4. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

A. This policy applies to all IEHP Covered 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. IEHP monitors plan-wide adherence to these access standards through access studies, review of grievances and other methods.

C. IEHP shall not prevent, discourage, or discipline a network Provider or employee for informing a Member about the timely access standards.[1]

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.

DEFINITIONS:

A. **Appointment Waiting Time –** The time from the initial request for health care services by a Member or the Member'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.[2] A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.

B. **Emergency Medical Condition** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:[3]

   1. Placing the patient's health in serious jeopardy;
   2. Serious impairment to bodily function; or
   3. Serious dysfunction of any bodily organ or part.

C. **Urgent Care Services** – These are services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member

[1] California Health and Safety Code (Health & Saf. Code) § 1367.03(d)
[2] Title 28 California Code of Regulations (CCR) § 1300.67.2.2(b)(2)
[3] CA Health & Saf. Code § 1371.1 (b)

returns to the Plan's service area.[4]

D. **Urgent Visit** – These are health care services to address an urgent but non-emergency medical condition.

E. **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.

F. **Initial Health Assessment** – See Policy 5A, "Initial Health Assessment.

G. **Incidents of Non-Compliance Resulting in Substantial Harm -** A health care service plan or managed care entity shall have a duty of ordinary care to arrange for the provision of medically necessary health care service to its Members, where the health care services is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care when both of the following apply:

1. The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a Member; and
2. The Member suffered substantial harm.

For the purpose of this policy, substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss. Health care services need not be recommended or furnished by an in-plan provider, but may be recommended or furnished by any health care provider practicing within the scope of his or her practice. Health care services shall be recommended or furnished at any time prior to the inception of the action, and the recommendation need not be made prior to the occurrence of substantial harm.

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

I. **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.

J. **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.

K. **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.

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

M. **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

[4] Title 28 California Code of Regulations § 1300.67(g)(2)

health professional acting within his or her scope of practice and who is trained to screen or triage a Member who many need care, for the purpose of determining the urgency of the Member's need for care. Other qualified health professionals include nurse practitioners (NP) and physician assistants (PA).

N. **Network** - A discrete set of network Providers, the Plan has designated to deliver all covered services for a specific network service area.[5]

O. **Network Adequacy -** The sufficiency of a Plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements.[6]

P. **Network Provider – A**ny Provider[7] located inside or outside of the network service area of a designated network.[8]

Q. **Network Services Area -** The geographical area, and population points contained therein, where the plan is approved by DMHC to arrange health care services consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by DMHC on the web portal accessible at www.dmhc.ca.gov.[9]

R. **Preventive Care -** Health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full-service plan includes but is not limited to all of the basic health care services.[10,11,12]

S. **Patterns of Non-Compliance -** Timely Access to Care standards set forth in Title 28 California Code of Regulations (CCR) § 1300.67.2.2(c). For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of noncompliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.

The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to Members. The Department may consider any

[5] 28 CCR § 1300.67.2.2(b)(5)
[6] 28 CCR § 1300.67.2.2 (b)(6)
[7] CA Health & Saf. Code § 1345(i)
[8] 28 CCR § 1300.67.2.2(b)(10)
[9] 28 CCR § 1300.67.2.2(b)(11)
[10] 28 CCR § 1300.67.2.2(b)(3)
[11] CA Health & Saf. Code § 1345(b)(5)
[12] CA Health & Saf. Code § 1367.03(e)(3)

of the following factors in evaluating whether each instance identified is part of a pattern of non-compliance that is reasonably related:

1. Each instance is a violation of the same standard set forth in subsection (c) of this Rule;
2. Each instance involves the same network;
3. Each instance involves the same provider group, or subcontracted plan;
4. Each instance involves the same provider type;
5. Each instance involves the same network provider;
6. Each instance occurs in the same region. For purposes of this subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county;
7. The number of Members in the health plan's network and the total number of instances identified as part of a pattern;
8. Whether each instance occurred within the same twelve-month period; or
9. Whether each instance involves the same category of health care services.

T. **Plan-to-Plan Contract** - An arrangement between two plans, in which the subcontracted plan makes network Providers available to primary plan Members and may be responsible for other primary plan functions. Plan-to-plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan.

U. **Primary Plan** – A licensed plan that holds a contract with a group, Member, or a public agency, to arrange for the provision of health care services

V. **Subcontracted Plan** - A licensed plan or specialized plan that is contracted to allow a primary plan's Members access to the subcontracted plan's network Providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.

PROCEDURES:

A. **Access Standards for Clinical Services**

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

4. ACCESS STANDARDS

A. Access Standards

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 <u>not</u> require prior authorization[13]	Within 48 hours of request
Urgent visit for services that do require prior authorization[14]	Within 96 hours of request
Non-urgent (routine) visit[15]	Within 10 business days of request
Physical examination[16]	Within 36 business days of request
Initial health assessment	Within 120 calendar days of enrollment
Initial health assessment (under 18 months of age only)	Within 60 calendar days of enrollment
Well-Woman Examination[17]	Within 36 business days of request
Follow up exam	At the clinical judgment of the treating Provider regarding the speed and frequency of medically necessary care.[18]

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[19]	Within 48 hours of request
Urgent visit for services that do require prior authorization[20]	Within 96 hours of request
Urgent prenatal visit[21]	Within 48 hours of request
Non-urgent (routine) visit[22]	Within 15 business days of request
Non-urgent visit for ancillary services (for diagnosis or treatment of injury or other health condition)[23]	Within 15 business days of request
Initial Prenatal Visit	Within 10 business days of request

[13] Title 28 California Code of Regulations (CCR) § 1300.67.2.2
[14] 28 CCR § 1300.67.2.2
[15] Ibid.
[16] 28 CCR § 1300.67.2.2
[17] 28 CCR § 1300.67.2.2
[18] 28 CCR § 1300.67.2.2 (c)(5)(H)
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] KKA, § 1300.67.2.2

4. ACCESS STANDARDS

A. Access Standards

Specialist	
Type of Appointment	**Timeframe**
Non-urgent (routine) prenatal care[24]	Within 10 business days of request
Well-Woman Examination[25]	Within 36 business days
Follow up exam	At the clinical judgment of the treating Provider regarding the speed and frequency of medically necessary care.[26]

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.[27]

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.[28]

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.[29] Please see Policy 4B, "Missed Appointments," for more information.

d. Interpreter Services – Interpreter Services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment.[30,31]

[24] 28 CCR § 1300.67.2.2
[25] Ibid.
[26] 28 CCR § 1300.67.2.2 (c)(5)(H)
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] 28 CCR § 1300.67.2.2 (c)(4)
[31] Health and Safety Code § 1367.03 (a)(4)

4. ACCESS STANDARDS

A. Access Standards

2. Waiting Times

   a. Practitioner Office – For primary or specialty care, the waiting time for a scheduled appointment must be no longer than 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 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 10 minutes.[32] 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, 7am-7pm and Saturday/Sunday 8am-5pm) are returned within one (1) business day. Calls received after midnight are responded to the same business day.[33,34]

   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 30 minutes.[35,36]

3. Provider Appointment Availability Survey (PAAS)

   a. IEHP monitors appointment access for PCPs, Specialists and Behavioral Health Providers and assesses them against established standards at least annually. There is significant evidence that timely access to health care services results in better health outcomes, reduced health disparities, lower spending, including avoidable emergency room visits and hospital care.

   b. IEHP collects the required appointment access data from Practitioner offices using the Department of Managed Health Care (DMHC) PAAS methodology and tool. IEHP also evaluates the grievances and appeals data quarterly to identify potential issues with access to care, including incidents of non-compliance resulting in substantial harm to Member. Following the completion of the survey, all responses were compiled and entered into a results grid. The compliance rate then can be calculated to be compared with the goal established and the previous year's rate to

[32] 28 CCR § 1300.67.2.2
[33] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, ME 4, Element B
[34] NCQA, 2024 HP Standards and Guidelines, ME 5, Element B
[35] Ibid.
[36] 28 CCR § 1300.67.2.2(c)(8)(A)

identify patterns of non-compliance. Results of the quantitative analysis are presented to IEHP's Provider Network Access Subcommittee for review and identification of priorities for interventions. This includes establishing goals and objectives, opportunities for improvement, completion timeframes, monitoring of corrective action plans (CAPs), and ongoing analysis of the work completed during the measurement year.

c. CAP consists of follow-up call campaigns, Provider education, identifying and tracking any incidents that have resulted in substantial harm, peer review, and implementing corrective actions when necessary to address any patterns of non-compliance.

d. IEHP conducts an annual Provider Appointment Availability Access Study to identify potential inaccuracies and the steps it will take to verify the data accuracy, including the following:

1) Process for collecting information to identify network Providers reported to DMHC in the PAAS Report Forms;

2) How IEHP identifies potential inaccuracies;

3) A description of the sources IEHP uses to verify Provider information;

4) Steps IEHP will take to verify the key data, such as Provider location and Provider Specialty is accurate;

5) Processes for incorporation updated information from Provider Directory verification efforts into the PAAS Report Form; and

6) Processes for using the prior year's ineligible information to improve the PAAS Contact List.

4. Time or Distance Standards

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

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:[37]

1) For Riverside County, within_30 miles or 60 minutes travel time from the Member's residence; or

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

c. Proximity of Hospital – IEHP network hospitals must be located within 15 miles or

[37] Ibid.

30 minutes travel time from their assigned Members' residence, as applicable, based on geographic regions.[38]

5. Proximity of Pharmacy – IEHP network pharmacies must be located within 10 miles or 30 minutes travel time from the Members' residence, as applicable, based on geographic regions.
6. 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.[39]
7. IEHP follows Department of Managed Health Care (DMHC) regulatory requirements for Provider network adequacy to assure the required one full-time equivalent (FTE) Primary Care Provider (PCP) per 2,000 Member ratio. This ratio is calculated on the Plan's PCP network as a whole and is not applied to an individual PCP.
8. Long-Term Services and Supports (LTSS) – IEHP 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:[40]
    a. For Members residing in Riverside County, within seven (7) calendar days of request; or
    b. For Members residing in San Bernardino County, within 14 calendar days of request.
9. Provider Shortage – If timely appointments within the time or distance standards required are not available, then IEHP shall refer the Member to or assist in locating an 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.[41] IEHP shall arrange and authorize as appropriate covered services from Providers outside IEHP's contracted network if unavailable within the network, when medically necessary for the Member's condition. IEHP shall ensure when time or distance standards as established by regulators are not met and Member cost for medically necessary referrals shall not exceed applicable in-network co-payments, co-insurance, and deductibles.[42,43] It is important to note that IEHP 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

[38] 28 CCR § 1300.51
[39] Ibid.
[40] Ibid.
[41] 28 CCR § 1300.67.2.2
[42] 28 CCR § 1300.67.2.2 (c)(7)(C)
[43] NCQA, 2024 HP Standards and Guidelines, MED 1, Element D

specific areas

10. Telehealth Services – IEHP utilizes telehealth as an option for Members to obtain access to necessary health care services.[44]

11. Minimum Hours On-Site – PCPs must be on site and available for Member care a minimum of 16 hours per week, or meet the criteria identified in Policies 6D, "Residency Teaching Clinics" and 6E, "Rural Health Clinics." Non-prescribing Behavioral Health Providers (LMFTs and LCSWs) must be available for Member care a minimum of sixteen 16 hours per week.

12. 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:[45]

        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.[46] 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).[47] 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. 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.[48]

    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

[44] Ibid.
[45] 28 CCR § 1300.67.2
[46] Ibid.
[47] Ibid.
[48] 28 CCR § 1300.67.2.2

disposition of the call.

13. 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. [49]
    b. All PCP offices must have an active and working fax machine 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. 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[50] – 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 24 hours for urgent non-emergency calls.
14. 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 24 hours a day, seven (7) days a week.
    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

[49] 28 CCR § 1300.67.2.2
[50] Ibid.

any necessary medical records from such a visit and arranging any needed follow-up care.

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. **Filing and Reporting Procedures for identifying Network Providers**

1. The Regulatory Affairs (RA) team submits timely reports and filings to DMHC as mandated by IEHP's Knox-Keene License(s) and ad-hoc requests received from DMHC.
2. The RA team verifies that the information and data collected for reporting is true and correct and does not contain misstatements or omissions of material fact.
3. The Vice President, Compliance/Compliance Officer, and/or their designee is the primary point of contact for DMHC.
4. The RA team maintains copies of IEHP's Knox-Keene licenses.

D. **Utilization Management – Timeliness Standards**

Type of Request	Decision	Notification Timeframes
Urgent Pre-Service Requests ***Definition****: Member's condition is such that the Member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or when the nonurgent timeframe for making a determination would be detrimental to the Member's life or health, or could jeopardize Member's ability to regain maximum function.*	• Determine within 48 hours of receiving the request if the request does not meet the definition for urgent pre-service request. • If accepted as an urgent pre-service request, render a decision in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary and requested by the plan to make the determination. •	• If the request does not meet the definition for urgent pre-service request, notify the requesting Provider via fax within 48 hours of receiving the request (including holidays and weekends). • If accepted as an urgent pre-service request: ✓ The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision. ✓ The Member and Requesting Provider must be notified of the decision in writing within 72 hours of receipt of request. • For terminations, suspension, or reductions of previously authorized services, notify the Member at least 10 days prior to the effective date of the change.
Urgent Concurrent Requests (Example: Continued Home Health, Physical	• Determine within 48 hours of receiving the request the request	• If the request does not meet the definition for urgent concurrent request, notify the requesting

Therapy, Speech Therapy, and Occupational Therapy requests, only when initial preservice request for service did not expire) ***Definition**: Member's condition is such that the Member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or when the nonurgent timeframe for making a determination would be detrimental to the Member's life or health, or could jeopardize Member's ability to regain maximum function.*	does not meet the definition for urgent concurrent request. • If accepted as an urgent concurrent request, render a decision in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary and requested by the plan to make the determination. •	Provider via fax within 48 hours of receiving the request (including holidays and weekends). • If accepted as an urgent concurrent request: ✓ The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision. ✓ The Member and Requesting Provider must be notified of the decision in writing within 72 hours of receipt of request. • For terminations, suspension, or reductions of previously authorized services, notify the Member at least 10 days prior to the effective date of the change.
Standard (Non-Urgent) Pre-Service Requests	Render a decision in a timely fashion appropriate for the nature of the Member's condition, but no longer than five (5) business days from receipt of the information reasonably necessary and requested to make the determination. •	• The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision • The Member and Requesting Provider must be notified of the decision in writing within two (2) business days of the decision using the appropriate NOA template. • For terminations, suspension, or reductions of previously authorized services, notify the Member at least ten 10 days prior to the effective date of the change.
Standard (Non-Urgent) Concurrent Requests	Render a decision in a timely fashion appropriate for the nature of the Member's condition, but no longer than five (5) business days from receipt of the information reasonably necessary and requested to make the determination.	• The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision. • The Member and Requesting Provider must be notified of the decision in writing within two (2) business days of the decision

	•	using the appropriate NOA template. • For terminations, suspension, or reductions of previously authorized services, notify the Member at least 10 days prior to the effective date of the change.
Post-Service/ Retrospective Review	Render a decision within 30 calendar days of receiving the information that is reasonably necessary to make the retrospective authorization determination.	• The Member and Requesting Provider must be notified of the decision in writing within thirty 30 calendar days of receiving the information that is reasonably necessary to make the retrospective authorization determination.

*IEHP abides the following statement: "A health care service plan that authorizes a specific type of treatment by a Provider shall not rescind or modify this authorization after the Provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to the Member under a plan."[51]

E. **Member Experience Survey –** A Member Experience Survey is performed annually by IEHP according to NCQA's HEDIS® methodology. The HEDIS® specifications require health plans to utilize CAHPS®, and to administer the survey through a third party, NCQA certified survey vendor. Survey results are shared with DHCS, NCQA, CMS Governing Board and QM Committee.

F. **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

1. IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess Member experience with the services and care received based on a statistically valid and reliable survey methodology. CAHPS® is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas to evaluate:

   a. Member perspective and concerns regarding experience obtaining timely appointments within the standards;

   b. Experience with health care services related to access to care, coordination of care, office customer service, health plan experience, and personal doctor;

   c. Satisfaction with IEHP Programs;

   d. Member grievances and appeals; and

   e. Member Services Department's call services levels.

[51] Health and Safety Code §1371.8

2. CAHPS® surveys serve as a means to provide usable information about quality of care received by the Members. IEHP uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, IEHP reviews the CAHPS® results and compared with prior year results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.
3. For the CAHPS® survey, IEHP will:[52]
    a. Inform Members of their rights to obtain an appointment within each of the time-elapsed standards including notice of their right to receive interpreter services at the appointment;[53]
    b. Evaluate the experience of limited English proficient (LEP) Members in obtaining interpreter services by obtaining Members' perspectives and concerns regarding coordination of appointments with an interpreter, availability of interpreters who speak the Member's preferred language and the quality of interpreter services received; and
    c. Translate the Member Experience Survey into IEHP's threshold languages.

G. **Internal Member Experience Studies**

1. BH Member Experience Survey: IEHP surveys Members who are receiving behavioral care services at least annually to evaluate their experience with the services received. The survey focuses on key areas like getting care needed; getting appointments to BH Practitioners; experience with IEHP staff and network of BH Practitioners; and other key areas of the Plan operations. The goal of the experience n study is to identify and implement opportunities to improve Member experience.
2. Behavioral Health Treatment (BHT) Autism Member experience Survey: IEHP conducts an internal survey for Medi-Cal Members to assess Member Experience with IEHP's Behavioral Health Treatment (BHT) services. The survey focuses on key areas like Access to BHT services; experience with their BHT Provider; experience with IEHP's BH & CM Department and other key areas of the Plan operations. The goal of the experience study is to identify, review and implement opportunities to improve services and Member experience.
3. Population Health Management (PHM) Population Assessment - Member Experience Survey: Annually, IEHP conducts an internal member experience survey for Medi-Cal Members to assess Member Experience with IEHP's Population Health Management programs. The survey focuses on Member feedback from at least two programs (e.g. disease management or wellness programs). Feedback is specific to the programs being evaluated. Additionally, IEHP analyzes complaints to identify opportunities to improve

[52] Ibid.
[53] 28 CCR § 1300.67.2.2(c)(4)

experience.

H. **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.
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.
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.
4. Access Standards for Behavioral Health Services – The following information delineates the access standards for availability of services to Covered California 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:
   b. Behavioral health care services are provided by the IEHP BH Program. Covered California Members receive annual alcohol misuse screening from their PCP and if screened positive, the 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 Alcohol treatment program. During normal business hours referral assistance is available through IEHP. Appointment standards:

Behavioral Health[54]	
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

[54] NCQA, 2024 HP Standards and Guidelines, NET 2, Element B, Factors 1-4

Behavioral Health[54]	
Type of Visit	**Timeframe**
Urgent visit for behavioral health needs that do not require an authorization	Within 48 hours of request
Urgent visit for behavioral health need that do require authorization	Within 48 hours of request
Initial routine (non-urgent) visit with a Behavioral Health Care Provider	Within 10 business days of request
Follow-up routine (non-urgent) visit with a Behavioral Health Care Provider	Within 10 business days of request
Follow-up routine (non-urgent) visit with a Non-Physician Mental Health Care or Substance Use Disorder Provider[55]	Within 10 business days of the prior appointment or at the clinical judgment of the treating Provider regarding the speed and frequency of medically necessary care[56]

c. After Hours Access for Behavioral Health Care:

1) All Behavioral Health Providers are required to have an automated answering system 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.

5. Access to Dental Services – IEHP ensures that its dental network has adequate capacity and availability of licensed health care providers to offer Members appointments for covered dental services within the following standards:[57]

Dental Services	
Type of Visit	**Timeframe**
Urgent appointments	Within 72 hours of the time of request for appointment, when consistent with the Member's individual needs and as required by professionally recognized standards for dental practice
Non-urgent appointments	Within 36 business days of the request for appointment

[55] 28 CCR § 1300.67.2.2
[56] 28 CCR § 1300.67.2.2 (c)(5)(H)
[57] 28 CCR § 1300.67.2.2(c)(6)

4. ACCESS STANDARDS

A. Access Standards

Dental Services	
Type of Visit	**Timeframe**
Preventive dental care appointments	Within 40 business days of the request for appointment

Monitoring and Corrective Action Plan Process

A. On a quarterly basis, IEHP reviews and evaluates the Quarterly Monitoring Report Template (QMRT) regarding our ability to meet timely access surveys and network adequacy requirements, investigation of complaints, grievances and Appeals, issues of non-compliance with contractual requirements and policy guidance; IEHP network monitoring and oversight assessments, quality of care indicators, data reviews for utilization capacity, and Provider-to-Member rations; authorization of OON requests, and the provision of transportation services IEHP's quarterly compliance monitoring process pertaining to network adequacy shall ensure that Members have access to the full range of covered services through an adequate network.[58,59]

B. 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.

      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 in Riverside and San

[58] 28 CCR § 1300.67.2.2 (d)(2)(D)
[59] DHCS APL 23-001

Bernardino Counties. 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 telephone procedures via the 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 Directory and the IEHP website.

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.

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

D. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.

E. 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.

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4. ACCESS STANDARDS

B. Missed Appointments

APPLIES TO:

A. This policy applies to all IEHP Covered Providers.

POLICY:

A. Providers must implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, and initial health assessments, which include procedures for follow-up on missed appointments.[1]

PROCEDURES:

A. PCPs must have a process in place to follow-up on missed appointments. Appointments must be promptly rescheduled, when necessary, in a manner that is appropriate for the Member's health care needs, ensures continuity of care[2] and includes at least the following:

1. Notation of the missed appointment in the Member's medical record.
2. Review of the potential impact of the missed appointment on the Member's health status including review of the reason for the appointment by a licensed staff member of the PCP's office (RN, PA, NP, DO or MD) as appropriate.
3. Notation in the chart describing follow-up for the missed appointment including one of the following actions:
    a. No action if there is no effect on the Member due to the missed appointment; or
    b. A letter or phone call to the Member as appropriate, given the type of appointment missed and the potential impact on the Member.
4. At least one (1) attempt must be made to contact a Member due to a missed appointment.
5. Documentation of the attempts must be entered in the Member's medical record and copies of letters retained.
6. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.
7. Office staff in Provider offices must be trained in, and be familiar with, the missed appointment procedure specific to their site.
8. Providers cannot charge Members for any missed appointments. See Policy 12J, "Providers Charging Members."

B. Monitoring

[1] Title 28 California Code of Regulations (CCR), § 1300.67.2.2
[2] 28 CCR § 1300.67.2.2(c)(3)

4. ACCESS STANDARDS

B. Missed Appointments

1. IEHP Quality Management Department monitors missed appointments through the Facility Site Review (FSR) and Medical Record Review (MRR) process, initially and at minimum every three (3) years thereafter.

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4. ACCESS STANDARDS

C. Non-Emergency Medical Transportation Services

APPLIES TO:

A. This policy applies to IEHP Covered Members.

POLICY:

A. IEHP provides Non-Emergency Medical Transportation (NEMT) services when prior authorized. Services include:

1. Non-emergency ground ambulance transportation from one medical facility to another when prior authorized by IEHP or Plan-contracted provider.
2. Non-emergency air ambulance transport when prior authorized by IEHP from one medical facility to another.
3. Non-emergency ambulance and psychiatric transport services within the service area if:

    a. IEHP or Plan-contracted physician determines that the Member's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and

    b. The use of other means of transportation would endanger the Member's health..

DEFINITIONS:

A. Non-Emergency Medical Transportation (NEMT) – medically necessary transportation to or from an IEHP contracted provider or facility.

PURPOSE:

A. To ensure that Members have transportation access for medically necessary transfers to and from IEHP contracted facilities and non-emergency ambulance and psychiatric transport services within the service area.

PROCEDURES:

General Information

Member Rights and Responsibilities

A. Members requiring NEMT should contact IEHP Member Services Department at (800) 440-4347 at least two (2) business days prior to requested service to ensure transportation is arranged in a timely manner.

1. If the Member requesting NEMT has justification for why IEHP needs to transport them under five (5) business days or 48-hour time frame, the Member may call IEHP's Member Services Department at (800) 440-4347.

B. Members or Providers must contact IEHP within 24 hours of scheduled transportation when transportation services are no longer required or canceled.

C. Members are responsible for the applicable cost share for covered NEMT services.

IEHP Responsibilities

A. IEHP or its Transportation Broker coordinates with transportation providers to ensure we meet timely access standards when providing NEMT. See Policy 4A, "Access Standards" for more information.

B. IEHP makes its best effort to provide and coordinate NEMT for covered services.

C. IEHP bears authorization responsibility for transportation services. Members will be responsible for the appropriate cost share.

Coverage and Limitations

A. IEHP will provide NEMT services to the Member. Members may only travel to and from the network medical/mental health facilities, within the San Bernardino and Riverside counties, unless the service is not available within the two (2) counties.

B. Paramedic, ambulance, or ambulance transport services are not covered in these situations:

1. If IEHP determines that the ambulance or ambulance transport services were never performed.
2. Upon findings of fraud, incorrect billing, that the provision of services that were not covered under the plan, or that membership was invalid at the time services were delivered for the pending emergency claim.
3. Non-emergent ambulance transport services not authorized.

C. IEHP will not provide transportation services to any service that is not covered by IEHP.

D. IEHP can direct all NEMT requests to in-network transportation providers. If no in-network provider can accommodate the Member's transportation needs based on their medical, physical, or mental condition, arrangements are made for the Member to receive services from an appropriately qualified provider outside the IEHP network.

Non-Emergency Medical Transportation (NEMT)

Prior Authorization

A. NEMT services are a covered benefit when a Member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider or a physician extender, for purposes of enabling a Member to obtain medically necessary covered services.

B. NEMT services are subject to prior authorization. IEHP will authorize the appropriate modality prescribed by the Member's PCP or treating Provider.

4. ACCESS STANDARDS

C. Non-Emergency Medical Transportation Services

C. Prior authorization is required, when NEMT services are provided to a Member being transferred from an emergency room to an inpatient setting, or an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

D. IEHP authorizes the type of NEMT that is adequate for the Member's medical needs if multiple modalities are selected by the Member's Provider

E. IEHP ensures door-to-door assistance is being provided for all Members receiving NEMT services.

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4. ACCESS STANDARDS

D. Access to Care for Members with Access and Functional Needs

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP ensures equal access to the provision of high quality interpreter and linguistic services for Members and potential Members with Limited English Proficiency (LEP) Members and/or disabilities.[1]

B. IEHP prohibits discrimination against Members on the basis of disability or Limited English Proficiency (LEP).[2] All IEHP Providers contracted to provide care to Members are required to provide and maintain access to facilities and services to individuals with access and functional needs.[3]

DEFINITIONS:

A. Service animals – any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability.[4,5]

1. Service animal activities include but are not limited to: guiding people who are blind, alerting individuals who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other special tasks.
2. Service animals include: Guide dogs; signal dogs; or other dogs individually trained to provide assistance to a person with a disability.

   Miniature horses that have been individually trained to do work or perform tasks for people with disabilities can be covered by IEHP in accordance with Americans with Disabilities Act (ADA) regulation standards. Service animals are working animals, not pets.[6]

PROCEDURES:

A. Prior to a Primary Care Provider (PCP) being approved to be assigned Members, IEHP performs a comprehensive access survey for people with disabilities during the initial facility site review of PCP sites. This survey is repeated every three (3) years thereafter.

[1] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 6, Section 6.6, Customer Care
[1] Title 42 United States Code (USC) § 18116 et.seq
[3] Ibid.
[4] Title 28 Code of Federal Regulations (CFR) § 35.136
[5] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Service Animals, 2/24/20
[6] 28 CFR § 35.136

B. **Providers who are anticipating modification to their facilities must meet Americans with Disabilities Act Accessibility Guidelines (ADAAG).**[7]

1. The ADA and California's Code of Regulations Title 24 require health care Providers to follow specific accessibility standards and codes when constructing new facilities, and when making alterations that could affect access to or use of the facility by people with disabilities.[8,9]

2. Providers that need additional assistance in regards to ADAAG can reach out to IEHP's ADA access line through its Provider Call Center at (909) 890-2054 or view the ADAAG online:https://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-ada-standards/background/adaag#purpose. For more information on the ADA, Providers can visit IEHP's "ADA and Beyond" web page: https://www.iehp.org/en/providers/special-programs?target=independent-living-and-diversity-resources

C. **Service Animals**[10]

1. Access must be provided, whenever feasible, to service animals.

   a. Providers are prohibited from requiring "certification" or proof of an animal's training, or proof of a person's disability, for the purposes of access. Staff may ask two (2) questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform? Evidence of current vaccinations, may be requested.

   b. Providers must make reasonable modifications in their policies, practices and procedures when necessary to accommodate Members with disabilities. Generally, this includes modifying any no-pet policies to permit use of a service animal by an individual with a disability.

2. A service animal must be permitted to accompany the Member to all areas of the facility where Members are normally permitted unless a medical justification demonstrates that the presence or use of a service animal would pose a health risk in certain parts of the institution directly involved.[11]

3. Providers may request that the Member be separated from their service animal for short periods of time, if it is necessary to provide a service (i.e. Aqua PT, Audiology testing, or other procedures where there is limited space). The separation should not be any longer than it takes to provide the service.[12]

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[7] 28 CFR part 36, subpart D, "New Construction and Alterations"
[8] 42 USC § 12101
[9] 24 CFR § 570.614
[10] 28 CFR §35.136
[12] Americans with Disabilities Act (ADA), 2010 Revised Requirements, Service Animals
[12] ADA, 2010 Revised Requirements, Service Animals

4. Care and supervision of a service animal are the responsibility of the Member and/or authorized representative. Neither IEHP nor its Providers are required to supervise or care for the service animal. Members need to make their own arrangements to have someone feed, water and walk the animal during necessary separation in a medical facility.[13]
5. A service animal shall be under the control of its handler. A service animal shall have a harness, leash, or other tether, unless either the handler is unable because of a disability to use a harness, leash, or other tether, or the use of a harness, leash, or other tether would interfere with the service animal´s safe, effective performance of work or tasks, in which case the service animal must be otherwise under the handler´s control (*e.g.*, voice control, signals, or other effective means).[14]
6. Restrictions on Service Animals
    a. A person with a disability cannot be asked by Providers to remove their service animal from the premises unless:[15]
        1) The nature of the goods and services provided, or accommodations offered at the Provider's medical facility would be significantly altered.
        2) The safe operation of the medical facility would be jeopardized, or the animal poses a direct threat to the health or safety of others, such as preventing what should be a sterile environment (such as a surgical suite) or present a threat to others' safety (such as an animal being out of control and the owner does not take effective action). Such areas may include, but are not limited to, the following:
            - Operating room suites and post-anesthesia rooms;
            - Burn unit;
            - Coronary care units;
            - Intensive care units;
            - Oncology units;
            - Psychiatric units;
            - Isolation areas;
            - Medication storage areas; and
            - Clean or sterile supply areas.

[13] 28 CFR § 35.136(e)
[14] 28 CFR **§ 35.**136**(**d**)**
[15] ADA, 2010 Revised Requirements, Service Animals

D. Access to Care for Deaf or Hard-of-Hearing

1. IEHP provides appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills upon request.[16] This includes assistive listening systems, sign language interpreters, captioning, written communication, and electronic format.[17]
2. Requests for interpreter services at PCP sites, Skilled Nursing Facilities (SNFs), and outpatient visits for Members who are deaf or hard-of-hearing may originate from:
    a. Member;
    b. Family member and/or Authorized Representative;
    c. Member's PCP or Specialist;
    d. Member's Plan; or
    e. IEHP.
3. IEHP can better ensure the availability of interpreters for a medical appointment if given at least five (5) working days' notice. As such, those requesting interpreter services should call IEHP Member Services at (800) 440-IEHP (4347)/ TTY (800) 718-4347 at least five (5) working days in advance of the medical appointment and provide the following information:
    a. Member's full name;
    b. IEHP Member Identification Number or Social Security Number;
    c. PCP or Specialist's name;
    d. Date and location of appointment;
    e. Time and expected length of appointment;
    f. Type of interpretation needed (e.g., ASL, oral, or written);
    g. Preferred gender of the interpreter required; and
    h. Single or an on-going appointment.
4. It is recommended that the Member or Provider make arrangements for an interpreter at the same time that the medical appointment is being scheduled.
5. IEHP and its Providers may not suggest or require that Members provide their own sign language or oral interpreters. However, a family member or friend may be used as an interpreter if this is requested by the Member after being informed of their right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services or violate the Member's confidentiality. Minors should not be

[16] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.042
[17] Ibid.

used as interpreters except for extraordinary circumstances such as medical emergencies. The Member's refusal of free interpreter services and their request to use family members, friends, or a minor child as an interpreter must be documented in the Members' medical record. [18]

6. Video Remote Interpreting (VRI) services do not require a prior authorization from IEHP. VRI is available to Members who are deaf or hard-of-hearing while accessing health plan services at contracted Urgent Care Facilities and SNFs.
    a. Providers may contact IEHP through its Provider Call Center for VRI set-up and technical assistance at (909) 890-2054.
    b. The following Member information will be collected by the VRI vendor at the start of the VRI session:
        1. IEHP Member First Name;
        2. IEHP Member Last Name; and
        3. IEHP Member Date of Birth.
7. Medical appointments may be rescheduled by a Member's health care Provider, upon agreement of both parties, if there is no qualified interpreter available for the Member at that time.
8. Members have the right to file a grievance if their access accommodations are unjustifiably denied.[19]
9. Grievances and Member requests for disenrollment mentioning inadequate access for people with disabilities are carefully analyzed and investigated to determine areas where improvements can be made.

E. **IEHP and Provider Responsibilities**

1. For interpretation services, including American Sign Language (ASL), oral, and signed English, all Practitioners must provide interpreters as requested for Member appointments at no charge to the Member.[20]
2. All Hospitals must provide interpreters as needed for inpatient and emergency services. The Hospitals are responsible for the cost and arrangement of interpretation services.[21]

[18] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.03
[19] Ibid.
[20] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.031
[21] 28 CCR § 1300.67.04

3. IEHP is responsible for the cost of the interpretation services for PCP and outpatient visits.[22,23]
4. IEHP authorizes all interpretation service requests and will make the arrangements, which include, but are not limited to:
   a. Confirming with the agency the scheduled interpreter's name and expected arrival time;
   b. Providing a telephonic confirmation to the health care Provider; and
   c. Providing confirmation to the Member through their preferred method of communication, e.g., telephone, TTY, Video Phone Relay, California Relay Services (Teletypewriter (TTY)/Voice Carry-Over (VCO)/Hearing Carry-Over (HCO)), or e-mail.
5. IEHP is responsible for the cost of ASL VRI services for Members at contracted Urgent Care Facilities and SNFs.[24] Contracted Urgent Care Facilities and SNFs are responsible for the cost, maintenance, and connectivity (Wi-Fi, Cellular, LAN) of IEHP-approved VRI equipment (See "Attachment/Video Remote Interpretation Approved Devices and Technical Specifications" found in the IEHP website. [25]
6. Members and their family members, friends, associates, and/or authorized representatives may make standing requests to receive all written Member information, including clinical Member information, in a specified threshold language and/or in an alternative format (such as braille, large-size print, secure electronic, or audio formats) by contacting IEHP Member Services.[26,27]
7. IEHP consults stakeholders with disabilities to continuously evaluate and maintain accessibility of services for Members with disabilities.

[22] Ibid.
[23] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.03
[24] 28 CCR § 1300.67.04
[25] https://www.iehp.org/en/providers/provider-resources?target=forms
[26] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.03
[27] CA Welf. & Inst. Code, § 1367.04

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4. ACCESS STANDARDS

E. Access to Services with Special Arrangements

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP ensures that Members have access to medically necessary covered services, including but not limited to services with special arrangements.

PURPOSE:

A. To ensure that Members have access to services with special arrangements.

DEFINITION:

A. Sensitive Services – All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and minor consent services, as outlined in this policy.[1]

PROCEDURES:

A. Services with special arrangements include the following:

1. **Family Planning** – Members may access family planning services through any contracted or non-contracted family planning Provider without prior authorization. See Policy 5G, "Family Planning Services."
2. **Sexually Transmitted Infection (STI) Preventive Care, Diagnosis and Treatment** – Members may access STI services without prior authorization both within IEHP's Provider network and from an out-of-network Local Health Department (LHD), any qualified family planning Provider, or any other Provider who treats STIs within his or her scope of practice.[2] See Policy 5G, "Sexually Transmitted Infection Services."
3. **HIV Testing and Counseling** – Members may access confidential HIV testing and counseling services without prior authorization within IEHP's Provider network and from an out-of-network LHD or any qualified family planning Provider.[3,4] See Policy 5H, "HIV Testing and Counseling."
4. **Immunization –** Immunizations are preventive services not subject to prior authorization requirements.[5] See Policy 5B, "Adult Preventive Services."
5. **Indian Health Services (IHS) Programs –**Members must have timely access to Indian

[1] California Civil Code (Civ. Code) § 56.05(p)
[2] California Health and Safety Code (Health & Saf. Code) § 1342.3
[3] CA Health & Saf. Code § 1367.46
[4] CA Health & Saf. Code § 1342.74
[5] CA Health & Saf. Code § 1367.002

Health Services (IHS) Providers within the Plan's network, where available. IHS Providers, whether within or outside the network, can provide referrals directly to network Providers without requiring a referral from a network Primary Care Provider (PCP) or prior authorization.

B. Minor Consent Services

1. Members under the age of 18 may access the following services through any Provider within IEHP's Provider network without parental consent:
   a. Treatment for sexual assault, including rape;[6]
   b. Treatment for intimate partner violence;[7]
   c. Drug or alcohol treatment services (for children 12 years of age and older);[8]
   d. Pregnancy-related services;[9]
   e. Family planning services;[10]
   f. STI preventive care, diagnosis, and/or treatment (for children 12 years of age and older);[11]
   g. HIV testing;
   h. Behavioral health care (outpatient mental health care for children 12 years of age and older);[12] and
   i. Abortion services.[13]
2. There are additional regulations that deal specifically with services provided to minors, See "Attachment/California Minor Consent and Confidentiality Law" found on the IEHP website.[14] Prior to any reliance on the information included, please check the citations for a comprehensive understanding of the statutes, as well as any updates and/or changes to the law. Additionally, please refer to your legal counsel for official interpretation or other laws/regulations that may be applicable.

C. Other authorization or access requirements include:

1. **Pregnancy-Related Services –** Services do not require prior authorization and can be provided by any credentialed obstetrical Practitioner within the IHEP network.
2. **Abortion Services –** Abortion is a covered benefit regardless of the gestational age of

[6] California Family Code (Fam. Code) §§ 6927 & 6928
[7] CA Fam. Code § 6930
[8] CA Fam. Code § 6929
[9] CA Fam. Code § 6925
[10] Ibid.
[11] CA Fam. Code § 6926
[12] CA Fam. Code § 6924
[13] CA Fam. Code § 6925
[14] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

the fetus. Medical justification is not required. Services do not require prior authorization and can be obtained through any contracted or non-contracted qualified Provider.[15] Coverage includes medical services and supplies incidental or preliminary to an abortion. The Plan does not impose lifetime limits on the coverage of outpatient abortion services. However, no physician or other health care provider who objects to performing abortion services is required to do so, and no person refusing to perform an abortion is to be subject to retaliation in any form for such a choice.[16]

3. **Behavioral Health Care** - The PCP is responsible for behavioral health care within his/her scope of practice, otherwise, the Member may be referred or may self-refer to the appropriate Behavioral Health Provider or County Behavioral Health Department. See Policy 07G, "Behavioral Health – Behavioral Health Services" for more information.

4. For more specific information regarding authorization requirements and other details, see Sections 5, "Medical Care Standards" and 9A, "Utilization Management - Delegation and Monitoring."

D. If a Provider has religious or ethical objections to perform or otherwise support the provision of covered services, IEHP will timely arrange for, coordinate, and ensure the Member receives the covered services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure at no additional expense to the Member.

E. Medical information related to sensitive services must only be disclosed to the Member receiving care, absent an express authorization of the Member.

F. Members are informed of their rights to access sensitive services and services with special arrangements through the Member Handbook.

G. Members, regardless of age, may obtain information regarding access to care and assistance with scheduling appointments for sensitive services through IEHP Member Services at (800) 440-4347 or their PCP's office. Assistance is provided with complete confidentiality.

H. Periodic monitoring of Provider compliance is performed through review of encounter data and medical record review.

[15] CA Health & Saf. Code § 1367.251
[16] CA Health & Saf. Code § 123420

4. ACCESS STANDARDS

E. Access to Services with Special Arrangements

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4. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP allows women to directly access, without prior authorization, obstetrical or gynecological (OB/GYN) Physician services through participating OB/GYNs or Family Practitioners (FP) that meet IEHP credentialing standards to provide obstetrical and gynecological services.[1]

B. Members may only obtain direct access from those OB/GYNs or FPs within the Plan's network to which they are assigned and use their assigned contracted Hospital for facility-based services.

PROCEDURES:

A. FPs participating under this policy must be contracted and credentialed by IEHP, adhering to standards for obstetrical privileges.

B. Typical conditions and procedures for which a woman can directly access an OB/GYN or eligible FP include, but are not limited to, the following. Please see Section 5, "Medical Care Standards" for services that may be obtained from contracted and non-contracted providers.

1. Abdominal/Pelvic Pain
    a. Salpingo-oophoritis
    b. Endometriosis
    c. Pelvic Inflammatory Disease (PID)
2. Abortion
3. Abnormal uterine bleeding
4. Breast Mass
5. Bartholin Gland Enlargement/Cyst
6. Dysmenorrhea
7. Ectopic Pregnancy
8. Endometriosis
9. Dysuria
10. Estrogen Replacement
    a. Therapy/hormonal changes
11. Family Planning/Birth Control
12. Mastitis

[1] California Health and Safety Code (Health & Saf. Code) § 1367.695

13. Menopause
14. Premenstrual Syndrome (PMS)
15. Pregnancy/Perinatal Care
16. Sexually Transmitted Infection (STI) Testing and/or Treatment
17. Vaginitis
18. Well Woman Exam
    a. Cervical Cancer Screening
    b. Breast Exam
19. Colposcopy
20. Endometrial Biopsy

C. The OB/GYN or FP providing care to Members under this policy must obtain prior authorization from IEHP for procedures, surgery, or other services beyond a "well woman" exam, routine or follow-up office visits. Examples of services requiring prior authorization include, but are not limited to, the following:

1. Diagnostic Procedures
    a. Amniocentesis
    b. Computer Tomography (CT)
    c. Ultrasound
    d. Other specialty diagnostic procedures
    e. Magnetic Resonance Imaging (MRI)
2. Services
    a. Referrals to other specialists
3. Surgical Intervention
    a. Dilation and Curettage (D & C)
    b. Hysterectomy
    c. Laparoscopy
4. Treatments
    a. Cone biopsy
    b. Cryosurgery

D. Any OB/GYN or FP providing care to Members under this policy is required to communicate to the Member's PCP the Member's condition, treatment, and any need for follow-up care. See Policy 9D, "Pre-service Referral Authorization Process".

E. IEHP must reimburse OB/GYNs and FPs providing care to Members under this policy utilizing appropriate claims review and processing standards. Approval types for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.

4. ACCESS STANDARDS

F. Open Access to Obstetrical or Gynecological Services

F. OB/GYNs and FPs providing care to Members under this policy must appeal denied or disputed claims to IEHP-Covered. Claims appeal should be directed to IEHP at:

Inland Empire Health Plan
Claims Department
P.O. Box 4409
Rancho Cucamonga, CA 91729-1800

G. IEHP has a structure in place to monitor compliance with this policy. Process should include, but not be limited to, review of denied OB/GYN services, review of Member and Provider grievances, and review of Provider appeals and denial of OB/GYN Provider claims.

H. Information regarding this policy or questions related to it can be obtained by calling the IEHP Provider Call Center at (909) 890-2054.

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4. ACCESS STANDARDS

G. Cultural and Linguistic Services

1. Language Assistance Capabilities

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP ensures effective communication with individuals with disabilities and provides meaningful access to Members and potential Members with limited English proficiency (LEP) through the administration of the Cultural and Linguistics Program and Disability Program.[1]

B. IEHP provides oral and written Member information in the threshold languages designated by the Department of Health Care Services (DHCS), in accordance with federal and state regulations.[2,3]

DEFINITIONS:

A. Threshold Language – DHCS' Medi-Cal Managed Care Division (MMCD) defines threshold language as any primary language of at least 5% of the eligible individuals in a plan's service area.[4]

B. Point of contact – An instance in which an enrollee accesses the services covered under the Plan contract, including administrative and clinical services, and telephonic and in-person contacts.[5]

C. Qualified Interpreter – A qualified interpreter for an individual with a disability or LEP is an interpreter who:[6]

1. Have demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP Member.
2. Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
3. Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.

PROCEDURES:

A. **Provider Language Capability**

[1] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 6, Section 6.3, Application and Notices
[2] Ibid.
[3] Title 42 Code of Federal Regulations (CFR) §438.10(d)
[4] 42 CFR § 422.2268(a)(7)
[5] Title 28, California Code of Regulations (CCR) § 1300.67.04(c)(2)(A)
[6] Health & Saf. Code § 1300.67.04(d)(4)(a)

1. All IEHP network Providers, including but not limited to Hospitals, Pharmacies, and Long Term Services and Supports (LTSS) Providers, must provide equal access to health care services, both clinical and non-clinical, in a linguistically competent manner for Members who are LEP or non-English speaking.[7,8]
2. IEHP lists all language capabilities of Providers and/or their staff in the Provider Directory.[9]
3. IEHP verifies the capability of Providers to provide services in the threshold language at the time of entry into the network. IEHP continues to monitor Provider language capabilities through an annual language competency audit.[10,11] See Policy 4G1, "Cultural and Linguistic Services – Language Capabilities" for more information.
4. Providers must provide written materials to Members in designated threshold languages.[12]

B. **Interpretation Services**

1. All Hospitals must provide interpreters as needed for inpatient and emergency services. The Hospitals are responsible for the cost and arrangement of interpretation services.[13]
2. Providers must be able to facilitate interpreter services as needed for Member appointments. IEHP covers the costs of the interpretation services for Primary Care Provider (PCP) and outpatient visits.[14]
    a. Sign language interpretation must be provided in accordance with Policy 4D, "Access to Care for Member with Access and Functional Needs."
3. IEHP has contracted with a qualified telephonic interpretation service to provide telephonic interpretation services to Members 24 hours a day, seven (7) days a week. IEHP Members and Providers may access this service at no cost.
    a. Members and Providers can call IEHP Member Services to access this telephone interpretation service during business hours.
    b. After business hours, Members and Providers can call the 24-Hour Nurse Advice Line at (888) 244-IEHP (4347),or dial 711 for TTY users to access qualified interpretation services.

[7] California Health and Safety Code (Health & Saf. Code) § 1367.03
[8] California Health and Safety Code (Health & Saf. Code) § 1367.04
[9] Health & Saf. Code § 1300.67.04
[10] 28 CCR § 1300.67.04(d)(9)(C)
[11] Health & Saf. Code § 1300.67.04
[12] 42 CFR §438.10(d)(3)
[13] 28 CCR § 1300.67.04(c)(2)(G)(iv)
[14] Health & Saf. Code § 1300.67.03

C. Members have the right to request a qualified interpreter at no charge for discussions of medical information and behavioral health information at key points of contact.[15, 16]

D. Providers must not require or suggest the use of family members or friends as interpreters. However, a family member or friend may be used as an interpreter if this is requested by the Member after being informed of their right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services or violate the Member's confidentiality. Minors should not be used as interpreters except for extraordinary circumstances such as medical emergencies.[17,18]

E. Providers should document the Member's request for or refusal of interpreter services in their medical record.[19]

F. Members communicating with IEHP staff in a foreign language are offered qualified interpreter services via internal or contracted services.

G. IEHP ensures written Member information are fully translated and provided in threshold languages upon request, at no cost and in a timely fashion appropriate for the language and format being requested and taking into consideration the special needs of Members and potential Members with disabilities or limited English proficiency.[20]

H. Members have the right to file a complaint or grievance if their linguistic needs are not met.[21] Members' concerns about the linguistic capabilities in a Provider's office are followed up by IEHP, and the IEHP Provider database is corrected, as necessary. See Policy 10A, "Member Grievance Resolution Process and 10B, "Member Appeal Resolution Process" for more information.

I. Members who do not select a PCP at the time of enrollment are assigned to a PCP through the auto-assignment process. Language compatibility is one of the factors in the PCP assignment.

[15] Health & Saf. Code § 1300.67.04
[16] 28 CCR § 1300.67.04(c)(1)(G)
[17] Health & Saf. Code § 1300.67.04(4)(c)
[18] 28 CCR § 1300.67.04(c)(1)(C)
[19] Ibid.
[20] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 6, Section 6.3, Application and Notices
[21] Ibid.

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G. Cultural and Linguistic Services

1. Language Assistance Capabilities

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G. Cultural and Linguistic Services
2. Non-Discrimination

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. All Members must receive access to all covered services without restriction based on race, color, national origin, sex, age, mental or physical disability or medical condition, ethnicity, ethnic group identification, ancestry, language, religion, , gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment.[1,2,3,4]

PROCEDURES:

A. All IEHP contracted Providers and other subcontractors are required to render services to all Members assigned or referred to them. Providers and other subcontractors may not refuse services to any Member based on the criteria listed in this policy.[5]

B. IEHP investigates all grievances alleging discrimination, and takes appropriate action with Team Members, Provider organizations, and other subcontractors. All discrimination-related grievances are forwarded to the Department of Health Care Services (DHCS) for review and appropriate action.[6]

C. IEHP posts Notice of Non-Discrimination on all publications and communications targeted to Members, potential Members, and the public. Notice is posted in a conspicuously visible font size in physical locations where IEHP interacts with the public, as well as in a conspicuous location on the IEHP website that is accessible on the home page.[7]

[1] Title 42 Code of Federal Regulations (CFR) § 422.110(a)
[2] 45 CFR Part 92
[3] California Welfare and institutions Code (Welf. & Inst. Code) § 14029.91
[4] CA Government Code (Gov. Code) § 11135(a)
[5] 45 CFR Part 92
[6] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.68
[7] California Welfare and Institutions Code (Welf. & Inst. Code), § 1358.24

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H. Access to Care During a Federal, State or Public Health Emergency

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP maintain policies and procedures that ensure Members' access to medically necessary health care services, equipment and covered drugs is not disrupted in these situations:

1. Members being displaced by a state of emergency;[1,2]
2. Issuance of a presidential major disaster or emergency declaration; or
3. Declaration of a public health emergency by the Secretary of Health and Human Services.

PURPOSE:

A. To ensure that Members maintain access to medically necessary health care services, equipment, and covered drugs during a Federal, State, or public health emergency.

DEFINITIONS:

A. State of Emergency – Duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions such as but not limited to air pollution, fire, flood, storm, epidemic, riot, drought, cyberterrorism, sudden and severe energy shortage, and plant or animal infestation or disease.[3]

B. Presidential Major Disaster – The United States President can declare a major disaster for any natural event, that the President determines has caused damage of such severity that it is beyond the combined capabilities of state and local government to respond.[4]

C. Presidential Emergency Declarations - The United States President can declare an emergency for any occasion or instance when the President determines federal assistance is needed.[5]

D. Public Health Emergency – The Secretary of DHHS may determine that a disease or disorder presents a public health emergency; or that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. These declarations last for the duration of the emergency or 90 days but may be extended by the Secretary.[6]

PROCEDURES:

[1] California Health and Safety Code (Health & Saf. Code) § 1368.7(a)
[2] CA Insurance Code (Ins. Code) § 10112.95
[3] CA Government Code (Gov. Code) § 8558
[4] https://www.fema.gov/disaster-declaration-process
[5] Ibid.
[6] http://www.phe.gov/preparedness/legal/pages/phedeclaration.aspx

4. ACCESS STANDARDS

H. Access to Care During a Federal, State or Public Health Emergency

A. IEHP educates Members proactively on how to access medically necessary health care services, equipment, and covered drugs during a Federal, State, or public health emergency.

B. IEHP monitors the Federal Emergency Management Agency (FEMA) for issuance of Presidential Major Disaster or Emergency Declarations, the Department of Health and Human Services (DHHS) website for public health emergency declarations, the Centers for Medicare and Medicaid Services (CMS) website, the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) for State of Emergency declarations, along with county websites and other non-regulatory entities such as Southern California Edison.

C. IEHP informs DMHC and DHCS of the following within 48 hours of a declaration of a State of Emergency that displaces or has the immediate potential to displace Members:[7,8]

1. Describing whether the health Plan has experienced or expects to experience any disruption to Plan operations;
2. Explaining how the Plan is communicating with potentially impacted Members; and
3. Summarizing actions the Plan has taken or is in process of taking to ensure the health care needs of Members are met.

D. IEHP performs to ensure Members continue to have access to medically necessary health care services, equipment, and covered drugs during a Federal, State, or public health emergency:

1. Upon identification or notification of a Federal, State, or public health emergency declaration, IEHP identifies Members affected or at risk of being affected by the declaration.
2. IEHP notifies its Providers and Members of the nature and authority declaring the state of emergency and steps the health plan will complete to support its Members and Provider network:
    a. Members - Communication will be made through, but not limited to, these methods: texts, calls, website banners, social media, web content, etc.
    b. Providers/Facilities/Pharmacy Network – Communication will be made through, but not limited to, these methods: blast fax, e-mail, website banners, Pharmacy and Provider web pages, etc.

E. IEHP ensures that Members maintain access to medically necessary health care services, equipment, and covered drugs.[9,10]

1. Relaxing prior authorization requirements for medically necessary drugs and services;

[7] CA Health & Saf. Code § 1368.7(b)
[8] Ibid.
[9] CA Health & Saf. Code § 1368.7(b)
[10] CA Ins. Code § 10112.95

2. Extending filing deadlines for claims;
3. Authorizing a Member to replace medical equipment or supplies;
4. Allowing a Member to access an appropriate out-of-network provider if an in-network Provider is unavailable due to the state of emergency or if the Member is out of the area due to displacement;
5. Encouraging Members to maintain routine care via all applicable means including telehealth visits;
6. Having a toll-free telephone number that an affected Member may call for answers to questions, including questions about the loss of health insurance identification cards, and access to care; and
7. Suspending prescription refill limitations and allowing an impacted Member to refill their prescriptions at an out-of-network pharmacy.

F. IEHP's Behavioral Health and Care Management (BH & CM) department coordinates with the Riverside University Health System (RUHS) Behavioral Health and San Bernardino County Behavioral Health Departments to ensure access to behavioral health care for Members during these emergencies.

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