

**The Health Plan Standards
for Access to Care and Services
(PROVIDER)**



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Approved by: Mark C. Kenamond, M.D. **Date:** 7-5-18

Disclaimer

This document is intended as a guideline only. The guideline is not a substitute for the exercise of the physician's independent medical judgment.



STANDARDS FOR ACCESS TO CARE AND SERVICES (PROVIDERS)

STANDARD FOR ACCESS TO APPOINTMENTS:

1. **Routine Non-Urgent/Preventive Care:** Established members of The Health Plan calling for adult or child well care appointments should be scheduled within ≤ 21 days. These clinical preventive services include, annual physical examinations, routine screenings and preventive care such as immunizations, blood pressure checks, labs and screenings that can prevent or detect disease in its early stages such as hypertension, elevated cholesterol, high blood sugar, and cancer.
2. **Urgent care:** The Health Plan members calling for urgent care should be scheduled ≤ 48 hours. These members have a disabling symptom or condition that, if not treated, could result in a more intense level of treatment. For example: minor burns, sprains/strains, etc.
3. **Not Urgent/Sick Care:** The Health Plan members calling for not urgent/not emergent symptomatic care should be scheduled within ≤ 48 hours, as clinically indicated. These clinical services provide care for symptomatic conditions and therefore differ from wellness care. For Example: cold/flu symptoms, sore throat etc.
4. **Emergent CARE:** The Health Plan members are to be seen immediately when emergent care is needed. If they can not be seen immediately, they should be sent to ER or advised to call 911. These members can have a dramatic increase in morbidity or mortality without this care, thereby necessitating immediate evaluation and treatment.
5. **Prenatal Care Visit:** The Health Plan members should have an initial prenatal care visit scheduled within 14 days of the date on which the woman is found to be pregnant.
6. **After-Hours care (PCP):** The Health Plan members are to be contacted by their primary care physician or a designated covering

physician within one hour of a member leaving a message through an answering service or similar arrangements for after-hours care, on weekends, and holidays.

STANDARD FOR ACCESS TO APPOINTMENTS: BEHAVIORAL HEALTH

1. **Routine Office:** The Health Plan members calling for routine office visit should be scheduled within 10 working days, as clinically indicated.
2. **Follow-Up Routine Care Appointments:** The Health Plan members calling for a follow-up routine care appointment to evaluate patient progress and other changes that have taken place since the previous visit should occur within thirty (30) working days of a previous visit for practitioners that have prescription privileges and within (20) days of a previous visit for practitioners that do not have prescription privileges.
3. **Urgent Care:** The Health Plan members calling for urgent care should be scheduled within 48 hours. These members are experiencing a worsening of symptoms or new symptoms that, if not treated could result in a more intense level of treatment.
4. **Non-life-threatening emergency:** The Health Plan members are to be seen within 6 hours. These members are exhibiting extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, compromised ability to function or is otherwise agitated and unable to be calmed.

STANDARD FOR WAITING TIME IN PHYSICIAN OFFICE:

Every effort shall be made to ensure that patients are seen in the office within forty-five (45) minutes of the scheduled appointment time.

Every effort should be made by the office to reschedule appointments in the event of an emergency for the physician.

STANDARD FOR WAITING TIME IN THE EMERGENCY ROOM:

The Health Plan members shall wait no more than one hour before being seen and treatment initiated by medical personnel in the emergency room setting.

STANDARD WAITING TIME FOR RETURN CALL FROM PHYSICIAN (AFTER OFFICE HOURS)

The Health Plan members shall wait no more than one hour before receiving a return call from their physician after office hours, on weekends, and on holidays.

NOTE: ALL STANDARDS FOR ACCESS TO OFFICE APPOINTMENTS ARE MONITORED THROUGHOUT THE YEAR THROUGH PHONE SURVEYS, MEMBER SATISFACTION SURVEYS, AND THROUGH THE MEMBER COMPLAINT PROCESS.

**THE HEALTH PLAN
STANDARDS FOR ACCESS TO CARE AND SERVICES
(INTERNAL)**

STANDARD FOR MEMBER SERVICE (COMMUNICATION)

1. **Telephone Response Time** - At least 90% of all incoming calls will be answered within 30 seconds.

Behavioral Health Standard: same

2. **Telephone Abandon Rate** - The abandon rate will not exceed 5% of all incoming calls.

Behavioral Health Standard: same

3. **Telephone "On Hold" Time**

At least 90% of all incoming calls will have an average hold time of no more than 30 seconds.

STANDARDS FOR PHYSICIAN AND FACILITY AVAILABILITY (All Lines of Business except MHT)

1. At least 90% of all members must have access to a primary care physician within 10 miles of their residence.
2. At least 90% of all members must have access to an obstetrician/gynecologist within 20 miles of their residence.
3. At least 90% of all members must have access to the following identified high-volume specialists within 45 miles of their residence:
 - Orthopedist
 - Ophthalmologist
 - Cardiologist
 - Dermatologist
 - Podiatrist
 - Oncologist
4. At least 90% of all members must have access to a hospital within 45 miles of their residence.
5. The overall ratio of The Health Plan members to primary care physician is no greater than 300:1.
6. The overall ratio of The Health Plan members to obstetrician/gynecologists is no greater than 1000:1.
7. The overall ratio of The Health Plan members to orthopedists, ophthalmologists, cardiologists, dermatologists, podiatrist, and oncologist is no greater than 2000:1.

STANDARDS FOR ACCESS TO BEHAVIORAL HEALTH: HIGH VOLUME SPECIALISTS

1. At least 90% of all members must have access to the following high-volume behavioral health specialist within 45 miles of their residence:

Counselor Therapists

2. The overall ratio of The Health Plan members to counselor therapists is no greater than 2000:1.

STANDARDS FOR PHYSICIAN AND FACILITY AVAILABILITY: MHT

1. At least 90% of all members must have access to a primary care physician within 25 miles (30 minutes travel time) of their residence.
2. At least 90% of all members must have access to an OB/GYN or Nurse Midwife within 25 miles (30 minutes travel time) of their residence.
3. At least 90% of all members must have access to high-volume specialists within 25 miles (30 minutes travel time) of their residence.
4. At least 90% of members must have access to basic hospital services within 37.5 miles (45 minutes travel time) of their residence.
5. At least 90% of members must have access to tertiary hospital services within 50 miles (60 minutes travel time) of their residence.
6. The overall ratio of The Health Plan members to PCPs is no greater than 500:1.
7. The overall ratio of The Health Plan members to OB/GYN, Nurse Midwives is not greater than 1000:1.