POLICY AND PROCEDURE

POLICY NAME: Provider Appointment Accessibility Standards & Evaluation	**POLICY ID:** LA.PRVR.04
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Provider Relations
EFFECTIVE DATE: 1/12, 12/15	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 8/13, 5/14, 11/14, 9/15, 11/16, 2/17, 10/17, 10/18, 5/19, 4/20, 1/21, 6/21, 6/22, 6/23, 4/24, 3/25, 8/25, 9/25	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines the Accessibility Standards applicable to Louisiana Healthcare Connections contracted providers along with evaluation of established and measurable standards for appointment access based on NCQA timeliness standards and/or contractual requirements set forth by the State of Louisiana's Department of Health (LDH).

PURPOSE:
To define the accessibility standards applicable to Louisiana Healthcare Connections contracted providers and to describe the methods used by the health plan to monitor that accessibility standards are maintained. The plan outlines a mechanism utilized to monitor member access to primary care services, specialty services, and member services, and to describe the corrective actions taken if they are not met by contracted providers. Louisiana Healthcare Connections' providers shall ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment for Medicaid members with physical or mental disabilities.

SCOPE:
This policy and procedure applies to Louisiana Healthcare Connections (LHCC) Provider Relations department.

POLICY:
The plan Provider Relations department measures access to primary care services, behavioral health services and specialty services at least annually. The plan Member Services department measures telephone access to the member services department at least monthly. The Quality Assessment & Performance Improvement Committee (QAPIC), or designated subcommittee, will analyze the data and make recommendations to address deficiencies in member access to practitioners or member services. Results are reported and reviewed by the QAPIC.

PROCEDURE:
Plan will establish quantifiable and measurable standards for appointment access based on NCQA timeliness standards and/or contractual requirements set forth by the State of Louisiana's Department of Health and hospital (LDH) (whichever is the most stringent).

A. Primary Care Appointment Access Standards

The standards for primary care physician (PCP) access appointments include, at a minimum, primary care regular/routine, non-urgent or preventative visits, urgent/sick care appointments, non-urgent sick care, and after-hours.

1. Regular/routine, non-urgent or preventative visits within 6 weeks
2. Urgent/sick care appointments within 48 hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week.
3. Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition.
4. Appropriate after-hours case access:
    - The PCP's office telephone is answered after-hours by an answering service that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
    - The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and

- The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

5. Unacceptable PCP after-hours coverage:
   - The PCP's office telephone is only answered during office hours.
   - The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message.
   - The PCP's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
   - Returning after-hours calls outside of 30 minutes.

B. Behavioral Health Appointment Access Standards

The behavioral health appointments included, at a minimum, care for non-life-threatening emergencies, urgent care, initial visit for routine care, and follow-up routine care.

1. Behavioral health appointment data must be collected and analyzed separately *by prescribers* (i.e., behavioral health practitioners who prescribe medications such as psychiatrists) and *non-prescribers* (i.e., practitioners who do not prescribe medications such as psychologists or licensed social workers) for each appointment type.
2. Care for non-life-threatening emergencies prescribers/non-prescribers within (1) hour:
   - The plan must direct members with non-life-threatening emergencies to crisis centers or the emergency room (ER).
3. Urgent care ~~appointments~~appointments for prescribers/non-prescribers within 48 hours.
4. Initial visit for routine care prescribers/non-prescribers within 10 business days.
5. Follow-up routine care:
   - Prescribers – within 30 days
   - Non-prescribers – within 20 days

C. Specialty Care Appointment Access Standards

The plan follows state Medicaid contract recommended accessibility standards for all lines of business, unless otherwise specified.

1. Appointment access standards included, at a minimum, high-volume specialist (i.e., OB/GYNs) and high-impact specialist (i.e., Oncologist) as identified for practitioner availability evaluation.
2. Specialty care appointments/consultations (i.e., GYN/Oncology) within one (1) month of referral or as clinically indicated.
   - High-volume specialty appointment accessibility standards must include GYN routine appointment accessibility along with Maternity Care appointment accessibility standards.
3. Maternity Care
   - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing ~~member~~members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy.
     a) Initial Family Planning visit within their first trimester within seven (7) days
     b) Initial prenatal visit within their first trimester within fourteen (14) days
     c) Initial prenatal visit within their second trimester within seven (7) days
     d) Initial prenatal visit within their third trimester within three (3) days
     e) High risk pregnancy initial visit within three (3) days of identification of high risk by the plan or maternity care provider, or immediately if an emergency exists

D. Additional Timely Access Appointment Standards

1. Emergent or emergency visits – immediately upon presentation at the service delivery site. Emergency services must be available at all times.
2. ER follow-up visits – in accordance with ER attending provider discharge instructions
3. Lab and X-ray services (usual and customary) – not to exceed three (3) weeks for regular appointments and

forty-eight (48) hours for urgent care or as clinically indicated

4. Network providers are to offer hours of operation in the same manner for members and non-Medicaid members.

~~3.~~5. In network providers must make services included in the contract available 24 hours a day, seven days a week, when medically necessary.

E. In Office Waiting Time for Scheduled Appointments

Appointment wait times should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room.

- Providers may be delayed when they "work in" urgent cases, when a serious problem is found with a previous patient, or when a previous patient requires more services or education than was described at the time the appointment was scheduled. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment.
- Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
- Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

F. Member Services Telephone Access Standards

The Plan collects and performs analysis to measure performance against defined telephone access standards as follows:

- Ninety-five percent (95%) of all calls answered within 30 seconds. Calls are directed to an automatic call pickup system with IVR options
- Less than one percent (1%) of calls receive a busy signal
- Call abandonment rate less than or equal to five percent < (5%)
- Average speed of answer less than 30 seconds
- Average hold time less than three (3) minutes. Hold time, or wait time, for the purposes of this policy includes:
  - the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and
  - the measure of time when a customer service representative places a caller on hold.

Results are reported to the QAPIC at least annually and are included in the annual QI Program Evaluation.

G. Data Collection Methods/Data Sources

Data sources may include but are not limited to:

1. Applicable results of the HEDIS/CAHPS survey. Survey questions applicable to assessing access to practitioner services include:
   - % of members who reported that they "always" or "usually" got regular or routine care as soon as they wanted it (satisfaction with timeliness)
   - % of members who reported that they "always" or "usually" got urgent appointments as soon as they wanted them (satisfaction with timeliness)
   - % of members who report they "always" or "usually" obtained a specialist appointment as soon as they needed/wanted it.
2. Member complaints/grievances about access to specific practitioners, groups, or geographic areas. On an annual basis, the Member Services Department will compile a report of all access-related issues documented during the prior 12-month period.
3. Site specific surveys/audits regarding access to ~~PCP~~ network provider offices. The Plan's Provider Relations representatives and/or Clinical Quality Improvement Department will conduct random access audits for PCP services, Behavioral Health high-volume specialist (at a minimum OB/GYN), and high-impact specialist (at a minimum Oncology) using a standard audit methodology/tool.
   a) Audits may be performed telephonically or onsite over the course of the year.

b) The sample of PCPs included in the audit must treat at least 50% of Plan total membership.
c) Providers must meet 90% compliance of the State defined standards noted above.
d) If minimum compliance is not met, the provider, network, or group will be asked to comply with a 2-step written Performance Improvement Plan (PIP)/ Corrective Action Plan.
e) Louisiana Healthcare Connections will send a letter notifying the practice they are not compliant and educate them on the acceptable coverage response. The practice will be responsible for making adjustments to become compliant with this LDH requirement.
f) Louisiana Healthcare Connections will monitor the implementation of the PIP. If after allowing the practice one (1) month to demonstrate a change and compliance is still not achieved, the following process will be followed:
    i. Louisiana Healthcare Connections will send a second letter to the practice indicating they are still not in compliance and ask that the practice complete and submit a Corrective Action Plan (CAP) within 2 weeks. Another audit will be performed within the next quarter to document improvement.
    ii. If the provider remains non-compliant after a second audit, the case will be brought to the Quality Improvement Committee for review and recommended next steps for corrective action.

H. Analysis and Improvement

1. The assessment is reported to the QAPIC at the individual practitioner, physician network, and/or medical group levels and/or as an aggregate as appropriate by provider type at least annually, although interim quarterly reports may also be reported to the QAPIC.
2. The QAPIC, or designated subcommittee, will review the information for opportunities for improvement. Analysis of data must include practice-specific and Plan-wide comparison of results against the standard and analysis of the causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results.
3. Interventions will be developed where indicated. Examples of interventions include:
    - Expanding the network
    - Working with individual practices to improve their scheduling systems
    - Targeting a specific specialty or geographic area for special recruitment efforts
4. Effectiveness of interventions are measured and reported at least annually in the QI Program evaluation.
5. The audit and evaluation documents will be maintained in the Quality Improvement Department in a secure area. Access will be limited to those individuals outlined in the Quality Improvement Program Description

REFERENCES:
LDH Model Contract 3.0 (section 2.9.3)

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS:
La R.S. 46:460.54 does NOT apply to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Under the procedure heading added statement: assess appointment accessibility standards during field visits and document the results on the provider visit record form and CRM. Under the procedure heading removed statement: regarding appointment availability during routine visits by asking specific questions and submitting findings to LHC for review. Under the procedure heading added statement: field visit assessment and phantom calls Under the procedure heading deleted statement: surveys and the calls	08/23/13

	Under the procedure heading added field visit assessment and phantom Under the procedure heading deleted statement: survey	
Annual Review	Changed acronym from LHC to LHCC Added follow up visit under type of appointment and the scheduling time frame Added office waiting time for scheduled appointments under type of appointment and the scheduling time frame Added statement: Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times Removed on provider visit record under procedure and replaced it with Customer Relationship Management and Louisiana Healthcare Connections SharePoint	05/23/14
Annual Review	Inserted verbiage from the RFP Section 7.2. Also, formatted the chart title, changed LHC to LHCC, deleted Family Planning Services, and changed ER to ED.	11/14/16
Ad Hoc Review	Updated BH standard for Behavioral Health routine non urgent care to 10 business days	02/2017
Annual Review	Changed for behavioral healthcare, routine, non-urgent appointments shall be arranged within ten (10) days of referral, instead of 14 days. Changed Provider Relations to Provider Network Added Reference to Policy, LA.QI.05: Evaluation of the Accessibility of Service.	10/24/17
Annual Review	Updated language to match RFP 7.2.1	10/24/18
Ad Hoc Review	Added language to match RFP 7.1.3, 7.1.7, 7.1.8, 7.2.1.2, 7.2.1.4, and 7.2.1.7	05/16/19
Ad Hoc Review	No revisions	04/24/20
Ad Hoc Review	Updated to meet the 2020 NCQA standards	01/25/21
Annual Review	No revisions	06/29/22
Annual Review	Reformatted to latest Policy Template Document name changed to include process evaluation. Revisions made to accommodate NCQA and DHH accessibility standards. Combined LA.QI.05 and LA.PRVR.04. Updated Contract Reference	06/13/23
Annual Review	Removed one bullet that is not applicable. Grammatical and Non-Material edits.	05/14/24
Annual Review	Removed two semi colons added periods. Grammatical and Non-Material edits.	03/06/25
Ad Hoc Review	Added “Initial Family Planning visit within their first trimester within seven (7) days” to Specialty Care Appointment Access Standards per HSAG review	08/12/25
Ad Hoc Review	Added “Network providers are to offer hours of operation in the same manner for members and non-Medicaid members. A. In network providers must make services included in the contract available 24 hours a day, seven days a week, when medically necessary to Additional Timely Access Appointment Standards ” per HSAG review. Added Grammatical and Non-Material edits.	9/5/2025

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.