Timely Access Policies and Procedures, Comment Letter, Filing # 20230632-2 approval received on 8/16/2023. **Revision 2023-06:** Per DHCS APL 23-006, Delegation and Subcontractor Network Certification, approval received on 7/26/2023. **Revision 2023-05:** Additional language added to capture office hour monitoring processes, network provider adequacy and delegation oversight; additional revisions made to bring policy in line with DMHC implementation of Timely Access Regulation and DHCS APL 23-001 Annual Network Certification. Approval received per 23-001 on 5/25/2023. Revisions made per DMHC APL 22-026, Comment Letter, Filing # 20230632-1. **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.

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.