PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPNET100 (previously MPQP1023/QP100123)</td><td colspan="3">Lead Department: Network Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Access Standards and Monitoring</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/19/2003</td><td colspan="4">Next Review Date: 06/10/2026
Last Review Date: 06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☒ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 06/11/2025</td></tr>
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I. RELATED POLICIES:

A. MCCP2018 – Advice Nurse Program

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services
D. Finance
E. Compliance

III. DEFINITIONS:

A. High-Impact Specialist: Partnership HealthPlan of California (Partnership) shall annually identify high-impact specialists by a) identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or b) identifying practitioner types where treatment requires significant resources. Partnership will include oncology/hematology as a high impact specialty type every year.
B. High-Volume Behavioral Healthcare Practitioner: Partnership shall identify high volume behavioral healthcare practitioner types by assessing the number of unique members seen by a given practitioner type within a calendar year. Partnership annually selects the top four practitioner types with the largest numbers of unique members seen.
C. High-Volume Specialist (Non-Hospital Specialist): Partnership shall identify high-volume specialists by using available claim and encounter data to identify the number of unique members seen by a given specialty type within a calendar year. Partnership will select the top six specialty types with the largest numbers of unique members seen. Partnership will include obstetrics/gynecology as a high-volume specialty type every year.
D. Rural Counties: Counties with a population density of <50 people per square mile (according to current Department of Health Care Services (DHCS) standards) include Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity.
E. Suburban or Small Counties: Counties with a population density of 51 to 200 people per square mile (according to current DHCS standards) include Lake, Napa and Yolo.
F. Urban or Medium Counties: Counties with a population density of 201 to 600 people per square mile (according to current DHCS standards) include Marin, Solano and Sonoma.
G. Triage or Screening: The assessment of a member'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 a member who may need care, for the purpose of determining the urgency of the member's need for care.

H. Triage or Screening Wait Time: The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.
I. Urgent Care: Health care for a condition that requires prompt attention.

IV. ATTACHMENTS:

A. Standards for Core Specialists

V. PURPOSE:

VI. To define access standards and the framework for monitoring compliance with those standards across primary care, specialty care and mental health care.

VII. POLICY / PROCEDURE:

Partnership HealthPlan of California is committed to ensuring that its members have the availability of and accessibility to providers to meet their health care needs. Partnership has established standards for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone availability. Partnership monitors provider availability and accessibility on an annual basis Partnership will monitor and ensure sufficient providers are in the network and service areas for provider types that include but are not limited to: CalAIM, Enhanced Care Management, Community Supports, Community Health Workers, and the Department of Health Care Services (DHCS)-mandated benefits or services. Partnership will collaborate with network hospitals and birthing centers to eliminate barriers to doula access when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits, regardless of outcome: stillbirth, abortion, miscarriage, or live birth.

A. Availability of Practitioners

Partnership maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners and monitors how effectively this network meets the needs and preferences of our members.

1. Partnership maintains an overall ratio of total network physicians to members of 1 FTE physician to every 1,200 members (DHCS standard).
2. Cultural Needs and Preferences:
   a. Partnership assesses the cultural, ethnic, racial and linguistic needs of its members annually and adjusts the availability of practitioners within the network, if necessary (National Committee for Quality Assurance [NCQA] requirement).
3. Practitioners Providing Primary Care: To evaluate the availability of practitioners who provide primary care services, including general medicine or family medicine, internal medicine and pediatrics, Partnership:
   a. Establishes measureable standards for the number of each type of practitioner providing primary care.

NUMBER OF PRACTITIONERS, PRIMARY CARE [1]		
Practitioner Type	**Measure: Ratio**	**Standard/Performance Goal**
Primary Care Provider overall	Primary care provider to member (adult and children)	1:≤ 2,000
Family Practice/General Practice	Family or General practice practitioner to member (adult and children)	1:≤ 2,000
Pediatrics	Pediatricians to members (children)	1:≤ 2,000
Internist	Internists to members (adult)	1:≤ 3,000

b. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, PRIMARY CARE [2]		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
Primary Care Physician overall	1 within 10 miles and 30 minutes from the member's residence (DHCS standard)	≥ 95%
Family Medicine /General Practitioner	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Pediatrics	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Internist	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Obstetrics/Gynecology	1 within 10 miles and 30 minutes from the member's residence (DHCS standard)	≥ 95%

c. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care (NCQA requirement).
d. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care (NCQA requirement).

4. Practitioners Providing Specialty Care: To evaluate the availability of specialists in Partnership's delivery system, Partnership:
   a. Identifies high-volume specialists (NCQA requirement) by assessing the number of unique members seen by a given specialty type within a calendar year. Partnership annually selects the top six specialty types with the largest numbers of unique members seen. Ratios for identified high- volume specialists that are also an identified core specialist will be the same as the core specialty standard. (See Attachment A.)
   b. Identifies high-impact specialists (NCQA requirement) by identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or identifying practitioner types

[1] DHCS requires an overall PCP-to-member ratio of 1 FTE PCP to every 2,000 members. NCQA requires health plans to set ratio goals individually by primary care provider type, including Family Practice, Pediatrics, and Internist; however, the exact performance goals are internally determined by Partnership.

[2] DHCS requires member access to primary care overall within 10 miles and 30 minutes from member's residence. NCQA requires health plans to set geographic distribution goals individually by primary care provider type, including Family Practice, Pediatrics, and Internist; however, the exact standards and performance goals are internally determined by Partnership.

where treatment requires significant resources. Partnership's current high-impact specialty type is:

1) Oncology/Hematology

c. Monitors geographic availability for additional specialty types defined by DHCS as "Core Specialists."

DHCS ADULT AND PEDIATRIC CORE SPECIALISTS			
Cardiology/Interventional Cardiology*	Gastroenterology	Nephrology	Orthopedic Surgery*
Dermatology*	General Surgery*	Neurology	Physical Medicine and Rehabilitation
Endocrinology	Oncology/ Hematology **		Psychiatry
ENT/Otolaryngology	HIV/AIDS Specialists/Infectious Diseases	Ophthalmology*	Pulmonology
*High-volume specialty type; **High-impact specialty type			

NUMBER OF PRACTITONERS, HIGH IMPACT		
Practitioner Type	Measure Ratio	Standard Performance Goal (Ratio of specialists to members)
Oncology/Hematology	Oncology Hematology to Member	1: ≤ 25,000

d. Establishes measureable standards for the geographic distribution of each type of specialist (high-volume, high-impact, and DHCS Core).

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, SPECIALTY CARE [3]		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
• Cardiology*+ • Dermatology*+ • Endocrinology+ • ENT/Otolaryngology+ • Gastroenterology+ • General Surgery*+ • HIV/AIDS Specialists/Infectious Diseases+ • Nephrology+ • Neurology+ • Obstetrics/Gynecology (as specialist)* • Ophthalmology*+ • Orthopedics*+ • Physical Medicine and Rehabilitation+ • Pulmonology+	• Urban/Medium: One within 30 miles and 60 minutes from member's residence • Suburban/Small: One within 45 miles and 75 minutes from member's residence • Rural: One within 60 miles and 90 minutes from member's residence (DHCS Standard)	≥ 90%
Oncology/Hematology **+		≥ 80%
*High-volume specialty type; **High-impact specialty type; +DHCS Core Specialists		

e. Analyzes performance against the established specialty care availability standards at least annually (NCQA requirement).

5. Practitioners Providing Behavioral Healthcare: To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, Partnership:
   a. Identifies high volume behavioral healthcare practitioners (NCQA requirement) by assessing the number of unique members seen by a given practitioner type within a calendar year. Partnership annually selects the top four practitioner types with the largest numbers of unique members
      seen. Partnership's current high-volume practitioner types are:
      i. Psychiatrist
      ii. Clinical psychologist
      iii. Licensed clinical social worker
      iv. Marriage and family counselor
   b. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner.

[3] DHCS sets geographic distribution requirements for all DHCS Core Specialty types. NCQA requires geographic distribution standards for all high-volume and high-impact specialty types but does not dictate the exact standards or performance goals. Partnership has adopted the DHCS geographic distribution standard across all monitored specialty types; the performance goal is internally determined by Partnership.

NUMBER OF PRACTITIONERS, BEHAVIORAL HEALTHCARE [4]		
Practitioner Type	**Measure: Ratio**	**Standard/ Performance Goal**
Psychiatrist	Psychiatrist to members	1: ≤50,000
Clinical psychologist	Clinical psychologist to member	1: ≤30,000
Licensed clinical social	Licensed clinical social worker to member	1: ≤10,000
Marriage and family counselor	Marriage and family counselors to members	1: ≤10,000

c. Establishes measureable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner.

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, BEHAVIORAL HEALTHCARE [5]		
Practitioner Type	**Standard: Geographic Distance**	**Performance Goal**
• Psychiatrist[+] • Clinical psychologist • Licensed clinical social • Marriage and family counselor [+]DHCS Core Specialist	• Urban/Medium: One within 30 miles and 60 minutes from member's residence • Suburban/Small: One within 45 miles and 75 minutes from member's residence • Rural: One within 60 miles and 90 minutes from member's residence (DHCS Standard)	≥ 90%

d. Analyzes performance against the established behavioral healthcare availability standards annually (NCQA requirement).

6. Pharmacy: To evaluate the availability of pharmacy services, Partnership establishes measureable standards for the geographic distribution of pharmacies.

GEOGRAPHIC DISTRIBUTION OF PHARMACIES	
Practitioner Type	**Standard: Geographic Distance**
Pharmacy	One within 10 miles and 30 minutes from member's residence (DHCS standard)

7. Hospitals: To evaluate the availability of hospital services, Partnership establishes measureable standards for the geographic distribution of hospitals.

GEOGRAPHIC DISTRIBUTION OF HOSPITALS	
Practitioner Type	**Standard: Geographic Distance**
Hospital	One within 15 miles and 30 minutes from member's residence (DHCS standard)

[4] NCQA requires Partnership to establish measurable standards for the number of each type of high-volume behavioral healthcare practitioners; however, the exact standards are internally determined by Partnership.

[5] DHCS sets geographic distribution requirements for psychiatrists (DHCS Core Specialty). NCQA requires geographic distribution standards for all high-volume behavioral health care practitioner types, but does not dictate the exact standards. Partnership has adopted the DHCS geographic distribution standards across all monitored behavioral health care practitioner types; the performance goal is internally determined by Partnership.

B. Accessibility of Services

Partnership provides and maintains appropriate access to primary care, specialty care and behavioral healthcare services. These timeframes will only be extended if it is determined by the treating health provider that waiting will not have a detrimental impact on the member's health and it must be noted in the member's medical record.

1. Access to Primary Care
   a. Regular and Routine Care Appointments:
      1) Non-Urgent Primary Care Appointments: These appointments include preventive visits and follow-up visits. Appointments should be provided within 10 business days of request.
      2) Prenatal Care Appointments: Pregnant members should be provided an initial prenatal care appointment within 10 business days of request.
      3) Newborn Appointments: Infants discharged from hospital in less than 48 hours of life after delivery should be seen within 48 hours of discharge. The follow-up visit can take place in a home or clinic setting as long as the health care professionals examining the infant are competent in newborn assessment and the results of the follow-up visit are reported to the infant's physician or his or her designees on the day of the visit where the PCP is not examining the infant. (Partnership standard)
   b. Urgent Care Appointments
      1) Appointments that do not require prior authorization- within 48 hours of a request.

ACCESSIBILITY TO PRIMARY CARE PRACTITIONERS [6]	
Timely Access Standard	**Performance Goal**
Non-Urgent Care primary care appointments within 10 business days of request (DHCS standard)	≥ 90%
Prenatal Care appointments within 10 business days of request (DHCS standard)	≥ 90%
Newborn appointments within 48 hours of discharge (Partnership standard)	≥ 90%
Urgent Care appointments without prior authorization within 48 hours of request (DHCS standard)	≥ 90%

2. Access to Specialty Care
   a. Appointments for non-urgent specialty care shall be provided within 15 business days of member's referral. (This standard applies to all Specialty type referenced in section A.4.e.)

ACCESSIBILITY TO SPECIALTY CARE PRACTITIONERS [7]	
Timely Access Standard	**Performance Goal**
Non-Urgent Care specialty appointments within 15 business days of request (DHCS standard)	≥ 80%

3. Access to Behavioral Healthcare
   a. Routine office visits (initial and follow-up care) within 10 business days of member's request (DHCS and NCQA standard).
   b. Urgent and Emergency care: Coverage for moderate to severe behavioral health is a carved out

[6] NCQA requires that Partnership set primary care appointment accessibility standards for regular and routine care appointments and urgent care appointments, but does not dictate what the standards should be. Where indicated, Partnership has adopted the DHCS appointment access standard.

[7] NCQA requires that Partnership set specialty care appointment accessibility standards for high-volume and high-impact specialty care but does not dictate what the standards should be. Where indicated, Partnership has adopted the DHCS appointment access standard.

benefit and members are referred out to county emergency services. Members who contact Partnership or contact our delegated providers, Beacon Health Options and Kaiser Permanente, with a psychiatric emergency are immediately redirected to county mental health providers for appropriate psychiatric crises intervention and follow-up care. Both Partnership and our delegated providers have policies and protocols in place to ensure the member's safety and well-being during such redirection.

ACCESSIBILITY TO BEHAVIORAL HEALTHCARE	
Timely Access Standard	**Performance Goal**
Routine office visits (initial and follow-up care) within 10 business days of request (DHCS standard)	≥ 80%

4. Access to Long Term Services and Support (LTSS)
    a. Access to LTSS services within 14 calendar days of request for rural and small counties
    b. Access to LTSS services within 7 business days of request for medium counties
    c. Access to LTSS services within 5 business days of request for dense counties

ACCESSIBILITY TO LONG TERM SERVICES AND SUPPORT Standards effective post PAC approval – June 2019			
Timely Access Standard by County Size			
	Rural/Small	Medium	**Performance Goal**
Skilled Nursing Facility Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 7 business days of request	≥ 80%

5. Access to Emergency Care
    a. Emergency treatment must be available immediately to all members 24 hours a day. During hours when PCP offices are closed, members should be directed to an after-hours or emergency care location depending on the nature of the problem.

C. Primary Care Practitioner and Specialty Care Office Hours and Telephone Access Standards
1. Regular Business Hours
    a. PCP practices must be open and staffed by a clinician(s) who is available to members for a minimum of 20 hours per week. PCPs with multiple sites less than ten (10) miles apart that see members at either site may combine open hours to meet the requirements. Exceptions to this requirement can be made by the Partnership Chief Medical Officer (CMO) based on need for access to primary care services. PCP sites granted this exception must assist members with coordination of care when the assigned PCP office is not open and submit a referral authorization to another PCP site.
    b. Office hours and an emergency 24-hour number must be displayed in a clearly visible area, window, or door.
    c. Hours of operation must be adequate and convenient for members to schedule appointments and should not in any way discriminate against Partnership HealthPlan members.

d. When calling the provider's office:
   1) Phone calls are answered within 5 rings
   2) Maximum time on hold is 5 minutes
   3) Phone messages left for provider during regular business hours should be responded to within 30 minutes of the call.
   4) Number of minutes waiting from scheduled appointment time to being seen must not exceed 30 minutes unless practitioner unexpectedly delayed.
   5) Emergency calls must be immediately reviewed by a qualified clinician who will determine urgency of the appointment or referral as indicated.

2. After Hours[8]
   a. Provider practices must be available or arrange for services 24 hours/7 days per week.
   b. The telephone triage or screening services must be provided in a timely manner appropriate for the member's condition; the member's wait time for screening or triage services must not exceed 30 minutes.
   c. Medically unlicensed persons handling member calls may ask questions on behalf of a licensed person to help ascertain the condition of the member so that the member can be referred to licensed staff. Unlicensed persons cannot use the answers to those questions to assess or make any decisions regarding the condition of a member, or to determine when a member needs to be seen by a licensed medical professional.
   d. After-hours advice must be provided by a licensed or registered professional whose scope of practice includes making assessments and recommending interventions.
      1) Provider must make best efforts to ensure a Member's existing Mental Health Provider is notified during an Urgent Care situation.
   e. Provider offices may use the Partnership Advice Nurse line, which is available to members 24 hours a day, 7 days a week. Providers who use Partnership Advice Nurse Line for after-hours support must actively promote the service to Partnership members.
   f. Provider offices must communicate their after-hours procedure to members. At a minimum, this communication should include:
      1) Clear communication to patients via answering machine or on call service:
         a) To call 911 or go to the nearest Emergency Room for medical emergencies.
         b) How to access after-hours medical advice
      2) Posted after hour procedure on provider site door and communicated verbally or by informational packets.

After Hours Access	
Timely Access Standard	**Performance Goal**
Answering machine or answering services	≥ 90%
Instructions to call 911/ER	≥ 90%
Instructions to reach MD/Advice Nurse	≥ 90%
Wait times for screening or triage services must not exceed 30 minutes	≥ 90%

[8] NCQA requires that Partnership set primary care after-hours care standards.

D. Assessment of Network Adequacy
   1. On an annual basis, Partnership analyzes access and availability performance against the standards set forth in this policy. Additionally, Partnership annually assesses member experience with network adequacy by analyzing patient experience survey results, data from network adequacy grievances and appeals, and requests for/utilization of out-of-network services (NCQA requirement). This analysis informs Partnership of any access issues specific to geographic areas and/or types of providers. Where applicable, Partnership implements interventions to address opportunities for improvement and measures the

      effectiveness of those interventions (NCQA requirement). Analysis results and related interventions are reviewed by Partnership's Quality Improvement committees.
   2. Partnership conducts additional assessment of network language and cultural deficits that may exist. Analysis results and related interventions are reviewed by Partnership's Director of Health Equity and the Population Health team. Actions will be taken to address any identified gaps which may include, but not limited to, additional telephone or video interpretation services; resources for culturally and linguistically appropriate health education materials; lists of ancillary providers who offer services in non-English languages; community resources that focus on specific cultural or linguistic services; and practitioner training for diversity, equity, and language services.
   3. Network adequacy for organizations delegated for primary care, specialty care, or behavioral healthcare: Partnership annually reviews its delegate's network management procedures and evaluates delegate's performance against NCQA and DHCS standards for delegated activities. Partnership also semiannually evaluates regular reports, as specified in the delegation agreement.

E. Communication
   1. Partnership communicates access standards to:
      a. Members through newsletters, Evidence of Coverage (EOC) and other education materials. Provider directories are also available to members online or upon request.
      b. Providers through the Provider Manual, provider newsletter and/or bulletins, initial provider training and during monthly provider training sessions.

VIII. REFERENCES:

A. DHCS Contract
B. 2025 NCQA Network Adequacy Standards:
   1. NET 1:
      a. Element A – Factors 1-2
      b. Element B – Factors 1-4
      c. Element C – Factors 1-5
      d. Element D – Factors 1-4
   2. NET 2:
      a. Element A – Factors 1-3
      b. Element B – Factors 1-4
      c. Element C – Factors 1-2
   3. NET 3:
      a. Element A – Factors 1-4

b. Element B – Factors 1-3
c. Element C – Factors 1-3

C. DHCS All Plan Letter (APL) 20-003, Network Certification Requirements (Feb. 27, 2020)

IX. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

X. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director, Network Services

XI. REVISION DATES:

Medi-Cal
09/15/04; 03/15/06; 06/21/06; 12/20/06; 06/18/08; 10/21/09; 02/16/11; 10/31/12; 03/20/13; 03/19/14; 05/20/15; 09/20/17; *03/14/18; 08/08/18; 06/12/19; 04/08/20; 5/12/21, 10/13/21, 06/08/22, 08/09/23, 06/12/24, 05/13/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Medi-Cal
MPQP1023 – 02/19/2003 to 04/08/2020

PartnershipAdvantage:
QP10012 - 06/21/2006 to 12/21/2006
MPQP1023 – 12/21/2006 to 01/01/2015

Healthy Families:
MPQP1023 - 02/16/2011 to 03/01/2013

Healthy Kids
KK QI 205 - 11/15/2005 to 06/21/06
MPQP1023 – 06/21/06; 12/20/06; 06/18/08; 10/21/09; 02/16/11; 10/31/12; 03/20/13; 03/19/14; 05/20/15 to 12/01/16 (Healthy Kids program ended 12/01/2016)