California's "Timely Access" Legislation and Requirements

The California Department of Managed Health Care (DMHC) recently finalized regulations that become effective on January 17, 2011 and require health plan patients to be seen by their providers in a timely manner. The primary intent of these regulations and the underlying legislation is to ensure that health plan enrollees have access to needed health care services in a timely manner. To accomplish this, the regulations require HMOs to ensure that their networks of providers have the capacity and availability to provide care to enrollees within certain timeframes for various levels of care.

These regulations will require each plan to ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes for non-emergency services:

Type of Service	Non-Urgent Need	Urgent Need	
	Prior Auth Requirements Are Not a Factor for Non-Urgent Services' Timeframes	No Prior Auth Required	Requires Prior Auth
Primary Care	10 business days	48 hours	96 hours
Specialist Care	15 business days	48 hours	96 hours
Ancillary Services	15 business days	48 hours	96 hours
Mental Health	10 business days	48 hours	96 hours

Note: When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment is required to be "promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice". Appointments for follow-up care are required to be scheduled according to the same standards as initial appointments.

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, 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.

Preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance

Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas.

Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable according to time standards within the network.

Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone.

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

Health Plans are required to have at least the following compliance monitoring policies and procedures:

- Tracking and documenting network capacity and availability
- Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology, to ascertain compliance with the standards
- Conducting an annual provider survey to solicit from physicians their perspective and concerns regarding compliance with the standards
- Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services
- Verifying the advanced access programs reported by contracted providers to confirm that appointments are scheduled consistent with the definition of "advanced access".
- A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access, including but not limited to taking all necessary and appropriate action to

identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance.

- Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: 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.

There are several terms contained in the legislation that providers and insurers need to be familiar with, including the following:

"Advanced access" means the provision of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

"Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

"Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition.

"Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

"Urgent care" means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.