9. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. All applicable practitioners including Primary Care Physicians (PCPs), PCP/ OB/GYNs, and Specialists must meet the access standards delineated below to participate in the IEHP network.

B. IEHP monitors practitioner access to care through IEHP and IPA performed access studies, review of grievances and other methods.

C. All Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

D. IEHP requires IPAs to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in C above.

1. All IPAs are required to provide or ensure that twenty-four (24)-hour, seven (7) days a week access to medical care for Members is available, including after business hours telephone access to a PCP or a triage system utilizing specific licensed personnel. For medical triage, licensed and trained screening or triage personnel include Registered Nurses (RN), Nurse Practitioners (NP) or Physician Assistants (PA). Physician backup must be available.

2. For behavioral health triage, licensed and trained screening or triage personnel include RNs or Master’s level behavioral health practitioners. Supervision must be provided by a licensed behavioral health care practitioner with a minimum of a Master’s degree and five (5) years of post-master’s clinical experience.

PROCEDURES:

A. Access Standards for Clinical Services - The following information delineates the access standards for availability of services to Members including primary care, specialty care, after hours emergency services, waiting times for appointments, and proximity of Specialists and Hospitals to primary care.

1. Appointment Standards:
9. ACCESS STANDARDS

A. Access Standards

<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Immediate disposition of Member to appropriate care setting</td>
</tr>
<tr>
<td>Urgent Visit</td>
<td>Forty-eight (48) hours</td>
</tr>
<tr>
<td>Urgent Visit, requiring authorization</td>
<td>Ninety-six (96) hours</td>
</tr>
<tr>
<td>Non-urgent, acute illness visit</td>
<td>Three (3) business days, or as directed by Physician</td>
</tr>
<tr>
<td>Routine non-urgent visit</td>
<td>Within ten (10) business days of request</td>
</tr>
<tr>
<td>Well Child Visit</td>
<td>Two (2) weeks</td>
</tr>
<tr>
<td>Routine physical (complete)</td>
<td>Thirty (30) Days</td>
</tr>
<tr>
<td>Initial health assessment</td>
<td>Within one hundred twenty (120) days of enrollment</td>
</tr>
<tr>
<td>Initial health assessment (under 18 month of age only)</td>
<td>Within sixty (60) days of enrollment</td>
</tr>
<tr>
<td>Routine pelvic, Pap and breast exam</td>
<td>Thirty (30) Days</td>
</tr>
<tr>
<td>Follow up exam</td>
<td>As directed by Physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Emergency</td>
<td>Immediate disposition of Member to appropriate care setting</td>
</tr>
<tr>
<td>Urgent Visit</td>
<td>Forty-eight (48) hours</td>
</tr>
<tr>
<td>Urgent prenatal Visit</td>
<td>Forty-eight (48) hours</td>
</tr>
<tr>
<td>Urgent Visit, requiring authorization</td>
<td>Ninety-six (96) hours</td>
</tr>
<tr>
<td>Non-urgent, acute illness visit</td>
<td>Three (3) business days, or as directed by Physician</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist Physician</td>
<td>Within fifteen (15) business days of request</td>
</tr>
<tr>
<td>Non-urgent with a non-Physician Behavioral Health Provider</td>
<td>Within ten (10) business days of request</td>
</tr>
<tr>
<td>Non-urgent ancillary services (for diagnosis and treatment)</td>
<td>Within fifteen (15) business days of request</td>
</tr>
<tr>
<td>Initial Prenatal Visit</td>
<td>One (1) week</td>
</tr>
<tr>
<td>Routine prenatal care</td>
<td>Two (2) weeks or as directed by Physician</td>
</tr>
<tr>
<td>Routine pelvic, Pap and breast exam</td>
<td>Thirty (30) Days</td>
</tr>
<tr>
<td>Follow up exam</td>
<td>As directed by Physician</td>
</tr>
</tbody>
</table>

2. 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 and other conditions, lab and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating
9. ACCESS STANDARDS

A. Access Standards

licensed Health Care Provider acting within the scope of his or her practice.

3. Practitioner Office Waiting Time - For primary or specialist care, the waiting time for a scheduled appointment must be no longer than sixty (60) minutes. Waiting times for Members that are advised to “walk-in” to be seen must be no longer than four (4) hours.

   a. Waiting time at Primary Care Physicians and Specialists’ offices will be collected by Provider Services Representatives at every in-service. On a semi-annual basis, all Practitioners will be asked to verify waiting time as part of the Provider Directory verification. The waiting time information collected will be analyzed and presented at a minimum annually at the Quality Improvement (QI) Subcommittee. The QI Subcommittee will make recommendations on actions to take if Practitioners are not complying with the waiting time standards.

4. Urgent Care Center Waiting Time – Urgent Care Centers are designed to serve Members with non-emergency conditions. Urgent Care Centers accept unscheduled walk-in patients, therefore waiting time in Urgent Care Centers can vary depending on the urgency of the Member condition.

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

6. Proximity of PCPs to Members – IEHP network PCPs must be located within ten (10) miles or thirty (30) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. This proximity standard must be met whether using private car, public bus, hospital, van, dial-a-ride, or Metrolink transportation.

7. Proximity of Specialists, OB/GYNs, Behavioral Health, and other Providers - IEHP network Specialists, OB/GYNs, Behavioral Health and other Providers must be located within thirty (30) miles or sixty (60) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink train transportation. On an annual basis, IEHP conducts a Provider Network Status Study for all Network Providers (see policy PRO_GEN 13 “Reporting - Annual Network Status Board Report”, page 1, Procedures B.3) to monitor compliance. IEHP ensures that network Specialists, OB/GYN, Behavioral Health and other Providers are compliant with the DHCS Network Adequacy Standards and meets the reasonable accessibility/availability standards required under the Knox-Keene Act.
9. ACCESS STANDARDS

A. Access Standards

8. Proximity of Hospital - IEHP network hospitals must be located within fifteen (15) miles or thirty (30) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink train transportation.

9. Proximity of Pharmacy - IEHP network pharmacies must be located within ten (10) miles or thirty (30) minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink train transportation.

10. Minimum Hours On-Site - The PCP must be on site and available for Member care a minimum of sixteen (16) hours per week, or meet the criteria identified in Policies 6D, “Residency Teaching Clinics” and 6E, “Rural Clinics.”

11. Telephone Answer Time - All telephone calls to a PCP or Specialist must be answered within six (6) rings. Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person.

12. Telephone Hold Time - A Member must not be kept on hold for more than ten (10) minutes. If a Member is placed on hold, an employee should let the Member know the reason for the delay and offer the Member the choice to either wait or have his/her call returned within the timeframe specified in this policy.

13. Telephone Access Standards - When a Member leaves a message with the office of a PCP or Specialist, requesting a return call, an employee of the office must attempt to return the Member’s call within the following timeframes and log that attempt:

   a. Within three (3) working days for a non-urgent matter (e.g. refills for medications that have not run out; requests for paperwork or medical records; requests for appointments for non-acute conditions)

   b. No later than the same day for an urgent (non-emergency) matter (e.g. refills of critical medications which have run out; acute illness or acute complaint not already dealt with at the Provider’s office)

   c. A minimum of three (3) attempts must be made to return the Member’s call. It is understood that the same staff member or Physician with whom the Member wishes to speak with, may or may not be the party available to return the Member’s call. It is also understood that the staff member returning the call may or may not be able to definitively address the Member’s issue during that call. However, it will be expected that the staff member returning the Member’s call be prepared to do at least one of the following during that return phone call:

      1) Determine the urgency of the Member’s request, solicit more information from the Member if needed, and act accordingly;
9. **ACCESS STANDARDS**

A. **Access Standards**

2) Reassure the Member if appropriate;

3) Agree to pass a message to the Member’s Physician or to another relevant staff member if appropriate; and/or

4) Provide the Member with a timeline or expectation of when the request can be definitively addressed.

d. This time requirement and policy for attempting to return Member phone calls (three (3) business days for non-urgent, same day for urgent non-emergency, with a minimum of three (3) attempts) is understood to be a minimal guideline; i.e. this policy is not meant to over-ride more rigorous internal office policy, if one is already in place.

e. Members who reach voice mail must receive detailed instructions on how to proceed.

14. All PCP offices must have an active and working fax machine twenty-four (24) hours per day, seven (7) days per week.

B. **Emergency Services** - IEHP has continuous availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and supportive paramedical personnel to provide covered services including the provision of all medical care necessary under emergency circumstances. IEHP network Physicians and Hospitals must provide access to appropriate triage personnel and emergency services twenty-four (24) hours a day, seven (7) days a week.

1. IEHP evaluates inappropriate use of Emergency Room services, issues regarding Member access to health care, and under- or over-utilization of services through assessment of encounter data, special studies, claims information, and medical record audits with oversight of the Quality Management (QM) Committee.

C. **Emergency Medical Condition** – This is a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

2. Serious impairment to bodily function; or

3. Serious dysfunction of any bodily organ or part.

D. **Urgent Care Services** – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity that care is needed within forty-eight (48) hours, but are not emergency medical conditions.

E. **Urgent Visit** – These are referrals to health care professionals who have advance education and training in a specific area but are not emergency medical conditions. Visit requires
9. ACCESS STANDARDS

A. Access Standards

prior authorization within ninety-six (96) hours.

F. **Follow-up of ED or Urgent Care Visits** – IPAs are responsible for informing PCPs of Members that receive an ED or Urgent Care visit, including information regarding needed follow-up, if any. PCPs are responsible for obtaining any necessary medical records from such a visit, and arranging any needed follow-up care.

G. **Routine Non-Urgent Visit** – These are health care services needed to diagnose and/or treat medical conditions that do not need urgent care or non-emergent attention. These visits are used for routine check-ups and can be scheduled within ten (10) business days of request.

H. **Non-urgent, Acute Illness Visit** – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity to be addressed within three (3) days, however, they do not warrant an urgent care visit.

I. **Initial Health Assessment** – See Policy 10A, “Initial Health Assessment.”

J. **Physical Exam** – This is a routine preventive exam occurring everyone to three (3) years. These visits must be scheduled within thirty (30) days.

K. **Well Child Visit** – These are periodic health care services needed to provide preventive health services for Members under the age of 21 years. These visits must be scheduled within two (2) weeks.

L. **Walk-In Clinic Visits** – If an IEHP Member is informed by the PCP or the PCP’s office staff that they may “walk-in” on a particular day for routine, non-urgent or non-urgent acute visits, the IEHP Member must be seen at that office on the same day in which the Member was advised to come in, and must not have a wait time in excess of four (4) hours.

M. **Urgent Prenatal** – These are health care services needed to diagnose and/or treat actual or perceived prenatal conditions that are of sufficient severity that care is needed within forty-eight (48) hours, but are not emergency medical conditions.

N. **Initial Prenatal** – These are health care services needed to determine potential risk factors and the care plan for a woman during the period of pregnancy. This exam must take place within one (1) week of confirmation of pregnancy.

O. **Routine Prenatal Care** – These are routine medical visits throughout the period of pregnancy. These visits consist of periodic exams and monitoring for the determination of the condition of both the fetus and the mother. These visits should be scheduled within two (2) weeks or as directed by the Physician in order to detect any untoward changes in the condition of the fetus or mother so that necessary treatment may be initiated.

P. **Non-urgent Specialist Appointment** – These are referrals to a health care professional who has advanced education and training in a specific area. The appointment to the Specialist is to be scheduled within fifteen (15) days of request unless otherwise indicated by the referring Physician.

Q. **Medical Triage Screening and Advice During Business Hours** – The IEHP Nurse
9. ACCESS STANDARDS

A. Access Standards

Advice Line (NAL) provides access to licensed triage personnel including RNs, NPs, and PAs 24 hours a day 7 days a week. By calling the NAL, Members are able to receive assistance with access to urgent or emergency services from a PCP, an on-call Physician, or licensed triage personnel. Licensed triage personnel use appropriate protocols and sound medical judgment in determining the disposition of the Member (e.g., refer to Urgent Care, Emergency Department). Triage and screening wait time must not exceed thirty (30) minutes. On a monthly basis, IEHP’s Family & Community Health Department monitors the triage and screening wait time by reviewing the NAL reports. All PCP sites must have licensed staff available for telephone or on-site triage for Members during normal business hours. For in-office triage services, approved licensed triage personnel include RNs, NPs, or PAs. IEHP has not developed specific in-office triage protocols; it is expected that all licensed triage personnel use appropriate medical judgment in determining the disposition of the patient (e.g., treat at office, refer to Urgent Care, Emergency Department, or call 911). There must be sufficient information on how to proceed for Members who reach voice mail.

R. After Hours PCP Access – IEHP provides Members with twenty-four (24) hours, seven (7) days a week direct access to a licensed triage person through the IEHP Nurse Advice Line. IEHP also requires that PCPs and IPAs have arrangements in place for telephone access twenty-four (24) hours a day, seven (7) days per week. Availability of the IEHP Nurse Advice Line does not supplant the requirement for PCPs and IPAs to maintain 24/7 telephone access. Members can access the IEHP Nurse Advice Line by calling the toll free phone number listed on the Member’s ID card. The IEHP Nurse Advice Line provides access to licensed triage personnel including RNs, NPs, and PAs. By calling the Nurse Advice Line, Members are able to receive assistance with access to urgent or emergency services from the assigned PCP, an on-call Physician, or licensed triage personnel. Licensed triage personnel use appropriate protocols and sound medical judgment in determining the disposition of the Member (e.g., refer to Urgent Care, Emergency Department). When a Member accesses service through the IEHP Nurse Advice Line, the Member’s PCP receives a faxed copy of the encounter including the Member’s medical situation and the disposition of the call. In the event that a Member calls a Physician’s office after hours, there must be sufficient access to information on how to proceed, either through an answering service or phone message instructions.

S. Missed Appointments – When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member’s health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section. Policy 9B, “Missed Appointments.” Missed and/or rescheduled appointments must be scheduled appropriate to the health care and continuity of care and needs of the Member.

T. Hospital Standards – All contracted hospitals must provide timely access for IEHP Members accessing Emergency Departments, being admitted for an inpatient stay, or utilizing hospital based diagnostic or treatment services. Hospital based clinics must meet
9. ACCESS STANDARDS

A. Access Standards

all the primary care and specialty access standards delineated above.

U. Provider Shortage - If timely appointments within the time or distance standards required are not available, then the IPA shall refer the Member to or assist in locating available and accessible contracted Provider to obtain the necessary health care services in a timely manner appropriate for the Member’s needs.

Special Access Standards

A. The following information outlines the standards for special access needs for Members including sensitive services and access for the disabled and hearing impaired, as well as dental, behavioral health, and special programs:

1. Sensitive Services for Minors and Adults - Providers and practitioners must have procedures to ensure that minors and adults have access to sensitive and confidential services as outlined in Policy 9E, “Access to Sensitive Services.” Minors and adolescents have the right of access to treatment and/or referral for sensitive services without parental consent. Sensitive services include: access to family planning, STI and HIV testing, and counseling services from qualified family planning Providers or the Local Health Department (LHD). Sensitive services for minors include sexual assault, drug or alcohol abuse, pregnancy, family planning, sexually transmitted infections, and behavioral health care.

2. Access for People with Disabilities - All IEHP facilities and practitioners are required to maintain access in accordance with the requirements of Title III of the Americans with Disabilities Act of 1990. Each PCP’s office is assessed to identify if barriers to Member care exist during the site reviews. Areas audited include but are not limited to: designated parking spaces, wheelchair access, restroom and drinking fountain access for wheelchair users, handrails near toilets, appropriately placed telephones, and appropriate signage. If a practitioner’s office or building is not accessible to Members with disabilities, an alternative access to care must be provided. See Policy 9D, “Access to Care for People with Disabilities.”

3. Access and Interpretation Services for People with Hearing Impairments and/or Limited English Proficiency - All IEHP network Providers and practitioners, including network pharmacy and vision practitioners, must provide services to limited English proficient Members in the Member’s primary language. For face-to-face interpretation services, including sign language, practitioners must provide interpreters, as needed, for Members’ appointments. IEHP is responsible for the cost of interpretation services. See Policies 9I2, “Cultural and Linguistic Services – Foreign Language Capabilities” and 9D1, “Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing.”

4. Interpretation Services - All Providers must provide services to limited English proficient Members in the Member’s primary language.

a. These linguistic capabilities must be available to Members twenty-four (24)
9. ACCESS STANDARDS

A. Access Standards

hours a day, seven (7) days a week.

b. During the process of adding a Physician to IEHP’s network, all Physicians are asked to indicate their foreign language abilities as well as their clinical and non-clinical office staff’s foreign language abilities. Assignment of Members to PCPs able to communicate in the Member’s preferred spoken language is done whenever possible.

c. Providers are encouraged to have bilingual practitioners and staff.

d. Providers may use face-to-face interpreters or telephonic interpretation services to meet the requirement of providing linguistic services to Members.

e. IEHP contracts with Pacific Interpreters to provide telephone interpretation services to Members. Providers access these services by contacting IEHP Member Services at (800) 440-4347. Pacific Interpreters offers interpretation services twenty-four (24) hours a day, seven (7) days a week.

f. Members or Providers must contact IEHP Member Services at least five (5) working days before the medical appointment to arrange for face-to-face interpreter service.

5. Access Standards for Behavioral Health Services – The following information delineates the access standards for availability of services to Medi-Cal Members for Behavioral Health care and after-hours emergency services.

a. The PCP is responsible for behavioral health/substance abuse care within his/her scope of practice, otherwise referrals are coordinated through IEHP at (800) 440-4347 or the designated Behavioral Health Plan:

1) Medi-Cal – Behavioral Health treatment services are provided by the IEHP BH Program as well as County Mental Health and County Drug and Alcohol treatment programs. Medi-Cal Members who meet specialty mental health criteria will be referred to the appropriate county for assessment and treatment. Medi-Cal Members will receive annual alcohol misuse screening from their PCP and if screened positive, the Member will receive brief intervention and full screening by the PCP or appropriately qualified Provider. Members needing treatment for alcohol dependence or drug addiction will be referred for assessment and treatment by the appropriate County Drug and Alcohol treatment program. During normal business hours referral assistance is available through IEHP or directly through the Mental Health Department in the county where the Member resides. After hours, weekends and holidays, referrals must be coordinated through the County Mental Health Departments.
9. ACCESS STANDARDS

A. Access Standards

<table>
<thead>
<tr>
<th>Riverside County Residents</th>
<th>Community Access, Referrals, Evaluation and Support (CARES) Line (800) 706-7500</th>
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</thead>
<tbody>
<tr>
<td>San Bernardino County Residents</td>
<td>San Bernardino County Access Unit (888) 743-1478</td>
</tr>
</tbody>
</table>

b. Appointment standards:

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Type of Visit</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-threatening emergency</td>
<td>Immediate disposition of Member to appropriate care setting</td>
<td></td>
</tr>
<tr>
<td>Non-life-threatening emergency</td>
<td>Six (6) hours</td>
<td></td>
</tr>
<tr>
<td>Urgent behavioral health needs</td>
<td>Within forty-eight (48) hours</td>
<td></td>
</tr>
<tr>
<td>Urgent behavioral health visit, requiring authorization</td>
<td>Within forty-eight (48) hours</td>
<td></td>
</tr>
<tr>
<td>Initial routine (non-urgent) visit with a Behavioral Health Care Provider</td>
<td>Within ten (10) business days of request</td>
<td></td>
</tr>
<tr>
<td>Follow-up routine (non-urgent)</td>
<td>Within ten (10) business days of request</td>
<td></td>
</tr>
</tbody>
</table>

c. After Hours Access for Behavioral Health Care:

1) All Behavioral Health Providers are required to have an automated answering system twenty-four (24) hours a day, seven (7) days a week, to direct Members to call 911 or go the nearest Emergency Room for any life threatening medical or psychiatric emergencies.

Monitoring

A. IEHP will annually assess the access standards of PCPs, high volume Specialists, Behavioral Health, and Ancillary Providers using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey Methodology. This methodology includes the use of the DMHC Provider Appointment Availability Survey for PCPs, Specialty Care Physicians and Non-Physician Mental Health Providers. The annual assessment is conducted to monitor the network for Providers that are not meeting access standards in order to take action to bring the Providers into compliance. For PCPs, the Plan will not perform a sampling of the Providers. Instead, the Plan will survey all active PCPs. IEHP will follow the sampling methodology as outlined by the DMHC for Specialty Care and Ancillary Care Providers. IEHP will separately report a rate of compliance for each of the time elapsed standards for each IPA located in each county of IEHP’s service area annually using the DMHC Provider Appointment Availability Survey Methodology and the DMHC Provider Appointment Availability Survey tools for PCPs, Non-Physician
9. ACCESS STANDARDS

A. Access Standards

Behavioral Health Providers, Specialty and Ancillary Care Providers (See Attachments, “DMHC Provider Appointment Availability Survey Methodology” and “DMHC Appointment Availability Survey Tools in Section 9). IEHP may utilize a 3rd party survey vendor to implement all or part of the DMHC Provider appointment Availability Survey methodology.

B. The Quality Management Department monitors missed appointments and in office wait times through the Facility Site and Medical Record Review process. The Provider Services team monitors office wait times by collecting wait time information during the Provider inservice to confirm compliance with access standards.

C. Additional monitoring is performed through the Potential Quality Incident (PQI) review process for individually identified Providers.

D. Monitoring of access and Interpretation Services occurs during the Medical Record Review (MRR) and Facility Site Review (FSR) processes. (See Policy MC_06A – Facility Site Review and Medical records Review Survey Requirements and Monitoring).

1. Facility Site Review Questions
   a. There is twenty-four (24)-hour access to interpreter services for non or Limited-English Proficient (LEP) Members.
      1) Interpreter services are made available in identified threshold languages specified for location of site.
      2) Persons providing language interpreter services on site are trained in medical interpretation.

2. Medical Record Review Question
   a. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.

Corrective Action Plan

A. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.

B. IEHP requests Corrective Action Plans (CAPs) to be submitted addressing deficiencies according to established policy or as otherwise directed by IEHP. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP of the audit results.

C. IEHP will provide advance written notice to contracted Providers affected by a CAP, including a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to Provider concerns regarding the plan’s corrective action.
9. ACCESS STANDARDS

A. Access Standards

D. Failure to submit CAPs may result in one of the following activities, depending on the seriousness of the deficiency:
   1. Delegate is frozen to new Member enrollment;
   2. Request for cure under contract compliance;
   3. Requirement to subcontract out the deficient activities within MSO or Delegate;
   4. Delegation of specified functions;
   5. Contract non-renewal; or

E. Delegates can appeal the results of any oversight activity or specialized study or audit in accordance with Policy 16C, “IPA, Hospital and Practitioner Grievance and Appeal Resolution Process.”

REFERENCES:

A. Title III of the Americans with Disabilities Act of 1990.
B. Final Rule (Mega Reg) is 81 FR 27498 and codified as 42 CFR Part 438.
C. §1300.67.2.2 Timely Access to Non-Emergency Health Care Services.
E. 2018 Joint Audit, Appointment Availability (AA-005) Item #3.
F. Final Rule (Mega Reg) is 81 FR 27497 and codified as 42 CFR Part 438 and Department of Health Care Services (DHCS) All Plan Letter (APL) 19-002 supersedes APL 18-005, “Network Certification Requirements” Attachment A.
G. MY 2018 TAR, Rule 1300.51(d)(1)(5).
H. MY TAR 2018, Rule 1300.67.2.2 (c)(8).
9. ACCESS STANDARDS

B. Missed Appointments

APPLIES TO:

A. This policy applies to all IEHP Providers.

POLICY:

A. The responsibility of follow-up for missed appointments is delegated to Primary Care Physicians (PCPs) with oversight by contracted IPAs and IEHP.

B. IEHP PCPs must maintain procedures to identify and follow-up on missed appointments including staff training.

PROCEDURES:

A. IEHP PCPs must have a process in place to follow-up on missed appointments that includes at least the following:

1. Notation of the missed appointment in the Member’s medical record.

2. Review of the potential impact of the missed appointment on the Member’s health status including review of the reason for the appointment by a licensed staff member of the PCP’s office (RN, PA, NP, DO or MD).

3. When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member’s health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

4. Notation in the chart describing follow-up for the missed appointment including one of the following actions:
   a. No action if there is no effect on the Member due to the missed appointment; or
   b. A letter or phone call to the Member as appropriate, given the type of appointment missed and the potential impact on the Member.

5. Three (3) attempts, at least one (1) by phone and one (1) by mail, must be made in attempting to contact a Member if the Member’s health status is potentially at significant risk due to missed appointments. Examples include:
   a. Members with serious chronic illnesses.
   b. Members with test results that are significant (e.g., abnormal cervical cancer screening).
   c. Members judged by the treating physician to be at risk for other reasons.

6. Documentation of the attempts must be entered in the Member’s medical record
9. ACCESS STANDARDS

B. Missed Appointments

and copies of letters retained.

7. Office staff in IEHP physician offices must be trained in, and be familiar with, the missed appointment procedure specific to their site.


B. Monitoring

1. IEHP Quality Management Department monitors missed appointments through the Facility Site and Medical Record Review process, initially and every three (3) years thereafter.

2. Additional monitoring is performed through the Potential Quality Incident (PQI) referral review process for individually identified providers.

REFERENCE:

A. §1300.67.2.2 Timely Access to Non-Emergency Health Care Services.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. IEHP provides both Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services for all prior authorized services and Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits covered under Medi-Cal Fee For Service (FFS) within the San Bernardino/Riverside Counties.

B. IEHP coordinates with transportation vendors to ensure compliance with regulatory access standards.

C. There are no limits in receiving NEMT/NMT services as long as the trip is validated to meet the guidelines stipulated in the Department of Health Care Services (DHCS) All Plan Letter (APL) 17-010.

1. All NMT and NEMT services must be arranged by IEHP. IEHP will make its best effort to authorize the lowest cost type of NEMT that is adequate for the Member’s medical needs.

2. Prior authorization is not required, when NEMT or NMT services are provided to a Member being transferred from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility.

D. Transportation to a Member’s home setting from facility or hospital is also covered when medical transportation by ambulance, litter van or wheelchair transportation are required due to Member’s medical and physical condition.

E. IEHP will provide NEMT/NMT services to:

1. The Member and one (1) additional passenger;

2. Unaccompanied minor(s) to seek sensitive services without requiring a written consent of a parent or a guardian; and

3. Unaccompanied minor(s) to seek non-sensitive services, requiring a written consent of a parent or a guardian.

F. IEHP will not provide transportation services to:

1. Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) Meetings;

2. Social Security Income (SSI) evaluations;

3. Workman’s Compensation Appointments;
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

4. IEHP Community Resource Center (CRC) unless a class has been scheduled through the Health Education Department;
5. Any service that is not covered by IEHP or Medi-Cal FFS; and/or
6. A Medicare Fee For Service (FFS) Member traveling out of San Bernardino/Riverside Counties.

G. IEHP will provide gas mileage reimbursement consistent with the Internal Revenue Service (IRS) rate for NMT services provided by private conveyance arranged by the Member for medical purposes when:

1. Member attestation is received by phone, electronically or in-person that:
   a. All other transportation resources available have been exhausted;
   b. The driver can provide proof of a valid driver’s license, valid vehicle registration and valid vehicle insurance; and
   c. Member has a physical, cognitive, mental or developmental limitation.
2. The trip has been prior authorized by IEHP

H. Financial responsibility for transportation services are defined in the Division Of Financial Responsibility (DOFR).

DEFINITIONS:

A. Non-Emergency Medical Transportation (NEMT) – Transportation to one’s IEHP or Delegate-approved medical appointment and/or Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits delivered through the Medi-Cal FFS by ambulance, litter van, wheelchair van, or air as per DHCS APL 17-010.

B. Non-Medical Transportation (NMT) – Roundtrip transportation to one’s IEHP or Delegate-approved medical appointment and/or Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits delivered through the Medi-Cal FFS by private car, taxi or bus, when the Member has reasonably exhausted other transportation resources.

C. Licensed Practitioner – Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwives (CNM), Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health/Substance Use Disorder Providers.

PURPOSE:

A. To ensure that Members have transportation access to medical, mental health, substance abuse and dental care services.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

PROCEDURES:

A. Members may only travel between home address on file and the medical/mental health facility, within the San Bernardino/Riverside counties, unless the service is not available within the two (2) counties.

B. NEMT and NMT will be arranged to locations that meet the Member’s needs and that are closest to their home address on file. For example, Pharmacy requests should be no more than five (5) miles away from the address on file and requests to a Laboratory should be no more than ten (10) miles away from the address on file. The only exception is when either service is not available within the mileage range described above.

C. Members may only be transported to the IEHP contracted Urgent Care within their region of residence.

D. Members requiring NEMT or NMT should contact IEHP Member Services Department at (800) 440-4347 for transportation services at least five (5) business days prior to requested service.

1. The exceptions to the above are:
   a. Dialysis;
   b. Pharmacy;
   c. Urgent Care;
   d. Wound Care;
   e. Cancer Treatment (radiation/chemotherapy);
   f. Pre-Op Appointments;
   g. Mental health appointments;
   h. Substance use appointments;
   i. Surgery; and
   j. Follow Up appointment from a recent Hospital Discharge.

Please note this is not an all-inclusive list. If Member has justification of why we need to transport, please have them call (800) 440-4347.

E. IEHP can direct all non-emergency transportation to contracted vendors within their network. If a contracted vendor is not available within the IEHP network that can accommodate the Member’s transportation needs based on the Member’s medical, physical, or mental condition, arrangements must be made for the Member to receive services from an appropriately qualified vendor outside the IEHP network.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

F. Requests for NEMT or NMT that do not adhere to APL 17-010 may be denied or partially approved:
   1. If the Practitioner’s or Member’s request for Member transportation is denied/partially approved, a formal written notification is sent to the Member and requesting Practitioner. This notification must include rationale for denial, alternative transportation recommendations, and information on how to appeal the decision.

G. Members must contact IEHP within twenty-four (24) hours when transportation services are no longer required or canceled. Members may receive written communication from IEHP UM for failure to notify IEHP UM representative after three (3) incidences.

H. Members who are found to have misused the transportation benefit will receive a formal written warning from IEHP and will be expected to correct their behavior. If the behavior is not corrected, IEHP will report the continued non-compliance as a potential incident of Fraud, Waste or Abuse (FWA) to the Department of Health Care Services Program Integrity Unit (DHCS PIU).

I. (For Non-Emergent Medical Transportation Only) For Members requiring NEMT services, their PCP or Licensed Practitioner must complete and submit the Physician Certification Statement (PCS) form to IEHP (See Attachment, “NEMT Physician Certification Statement Form” in Section 9). Contracted Providers may submit the form electronically through the secure IEHP Provider portal while non-contracted providers may fax the completed and signed form to IEHP at (909) 912-1049. Such statement remains in effect for twelve (12) months from date of the Practitioner’s signature.
   1. IEHP will not modify this form after the PCP or treating Physician has prescribed the form of transportation.
   2. IEHP will develop a process to capture data from the PCS form and report to DHCS, as required.

J. (For Non-Emergent Medical Transportation Only) IEHP will ensure door-to-door assistance to all Members receiving NEMT services.

K. IEHP will make their best effort to coordinate NMT services which may include use of a transportation vendor, issuance of bus passes and/or coordination with a transportation service program within the San Bernardino/Riverside counties.

L. Members may be issued a one (1) day pass for transportation if the following criteria are met:
   1. Transit was available.
   2. Trip was less than ninety (90) minutes in total duration.
9. ACCESS STANDARDS

C. Non-Emergency Medical and Non-Medical Transportation Services

3. Bus stop is no more than one (1) mile walking distance from the Member’s address on file.

M. Members who utilize the benefit everyday will be issued a thirty-one (31) day or a thirty (30) day bus pass depending on where they live.

N. With the exclusion of dialysis, standing orders will not be arranged for more than thirty (30) days at a time.

REFERENCES:

A. Title 22, California Code of Regulations §51323.

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-010, “Non-Emergency Medical and Non-Medical Transportation Services”.

9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. It is IEHP’s goal to ensure that all facilities and services are fully accessible to individuals with disabilities. In accordance with the requirements of Title III of the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act and other applicable Federal and State laws and regulations that prohibit discrimination on the basis of disability, all IEHP Providers and Practitioners contracted to provide care to Members are required to provide and maintain access for people with disabilities.

B. Access must be provided, whenever feasible, to service animals, as required by the ADA and pursuant to regulations.

C. IEHP performs a comprehensive access survey for people with disabilities during the initial facility review of Primary Care Physician (PCP) sites, prior to a Practitioner being approved to receive membership, as well as the high-volume specialists, high volume ancillary service Providers and high-volume Community-Based Adult Services (CBAS) Providers. This survey is repeated every three (3) years thereafter. The Physical Accessibility Review Survey (PARS) assessment tool is attached (See Attachments, “DHCS MMCD FSR Attachment C – Physical Accessibility Review Survey” for PCPs and high volume Specialist, “DHCS MMCD FSR Attachment D – Ancillary Physical Accessibility Review Survey” for high volume ancillary sites and “DHCS MMCD FSR Attachment E – CBAS Physical Accessibility Review Survey” for high volume Community-Based Adult Services (CBAS) Providers in Section 6).

D. IEHP consults stakeholders with disabilities to continuously evaluate and maintain accessibility of services for Members with disabilities.

DEFINITIONS:

A. Service animals are:
   1. Guide dogs;
   2. Signal dogs; or
   3. Other dogs individually trained to provide assistance to a person with a disability.

B. Medically qualified personnel include attending or consulting physicians, residents, and supervisory nurses.

PROCEDURES:
9. **ACCESS STANDARDS**

D. Access to Care for People with Disabilities

A. Office Access Standards

1. Each Provider and Practitioner office must demonstrate the following:
   a. Accessible parking spaces marked with adequate signage and having appropriate curb cuts within a reasonable distance from the facility’s main entrance;
   b. Easy wheelchair access to the main entrance via a ramp or absence of stairs or steps;
   c. Inaccessible entrances have signs indicating the location of the nearest accessible entrance;
   d. Provide an alternate access to care if the Provider and Practitioner’s office or building is not accessible to Members with disabilities;
   e. Restroom is wide enough to accommodate wheelchair-users or a mobile commode, or a bedpan and urinals are available for use;
   f. Adequately secured handrails near toilets are provided in at least one (1) restroom within the facility;
   g. Drinking fountains and/or water coolers are accessible to wheelchair-users, if available;
   h. If public telephones are available within the facility, at least one (1) is appropriately placed within access for people with disabilities and has teletypewriter (TTY) availability;
   i. All features for Members with disabilities are marked by adequate signage;
   j. Facility features designed specifically for access by people with disabilities are regularly inspected and repaired or replaced when necessary; and
   k. Grievances, complaints, and Member requests for disenrollment mentioning inadequate access for people with disabilities are carefully analyzed and researched to determine areas where improvements can be made.

B. Providers who are anticipating modification to their facilities must meet Americans with Disabilities Act Accessibility Guidelines (ADAAG).

1. The ADA establishes design requirements for the construction and alteration of facilities.

2. The ADA and California’s Title 24 requires health care Providers to follow specific accessibility standards and codes when constructing new facilities, and when making alterations that could affect access to or use of the facility by people with disabilities.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities


4. For more information on the ADA, go to IEHP’s “ADA and Beyond” web page: https://ww3.iehp.org/en/providers/additional-resources/ada-and-beyond/.

C. Service Animals:

1. Service animals are dogs that are individually trained to perform tasks for people with disabilities such as guiding people who are blind, alerting individuals who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other special tasks. Service animals are working animals, not pets.

   a. The ADA prohibits public accommodations from requiring “certification” or proof of an animal’s training, or proof of a person’s disability, for the purposes of access. Staff may ask two (2) questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform? However, evidence of current vaccinations such as rabies, may be requested.

   b. Providers must make reasonable modifications in their policies, practices and procedures when necessary to provide accommodations to Members with disabilities. Generally, this includes modifying any no-pets policy to permit use of a service animal by an individual with a disability.

2. A service animal must be permitted to accompany the Member to all areas of the facility where Members are normally permitted unless a medical justification showing that the presence or use of a service animal would pose a health risk in certain parts of the institution directly involved.

3. Providers may request that the Member be separated from their service animal for short periods of time, if it is necessary to provide a service (i.e. Aqua PT, Audiology testing, or other procedures where there is limited space). The separation should not be any longer than it takes to provide the service.

4. Care and supervision of a service animal are the responsibility of the Member and/or guardian.

   a. Neither IEHP nor its Providers are required to supervise or care for the service animal. Therefore, Members need to make their own arrangements to have someone feed, water and walk the animal during necessary separation in a medical facility.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

5. Restrictions on Service Animals
   a. A person with a disability cannot be asked to remove their service animal from the premises unless:
      1) The nature of the goods and services provided or accommodations offered at the Provider’s medical facility would be significantly altered.
      2) The safe operation of the medical facility would be jeopardized, or the animal poses a direct threat to the health or safety of others, such as preventing what should be a sterile environment (such as a surgical suite) or present a threat to others’ safety (such as an animal being out of control and the owner does not take effective action). Such areas may include, but are not limited to, the following:
         - Operating room suites and post-anesthesia rooms;
         - Burn unit;
         - Coronary care units;
         - Intensive care units;
         - Oncology units;
         - Psychiatric units;
         - Isolation areas;
         - Medication storage areas; and
         - Clean or sterile supply areas.

REFERENCES:
A. Title 42, United States Code §§ 12181-12189.
B. Title 29, United States Code § 701.
C. Title 28, Code of Federal Regulations Part 36, Appendix A.
D. Title 24, California Code of Regulations Part 2, Volume 1.
E. Title III of the Americans with Disabilities Act (ADA) of 1990.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities
   1. Members who are Deaf or Hard-of-Hearing

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP requires equal access to its medical care services in a non-discriminatory manner required by Title III, Regulation 28 Code of Federal Regulations (CFR) Part 36 and the Americans with Disabilities Act of 1990. All IEHP Providers and Practitioners contracted to provide care to Members are required to provide and maintain access for people with disabilities.

B. All hospitals must provide interpreters as needed for inpatient and emergency services. The hospitals are responsible for the cost and arrangement of interpretation services.

C. Requests for interpreter services at Primary Care Physician (PCP) sites, Skilled Nursing Facilities (SNFs), and outpatient visits for Members who are deaf or hard-of-hearing may originate from:
   1. Member;
   2. Family member;
   3. Member’s PCP or Specialist;
   4. Member’s IPA; or
   5. IEHP.

D. For interpretation services, including American Sign Language (ASL), oral, and signed English, all Practitioners must provide interpreters as requested for Member appointments at no charge to the Member.

E. IEHP and its Providers and Practitioners may not suggest or require that Members provide their own sign language or oral interpreters.

F. Members have the right not to use family members or friends as interpreters. If a Member chooses to use a family or friend in place of a qualified sign language or oral interpreter, signed documentation that interpreting services were offered and declined must be kept in the Member’s record.

G. It is recommended that the Member or Provider make arrangements for an interpreter at the same time that the medical appointment is being scheduled. Interpreter services can be scheduled by calling IEHP Member Services at (800) 440-IEHP (4347)/ TTY (800) 718-4347.
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities

1. Members who are Deaf or Hard-of-Hearing

H. IEHP can better ensure the availability of interpreters for a medical appointment if given at least five (5) working day notice.

I. Medical appointments may be rescheduled by a Member’s health care Provider upon agreement of both parties if there is no qualified interpreter available for the Member at that time.

J. IEHP is responsible for the cost of the interpretation services for PCP and outpatient visits.

K. IEHP is responsible for the cost of ASL Video Remote Interpreting (VRI) services for Members at contracted Urgent Care Facilities and SNFs.

L. Contracted Urgent Care Providers and SNFs are responsible for the cost, maintenance, and connectivity (Wi-Fi, Cellular, LAN) of IEHP-approved VRI equipment (See Attachment, “Video Remote Interpretation Approved Devices and Technical Specifications” in Section 9).

PROCEDURES:

A. In-person Sign Language Interpreter Requests

1. Members or Providers who are requesting interpreter services should call IEHP Member Services at (800) 440-IEHP (4347) at least five (5) working days in advance of the medical appointment and provide the following information:
   a. Member’s name;
   b. IEHP Member Identification Number or Social Security Number;
   c. PCP or specialist’s name;
   d. Date and location of appointment;
   e. Time and expected length of appointment;
   f. Type of interpretation needed (e.g., ASL, oral, or written);
   g. Preferred gender of the interpreter required; and
   h. Single or an on-going appointment.

2. IEHP must authorize all interpretation service requests. IEHP will call the contract interpreting services agency to make the arrangements.

3. IEHP will confirm with the agency the scheduled interpreter’s name and expected arrival time.

4. IEHP will provide notification of confirmation to Member’s PCP or specialist via a telephone call. IEHP will provide notification of confirmation to the Member via the Member’s preference, via telephone or using one of the following
9. ACCESS STANDARDS

D. Access to Care for People with Disabilities
   1. Members who are Deaf or Hard-of-Hearing

methods: TTY, Video Phone Relay, California Relay Services (TTY/VCO/HCO), or e-mail.

B. VRI Requests
   1. VRI is available to IEHP Members who are deaf or hard-of-hearing while accessing health plan services at contracted Urgent Care Facilities and SNFs.
   2. Providers may contact the IEHP Provider Relations Team for VRI set-up and technical assistance at (909) 890-2054 or (866) 223-4347.
   3. The following Member information will be collected at the start of the VRI session:
      a. IEHP Member First Name;
      b. IEHP Member Last Name; and
      c. IEHP Member Date of Birth.
   4. VRI services do not require a prior authorization from IEHP.

REFERENCES:

A. Title III of the Americans with Disabilities Act (ADA) of 1990.
C. Section 1557 of the Patient Protection and Affordable Care Act.
E. Access to Sensitive Services

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal Members.

POLICY:
A. Members have access to sensitive services through their Primary Care Physician (PCP), or other physicians within the IPA, or, in the case of certain services for Medi-Cal Members, any contracted or non-contracted qualified Practitioner.
B. Sensitive services include the following:
   1. Treatment for sexual assault;
   2. Drug or alcohol treatment services;
   3. Pregnancy-related services;
   4. Family planning services;
   5. Sexually transmitted infection preventive care, diagnosis, and/or treatment;
   6. HIV testing;
   7. Behavioral health care; and
   8. Abortion services.
C. Members are bound by the rules or procedures required for the specific services they are accessing.
D. Members are informed of their rights to access sensitive services through the Member Handbook.
E. There are additional regulations that deal specifically with services provided to minors. The following table represents a summary of minor consent laws as they apply to Sensitive Services. Please note that the table below is provided as a service to assist in the compliance of minor consent laws, but not intended to be authoritative. Prior to any reliance on the information below, please check the citations for a comprehensive understanding of the statutes, as well as any updates and/or changes to the law. Additionally, please refer to your legal counsel for official interpretation or other laws/regulations that may be applicable.
## California Minor Consent Laws

### Services youth can get without permission from their parent/guardian

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Can provider tell teen’s parent/guardian?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Minors of any age</td>
</tr>
<tr>
<td>Birth Control</td>
<td>Minors of any age</td>
</tr>
<tr>
<td>Pregnancy (Prev, Dx, Tx) Including inpatient care</td>
<td>Minors of any age</td>
</tr>
<tr>
<td>STI’s, Contagious and Reportable Diseases (Dx &amp; Tx) Family Code § 6926</td>
<td>Minors 12 yrs or older</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>Minors 12 yrs or older and assessed as competent to give informed consent</td>
</tr>
<tr>
<td>Alcohol/Drug Medical Care &amp; Counseling by Federally Assisted Treatment Program Including inpatient care Family Code § 6929(b) 42 C.F.R. § 2.14(b)</td>
<td>Minors 12 yrs or older</td>
</tr>
<tr>
<td>Alcohol/Drug Medical Care &amp; Counseling by Non-Federally Assisted Treatment Program Family Code § 6929(b)</td>
<td>Minors 12 yrs or older</td>
</tr>
<tr>
<td>Outpatient Mental Health Treatment (with conditions) Family Code § 6924(b)</td>
<td>Minors 12 yrs or older</td>
</tr>
<tr>
<td>Sexual Assault Family Code § 6928</td>
<td>Minors of any age</td>
</tr>
</tbody>
</table>

### Definitions:

- **Minor:** An individual who is under 18 years of age.

- **Confidentiality:** The Provider can only share patient information with permission of patient. Exceptions to confidentiality include reporting child abuse and billing insurance companies for health services.

- **Consent:** Giving your health care provider permission to share your information with others; or giving permission to receive a health service.

- **Notification:** The Provider is required to tell a minor’s parent/guardian that he/she received a specific health service. Notification does not mean access to medical records.

- **Contagious and reportable diseases:** Illnesses and infections that can spread quickly to other people and must be reported to government agencies.

- **Outpatient:** Services that do not require an overnight stay or hospitalization.

- **Sexual Assault:** For the purposes of minor consent alone, sexual assault includes but is not limited to acts of oral sex, sodomy, rape, and other violent crimes of a sexual nature that occur without one’s consent.

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Adolescent Health Working Group, Adapted from CALIFORNIA MINOR CONSENT LAWS © National Center for Youth Law: www.youthlaw.org. Revised 1/2011
9. ACCESS STANDARDS

E. Access to Sensitive Services

PURPOSE:
A. To ensure that Members have access to sensitive services.

PROCEDURES:
A. Treatment of sensitive services for minors may be obtained without parental consent through a Practitioner other than the PCP if so requested and consistent with other access policies and procedures.
B. Members, regardless of age, may obtain information regarding access to care and assistance with appointment scheduling for sensitive services through IEHP Member Services at (800) 440-4347 or their PCP’s office. Assistance is provided with complete confidentiality.
C. Periodic monitoring of Practitioner compliance is performed through chart review and assessment of encounter data.
D. Specific authorization or access requirements include:
   1. Sexual Assault - No prior authorization is required.
   2. Drug or Alcohol Treatment Services - Alcohol and substance abuse services are provided by the substance abuse treatment program at the Member’s county of residence of Medi-Cal Fee-For-Service (FFS). See Policy 12K2, “Behavioral Health – Alcohol and Drug Treatment Services” for more information.
   3. Pregnancy-Related Services - No prior authorization is required; services can be provided by any credentialed obstetrical Practitioner (OB/GYN or Family Practice) within the IPA’s network.
   4. Family Planning - No prior authorization is required; services can be obtained through any contracted or non-contracted qualified Practitioner.
   5. Sexually Transmitted Infection Preventive Care, Diagnosis and Treatment - No prior authorization is required; services can be obtained through the PCP, a Local Health Department (LHD) Practitioner, or any qualified Family Planning Practitioner if part of a family planning visit.
   6. HIV Testing - No prior authorization is required; services can be obtained through the PCP, LHD testing site, or any qualified Family Planning Practitioner if part of a family planning visit.
   7. Behavioral Health Care - The PCP is responsible for behavioral health care within his/her scope of practice, otherwise, the Member may be referred to the appropriate County Behavioral Health Department. Emergent referrals may be made to the IEHP BH Department. Please see Policy 12K1, “Behavioral Health – Behavioral Health Services” for more information.
9. ACCESS STANDARDS

E. Access to Sensitive Services

8. Abortion Services - No prior authorization is required; services can be obtained through any contracted or non-contracted qualified Practitioner.

E. For more specific information regarding authorization requirements and other details, see specific policies related to the particular service or condition as outlined in Section 10, “Medical Care Standards.”

REFERENCES:

A. Title 42 Code of Federal Regulations § 2.14(b).
B. California Family Code §§ 6924(b), 6925-6926, 6928-6929.
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In accordance with state law, IEHP requires that all IPAs (Delegates) must allow women direct access without referral for obstetrical or gynecological (OB/GYN) Practitioner services to a participating OB/GYN or Family Practitioner (FP) that meets IEHP credentialing standards to provide obstetrical and gynecological services.

B. IEHP requires Members to obtain direct access only from those OB/GYNs or FPs within the IPA to which they are assigned, and to use their assigned Hospital for facility-based services.

C. IEHP requires OB/GYNs or FPs to obtain prior authorization for any specialized procedures or other treatments outside of a “well woman” exam or routine obstetrical or gynecologic care.

D. IEHP requires OB/GYNs or FPs to communicate with the Member’s Primary Care Physician (PCP) regarding the Member’s condition, treatment, and follow-up care.

E. IEHP contracts define OB/GYN services as IPA responsibility. This responsibility includes payment of services accessed by Members under this policy. If it is determined that payment was denied for services under the Open Access policy, IEHP would reimburse the Provider and decap the IPA for the cost.

F. Persistent non-compliance related to this policy will result in action against the IPA.

PROCEDURES:

A. IPAs must allow Members with obstetrical or gynecological conditions to have direct access without referral to OB/GYNs or FPs that meet IEHP credentialing standards to provide obstetrical and gynecological services. Hospital services must be provided through the hospital to which the Member is assigned (See Attachment, “OBGYN Self-Referral Health and Safety Code 1367.695” in Section 9).

B. FPs participating under this policy must be credentialed by IPAs in accordance with IEHP standards for obstetrical privileges.

C. Typical conditions and procedures for which a woman can directly access an OB/GYN or eligible FP include, but are not limited to, the following:

1. Abdominal/Pelvic Pain
   a. Salpingo-oophoritis
   b. Endometriosis
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

c. Pelvic Inflammatory Disease (PID)

2. Abortion
3. Amenorrhea
4. Breast Lump
5. Bartholin Gland Enlargement/Cyst
6. Dysmenorrhea
7. Ectopic Pregnancy
8. Endometriosis
9. Dysuria
10. Estrogen Replacement
   a. Therapy/hormonal changes
11. Family Planning/Birth Control
12. Mastitis
13. Menopause
14. Menorrhagia
15. Premenstrual Syndrome (PMS)
16. Polymenorrhea
17. Pregnancy/Prenatal Care
18. Sexually Transmitted Infection (STI) Testing and/or Treatment
19. Vaginal Bleeding/Vaginal Discharge
20. Vaginitis
21. Well woman Exam
   a. Cervical Cancer Screening
   b. Breast Exam
22. Colposcopy
23. Endometrial Biopsy

D. The OB/GYN or FP providing care to Members accessing them under this policy must obtain prior authorization from their IPA for procedures, surgery or other services beyond routine or follow-up office visits. Examples of services requiring prior authorization include, but are not limited to, the following:

1. Diagnostic Procedures
9. **ACCESS STANDARDS**

F. **Open Access to Obstetrical or Gynecological Services**

a. Amniocentesis
b. CT
c. Ultrasound
d. Other specialty diagnostic procedures
e. MRI

2. Services
   a. Referrals to other specialists

3. Surgical Intervention
   a. Dilation and Curettage (D & C)
   b. Hysterectomy
   c. Laparoscopy

4. Treatments
   a. Cone biopsy
   b. Cryosurgery

E. Any OB/GYN or FP providing care to Members under this policy is required to communicate to the Member’s PCP, in writing, the Member’s condition, treatment and any need for follow-up care. OB/GYNs or FPs can meet this requirement by providing this information to the Member’s IPA, which then must forward the information to the PCP.

F. OB/GYNs and FPs providing care to Members under this policy are encouraged to either contact their IPA when initiating treatment, or to provide appropriate clinical information when submitting claims to the IPA to ensure timely and appropriate processing of claims.

G. IPAs are required to reimburse OB/GYNs and FPs providing care to Members under this policy according to the guidelines above utilizing appropriate claims review and processing standards. Approval types for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.

H. OB/GYNs and FPs providing care to Members under this policy must first appeal denied or disputed claims to the IPA. If the appeal is denied, claims appeal should be directed to IEHP at:

   Inland Empire Health Plan  
   Claims Department  
   P.O. Box 4349  
   Rancho Cucamonga, CA 91729-4349

I. If IEHP determines that an IPA has denied payment for a claim submitted by an
9. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

OB/GYN for a visit under Open Access policies, IEHP will reimburse the Provider and decap the IPA.

J. IPAs should have a structure in place to monitor compliance with OB/GYN Open Access services. Process should include, but not be limited to, review of denied services for OB/GYN services, review of Member and Provider grievances, and review of Provider appeals and denial of OB/GYN Provider claims.

K. IEHP will perform ongoing monitoring to assure compliance with these requirements. Persistent failure to comply with these requirements will result in negative action against the IPA, up to termination of the IEHP-IPA contract.

L. Information regarding this policy or questions related to it can be obtained by calling the IEHP Provider Relations Team at (909) 890-2054.

REFERENCE:

9. ACCESS STANDARDS

G. Cancer Screening and Treatment Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP requires that all IPAs approve screening tests for cancer by the Member’s Primary Care Physician (PCP) or other treating physician if the request is based on generally medically accepted practice such as, but not limited to, those approved by the Food and Drug Administration (FDA), United States Preventive Services Task Force (USPSTF), scientific evidence or IEHP policies and procedures.

B. IEHP requires Members to obtain all care and services for cancer screening or diagnostic testing only from credentialed IEHP participating Providers/Practitioners (including physicians, surgeons, nurse practitioners, certified nurse midwives, or other Providers of service) within the IPA to which they are assigned, as applicable.

C. IEHP requires Members obtaining care and services for cancer to receive services from the Member’s assigned hospital, as applicable.

D. If the Member’s treating physician, who is providing covered health care services recommends Member participation in a phase I through IV clinical trial for cancer, authorization is requested, and if approved, coverage must be provided for all routine Member care costs related to the clinical trial. The clinical trial’s endpoints must not be defined exclusively to test toxicity but must have a therapeutic intent.

E. For services related to the treatment of cancer, IPAs can subject requests from treating physicians to prior authorization process.

F. For reconstructive surgery or prosthetic devices necessary to restore symmetry for a Member after mastectomy, the IPA can subject the request to prior authorization process.

G. IEHP contracts define physician and other services as an IPA responsibility. This responsibility includes payment of services accessed by Members under this policy.

PROCEDURES:

A. All cancer screening requests must follow the process outlined in Policy 14G, “Pre-Service Referral Authorization Process” in accordance with community medical standards and IEHP’s policies and procedures:

1. Breast cancer screening.

2. Cervical cancer screening (e.g. cytology and HPV co-testing as appropriate).

3. Lung cancer screening (utilizing low dose computed tomography as appropriate).

4. Colorectal cancer screening (e.g. fecal immunochemical tests, fecal occult blood
G. Cancer Screening and Treatment Services

5. Prostate cancer screening.
6. Other cancer screening tests as appropriate and approved by the FDA.

B. In addition, for breast cancer screening and diagnostic testing, IPAs must authorize the following services upon referral from a Member’s treating physician (either the Member’s PCP, an OB/GYN that the Member is directly accessing per Policy 9F, “Open Access to Obstetrical or Gynecological Services,” or an authorized treating specialist):

1. Screening Mammography or Ultrasound – CDC (Center for Disease Control)/USPSTF (United States Preventative Services Task Force) recommend women 50-74 years of age should receive biennial mammography screening. Women 40-49 years of age with average risk of breast cancer should receive a biennial or per MD Referral mammography screening.
2. Diagnostic mammography.
3. Diagnostic biopsy – as ordered by an appropriate Specialist.

C. IPAs may require prior authorization for the following referral requests related to breast cancer services, but the services must be provided if medically necessary:

1. Surgical treatments – mastectomy, lumpectomy, etc.
2. Chemotherapy
3. Radiation therapy
4. Treatments for complications related to breast cancer treatments

D. IPAs may subject the following requests to prior authorization to determine the appropriate Practitioner, but the services must be provided:

1. Prosthetic devices or reconstructive surgery necessary to restore symmetry for the patient after mastectomy.

E. For a Member diagnosed with cancer who is accepted and authorized into a phase I through IV clinical trial for cancer, coverage must be provided for all routine Member care costs related to the clinical trials if the Member’s treating physician, who is providing covered health care services, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member.

1. “Routine Member care costs” mean the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered if not in connection with an approved clinical trial program. This includes:
   a. Services typically provided in the absence of a clinical trial;
   b. Services required solely for the provision of the investigational drug item, device, or service;
9. **ACCESS STANDARDS**

G. **Cancer Screening and Treatment Services**

c. Services required for the clinically appropriate monitoring of the investigational item or service;

d. Services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service; and

e. Services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

2. “Routine Member care costs” do not include the following:

a. Drugs or devices that have not been approved by the FDA and that are associated with the clinical trial;

b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Member may require as a result of the treatment being provided for purposes of the clinical trial;

c. Items or services provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member;

d. Services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Member’s health plan; and

e. Services customarily provided by the research sponsors free of charge for any Member in the clinical trial.

3. Treatment shall be provided in a clinical trial that:

a. Involves a drug that is exempt under federal regulations from a new drug application;

b. Is approved by one of the following:

   1) One of the National Institutes of Health;
   2) The FDA, in the form of an investigational new drug application;
   3) The United States Department of Defense; or
   4) The United States Veterans’ Administration.

4. The Member’s right to the Independent Medical Review process is not limited.

F. IPAs can direct all services noted above to Providers/Practitioners within their network within those Providers/Practitioners’ scope of practice. If an appropriately qualified Practitioner is not available within the IPA network, arrangements must be made for the Member to receive care from an appropriately qualified Providers/Practitioner outside the IPA network.
9. ACCESS STANDARDS

G. Cancer Screening and Treatment Services

G. Practitioners rendering breast cancer services to Members are encouraged to either contact their IPA when initiating treatment or to provide appropriate clinical information when submitting claims to the IPA to ensure timely and appropriate processing of claims.

H. IPAs are required to reimburse Providers/Practitioners rendering care to Members under this policy according to the guidelines above, including appropriate claims review and processing standards. Approvals for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.

I. Providers/Practitioners rendering care to Members must first appeal denied or disputed claims to the IPA. If the appeal is denied, the claims appeal should be directed to IEHP at:

Inland Empire Health Plan
Attention: Claims Appeals
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

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<tr>
<th>INLAND EMPIRE HEALTH PLAN</th>
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<tr>
<td><strong>Chief Approval:</strong> Signature on file</td>
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<td><strong>Chief Title:</strong> Chief Medical Officer</td>
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</table>
9.  ACCESS STANDARDS

H.  Cultural and Linguistic Services
    1.  Foreign Language Capabilities

APPLIES TO:

A.  This policy applies to all IEHP Medi-Cal Members who have Limited English Proficiency (LEP).

POLICY:

A.  The Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) designated Spanish and English as the only threshold languages in San Bernardino and Riverside Counties for Medi-Cal Members.

B.  All IEHP network Providers and Practitioners, including IPAs, Hospitals, Primary Care Physicians (PCPs), OB/GYNs, Specialists, Behavioral Health (BH) Providers, Behavioral Health Treatment (BHT) Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Facilities, Pharmacies, other Providers (e.g. Nurse Practitioners, Physician Assistants, Acupuncturists, Midwives, and Dentists), and Long Term Services and Supports (LTSS) Providers must provide services to Members with LEP in the Member’s primary language. Members cannot be required to provide their own interpreters or pay for them.

C.  Members have the right to request an interpreter at no charge for discussions of medical information, and at key points of contact.

D.  Providers should not require or suggest the use of family members or friends as interpreters. However, a family member or friend may be used as an interpreter if this is requested by the Member after being informed he/she has the right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services or violate the Member’s confidentiality. Minors should not be used as interpreters except for extraordinary circumstances such as medical emergencies.

E.  Providers should document the Member’s request for or refusal of interpreter services in their medical record.

F.  Providers may use face-to-face interpreters when requested at least five (5) working days before the medical appointment or telephonic interpretation services to meet the language requirement. These interpretation resources are available to Members twenty-four (24) hours a day/seven (7) days a week.

1.  Members and Providers can call IEHP Member Services at (800) 440-IEHP (4347), or (800) 718-4347 for TTY users to access this telephone interpretation service during business hours.

2.  After business hours, Members and Providers can call the 24-Hour Nurse Advice Line at (888) 244-IEHP (4347) to access interpretation services.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services
   1. Foreign Language Capabilities

G. IEHP and its network of Providers and Practitioners must provide written materials to Members in designated threshold languages.

H. All Providers and Practitioners, including Vision Practitioners, listed in the IEHP Provider Directory with Spanish-speaking capabilities are required to undergo an annual language competency audit to monitor bilingual Spanish services available to Members.

I. Members who do not select a PCP at the time of enrollment are assigned to a PCP. Language compatibility is one of the factors in the PCP assignment.

J. Members have the right to file a complaint or grievance if their linguistic needs are not met.

PROCEDURES:

A. Provider Language Capability
   1. IEHP lists all foreign language capabilities of Providers and/or their staff in the Provider Directory.
   2. Any Provider site indicating capability of a threshold language other than English must have staff who speaks that language available during the office’s regular business hours.
   3. Provider sites indicating capability of a threshold language other than English must provide all recorded messages and signage in the designated language.
   4. IEHP verifies the capability of Providers to provide services in the threshold language at the time of entry into the network.
      a. In order to be considered a Spanish-speaking office, Providers and/or staff must be able to converse fluently in both English and Spanish, use and pronounce medical and managed care terminologies, and be able to assist Members in completing appropriate forms.
      b. Provider sites approved as Spanish-speaking have this information listed in the Provider Directory to assist Members in the selection process.
      c. IEHP conducts annual audits of Provider sites listed in the Provider Directory to confirm ongoing threshold language capabilities in accordance with Policy 9H2, “Cultural and Linguistic Services - Spanish Language Competency Audits.”
   5. Members’ concerns about the interpretation capabilities in a Provider’s office are followed up by IEHP, and the IEHP provider database is corrected as necessary.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services
   1. Foreign Language Capabilities

B. Interpretation Services
   1. Providers and Practitioners may not require or suggest that Members provide their own interpreters.
   2. All hospitals must provide interpreters as needed for inpatient and emergency services. The hospitals are responsible for the cost and arrangement of interpretation services.
   3. Providers must provide interpreters as needed for Member appointments. IEHP covers the costs of the interpretation services for PCP and outpatient visits. Sign language interpretation must be provided in accordance with Policy 9D1, “Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing.”
   4. When face-to-face interpretation services are required, it is recommended that the Member or Provider schedule an interpreter at the same time or at least five (5) working days in advance of the medical appointment.
      a. Interpreter services are scheduled by calling IEHP Member Services at (800) 440-IEHP (4347), or (800) 718-4347 for TTY users. All requests for interpretation services must be scheduled and authorized by IEHP.
      b. Emergent and urgent interpreter service requests under five (5) working days are subject to interpreter availability.
   5. IEHP has contracted with Pacific Interpreters to provide telephonic interpretation services to Members. This company offers interpretation services, twenty-four (24) hours a day, seven (7) days a week. IEHP Members and Providers may access this service at no cost.
      a. Members and Providers can call IEHP Member Services to access this telephone interpretation service during business hours.
      b. After business hours, Members and Providers can call the 24-Hour Nurse Advice Line at (888) 244-IEHP (4347) to access interpretation services.
   6. Providers must document all Member requests for and refusal of interpreter services in the Member’s medical record.

REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-008 Supersedes APL 02-003, Standards for Determining Threshold Languages.
B. Title 42, Code of Federal Regulations (CFR) § 422.112(a) (8); 42.2264.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services
   1. Foreign Language Capabilities
9. ACCESS STANDARDS

H. Cultural and Linguistic Services
2. Spanish Language Competency Audits

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Providers.

POLICY:

A. IEHP verifies the capability of its Providers to provide services in the threshold languages when Providers indicate they have this capability at the time of their entry into the IEHP network. Currently, Spanish and English are the only threshold languages in Riverside and San Bernardino Counties as defined by DHCS.

B. IEHP conducts a language competency audit of all Primary Care Physicians (PCPs), OB/GYNs and Vision Providers offices that have been designated as having the ability to speak Spanish in the initial credentialing process and on an annual basis. These Providers are listed in the IEHP Provider Directory as having Spanish speaking capabilities.

PROCEDURES:

A. In order to be considered a Spanish speaking office, Providers and/or their staff must be able to converse fluently in Spanish, use and pronounce medical and managed care terminology, and be able to assist Members in completing appropriate forms.

B. On an annual basis IEHP evaluates Spanish-speaking Providers for language competency.

C. The technique utilized for assessing targeted language competency within the Provider site is set up as a monolingual Spanish speaking IEHP Team Member calling into the office to verify that someone in the office speaks Spanish. The caller immediately begins speaking Spanish and requests to speak to someone that speaks Spanish. The IEHP Team Member introduces her/himself as an IEHP employee and begins the audit.

D. The following information is documented from the call:
1. Who in the office speaks Spanish (Doctor/clinical staff and office staff, doctor/clinical staff only and non-clinical staff only). IEHP Team Member verifies with one Spanish speaking employee in each individual doctor’s office;
2. How many people in the office speak Spanish; and
3. That the use of answering machine or answering service when the office is closed
9. **ACCESS STANDARDS**

H. Cultural and Linguistic Services

2. Spanish Language Competency Audits

has Spanish options.

E. Providers who do not demonstrate adequate Spanish-speaking capabilities are not listed as a Spanish speaking office in the IEHP Provider Directory and are not assigned Members who express a preference for Spanish-speaking PCPs.

F. Providers receive a letter stating the results of the Spanish audit. The office will pass, fail or have a Corrective Action Plan (CAP). CAPs must be submitted within seven (7) days of receipt of audit results. The written or telephonic CAP must demonstrate how the office is addressing the deficiencies. Failure to supply a CAP may result in Spanish-speaking capability being removed from the Provider’s information in the IEHP Provider Directory.

G. CAPs are reviewed and evaluated by IEHP Credentialing Manager. For rejected CAPs, IEHP includes the specific reasons for rejecting any CAP. If a CAP is approved, IEHP staff will re-audit that location. If the re-audit passes, the Provider will keep his/her Spanish-speaking designation in the IEHP Provider Directory.

H. Until such time as an adequate CAP is received by IEHP, the provider will not be listed as a Spanish-speaking Provider in the IEHP Provider Directory and Members requesting a Spanish-speaking Provider will not be assigned.

I. Audit results are reported to DHCS on an annual basis.

J. Providers directly contracted with IEHP, wishing to appeal the results of the language competency audit must submit the written appeal to IEHP in accordance with Policy 16C, “IPA, Hospital and Practitioner Grievance and Appeals Resolution Process.”
9. ACCESS STANDARDS

H. Cultural and Linguistic Services

3. Non-Discrimination

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In accordance with Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations (CFR), Section 442.110, all Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

B. IEHP establishes methods to promote access and delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that Members have access to covered services that are delivered in a manner that meets their unique needs.

C. IEHP contracted Provider organizations must provide covered services to all IEHP Members assigned to them, at an appropriate facility, without imposing restrictions as listed above.

PROCEDURES:

A. IEHP assigns all Members to PCPs, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

B. All IEHP contracted Providers and other subcontractors are required to render services to all Members assigned or referred to them. Providers and other subcontractors may not refuse services to any Member based on the criteria listed above.

C. IEHP Providers and other subcontractors must provide covered services to Members in a uniform manner, at non-segregated locations.

D. IEHP investigates all grievances alleging discrimination, and takes appropriate action with Team Members, Provider organizations, and other subcontractors. All discrimination-related grievances are forwarded to the California Department of Health Care Services, for review and appropriate action.
9. ACCESS STANDARDS

H. Cultural and Linguistic Services

3. Non-Discrimination

REFERENCES:

A. Title VI of the Civil Rights Act.
## 9. ACCESS STANDARDS

**Attachments**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMHC Provider Appointment Availability Survey Methodology</td>
<td>9A</td>
</tr>
<tr>
<td>DMHC Provider Appointment Availability Survey Tools</td>
<td>9A</td>
</tr>
<tr>
<td>Medical Transportation Services - Title 22 Section 51323</td>
<td>9C</td>
</tr>
<tr>
<td>NEMT Physicians Certification Statement</td>
<td>9C</td>
</tr>
<tr>
<td>OBGYN Self-Referral - Health and Safety Code 1367.695</td>
<td>9F</td>
</tr>
<tr>
<td>Video Remote Interpretation Approved Devices and Technical Specifications</td>
<td>9D1</td>
</tr>
</tbody>
</table>
Provider Appointment Availability Survey
Measurement Year 2018

Survey Tool
Table of Contents

Survey Tool Introduction ........................................................................................................... 3
Online, Email and/or Fax Survey ............................................................................................. 4
Primary Care Physicians and Provider (PCP) Survey Script .................................................. 6
Specialty Care Physicians Survey Script .................................................................................. 9
Non-Physician Mental Health Providers (NPMH) Survey Script ............................................ 12
Ancillary Providers Survey Script ............................................................................................ 15
Provider Appointment Availability Survey
Measurement Year 2018

Survey Tool Introduction

The Department of Managed Health Care created five Survey Scripts to be used in administering the Provider Appointment Availability Survey (PAAS).

The Survey Tool includes the survey script language which must be used in conducting the survey. (Please review the MY 2018 PAAS 2018 Methodology for specifications related to allowable changes to the Survey Tool and eFiling requirements.) Instructions, related to completing specific fields or administering the survey, are in italics. Responses to the survey and compliance calculations must be recorded in the Raw Data Template and submitted to the Department in the health plan’s Timely Access Compliance Report.
Online, Email and/or Fax Survey

Please respond to this communication on or before mm/dd/yy; otherwise, we will contact you via phone to take this survey.

Thank you for participating in this online survey. Health plans are required to obtain information from their contracted providers regarding appointment availability. This [online/email/fax] survey is designed to help [insert health plan name(s)] better assess enrollee access to provider services. Please respond to this survey no later than five business days of this communication.

[If sending a reminder survey, the health plan should change the requested response time to indicate the amount of time remaining to respond.]

The date and time you respond to the survey is used to calculate appointment wait times. Please indicate the date and time of this response:

Date: (mm/dd/yy)
Time: (hh:mm am/pm) PT

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm). If the online software or program used to conduct the survey accurately captures the time and date of the response in Pacific Time, this question must be omitted and this data must be used to populate the response date and time in the Raw Data Template. All fax surveys must include this field.]

[Confirm the provider’s contact information, including name, address (optional), county, telephone number (optional), and specialty. Health plans may allow the provider to update the contact information during the survey or provide information on how to separately report any updates or corrections to the provider’s information. In addition, the health plan should confirm the provider is eligible to take the survey.]

Please indicate whether any of the following items apply to [Provider Name or FQHC] in [County]:

__ I do not practice in [County];
__ I am retired or for other reasons am no longer practicing;
__ I am not [insert one: a Primary Care Provider, a Cardiologist, an Endocrinologist, a Gastroenterologist, a Psychiatrist, a Non-Physician Mental Health Provider, affiliated with an entity or facility providing MRI services, affiliated with an entity or facility providing Mammogram services, or affiliated with an entity or facility providing Physical Therapy services];
__ [Provider Name or FQHC] is not affiliated with the email or fax number that this survey was sent to;
__ I do not provide [insert one: Primary Care, Cardiology, Endocrinology, Gastroenterology, Psychiatry, Non-Physician Mental Health Provider, MRI, mammogram, or Physical Therapy] appointments.
If any of the above items apply, [Provider Name or FQHC] is not eligible to take the survey and the survey is complete. Please submit the survey by [insert directions to submit the survey (e.g., fax the survey to a specific number or click the submission button)]. Thank you for your time. If none of the above items apply, please respond to the questions set forth below.

For services provided by [Provider Name or FQHC Name] in [County], please provide a response to the following questions:

**Question 1:**

Urgent service means health care for a condition, which requires prompt attention, but does not rise to the level of an emergency. When is [Provider Name or FQHC Name]’s next available appointment date and time for urgent services?

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT or indicate that this appointment type is not applicable and provide a brief explanation.]

[Urgent Appointments are not measured for Ancillary Providers in the MY 2018 PAAS Methodology. Please exclude this question from surveys sent to Ancillary Providers and renumber the questions appropriately.]

**Calculation 1:**

[Record on the Raw Data Template whether an urgent appointment is available within 48 hours (PCPs) or 96 hours (Specialists Physicians and Non-Physician Mental Health Providers). If NA, insert the explanation in the "Comment 1" field of the Raw Data Template.]

**Question 2:**

When is [Provider Name or FQHC Name]’s next available appointment date and time for non-urgent services?

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT or indicate that this appointment type is not applicable and provide a brief explanation.]

**Calculation 2:**

[Record on the Raw Data Template whether a non-urgent appointment is available within 15 business days (calculated as 21 calendar days) for Specialists Physicians and Ancillary Providers or within 10 business days (calculated as 14 calendar days) for PCPs and Non-Physician Mental Health Providers.\(^1\) If NA, insert the explanation in the “Comment 2” field of the Raw Data Template. If the provider does not offer urgent and non-urgent appointments, this provider is ineligible to take the survey.]

This concludes our survey. [Insert directions to submit the survey.] Thank you very much for your time. Have a nice day.

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\(^1\) When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends and holidays must be included when calculating calendar days.
Primary Care Physicians and Provider (PCP) Survey Script

Date Survey Completed: ______________________ [mm/dd/yy]
Time Survey Completed: ______________________ [hh:mm am/pm] PT
Provider First Name: ________________________________
Provider Last Name: ________________________________
Person Spoken to: __________________________________
Health plan creating survey data: ______________________
Name of individual conducting survey: ____________________
Provider Survey Type: ______________________ Primary Care Provider (PCP)
Specialty / Subspecialty: ______________________________
Address: _________________________________________ [Optional to validate]
County of this Office Location: ________________________
Provider Group/IPA/Medical Group Affiliation: ______________________
Network(s): __________________________________________

Introduction:

"Hello. My name is [Say Name]. I am calling on behalf of [health plan(s)] to conduct an appointment availability survey. Health plans are required to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes and includes no more than [two] questions. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider’s Name or Name of the FQHC]?

If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

Validate Provider Information

If yes, validate the office information above with the person spoken to and conduct the survey. The responder may need a physical address to respond to the survey. If so, please ensure that the surveyor has access to the provider’s address located within the appropriate county; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

If the provider is no longer affiliated with the office, provider group, or plan, mark the provider as ineligible for the survey, then move on to the next provider in the oversample list to ensure target sample sizes are met. In addition, if the provider does

---

2 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey and number of questions as appropriate.
not respond or declines to respond to one or more questions, please move to the next provider in the oversample list. (For more information, see Step 8 of the Methodology, under the headings "Replacements" and "Non-Responders.")

Surveyor Notes

• If the provider reports that the wait time depends upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (shorter duration time).

• If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available later that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for later that date is compliant.

Question 1:
“Urgent service means health care for a condition, which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or at the FQHC] for urgent services?”

Date: mm/dd/yy
Time: hh:mm am/pm PT

_____ Not applicable, this provider does not offer urgent appointments.

Calculation 1:
Calculate whether the appointment date and time in Question 1 is within 48 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

• Mark “Y” to indicate yes, there is an available urgent appointment within 48 hours. (Go to Question 2)
• Mark “N” to indicate no, there is no available urgent appointment within 48 hours. (Go to Question 2)
• Mark “NA” to indicate that this question is not applicable, because this provider does not offer non-urgent appointments. (Go to Question 2)

Question 2:
“When is the next available appointment date and time with [Provider Name or at the FQHC] for non-urgent services?”

Date: mm/dd/yy
Time: hh:mm am/pm PT

_____ Not applicable, this provider does not offer non-urgent appointments.
**Calculation 2:**

Calculate whether the appointment date and time in Question 2 is available within 10 business days (14 calendar days) of your request. Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

- **Mark “Y” to indicate yes, there is an available non-urgent appointment within 10 business days.** (Conclude Survey)
- **Mark “N” to indicate no, there is no available non-urgent appointment within 10 business days.** (Conclude Survey)
- **Mark “NA” to indicate that this question is not applicable, because this provider does not offer non-urgent appointments.** (If the provider does not offer urgent and non-urgent appointments, this provider is ineligible to take the survey. Conclude survey.)

“This concludes our survey. Thank you very much for your time. Have a nice day.”

---

3 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends and holidays must be included when calculating calendar days.
**Specialty Care Physicians Survey Script**

Date Survey Completed: ________________________________ [mm/dd/yy]  
Time Survey Completed: ________________________________ [hh:mm am/pm] PT

Provider First Name: _________________________________________  
Provider Last Name: _________________________________________  
Person Spoken to: ____________________________________________

Health plan creating survey data: ____________________________________  
Name of individual conducting survey: ________________________________  
Provider Survey Type:  
- _____ Specialist Physicians Combined  
- _____ Psychiatry

Appointment Type:  
- _____ Cardiology  
- _____ Endocrinology  
- _____ Gastroenterology  
- _____ Psychiatry

Specialty / Subspecialty: ____________________________________________  
Address: _______________________________________________________ [Optional to validate]  
County of this Office Location: ________________________________________

Provider Group/IPA/Medical Group Affiliation: _____________________________  
Network(s): ______________________________________________________

**Introduction:**

"Hello. My name is [Say Name]. I am calling on behalf of [health plan(s)] to conduct an appointment availability survey. Health plans are required to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes and includes no more than [two] questions. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider’s Name or Name of the FQHC]?”

If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

---

4 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey and number of questions as appropriate.
Validate Provider Information

If yes, validate the office information above with the person spoken to and conduct the survey. The responder may need a physical address to respond to the survey. If so, please ensure that the surveyor has access to the provider's address located within the appropriate county; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

If the provider is no longer affiliated with the office, provider group, or plan, mark the provider as ineligible for the survey, then move on to the next provider in the oversample list to ensure target sample sizes are met. In addition, if the provider does not respond or declines to respond to one or more questions, please move to the next provider in the oversample list. (For more information, see Step 8 of the Methodology, under the headings "Replacements" and "Non-Responders.")

Surveyor Notes

• If the provider reports that the wait time depends upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (shorter duration time).

• If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available later that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for later that date is compliant.

Question 1:

“Urgent service means health care for a condition, which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or Name of the FQHC] for urgent services?”

Date: mm/dd/yy
Time: hh:mm am/pm PT

Not applicable, this provider does not offer urgent appointments.

Calculation 1:

Calculate whether the appointment date and time in Question 1 is within 96 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

• Mark “Y” to indicate yes, there is an available urgent appointment within 96 hours. (Go to Question 2)
• Mark “N” to indicate no, there is no available urgent appointment within 96 hours. (Go to Question 2)
• Mark “NA” to indicate that this question is not applicable, because this provider does not offer urgent appointments. (Go to Question 2)

**Question 2:**

“When is the next available appointment date and time with [Provider Name or Name of the FQHC] for non-urgent services?”

**Date:** mm/dd/yy  
**Time:** hh:mm am/pm PT  
____  Not applicable, this provider does not offer non-urgent appointments.

**Calculation 2:**

Calculate whether the appointment date and time in Question 2 is available within 15 business days (21 calendar days) of your request. Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

• Mark “Y” to indicate yes, there is an available non-urgent appointment within 15 business days. (Conclude Survey)  
• Mark "N" to indicate no, there is no available non-urgent appointment within 15 business days. (Conclude Survey)  
• Mark “NA” to indicate that this question is not applicable, because this provider does not offer non-urgent appointments. (If the provider does not offer urgent and non-urgent appointments, this provider is ineligible to take the survey. Conclude survey.)

“This concludes our survey. Thank you very much for your time. Have a nice day.”

---

5 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends and holidays must be included when calculating calendar days.
Non-Physician Mental Health Providers (NPMH) Survey Script

Date Survey Completed: _________________________________ [mm/dd/yy]  
Time Survey Completed: _________________________________ [hh:mm am/pm] PT  
Provider First Name: ________________________________________________  
Provider Last Name: ________________________________________________  
Person Spoken to: ________________________________________________  
Health plan creating survey data: _______________________________________  
Name of individual conducting survey: ________________________________  
Provider Survey Type: _____________ Non-Physician Mental Health Provider (NPMH)  
License Type: _________________________________________________________  
Address: ____________________________________________ [Optional to validate]  
County of this Office Location: __________________________________________  
Provider Group/IPA/Medical Group Affiliation: ______________________________  
Network(s): ___________________________________________________________

**Introduction:**

"Hello. My name is [Say Name]. I am calling on behalf of [health plan(s)] to conduct an appointment availability survey. Health plans are required to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes and includes no more than [two] questions. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider's Name or Name of the FQHC]?

If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

**Validate Provider Information**

If yes, validate the office information above with the person spoken to and conduct the survey. The responder may need a physical address to respond to the survey. If so, please ensure that the surveyor has access to the provider's address located within the appropriate county; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

---

6 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey and number of questions as appropriate.
If the provider is no longer affiliated with the office, provider group, or plan, mark the provider as ineligible for the survey, then move on to the next provider in the oversample list to ensure target sample sizes are met. In addition, if the provider does not respond or declines to respond to one or more questions, please move to the next provider in the oversample list. (For more information, see Step 8 of the Methodology, under the headings "Replacements" and "Non-Responders.")

Surveyor Notes
• If the provider reports that the wait time would depend upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (shorter duration time).

• If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available later that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for later that date is compliant:

**Question 1:**
“Urgent service means health care for a condition, which requires prompt attention, but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or Name of FQHC] for urgent services?”

**Date:** mm/dd/yy  
**Time:** hh:mm am/pm PT  
____ Not applicable, this provider does not offer urgent appointments.

**Calculation 1:**
Calculate whether the appointment date and time in Question 1 is within 96 hours of this request. Calculate the number of hours between the time of your request and the time of the available appointment (weekends and holidays are included in calculating hours). Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

• Mark “Y” to indicate yes, there is an available urgent appointment within 96 hours.  
  (Go to Question 2)
• Mark “N” to indicate no, there is no available urgent appointment within 96 hours.  
  (Go to Question 2)
• Mark “NA” to indicate that this question is not applicable, because this provider does not offer urgent appointments.  (Go to Question 2)
**Question 2:**

“When is the next available appointment date and time with [Provider Name or Name of FQHC] for non-urgent services?”

**Date:** mm/dd/yy  
**Time:** hh:mm am/pm PT  
______ Not applicable, this provider does not offer non-urgent appointments.

**Calculation 2:**

Calculate whether the appointment date and time in Question 2 is available within 10 business days (14 calendar days) of your request. 

Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 10 business days. (Conclude Survey)
- Mark "N" to indicate no, there is no available non-urgent appointment within 10 business days. (Conclude Survey)
- Mark “NA” to indicate that this question is not applicable, because this provider does not offer non-urgent appointments. (If the provider does not offer urgent and non-urgent appointments, this provider is ineligible to take the survey. Conclude survey.)

“This concludes our survey. Thank you very much for your time. Have a nice day.”

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7 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends and holidays must be included when calculating calendar days.
Ancillary Providers Survey Script

Date Survey Completed: ______________________________________ [mm/dd/yy]
Time Survey Completed: _____________________________________ [hh:mm am/pm] PT
Provider First Name: _________________________________________
Provider Last Name: _________________________________________
Person Spoken to: ___________________________________________
Health plan creating survey data: ______________________________
Name of individual conducting survey: _________________________
Specialty / Subspecialty: ____________________________________
Provider Survey Type:

______ MRI
______ Mammogram
______ Physical Therapy
Address: ___________________________________________________
[Optional to validate]
County of this Office Location: ________________________________
Provider Group/IPA/Medical Group Affiliation: __________________
Network(s): ________________________________________________

Introduction:

"Hello. My name is [Say Name]. I am calling on behalf of [health plan(s)] to conduct an appointment availability survey. Health plans are required to obtain information from their contracted providers regarding appointment availability. This survey should take no more than [five] minutes and includes no more than [one] question[s]. Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider’s Name or Name of the FQHC]?

If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]

If no one is available, ask what time would be convenient during the next two business days to call-back. Schedule and conduct follow-up calls within two business days.

Validate Provider Information

If yes, validate the office information above with the person spoken to and conduct the survey. The responder may need a physical address to respond to the survey. If so, please ensure that the surveyor has access to the provider’s address located within the appropriate county; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.

8 If additional DMHC-approved questions are included, revise the time it is anticipated to take the survey and number of questions as appropriate.
If the provider is no longer affiliated with the office, provider group, or plan, mark the provider as ineligible for the survey, then move on to the next provider in the oversample list to ensure target sample sizes are met. In addition, if the provider does not respond or declines to respond to one or more questions, please move to the next provider in the oversample list. (For more information, see Step 8 of the Methodology, under the headings "Replacements" and "Non-Responders.")

**Surveyor Notes**

- If the provider reports that the wait time would depend upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (shorter duration time).

- If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available later that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for later that date is compliant.

**Question 1:**

“When is the next available appointment date and time with [Provider Facility or Entity Name or Name of the FQHC] for non-urgent [MRI, Mammogram, or Physical Therapy] services?”

Date: mm/dd/yy  
Time: hh:mm am/pm PT  
______ Not applicable, this provider does not offer non-urgent appointments.

**Calculation 1:**

Calculate whether the appointment date and time in Question 1 is available within 15 business days (21 calendar days) of your request. Indicate in the Raw Data Template whether the appointment is available within the appropriate timeframe:

- Mark “Y” to indicate yes, there is an available non-urgent appointment within 15 business days. (Conclude Survey)
- Mark “N” to indicate no, there is no available non-urgent appointment within 15 business days. (Conclude Survey)
- Mark “NA” to indicate that this question is not applicable, because this provider does not offer non-urgent appointments. (If the provider does not offer urgent or non-urgent appointments, this provider is ineligible to take the survey. Conclude survey.)

“This concludes our survey. Thank you very much for your time. Have a nice day.”

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9 When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends and holidays are included in calculating calendar days.
MEASUREMENT YEAR 2018

PROVIDER APPOINTMENT AVAILABILITY SURVEY

METHODOLOGY
Table of Contents

Step 1: Determine Which Networks to Survey ................................................................. 2
Step 2: Create Provider Contact List ............................................................................... 4
Step 3: Determine Sample and Oversample Size .......................................................... 6
Step 4: Select Random Samples ..................................................................................... 7
Step 5: Engage in Provider Outreach ............................................................................. 10
Step 6: Prepare Survey Questions .................................................................................. 11
Step 7: Administer Survey ............................................................................................. 12
Step 8: Calculate Compliance Rates ............................................................................... 16
Step 9: Create Quality Assurance Report ....................................................................... 21
Step 10: Submit the Health Plan’s Timely Access Compliance Report ............................ 22
Appendix 1: Random Number Generation ..................................................................... 23
Appendix 2: Multi-County Network Sample Size Chart .................................................. 23
Appendix 3: Single County Network Sample Size Chart .................................................. 26
Language Assistance Program Assessment Addendum ..................................................... 29
The Provider Appointment Availability Survey (“PAAS”) Methodology was developed by the Department of Managed Health Care (“Department”), pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS Methodology, published under authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2018 (“MY 2018”), all reporting health plans must adhere to the PAAS Methodology when developing and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

All health plans that are required to submit an annual Timely Access Compliance Report must maintain the administrative capacity necessary to gather compliance data in accordance with this mandatory methodology, validate compliance data, and identify and rectify compliance data errors, so that all documents submitted to the Department in connection with Timely Access Compliance Reports are accurate and present data regarding the Plan’s in-network providers.

Step-by-step instructions for using the MY 2018 PAAS Methodology are set forth below. The PAAS Templates include:

- **Results Template**;
- **Raw Data Template**; and
- **Provider Contact List Template (the complete list, before de-duplication)**.

The PAAS Templates and template instructions are available on the Department’s public Timely Access web page. The health plan’s MY 2018 Timely Access Compliance Report, including the completed PAAS Templates, must be submitted through the Timely Access web portal no later than March 31, 2019, pursuant to Rule 1300.67.2.2, subd. (g)(2). Populated samples of the PAAS Templates are available on the Department’s Timely Access web page.

**Step 1: Determine Which Networks to Survey**

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1 California Health and Safety Code sections 1340 et seq. (the “Act”). References herein to “Section” are to Sections of the Act. References to “Rule” refer to the regulations promulgated by the Department at California Code of Regulations, title 28.
Health plans must report a separate rate of compliance with the time elapsed standards for each county in each network (“County/Network”) for each Provider Survey Type. A network is a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business.

Health plans are not currently required to report a rate of compliance for networks serving exclusively Medicare Advantage or Cal-MediConnect enrollees. Health plans are required to submit rates of compliance for networks associated with a Medicare or Cal-MediConnect line-of-business, if that network also serves lines-of-businesses other than Medicare Advantage and Cal-MediConnect and these lines-of-business are subject to timely access reporting requirements.

**Plan-to-Plan Agreements**

Health plans must report a rate of compliance that is representative of all providers who are a part of the health plan’s network, whether the providers are contracted with the health plan directly, via a plan-to-plan agreement, or through another arrangement.

Health plans that contract with another full service or mental health Knox-Keene Act licensed plan (“Secondary Health Plan”) are required to include this information in the health plan’s *Timely Access Compliance Report* by incorporating by reference the relevant sections of the Secondary Health Plan’s *Timely Access Compliance Report*. Incorporation occurs in the health plan’s Profile in the Timely Access Portal. (The Annual Provider Network Submission Instruction Manual contains additional information about reporting plan-to-plan arrangements in the health plan’s profile.)

Prior to incorporating the Secondary Health Plan’s data into its *Timely Access Compliance Report*, the data should be carefully reviewed so that the health plan can complete the required affirmation regarding accuracy and completeness.

In addition, health plans must include a narrative in the *Timely Access Compliance Report* that identifies (1) the name of the Secondary Health Plan that delivers health services, (2) the type and scope of services delivered (e.g., full service or mental health services, including both psychiatric and non-physician mental health provider services), (3) the counties in which the Secondary Health Plan delivers health care services, and (4) the names of the health plan’s networks that are served through the plan-to-plan arrangement.

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2 This Methodology requires timely access rates of compliance be reported by county and network, rather than provider group. As a result, this methodology supersedes the provider group reporting requirement set forth in Rule 1300.67.2.2, subd. (g)(2)(B). (Section 1367.03, subd. (f)(3).) Accordingly, this subdivision is amended to require health plans to report “The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each county of the plan’s service area.”

3 Under Section 1395, health plans are required to affirm (at the time of submission) to the Department that its *Timely Access Compliance Report* is true, complete, and accurate. This includes portions of the health plan’s *timely Access Compliance Report* that have been incorporated by reference.
**Step 2: Create Provider Contact List**

The *Provider Contact List* is used to calculate the required target sample size and select a random sample of the health plan’s network providers to survey for each County/Network. The *Provider Contact List* must include all providers in the health plan’s network(s) as of December 31, 2017\(^4\) who furnish health care service through enrollee appointments for the following Provider Survey Types:

1. Primary Care Physicians and Primary Care Providers (collectively “PCPs”)\(^5\)
2. Specialists: Cardiologists, Endocrinologists, and Gastroenterologists\(^6\)
3. Psychiatrists\(^7\)
4. Non-Physician Mental Health Providers: Master Degree Providers, PhD and above, including Psychologists\(^8\)
5. Ancillary Providers: entities or facilities providing Physical Therapy Appointments, MRI Appointments, and Mammogram Appointments

Use the *Provider Contact List Template* Instructions to create at least five separate *Provider Contact List Templates* that identify each of the five Provider Survey Types set forth above.

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\(^4\) Health plans may use the data in the Annual Provider Network Review (“G Data”) Templates, required to be submitted on March 31, 2018, by Section 1367.035 and Rule 1300.67.2.2, subd. (g)(2)(G), to populate the *Provider Contact List* if all requirements of the PAAS Methodology and Template Instructions are met. If the health plan did not have a DMHC-approved network on December 31, 2018, the health plan must contact the DMHC for further guidance.

\(^5\) Primary Care Physicians may include Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine Physicians. For other specialty types, health plans must include only those providers that have agreed to serve as a PCP for the health plan. Primary Care Providers include physician assistants performing services under the supervision of a primary care physician in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code and/or nurse practitioners performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

\(^6\) Include only those physicians with the following specialty/subspecialty certification: Internal Medicine-Cardiovascular Disease, Internal Medicine-Endocrinology, Diabetes and Metabolism, and Internal Medicine-Gastroenterology.

\(^7\) Although Psychiatrists are included in the Specialists Physicians PAAS Templates, a separate Psychiatrists sample, distinct from the Specialist Physician sample, must be taken to report a rate of compliance for Psychiatrists in each County/Network.

\(^8\) Non-Physician Mental Health Providers with a Master’s Degree or Ph.D. that provide appointments may include Associate Clinical Social Worker, Clinical Nurse Specialist, Certificate of Clinical Competence for Speech-Language Pathology, Board Certified Assistant Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst Doctoral (BCBA-D), Licensed Clinical Social Worker/Master of Social Work, Marriage and Family Therapist Intern, Marriage and Family Therapist/Licensed Marriage and Family Therapist, Nurse Practitioner/Physician, Assistant/Advanced/Masters RN, Professional Clinical Counselor (LPCC), Psychologist, and School Psychologist (Certified School Psychology, National Certified School Psychologist).
Specialties, counties, and other look-up codes are available on the Department Timely Access web portal. Any provider or Provider Group/IPA that is no longer in network as of March 31, 2018 may be omitted from the Provider Contact List. A copy of each Provider Contact List (the complete list, before de-duplication) must be retained to be submitted to the Department in the health plan’s Timely Access Compliance Report.

De-duplicating the Provider Contact List

The goal of de-duplicating the Provider Contact List is to ensure that each provider in each county has an equal chance of being selected to be surveyed during the random sample selection process.

Review each Provider Contact List to remove all duplicate entries. Duplicate entries are rows where the same provider appears more than once in a single county for a single network. Any manual corrections that affect the de-duplication, such as slight name corrections, must be incorporated into the PAAS Templates submitted to the Department.

- De-duplicate each Provider Contact List (except Federally Qualified Health Center and Ancillary Providers) by the following fields: Provider Survey Type, Name of Network, County, NPI, First Name, and Last Name.
- De-duplicate the Ancillary Provider Contact List using the following fields: Name of Network, County, NPI, and Other Contracted Provider Facility Name.

Federally Qualified Health Center

The goal of the FQHC de-duplication is to ensure that during the random selection process that an FQHC has an equal chance of being selected to be surveyed as compared to any individual provider in the county for each network. FQHCs must be surveyed without regard to the availability of any individual provider or physical site. The Survey Tool requires that the health plan inquire about the next available appointment at the FQHC. Only the name of the FQHC may be used in administering the survey.

The telephone, fax and email address associated with the FQHCs should be listed in association with only the FQHC, not in association with individual providers who may practice at the FQHC. When creating the Provider Contact List, plans should not include provider’s telephone numbers, fax numbers and email addresses associated with individual providers practicing at FQHCs to avoid contacting an individual provider at the FQHC.

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9 Providers identified as not in network during the administration of the survey must be identified as ineligible and replaced with a provider from the oversample.

10 Health plans must use the unique National Provider Identification (NPI) number assigned to the individual provider (except for Ancillary Providers, health plans may not use an institutional NPI).

11 Welfare and Institutions Code section 4087.325, subd. (b) requires that enrollees be “assigned directly to the federally qualified health center … and not to any individual provider performing services on behalf of the federally qualified health center….”
• De-duplicate FQHCs by Provider Survey Type, Name of Network, FQHC (set forth in the Provider Group/IPA field), and County.

Step 3: Determine Sample and Oversample Size

Determine the Sample Size for Each Provider Survey Type in each County/Network

This Methodology ensures that an appropriate number of providers for each County/Network are surveyed to produce statistically reliable and comparable results across all health plans, in accordance with Section 1367.03, subd. (f)(2) and Rule 1300.67.2.2, subd. (g)(2)(B). The number of providers to be surveyed for each County/Network is determined separately for each of the five Provider Survey Types.  

For each Provider Survey Type in each Network/County, the health plan must either survey:

• A sample of providers; or
• All providers in the County/Network (Census).

When selecting a sample, determine the number of providers for each Provider Survey Type in each County/Network, as set forth in the de-duplicated Provider Contact List. Use either the Multi-County Network Sample Size Chart in Appendix 2 or the Single County Health Plans Sample Size Chart in Appendix 3 to determine the appropriate sample size. (To determine which sample size chart to use, the health plan must ascertain whether there is a single county or multiple counties within each network.)

• Example: Health Plan 1 has multiple counties in Network A. In San Francisco County, the de-duplicated Provider Contact List includes 84 PCPs in Network A. As a result Health Plan 1 refers to Appendix 2 to determine that a sample size of 41 PCPs is required for San Francisco County in Network A. While only 41 PCPs will be surveyed, the health plan elected to include the remaining 43 PCPs in the oversample for replacements. (The health plan could have selected 21 providers for the oversample based on the oversample options set forth below.)

• Example: Health Plan 2 has a single county in Network B. In San Francisco County the de-duplicated Provider Contact List includes 84 PCPs in Network B. As a result, Health Plan 2 uses the Appendix 3 to determine that a sample size of

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12 Combine Cardiologists, Endocrinologists, and Gastroenterologists to determine the sample size for the Specialist Physicians sample for each County/Network. Combine the entities or facilities providing Physical Therapy Appointments, MRI Appointments, and Mammogram Appointments to determine the sample size for the Ancillary Provider sample for each County/Network.

13 All Provider Survey Types should be sampled and surveyed in the same manner. For explanatory purposes, PCPs are used as examples throughout this Methodology.
60 PCPs is required. While only 60 PCPs will be surveyed, the remaining 24 PCPs are also selected for the oversample for replacements.

A health plan may survey a sample larger than what is set forth in the sample size charts (e.g., for internal quality assurance purposes), but it must only include results in its Raw Data and Results Templates for either all PCPs in the County/Network (Census) or the number of PCPs identified by the appropriate sample size chart. Where Census is used, all providers for the Provider Survey Type in the Network/County will be surveyed and no oversample selection is necessary.

Determine the Oversample Size for Replacements

Ineligible or non-responding providers must be replaced with another provider, if available in the County/Network, in order to meet the required target sample size and ensure that the health plan’s reported rates of compliance are statistically reliable and comparable, as required by Section 1367.03, subd. (f)(3) and Rule 1300.67.2.2, subd. (g)(2)(B). (See Replacements in Step 7 to ascertain whether a provider may be replaced.)

To allow for the replacement of providers, the health plan must select an oversample of each Provider Survey Type for the County/Network using the random sample selection process below in Step 4: Select Random Samples. The size of the oversample must be either (1) no less than 50% of the required target sample size or (2) all remaining providers in the County/Network.

Providers in the oversample must be surveyed and included on the Raw Data Template, only if replacements are needed. If the oversample is exhausted, but additional providers that were not selected as part of that Provider Survey Type sample or oversample remain in the County/Network, use this same process to add additional providers of that same Provider Survey Type to the oversample.

Step 4: Select Random Samples

Once the appropriate sample and oversample size for each Provider Survey Type in each County/Network has been determined, use the random sample selection process described below to select those providers that will be surveyed.

- Assign a random number to each provider in the health plan’s working copy of the de-duplicated Provider Contact List. (See Appendix 1 - Random Number Generation for further instructions.)
- Sort each de-duplicated Provider Contact List by the random number within each County/Network by each Provider Survey Type.
- From the randomly sorted Provider Contact List, select the required number of providers in the sample and oversample for the largest network in each county. (See Step 3: Determine Sample and Oversample Size for instructions.)
- If there is only one plan network in the county, move to Step 5.
Counties with Multiple Networks

The process used to sample multiple networks is designed to sample the smallest number of providers needed to produce results for all networks. For health plans with multiple networks in a single county, use the process described above to select a random sample from the network in the county with the largest number of providers. Once the first sample is selected, use the first name, last name, NPI, and county fields to identify whether the provider participates in the other networks in that county. (For Ancillary Providers, use the Other Contracted Provider Facility Name, NPI, and county fields.) Apply the providers sampled from the larger network to all of the smaller networks in which the sampled provider participates. (The Provider will be surveyed only once in a single county, the response will be applied to all networks the provider was selected to be surveyed in that county.)

Review each network by size to determine whether additional providers need to be sampled to meet the required target sample size. If so, select additional providers from that network in the randomly sorted de-duplicated Provider Contact List and apply these providers to all smaller networks in the county. This process will continue until a sufficient sample is identified for each Provider Survey Type in all Counties/Networks. (The oversample for replacement is selected following this same process.)

The following page contains examples for selecting the sample size for networks that include a single county and for networks that include multiple counties.

- **Example:** The Plan has four networks in Sacramento County: Network A has 500 PCPs, Networks B and C use an identical set of 300 PCPs, and Network D has 100 PCPs.\(^{14}\)
  
  - The Plan first randomly selects 67 PCPs to be surveyed from Network A, the largest network. Of those randomly selected PCPs from Network A, 55 are in Networks B and C, and 40 are in Network D.
  
  - Networks B and C have 300 PCPs and require a sample of 62 providers. The 55 PCPs selected from Network A’s sample are used for these networks. The first unique 7 providers from the randomly sorted list from Network B are also selected to meet the required target sample size of 62. Because Networks B and C use the exact same set of providers, no additional steps are required for these networks. Of the 7 PCPs selected for Networks C and D, 6 were also in Network D.

\(^{14}\) The required target sample sizes for each network in the example below are determined using Appendix 2: Multi-County Network Sample Size Chart because the health plan has multiple counties in each network.
Network D has 100 PCPs and requires a sample of 44. Because 40 PCPs from Network D were selected in Network A’s sample, Network D only needs an additional 4 PCPs to meet the required target sample size for this county. The first 4 of the 6 unique providers are selected from the second random sample taken from Networks B and C to meet the required target sample size of 44.

Table 1 – Example of a Health Plan with Four Networks in a Single County

<table>
<thead>
<tr>
<th></th>
<th>Network A</th>
<th>Networks B and C (uses same providers)</th>
<th>Network D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of PCP Network</td>
<td>500 (67)</td>
<td>300 (62)</td>
<td>100 (44)</td>
</tr>
<tr>
<td>(Required Sample Size)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Sample From</td>
<td>67</td>
<td>55</td>
<td>40</td>
</tr>
<tr>
<td>Network A</td>
<td></td>
<td>(all 55 providers previously identified</td>
<td>(all 40 providers previously identified in Network A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in Network A)</td>
<td></td>
</tr>
<tr>
<td>Second Sample From</td>
<td>0</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Networks B and C</td>
<td></td>
<td>(first 7 randomly selected providers</td>
<td>(first 4 of the 6 providers previously identified in Networks B and C)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from Network B)</td>
<td></td>
</tr>
<tr>
<td>Total Number of</td>
<td>67</td>
<td>62</td>
<td>44</td>
</tr>
<tr>
<td>Providers Sampled</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provide surveyors the Raw Data Template with the providers that were randomly selected to be surveyed as part of the sample and oversample.
**Step 5: Engage in Provider Outreach**

In order to accurately report network performance across the time elapsed standards, health plans must obtain survey responses from a meaningful number of providers. Simple, strategic communications with health plan-contracted providers can yield a significant increase in response rates, putting the health plan (and its contracted providers) in the best position to demonstrate compliance with Timely Access appointment availability standards. Special focus for provider groups and provider types that had high non-response rates in prior measurement years is recommended.

Health plans may consider outreach communications that:

- Inform providers about the importance of participating in the survey;
- Help the provider or provider group understand what the survey is, why it is being done, how it is administered, and the types of questions that will be asked;
- Identify the date range during which the survey is likely to occur;
- Inform providers that rates of compliance and response rates will be part of publicly available information;
- Offer information on how the provider or provider group may provide this information through Extraction to avoid providing this information through another survey mode; and
- Remind providers about any contractual obligations indicating that they must provide appointment availability information to the health plan. (See Section 1367.03, subd. (f)(1).)

In situations where the volume of non-responding providers does not allow for completion of the survey in accordance with this Methodology’s required target sample sizes, the health plan may be required to institute a corrective action plan that includes steps necessary to secure responses from the number of providers necessary to fully complete the PAAS survey in future years. Inability by a health plan to reach the required target sample sizes and complete the PAAS survey may result in referral to the Department’s Office of Enforcement.
Step 6: Prepare Survey Questions
The Department developed a Telephone Survey Tool and an Online/Email and Fax Survey Tool, to be used with the MY 2018 Methodology. Health plans are permitted to make minor adjustments to the Online/Email and Fax Survey Tool introductory language and add language that allows confirmations of the provider’s identifying information. All Survey Tools may be amended to indicate that the provider is contractually required to provide this information, if applicable.

In addition, health plans may incorporate additional survey questions and required provider contacts and/or notifications into the Department’s Survey Tools, if all of the following conditions are met:

- All of the Department’s PAAS Methodology is followed.
- The Department’s questions, set forth in the Survey Tool, are included as a block at beginning of the survey. No modifications are made to Survey Tool’s individual items or the item order.
- The resulting survey is not too exhaustive (which may decrease willingness to respond or may frustrate providers responding to the survey).
- The data and responses for the Department’s PAAS questions are transferred to the Department’s PAAS Raw Data Template and Results Template.
- The contact and/or notification complies with all other requirements of the Act.
- The redlined revisions are filed as an Exhibit J-13 in eFile within 30 days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).
- In prior years, the DMHC’s Survey Tool included a follow-up question: “Is there another practitioner in the same physical office who could see the patient sooner? (If yes) On what date and time is the earliest appointment?” This question is no longer allowed to be used in connection with the MY 2018 PAAS Survey Tool.
- All Survey Tools used in the administration of the survey must also be submitted as part of the Timely Access Compliance Report. The health plan must include revisions to the Survey Tools in redline. This may be accomplished by linking the eFiling Number of the Exhibit J-13 in section A Policy and Procedures of Timely Access Compliance Report submission.
Health plans may use software or a computer program for capturing survey results, if the following requirements are met:

- The survey questions are identical to the survey questions in the Survey Tool.
- The health plan captures the same data fields included in the Survey Tool.
- The health plan populates the Provider Contact List, Raw Data and Results Templates in accordance with the template instructions and submits these documents in its Timely Access Compliance Report submission.

**Step 7: Administer Survey**

**Timeframe and Waves**

All surveys must occur between April 1, 2018 and December 31, 2018. The surveys must be conducted in two waves. For each county, approximately 50% (and no more than 60%) of the providers will be surveyed in each wave. The two survey waves may be of any duration necessary to complete the survey of all providers included in the wave, unless Electronic Extraction is used. (See Option 1 in Survey Administration Modalities, below, for further details related to Electronic Extraction waves duration.) Waves must be spaced at least three weeks apart. Health plans may sequence the survey administration so that the waves are staggered by Provider Survey Type to avoid periods in which surveys are not being administered.

**Survey Administration Modality**

All surveys must be administered using either Extraction (Option 1) or the Three Step Protocol (Option 2), set forth below. Where Extraction is available for only a subset of providers in a County/Network, health plans may use a combination of Options 1 and 2. Once the health plan has a response (or has identified the provider as being ineligible or non-responsive), apply that response or outcome to that provider for all networks within the county.

**Option 1: Manual or Electronic Extraction**

Health plans may extract the next available urgent and non-urgent appointments for providers that were selected to be surveyed from the provider’s practice management software. The extraction process may be done manually (e.g., individual urgent and non-urgent appointment queries manually ran for each provider) or electronically (e.g., the next available urgent and non-urgent appointments are downloaded), if all of the following requirements are met:

- Prior to administering the survey, a reliable method is in place to identify the providers that are able and willing to allow the health plan to access the next available urgent and non-urgent appointment via Extraction.
- The method for extracting appointment data from a provider or provider group/IPA’s practice management software is reliable.
• The method for extracting appointment data from a provider or provider group/IPA's allows the health plan to distinguish ineligible and non-responding providers.

• The date and time the extraction of the appointment data occurred (e.g., the date the practice management software is queried or downloaded) is captured and used to populate the “Date Survey Completed” and the “Time Survey Completed” field on the Raw Data Template.

• The extraction method used by the health plan captures the date and time of the next available urgent and non-urgent appointment for the individual provider sampled. The health plan must populate this information in the appropriate survey question field on the Raw Data Template.

• The date and time of the extraction and the first available urgent and non-urgent appointment must accurately represent what would be available to an enrollee if an appointment was requested by an enrollee on the date of extraction.

• The Department’s Methodology and administration procedures are followed, including selection of the random sample of providers. The sample may not be selected based on whether providers’ scheduling data can be accessed via Extraction.

• Unless surveying a Census in a County/Network, the health plan must include only those providers who were randomly selected to be sampled on the Raw Data and Results Template, even if Electronic Extraction is available for all providers in a provider group/IPA.

• The health plan completes the Provider Contact List, Raw Data and Results Templates in accordance with the instructions set forth in each template and submits these documents as part of its Timely Access Compliance Report submission.

For Electronic Extraction, the health plan must randomly assign extraction dates to provider groups/IPAs with accessible practice management software over a three-week period during each of the survey waves. If the total number of providers in any provider group/IPA selected for Extraction does not exceed 50%-60% of the entire sample for the county, the health plan may include all providers in the provider group/IPA that will provide appointment data by Extraction in Wave 1 or Wave 2. (This may allow the health plan to access the provider group/IPA’s practice management software only once.) If a single provider group/IPA constitutes more than half of the sample, the health plan must extract data from the provider group/IPA across both waves.
Option 2: The Three Step Protocol

The Three Step Protocol sets forth a sequence all health plans using Option 2 must follow in administering the survey. The sequence is ordered to reduce disruption to providers.

1. **Initiate the Survey via Email or Fax:** The health plan must initiate the survey by sending a survey invitation either by email or fax. (If an email or fax contact is not available, the health plan must skip to Step 3: Conduct a Phone Survey.) The invitation may be addressed to one or more providers at the same email or fax contact; however, the survey must require each provider to provide individual responses to the survey questions. The survey invitation must:
   - Either include the survey or direct the provider to take the survey through an online portal.
   - Indicate that the provider has five business days to respond, otherwise the provider will be contacted by phone to take the survey.

2. **Send a Survey Reminder:** If the provider has not responded within two business days of sending the initial survey invitation, a reminder notice may be sent. If the plan elects to send a reminder notice, it must notify providers who have not responded of the remaining time to respond to the survey. Email or fax responses received after five business days of sending the survey invitation shall not be counted as responsive to the email or fax survey and a phone survey must be initiated.

3. **Conduct a Phone Survey:** If the provider does not respond to the email or fax survey invitation within five business days, the health plan must initiate the survey via telephone, using the Telephone Survey Tool, within ten business days of the expiration of the initial survey attempt conducted via email or fax.
   - Health plans may conduct the survey of several providers during a single phone call, but the provider’s must respond to the survey questions individually.
   - If a provider’s office does not answer the initial call, the surveyor must call the provider back on or before the next business day to initiate the phone survey. If possible, the surveyor may also leave a message requesting that the provider complete the survey via a call-back number within two business days of the message.
   - If a provider declines to respond to the survey, the surveyor must offer the provider’s office the option to respond at a later time. If the provider is willing to participate later, the health plan must offer the provider the option to receive a (scheduled or unscheduled) follow-up call within the next two business days.
If the provider does not complete the telephone survey within two business days of the initial phone call, the provider must be recorded as a non-responder and replaced with a provider from the oversample.

Replacements of Non-Responding and Ineligible Providers
Whether using Extraction or the Three Step Protocol, an ineligible or non-responding provider (defined below) must be replaced if another provider from the oversample of the same Provider Survey Type and within the same County/Network is available. If a replacement of a provider is needed, the surveyor will use the next available provider as a replacement until the required sample size is reached. The health plan will continue to replace providers until either the required sample size is reached or all of the providers of that same Provider Survey Type in the County/Network have been exhausted. (This may require the health plan to select additional oversample providers, as set forth in Step 4 above.)

Non-Responding Providers
A non-responding provider is a provider that does not respond to one or more applicable items within two business days of the phone call attempt or that declines to participate in the survey.

Ineligible Providers
A provider is ineligible if he/she:

- No longer participates in the health plan’s network at the time the survey is administered or did not participate in the health plan’s network when the Provider Contact List was created;
- Does not practice in the county at the time the survey is administered or when the Provider Contact List was created;
- Retired or for other reasons is no longer practicing;
- Was included in the Provider Contact List under an incorrect Provider Survey Type;
- Was unable to be surveyed because he/she is listed in the database with incorrect contact information that could not be corrected; or
- Does not offer enrollees appointments (e.g., provides only hospital-based services or peer-to-peer consultation services).

The health plan’s discovery that a provider is ineligible may inform the health plan of a change of information requiring an update of the health plan’s online provider directory, in accordance with the requirements set forth in Section 1367.27, subd. (e). In addition, health plans must use the information obtained in administering the survey to update health plan records to improve the Provider Contact List for the following measurement year (e.g., update contact information and exclude all ineligible providers that are retired from future Provider Contact Lists).

(Revised 04/16/18)
Survey Administration Notes

- If the provider reports that the date and time of the next available appointment depends upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (the shorter duration time).
- If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available later that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for later that day is compliant.  
- Referral of a patient to a different provider in a different office (e.g. a separate urgent care center) cannot be recorded as the initially surveyed provider providing an appointment. An appointment offered at a different office in the same county with the same provider can be recorded as an available appointment with the initially surveyed provider. (For FQHCs, availability at a separate site within the same FQHC qualifies as an available appointment.)
- If a provider’s office indicates that urgent appointments are not offered, record “NA” on the Raw Data Template in the applicable urgent appointment and compliance determination fields.
- All survey calls must be conducted during normal business hours.

Step 8: Calculate Compliance Rates

Health plans must calculate a compliance rate and the percentage of providers that were ineligible or did not respond. These figures must be calculated for each County/Network using the responses to the survey questions for each Provider Survey Type. Use the Results Template Instructions, the Plan’s Raw Data Template, and the calculation instructions set forth below to complete these calculations and enter this information on the Results Template.

Calculating Timeframes

For consistency, timeframes must be calculated in accordance with the following instructions:

- When calculating timeframes to make a compliance determination use the date and time the provider responded to the survey or extracted the appointment from the provider’s practice management software as the date of the request for the appointment. Do not use the date of the initial contact for this calculation (e.g., where email is used or a follow-up survey is necessary use the date the provider responded, not the date the communication was sent).
- Urgent appointments are measured in hours and include weekends and holidays. As a result, health plans must capture the date and time the provider responded to the questions and the date and time of the first available appointment identified by the provider’s office.

15 See Rule 1300.67.2.2, subd. (b)(1).
Non-urgent appointment standards are set forth in the Timely Access regulation in business days. For consistency, all health plans must use the following rules in calculating timeframes:

- Count 14 calendar days (including weekends and holidays) to calculate the 10 business day standard.
- Count 21 calendar days (including weekends and holidays) to calculate the 15 business day standard.
- When calculating calendar days, exclude the first day (e.g., the day of the request) and include the last day.

Example: If a PCP responds with an appointment date and time on Tuesday the 15th, then the appointment identified must be on or before Tuesday the 29th in order to meet the 10 business day standard (calculated by counting forward 14 calendar days) for non-urgent primary care appointments. 16

Compliance Determinations
For each response to the question related to the next available appointment (whether obtained through the Three Step Protocol or through Extraction), a compliance determination must be recorded on the Raw Data Template in accordance with the following instructions:

- Record the date and time of the next available urgent care appointment provided in response to Question 1 and the next available non-urgent care appointment provided in response to Question 2 17.

Urgent Appointments
- If the response to Question 1 indicates that: “Yes, there is an available appointment within [48 hours for PCPs or 96 hours for Specialist and NPMH]” (as applicable), the provider is counted as compliant for urgent care appointments in Calculation 1.
- If the provider’s response to Question 1 indicates: “No, there is no available appointment within [48 hours for PCPs or 96 hours for Specialist and NPMH]” (as applicable), the provider is counted as non-compliant in Calculation 1.

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16 In this example, days would be counted as follows: Tuesday the 15th is not counted (because, as the day of the request, it is excluded), Day 1: Wednesday the 16th, Day 2: Thursday the 17th, Day 3: Friday the 18th, Day 4: Saturday the 19th, Day 5: Sunday the 20th, Day 6: Monday the 21st, Day 7: Tuesday the 22nd, Day 8: Wednesday the 23rd, Day 9: Thursday the 24th, Day 10: Friday the 25th, Day 11: Saturday the 26th, Day 12: Sunday the 27th, Day 13: Monday the 28th, Day 14: Tuesday the 29th.

17 For Ancillary Providers the question related to the next available non-urgent care appointment is Question 1. For all other provider types, the question related to the next available non-urgent care appointment is Question 2. For Ancillary Providers, conduct the compliance calculations using the same instructions but replace “Question 1” with “Question 2” in these instructions.
Non-Urgent Appointments

- If the response to Question 2 indicates that: “Yes, there is an available appointment within [10 business days for PCPs and NPMH or 15 business days for Specialist and Ancillary providers]" (as applicable), the provider is counted as compliant in Calculation 2.
- If the provider's response to Question 2 indicates: “No, there is no available appointment within [10 business days for PCPs and NPMH or 15 business days for Specialist and Ancillary providers]" (as applicable), the provider is counted as non-compliant in Calculation 2.

Rate of Compliance

The *Results Template* includes a formula that divides the total number of compliant providers (the numerator) by the total number of providers that responded (the denominator) and records the rate of compliance as a percentage (e.g., 89%) on the *Results Template*. If more providers are surveyed than required to meet the required target sample size for a County/Network, use only the first providers randomly selected for that network to meet the target sample size and calculate the information on the *Results Template*. Using the compliance determinations set forth on the *Raw Data Template*, the health plan must record a numerator and denominator for each of the appointment standards. The numerator and denominator must be calculated and recorded on the *Results Template* for each County/Network for each Provider Survey Type to develop the rate of compliance, in accordance with the following instructions:

Urgent Appointments

- Add together the total number of compliant providers based on Calculation 1. Record this number (the numerator) in either the “Number of Providers with an Urgent Care Appointment with no Prior Auth within 48 Hours” field or the “Number of Providers with an Urgent Care Appointment with Prior Auth within 96 Hours” field (as applicable).
- Calculate the total number of responding providers, which includes compliant and non-compliant providers. Do not count “NA” responses in the denominator or numerator for the 48 or 96 hour urgent care appointment standards. Record this number (the denominator) in the “Number of Providers Responded to an Urgent Care Appointment with no Prior Auth within 48 Hours” field or the “Number of Providers Responded to an Urgent Care Appointment with Prior Auth within 96 Hours” field (as applicable).

Non-Urgent Appointments

- Add the total number of compliant providers from Calculation 2. Record this number (the numerator) in either the “Number of Providers with a Non-Urgent Care Appointment within 10 Days" field or the “Number of Providers with a Non-Urgent Care Appointment within 15 Days" field (as applicable).
• Calculate the total number of responding providers, which includes compliant and non-compliant providers. Record this number (the denominator) in the "Number of Providers Responded to a Non-Urgent Care Appointment within 10 Days" field or the "Number of Providers Responded to a Non-Urgent Care Appointment within 15 Days" field (as applicable).

Calculating the Percentage of Ineligible and Non-Responding Providers
The health plan must separately report the percentage of providers that are ineligible and those who do not respond or declined to respond to one or more survey question for each Provider Survey Type in each County/Network on the Results Template. The Results Template includes a formula to calculate both percentages. To use this formula, the health plan must record on the Results Template the numerator for each Provider Survey Type in each County/Network, in accordance with the following instructions:

Ineligible Providers (See Table 2)

For each County/Network for each Provider Survey Type:
• Count the number of ineligible providers from the sample and any oversample (the numerator) on the Raw Data Template. Record this number on the Results Template in the “Number of Ineligible Providers” field.
• The Results Template adds the “Number of Providers Responded via Survey,” the “Number of Providers Responded via Extraction,” the “Number of Non-Responding Providers,” and the “Number of Ineligible Providers” to calculate the denominator.
• The Results Template formula then divides the numerator by the denominator to calculate and record the percentage of ineligible providers on the Results Template in the “Percentage of Ineligible Providers” field.

Non-Responding Providers (See Table 2)

For each County/Network for each Provider Survey Type:
• Count the number of non-responding providers in the sample and in the oversample (the numerator) from the Raw Data Template. Record this number on the Results Template in the “Number of Non-Responding Providers” field.
• The Results Template adds the “Number of Providers Responded via Survey,” the “Number of Providers Responded via Extraction,” and the “Number of Non-Responding Providers” to calculate the denominator.
• The Results Template formula then divides the numerator by the denominator to calculate and record the percentage of non-responding providers on the Results Template in the “Percentage of Non-Responding Providers” field.

18 Ineligible and non-responders may be identified through the Three Step Protocol or through Extraction.
### Table 2 – Example of How to Calculate the Percentage of Ineligible and Non-Responding PCPs

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PCPs in County/Network (using Appendix A)</td>
<td>37</td>
</tr>
<tr>
<td>Target Sample Size</td>
<td>27</td>
</tr>
<tr>
<td><strong>Initial Sample of 27:</strong></td>
<td></td>
</tr>
<tr>
<td>PCPs that responded to all survey questions or through Extraction in County/Network</td>
<td>21</td>
</tr>
<tr>
<td>PCPs that declined to respond or did not respond to all survey questions or through Extraction in County/Network</td>
<td>4</td>
</tr>
<tr>
<td>PCPs that were ineligible (e.g., retired) in County/Network</td>
<td>2</td>
</tr>
<tr>
<td><strong>Oversample:</strong> (PCPs used as replacements for ineligible and non-responding PCPs)</td>
<td></td>
</tr>
<tr>
<td>PCPs from oversample that responded to survey questions or provided data through Extraction in County/Network</td>
<td>6</td>
</tr>
<tr>
<td>PCPs from oversample that were ineligible or declined to respond in County/Network</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total for PCPs in County/Network (includes Initial Sample and Oversample)</strong></td>
<td></td>
</tr>
<tr>
<td>Number of Non-Responding PCPs in County/Network</td>
<td>4</td>
</tr>
<tr>
<td>Number of PCPs Responded via Survey and Extraction in County/Network (21 initial and 6 replacements)</td>
<td>27</td>
</tr>
<tr>
<td>Add the Number of PCPs Responded via Survey, the Number of PCPs Responded via Extraction, and the Number of Non-Responding PCPs in County/Network (27+4) (denominator)</td>
<td>31</td>
</tr>
<tr>
<td>Percentage of Non-Responding PCPs in County/Network (4/31=.129)</td>
<td>13%</td>
</tr>
<tr>
<td>Number of Ineligible PCPs in County/Network</td>
<td>2</td>
</tr>
<tr>
<td>Number of PCPs Responded in County/Network (21 initial and 6 replacements)</td>
<td>27</td>
</tr>
<tr>
<td>Add the Number of Ineligible PCPs, the Number of Non-Responding PCPs, and the Number of PCPs Responded via Survey and via Extraction in County/Network (2+27+4) (denominator)</td>
<td>33</td>
</tr>
<tr>
<td>Percentage of Ineligible PCPs in County/Network (2/33=.061)</td>
<td>6%</td>
</tr>
</tbody>
</table>
**Step 9: Create Quality Assurance Report**

Each health plan must have a quality assurance process to ensure that it followed the PAAS Methodology and PAAS Template instructions, met all *Timely Access Compliance Report* statutory and regulatory requirements, and that all information in the *Timely Access Compliance Report*, submitted to the Department, is true, complete, and accurate, pursuant to Section 1396.

As part of this quality assurance process, the health plan shall contract with an external vendor to conduct a review to ensure accuracy and completeness of the health plan’s MY 2018 PAAS data and processes. This review and the quality assurance process must be completed prior to submission of the *Timely Access Compliance Report* to the Department, on or before March 31, 2019. At a minimum, the external vendor’s review must ensure all of the following:

- The health plan used the Department-issued PAAS Templates for MY 2018.
- The health plan reported survey results for all Provider Survey Types that were required to be surveyed, as applicable, based on the composition of the health plan’s network as of December 31, 2017.
- The *Timely Access Compliance Report* (including the *Provider Contact List Template*, the *Raw Data Template*, and the *Results Template*) accurately reflects and reports compliance for providers who were under contract with and part of the health plan’s Department-regulated network(s) at the time the *Provider Contact List* was generated.
- All rates of compliance and compliance determinations recorded on the *Raw Data and Results Template* are accurately calculated, consistent with, and supported by data entered on the health plan’s *Raw Data Template* (including those calculations embedded on the *Results Templates*).
- The administration of the survey followed the mandatory Department PAAS Methodology for MY 2018, including, but not limited to, conducting the survey during the appropriate measurement year and ensuring adherence to all target sample sizes and other parameters required under the Methodology and PAAS Template instructions, in accordance with Section 1367.03, subd. (f)(3).

In its *Timely Access Compliance Report*, the health plan must submit a *Quality Assurance Report*, prepared by an external vendor, outlining the results of the review and includes:

- Details regarding the review of each verification item identified above.
- A summary of the findings from the review, including completion of the DMHC-issued Addendum to the Quality Assurance Report.
- Identification of any changes and/or corrections made as a result of the data and quality assurance review.
- Any explanations for issues identified, including those determined to be compliant with this Methodology.
• For any identified errors or issues that the health plan does not correct or is unable to correct, the health plan must explain why it was unable to comply with the MY 2018 PAAS Methodology and identify steps to be taken by the health plan to ensure compliance during future reporting years. (See Section 1367.03, subd. (f)(3).)

The Quality Assurance Report and any accompanying health plan explanations must be submitted in the Comment/Narrative section of the Department Timely Access Web Portal.

**Step 10: Submit the Health Plan’s Timely Access Compliance Report**

On March 31, 2019, as part of its annual Timely Access Compliance Report, each health plan must submit the following items to the Department for each of the Provider Survey Types, identified in Step 2 on page 4:

- Results Template;
- Raw Data Template; and
- Provider Contact List Template (the complete list, before de-duplication).

The health plan’s Timely Access Compliance Report must be submitted through the Department Timely Access Web Portal. Please refer to the Timely Access Compliance Report Instructions, available on the on Department’s Timely Access web page, for further details regarding submission of each required element.
Appendix 1: Random Number Generation

Once a health plan has determined the appropriate sample size for each County/Network, it will need to determine which providers to call and survey. The random number identifies which providers to survey and include in the Raw Data Template from the health plan’s working copy of the de-duplicated Provider Contact List. Health plans may use excel, SAS, or other statistical software to assign a random number to each provider for sample selection. Steps to generate a random number using excel and SAS are described below.

Excel Method
1. For each County/Network, place the PCPs, Specialist Physicians, Psychiatrists, Non-Physician Mental Health Providers, and Ancillary Providers in separate workbook tabs. Then perform the sorting steps set forth below by County/Network, Provider Survey Type, and Random Number.
2. Create a new column to the left of “A” on your spreadsheet by highlighting column A and select “insert” then “insert sheet columns.”
3. Create a formula to generate the random number by typing “=Rand()” into the newly created column A.
4. Copy and paste the function down column A beside each provider in the table. If done correctly, a list of numbers with decimals in column A will be generated.
5. To convert the formula to a numeric value for sorting purposes, insert a new column A. Highlight Column B (now containing the Random formula), from the “Home” tab select “copy,” “paste,” and “paste values.” (Once this step is complete, delete column B containing the “Rand=()” formula to avoid confusion during the sorting process.)
6. Highlight the entire spreadsheet by clicking on the very top left of the spreadsheet (gray area where A and 1 intersect). Go to Data, select “Sort,” and sort by column A (the random number). Check “my data has headers” so that the headers will remain.
7. Starting with the first row, use the number of rows indicated by the required target sample size for the County/Network (plus additional rows for the oversample unless the health plan intends to supply the surveyors with the entire list, in random order) to select the providers to be surveyed and included in the Raw Data Template. It may be helpful to add columns to the health plan’s working documents to label the primary sample vs. oversample so that the surveyor will not unnecessarily survey providers in oversample beyond those needed as replacements.

SAS Method
A simple random sample may be generated using the SURVEYSELECT procedure in SAS. Using the simple random sample methodology and no stratification in the sample design, the selection probability is the same for all units in the sample.
Appendix 2: Multi-County Network Sample Size Chart

To determine the required target sample size for networks with multiple counties, identify the number of providers in the County/Network in the “Number of Providers in County/Network” column and the corresponding required target sample size.

<table>
<thead>
<tr>
<th>Number of Providers in County / Network</th>
<th>Required Target Sample Size</th>
<th>Number of Providers in County / Network</th>
<th>Required Target Sample Size</th>
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Sample sizes were calculated to produce confidence limits of +/- 8% for an expected compliance rate of 85% with a 95% confidence level. In other words, we would be 95% sure that the actual County/Network compliance rate is within +8% given a compliance rate estimate of 85%. This table was created using a sample size calculation with a finite population correction: 
\[ n = \frac{N \cdot p(1-p)}{\left(\frac{d^2}{Z^2}\right) \left(\frac{N-1}{N-1}\right) + p(1-p)} \]

where \( n \) is the sample size, \( N \) represents the number of providers in a County/Network (population size), \( p \) is the rate of .85, \( d \) is the confidence limit of .08, and \( Z \) is the score of 1.96 required for a 95% confidence level. These target sample sizes are expected to produce confidence limits of +/- 2% or lower at the health plan level of reporting for most health plan networks.
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<th>Required Target Sample Size</th>
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Appendix 3: Single County Network Sample Size Chart

To determine the required target sample size for networks with a single county, identify the number of providers in the County/Network in the “Number of Providers in County/Network” column and the corresponding required target sample size.

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20 Sample sizes were calculated to produce confidence limits of ±- 5% for an expected compliance rate of 85% with a 95% confidence level. See footnote 14 for description and formula of sample size calculation with finite population. These target sample sizes are expected to produce maximum confidence limits of ±- 5% for single-county networks.
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<td>41650 and above</td>
<td>196</td>
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Language Assistance Program Assessment Addendum

Health plans must assess provider perspective and concerns with the health plan’s language assistance program regarding:

- The coordination of appointments with an interpreter.
- The availability of an appropriate range of interpreters, and
- The training and competency of available interpreters.

These additional required questions—designed to elicit providers concerns and perspectives—may be posed through one of the following mechanisms:

1. The health plan’s existing Annual Provider Satisfaction Survey (See Rule 1300.67.2.2, subd. (c)(4) and (d)(2)(C));

2. In a separate provider survey; or

3. At the end of the PAAS Survey Tool, the health plan may include additional questions regarding these topics.

Any redlined revisions to the applicable mechanism and policies and procedures to implement these requirements must be filed as an Exhibit J-13 in eFile within 30 of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

Results for the current year and a comparison of the prior year’s results must be reported with the plan’s Timely Access Compliance Report in the Comment/Narrative section. In addition, health plans are required to utilize information obtained related to provider perspectives and concerns in this area in connection with the plan’s timely access monitoring quality assurance activities and language assistance program compliance monitoring for MY 2018. (See Section 1367.01, Rule 1300.67.2.2, subd. (d), and Rules 1300.67.04, subds. (c)(2)(E) and (c)(4)(A).)
§ 51323. Medical Transportation Services.

22 CA ADC § 51323

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

(a) Ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.

(1) Ambulance services are covered when the patient's medical condition contraindicates the use of other forms of medical transportation.

(2) Litter van services are covered when the patient's medical and physical condition:

(A) Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport.

2. LEA specialized medical transportation services shall not be subject to subsection (a)(2)(A)1.

(B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.

(3) Wheelchair van services are covered when the patient's medical and physical condition:

(A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

(B) Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation.

2. LEA specialized medical transportation services shall not be subject to subsection (a)(3)(B)1.

(C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(D) Does not require the specialized services, equipment and personnel provided in an ambulance, because the patient is in stable condition and does not need constant observation.

(b) Authorization shall be granted or Medi-Cal reimbursement shall be approved only for the lowest cost type of medical transportation that is adequate for the patient's medical needs, and is available at the time transportation is required.

(1) Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the patient. Each claim for program reimbursement of emergency medical transportation shall be accompanied by a written statement which will support a finding that an emergency existed. Notwithstanding Section 51056 (b), the statement may be made by the provider of the emergency transportation, describing the circumstances necessitating the emergency service. The statement shall include the name of the person or agency requesting the service, the nature and time of the emergency, the facility to which the patient was transported, relevant clinical information about the patient's condition, why the emergency services rendered were considered to be immediately necessary and the name of the physician accepting responsibility for the patient at the facility.
(2) All nonemergency medical transportation, necessary to obtain program covered services, requires a physician's, dentist's or podiatrist's prescription and prior authorization except as provided in (C).

(A) When the service needed is of such an urgent nature that written authorization could not have reasonably been submitted beforehand, the medical transportation provider may request prior authorization by telephone. Such telephone authorization shall be valid only if confirmed by a written request for authorization.

(B) Transportation shall be authorized only to the nearest facility capable of meeting the patient's medical needs.

(C) Nonemergency transportation services are exempt from prior authorization when provided to a patient being transferred from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility licensed pursuant to Section 1250 of the Health and Safety Code.

c) Medical transportation by air is covered under the following conditions:

(1) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply:

(A) The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1).

(B) The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1).

(2) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14115.8, 14124.5 and 14132.06, Welfare and Institutions Code. Reference: Sections 14115.8, 14132, 14132.06 and 14136.3, Welfare and Institutions Code.

HISTORY

1. New subsection (d) filed 7-6-82 as an emergency; effective upon filing (Register 82, No. 28). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 11-3-82. For prior history, see Register 82, No. 18.

2. Certificate of Compliance as to 7-6-82 order transmitted to OAL 11-3-82 and filed 12-3-82 (Register 82, No. 49).

3. Amendment of subsection (b) filed 4-11-84; effective thirtieth day thereafter (Register 84, No. 15).

4. Repealer of subsection (d) filed 8-9-85; effective thirtieth day thereafter (Register 85, No. 32).

5. Amendment of subsection (b)(2)(C), designation of portion of subsection (b)(2)(C) as new subsection (b)(2)(C)1. and amendment thereof, new subsections (b)(2)(C)2.-3., and amendment of Note filed 4-1-96 as an emergency; operative 4-1-96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 9-30-96 pursuant to Welfare and Institutions Code section 14132.22 or emergency language will be repealed by operation of law on the following day.

6. Editorial correction of History 5 (Register 96, No. 35).

7. Amendment of subsection (b)(2)(C), designation of portion of subsection (b)(2)(C) as new subsection (b)(2)(C)1. and amendment thereof, new subsections (b)(2)(C)2.-3., and amendment of Note refiled 8-28-96 as an emergency; operative 9-30-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-28-97 or emergency language will be repealed by operation of law on the following day.

8. Editorial correction of subsection (b)(2)(C). (Register 97, No. 11).

9. Certificate of Compliance as to 8-28-96 order transmitted to OAL 1-23-97 and filed 3-10-97 (Register 97, No. 11).

10. Change without regulatory effect amending subsection (b)(2)(C), repealing subsections (b)(2)(C)1.-3. and amending Note filed 6-12-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 24).


This database is current through 4/28/17 Register 2017, No. 17

22 CCR § 51323, 22 CA ADC § 51323
**Non-Emergency Medical Transportation (NEMT) Physician Certification Statement**

**INSTRUCTIONS**

1. IEHP requires the submission of this Physician Certification Statement form, signed by the Member’s Primary Care Physician or treating Physician when requesting for Non-Emergent Medical Transportation (NEMT) services. This certification is valid for one (1) year from the date of the physician’s signature.

2. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) do not require the submission of this form. Members requesting NMT services should be directed to call American Logistics Company at (855) 673-3195.

3. Please fax the completed and signed form to IEHP at (909) 912-1049.

**MEMBER INFORMATION**

<table>
<thead>
<tr>
<th>Member Name</th>
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<tbody>
<tr>
<td>Member DOB</td>
<td>Member IEHP ID</td>
</tr>
<tr>
<td>Date Transportation Needed</td>
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</tbody>
</table>

**Mode of Transportation Needed. Please check (✓) one.**

- [ ] Ambulance
- [ ] Litter van/Gurney
- [ ] Wheelchair van
- [ ] Car/Sedan
- [ ] Air
- [ ] Other

**Physical and Medical Limitations. Please check (✓) all that applies.**

- [ ] Paraplegic
- [ ] Hemiplegic
- [ ] Non-ambulatory
- [ ] High fall risk due to (please specify) ______________
- [ ] Poor exercise tolerance
- [ ] Requires oxygen
- [ ] Hemodialysis
- [ ] Requires extensive medical support (e.g., ventilator, IV)
- [ ] Dementia
- [ ] Behavioral issues
- [ ] Blind
- [ ] Other (please specify) ______________

**CERTIFICATION STATEMENT**

I certify and attest that I am the treating Physician/Primary Care Physician for the member and have determined medical necessity for the transportation indicated above.

<table>
<thead>
<tr>
<th>Physician/Provider Name</th>
<th>NPI #</th>
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<tbody>
<tr>
<td>Physician/Provider Signature</td>
<td>Date</td>
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HEALTH AND SAFETY CODE
SECTION 1367.695

1367.695. (a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not be construed to diminish the provisions of Section 1367.69.

(e) The Department of Managed Health Care shall report to the Legislature, on or before January 1, 2000, on the implementation of this section.

11/14/2012
### Video Remote Interpretation

**Approved Devices and Technical Specifications**

<table>
<thead>
<tr>
<th>Approved Devices</th>
<th>Minimum Requirements</th>
</tr>
</thead>
</table>
| Apple iPad Air, iPad Air 2, iPad Pro (Tablet) | • A7 chip with 64-bit architecture  
• 16gb Storage  
• 720p HD Video Camera  
• Wi-Fi Capability 802.11n with MIMO  
• Cellular capabilities (if needed) |
| Microsoft Surface Pro 3 (Tablet)       | • Windows 8 (including 64 bit versions), DirectX 9.0c or higher  
• Core 2 Duo class, 3GHz  
• 4GB Ram  
• 250Mb unused hard-disk space  
• Wi-Fi capability (802.11a/b/g/n)  
• 5.0 megapixel front facing camera |
| PC Laptop                              | • Windows 8 (including 64 bit versions), DirectX 9.0c or higher  
• Core 2 Duo class, 3GHz  
• 4GB Ram  
• 250Mb unused hard-disk space  
• Wi-Fi capability (802.11a/b/g/n)  
• Webcam |
<table>
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<tr>
<th>Application Requirements</th>
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<tbody>
<tr>
<td>• The required &quot;Outbound Only&quot; ports for each used product must be opened on the firewall.</td>
</tr>
<tr>
<td>• Each concurrent video interpreted call requires a minimum bandwidth of 384k.</td>
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<tr>
<td>• Language Line requires the Urgent Care Facility to have a non-saturated internet connection.</td>
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<tr>
<td>• For the Stratus Video App software the Urgent Care Facility must provide a wireless network with enough coverage, capacity, and security for connectivity over the network. The network should be designed and structured to provide 384k of bandwidth for each simultaneous video call.</td>
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