9. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

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

POLICY:

A. All applicable Practitioners including Primary Care Providers (PCPs) and Specialists must meet the access standards delineated below to participate in the IEHP network.

B. IPAs are responsible for monitoring their network to ensure adherence with the access standards described in this policy.

C. IEHP monitors plan-wide adherence to these access standards through IEHP and IPA performed access studies, review of grievances and other methods.

D. All Members must receive access to all covered services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code Section 422.56, except as needed to provide equal access to Limited English Proficiency (LEP) Members or Members with disabilities, or as medically indicated.[1]

DEFINITIONS:

A. **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.

B. **Urgent Care Services** – These are health care services needed to diagnose and/or treat medical conditions that are of enough severity that care is needed urgently but are not emergency medical conditions.

C. **Urgent Visit** – These are visit to health care professionals to address an urgent but non-emergency medical conditions.

D. **Non-Urgent (Routine) Visit** – These are health care services needed to diagnose and/or treat medical conditions that do not need urgent care or emergent attention.

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2, Provision 28, Discrimination Prohibitions

E. **Initial Health Assessment** – See Policy 10A, "Initial Health Assessment.

F. **Physical Examination –** This is a routine preventive exam occurring every one to three (1-3) years.

G. **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 urgent or routine visits, the IEHP Member must be seen at that office on the same day in which the Member was advised to visit.

H. **Urgent Prenatal Visit** – 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 urgently but are not emergency medical conditions.

I. **Initial Prenatal Visit** – These are health care services needed to determine potential risk factors and the care plan for a woman during the period of pregnancy.

J. **Non-Urgent (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.

K. **Non-Urgent (Routine) Specialist Visit** – These are referrals to a health care professional who has advanced education and training in a specific area.

L. **Triage or Screening** – This means the assessment of a Member's health concerns and symptoms through communication with a physician, registered nurse (RN), or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who many need care, for the purpose of determining the urgency of the enrollee's need for care. Other qualified health professionals include nurse practitioners (NP) and physician assistants (PA).

PROCEDURES:

A. **Access Standards for Clinical Services**

1. Appointment Availability Standards - Members must be offered appointments within the following timeframes:[2]

Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) Primary Care	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do not require prior authorization[3]	Within forty-eight (48) hours of request

[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[3] Knox-Keene Health Care Service Plan Act of 1975, § 1300.67.2.2

9. ACCESS STANDARDS

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Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) Primary Care	
Type of Appointment	**Timeframe**
Urgent visit for services that do require prior authorization[4]	Within ninety-six (96) hours of request
Non-urgent (routine) visit[5,6]	Within ten (10) business days of request
Physical examination[7]	Within thirty-six (36) business days of request
Initial health assessment[8,9]	Within one hundred twenty (120) calendar days of enrollment
Initial health assessment (under 18 months of age only)	Within sixty (60) calendar days of enrollment
Well-Woman Examination[10]	Within thirty-six (36) business days of request
Follow up exam	As directed by Physician

Specialist	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do <u>not</u> require prior authorization[11]	Within forty-eight (48) hours of request
Urgent visit for services that do require prior authorization[12]	Within ninety-six (96) hours of request
Urgent prenatal visit[13]	Within forty-eight (48) hours of request
Non-urgent (routine) visit[14,15]	Within fifteen (15) business days of request
Non-urgent visit for ancillary services (for diagnosis or treatment of injury or other health condition)[16]	Within fifteen (15) business days of request

[4] KKA, § 1300.67.2.2
[5] Ibid.
[6] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-006 Supersedes APL 20-003, "Network Certification Requirements
[7] KKA, § 1300.67.2.2
[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Member under Twenty-One (21) Years of Age
[9] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 6, Services for Adults
[10] KKA, § 1300.67.2.2
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] DHCS APL 21-006
[16] KKA, § 1300.67.2.2

9. ACCESS STANDARDS

A. Access Standards

Specialist	
Type of Appointment	**Timeframe**
Initial Prenatal Visit[17]	Within ten (10) business days of request
Non-urgent (routine) prenatal care[18]	Within ten (10) business days of request
Well-Woman Examination[19]	Within thirty-six (36) business days
Follow up exam	As directed by Physician

a. Shortening or Expanding Appointment Times – The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, 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 Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.[20]

b. Preventive Care – Preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care Practitioner acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to Specialists for chronic conditions, periodic office visits to monitor and treat pregnancy and other conditions, laboratory and radiological monitoring for recurrence of disease.[21]

c. 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 ensure the Member's timely access to needed health care services.[22] Please see Policy 9B, "Missed Appointments," for more information.

2. Waiting Times[23]

a. Practitioner Office – For primary or specialty 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.

b. Urgent Care Center – Urgent Care Centers are designed to serve Members, who are

[17] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[18] KKA, § 1300.67.2.2
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements

unable to make an appointment with their PCP or Specialist for their urgent non-emergent conditions. Urgent Care Centers accept unscheduled walk-in patients; therefore, waiting time in Urgent Care Centers can vary depending on the number of Members waiting to be seen.

c. Health Plan Call Center – During normal business hours, the waiting time for a Member to speak by telephone with a plan representative knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten (10) minutes.[24] Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person. Calls received after normal business hours (Monday-Friday, 8am-5pm) are returned within one (1) business day. Calls received after midnight are responded to the same business day.[25,26]

d. Triage, Screening and Advice – The waiting time 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, must not exceed thirty (30) minutes.[27]

3. Time or Distance Standards

a. Proximity of PCPs and OB/GYN Primary Care to Members – IEHP network PCPs must be located within ten (10) miles or thirty (30) minutes travel time from the Member's residence, as applicable, based on geographic regions.[28]

b. Proximity of Specialists, OB/GYNs, Behavioral Health, and other Providers – IEHP network Specialists, OB/GYNs, Behavioral Health and other Providers must be located within these distances:[29]

1) For Riverside County, within thirty (30) miles or sixty (60) minutes travel time from the Member's residence; or

2) For San Bernardino County, within forty-five (45) miles or seventy-five (75) minutes travel time from the Member's residence.

c. Proximity of Hospital – IEHP network hospitals must be located within fifteen (15) miles or thirty (30) minutes travel time from their assigned Members' residence, as applicable, based on geographic regions.[30,31]

4. Proximity of Pharmacy – IEHP network pharmacies must be located within ten (10) miles or thirty (30) minutes travel time from the Members' residence, as applicable, based on

[24] KKA, § 1300.67.2.2
[25] National Committee for Quality Assurance (NCQA), 2021 Health Plan Standards and Guidelines, ME 4, Element B
[26] NCQA, 2021 HP Standards and Guidelines, ME 5, Element B
[27] Ibid.
[28] DHCS APL 21-006
[29] Ibid.
[30] KKA, § 1300.51
[31] DHCS APL 21-006

geographic regions.[32]

5. In instances where IEHP does not meet time or distance standards for specific Provider types in IEHP's service region, IEHP will allow Members to see a Provider who is not currently in IEHP's contracted network under the requirements of an Annual Network Certification (ANC) Corrective Action Plan. Non-contracted or Out of Network Providers must be agreeable to rates of payment established with IEHP and not have any documented quality of care concerns in IEHP's systems.[33] (See Attachments, Alternative Access Request – Riverside County" and "Alternative Access Request – San Bernardino County" in Section 14 for currently identified impacted service areas and specialty.)
6. Long-Term Services and Supports (LTSS) – IEHP and its IPAs collaborate with facilities to ensure that Members are placed in Skilled Nursing Facilities (SNFs) or Intermediate Care Facility for the Developmentally Disabled (ICF-DDs), as clinically indicated, within these timeframes:[34]
    a. For Members residing in Riverside County, within seven (7) calendar days of request; or
    b. For Members residing in San Bernardino County, within fourteen (14) calendar days of request.
7. 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 in neighboring service areas to obtain the necessary health care services in a timely manner appropriate for the Member's needs. [35,36] The IPA shall arrange and authorize as appropriate specialty services from specialists outside IEHP's contracted network if unavailable within the network, when medically necessary for the enrollee's condition or when time or distance standards as established by regulators are not met and at no cost to the Enrollee.[37,38] It is important to note that IEHP or its delegated IPAs may not meet Time or Distance Standards for certain zip codes or specialties due to a lack of available Providers with whom to contract in those specific areas but have approved Alternative Access Standards as approved by DHCS.[39] Please see Policy 14D, "Pre-Service Referral Authorization Process" for more information.
8. Telehealth Services – IEHP utilizes telehealth as an option for Members to obtain access to necessary health care services.[40] Please see Policy 18P, "Virtual Care" for more

[32] DHCS APL 21-006
[33] Ibid.
[34] Ibid.
[35] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[36] KKA, § 1300.67.2.2
[37] Ibid.
[38] NCQA, 2021 HP Standards and Guidelines, MED 1, Element D
[39] DHCS APL 21-006
[40] Ibid.

information.

9. 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 Health Clinics."

10. Triage, Screening and Advice Services

    a. PCP Offices – All PCP sites must maintain a procedure for triaging or screening Member calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller: [41,42]

        1) Regarding the length of wait for a return call from the provider; and

        2) How the caller may obtain urgent or emergency care, including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

        Triage services must be provided by a physician, registered nurse , or other qualified health professional acting within their scope of practice and who is trained to screen or triage a Member who may need care.[43] Examples of qualified health professional may include but not be limited to nurse practitioners (NPs) or physician assistants (PA).

    b. After Hours – IEHP provides triage, screening and advice services by telephone 24 hours a day, 7 days a week through its Nurse Advice Line (NAL).[44] By calling the NAL, Members are able to receive assistance with access to urgent or emergency services from an on-call Physician, or licensed triage personnel.[45] 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). In the event a Member calls a Physician's office after hours, there must be enough access to information on how to proceed, either through an answering service or phone message instructions.[46]

    c. Follow-Up After Accessing the Nurse Advice Line (NAL) – IEHP informs PCPs through the secure Provider portal, when their assigned Member accesses service through the IEHP NAL, including the Member's medical situation and the disposition of the call.

[41] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[42] KKA, § 1300.67.2
[43] Ibid.
[44] Ibid.
[45] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[46] KKA, § 1300.67.2.2

11. Telephone Procedures
    a. All PCP offices must have an answering machine and/or answering service during and after business hours. Members who reach voicemail must receive detailed instructions on how to proceed, including but not limited to how to obtain urgent or emergency care.[47]
    b. All PCP offices must have an active and working fax machine twenty-four (24) hours per day, seven (7) days per week. PCP offices that do not have an active and working fax machine should call the Provider Relations Team at (909) 890-2054.
    c. Returning Calls – Provider offices must have a process in place to return Member phone calls.[48] It is understood that the staff member or Physician with whom the Member wishes to speak, may or may not be the party available to return the Member's call. Consequently, the staff member returning the call may or may not be able to definitively address the Member's issue during the call. However, it is 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;
        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. Standards for Returning Calls[49] – Provider offices must, at minimum, perform and document three (3) attempts to return Member phone calls within three (3) business days for non-urgent calls and within twenty-four (24) hours for urgent non-emergency calls.
12. 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. Please see Policy 14C, "Emergency Services" for more information.

[47] KKA, § 1300.67.2.2
[48] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 3, Access Requirements
[49] Ibid.

a. Follow-up of Emergency Department (ED) Visits – IEHP is responsible for informing PCPs of their assigned Members that receive emergency care, 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.[50]

B. **Hospital Standards –** All contracted Hospitals must provide access for Members that need to be admitted for emergency care, inpatient stay, or to utilize hospital-based diagnostic or treatment services.

C. **Special Access Standards**

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."

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 office is assessed to identify if barriers to Member care exist during facility site reviews. Areas audited include but are not limited to: designated parking spaces, wheelchair access, and restroom access for wheelchair users, handrails near toilets, and appropriate signage. If a Provider/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 who are Deaf or Hard-of-Hearing and/or with Limited English Proficiency – All IEHP network Providers, including network Pharmacy and Vision Practitioners, must provide services to Members with limited English proficiency in the Member's primary language. See Policies 9H1, "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. 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 use care within his/her scope of practice, otherwise referrals are coordinated through IEHP at (800) 440-4347 or the designated Behavioral Health Plan:

      1) Behavioral health care 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 are referred to the appropriate county for assessment and treatment. Medi-Cal Members receive annual alcohol misuse screening from their PCP and if screened positive, the

[50] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 7, Emergency Care

Member will receive brief intervention and full screening by the PCP or appropriately qualified Provider. Members needing treatment for alcohol dependence or drug addiction are referred for assessment and treatment to 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.

Riverside County Residents
Community Access, Referrals, Evaluation and Support (CARES) Line
(800) 706-7500

San Bernardino County Residents
San Bernardino County Access Unit
(888) 743-1478

b. Appointment standards:

Behavioral Health[51]	
Type of Visit	**Timeframe**
Life-threatening emergency	Immediate disposition of Member to appropriate care setting
Non-life-threatening emergency	Six (6) hours, or go to the ER
Urgent visit for behavioral health needs that do not require an authorization	Within forty-eight (48) hours of request
Urgent visit for behavioral health need that do require authorization	Within forty-eight (48) hours of request
Initial routine (non-urgent) with a Behavioral Health Care Provider	Within ten (10) business days of request
Follow-up routine (non-urgent) visit	Within ten (10) business days of request
Non-urgent visit with a non-Physician Behavioral Health Provider	Within ten (10) business days of request

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.

[51] NCQA, 2021 HP Standards and Guidelines, NET 2, Element B, Factor 1-4

9. ACCESS STANDARDS

A. Access Standards

Monitoring and Corrective Action Plan Process

A. IEHP monitors network adherence to these access standards through various methods, including but not limited to:

1. On an annual basis, IEHP conducts the Assessment of Network Adequacy Study to assess IEHP's Provider network in areas of Member Experience related to access, access to Providers, and Provider availability such as distribution and ratios. This study uses various sources of data, including but not limited to grievance and appeals data, CAHPS survey data, Annual Behavioral Health Member Experience Survey, Appointment Availability Survey results, and out-of-network data.

2. **Appointment Availability Standards** – On an annual basis, IEHP assesses the network's adherence to appointment availability standards for PCPs, high volume Specialists, Behavioral Health, and Ancillary Providers using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey (PAAS) 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 and act on Providers that are not meeting access standards to bring them into compliance.

   a. For PCPs, the Plan will not perform a sampling of the Providers. Instead, the Plan will survey all active PCPs.

   b. For Specialty Care and Ancillary Care Providers, IEHP will follow the sampling methodology as outlined by the DMHC for.

   Using the DMHC PAAS methodology and tools, IEHP reports on the health plan's overall rate of compliance for each of the time elapsed standards, and that of each IPA in Riverside and San Bernardino Counties (See Attachments, "DMHC Provider Appointment Availability Survey Methodology" and "DMHC Appointment Availability Survey Tools in Section 9). IEHP may utilize a third-party survey vendor to implement all or part of the DMHC PAAS Survey methodology.

3. **Missed Appointments** – The Quality Management Department monitors missed appointments, follow-up, and documentation efforts through the Facility Site Review (FSR) and Medical Record Review (MRR) survey process.

4. **Waiting Times** – The Quality Management Department monitors office wait times through the FSR/MRR survey process. The Provider Relations Team also monitors office wait times by collecting wait time information during the Provider in-service. On a semi-annual basis, all Practitioners are asked to verify office wait time as part of the Provider Directory verification process. On at least an annual basis, the Quality Improvement (QI) Subcommittee reviews the information collected and makes recommendations on actions to take if Practitioners are found to be non-compliant with office wait time standards.

5. **Time or Distance Standards –** On an annual basis, IEHP conducts the Provider Network Status Study to ensure that the health plan is compliant with time, distance, and Provider to Member ratio standards established by the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and DMHC, as well as to monitor guidelines provided by the National Committee for Quality Assurance (NCQA). The QI Subcommittee reviews the findings and makes recommendations on actions to take if the health plan is found to be non-compliant with these standards.
6. **Triage, Screening and Advice** – On a monthly basis, IEHP's Family & Community Health Department monitors the Nurse Advice Line's performance and adherence to after -hours triage, screening and advice standards by reviewing triage call center reports. On at least an annual basis, the QI Subcommittee reviews and makes recommendations on actions to take if the NAL provider is found to be non-compliant with triage, screening and advice standards.
7. **Telephone Procedures –** IEHP ensures PCPs have an established and maintained process for answering and returning Member calls through the Facility Site Review (FSR) and Medical Record Review (MRR) survey process. Additionally, all network Providers submit their Provider Information Verification Form as part of the semi-annual Provider Directory verification process. The QI Subcommittee reviews the information collected and makes recommendations on actions to take if Practitioners are found to be non-compliant with telephone answer and return call wait time standards.
8. **Access for People with Disabilities –** IEHP conducts the Physical Accessibility Review Survey (PARS) assessment on PCP, identified high volume Specialist, identified high volume Ancillary sites and all contracted Community Based Adult Services (CBAS) Providers as part of the FSR and MRR process. Information gathered from the PARS assessment are made available to IEHP Members through the IEHP Provider Director and the IEHP website. Please see Policy 6B, "Physical Accessibility Review Survey" for more information.
9. **Access and Interpretation Services for People are Deaf or Hard-of-Hearing and/or with Limited English Proficiency** – The Quality Management Department monitors compliance with these standards through these FSR/MRR survey questions:

   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.

   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.

B. Additional monitoring is performed through the review of grievances and Potential Quality Incidents (PQIs) for individually identified Providers.

C. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures. Please see Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements" for more information regarding the CAP process.

D. IEHP shares with its Delegates the annual plan-wide Appointment Availability and Access Study results. While IEHP does not require Delegates to submit CAPs for identified deficiencies in their network, IEHP does require Delegates to submit their Annual Appointment Availability and After-Hours Access Study program, results, corrective actions taken, follow up call campaigns and proof of Provider training given to remediate any identified deficiencies.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2022