9. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members and Providers.

POLICY:

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

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

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

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

E. 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. [2,3,4]

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.[5] 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** – This is a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:[6]

   1. Placing the health of the individual (or in the case of a pregnant woman, the health of the

[1] California Health and Safety Code (Health & Saf. Code) § 1367.03(d)
[2] Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Section 10.5.2
[3] Title 42 Code of Federal Regulations (CFR) §438.100 (b)(2)
[4] Medicare Communications and Marketing Guidelines (MCMG), "Anti-Discrimination", Section 30.1
[5] Title 28 California Code of Regulations (CCR) § 1300.67.2.2(b)(2)
[6] Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Section 20.2

woman or her unborn child) in serious jeopardy; or

2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

C. **Initial Health Assessment** – See Policy 10C, "Initial Health Assessment.

D. **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.

E. **Network -** A discrete set of network Providers, the Plan has designated to deliver all covered services for a specific network service area.[7]

F. **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.[8]

G. **Network Provider –** Any Provider[9] located inside or outside of the network service area of a designated network.[10]

H. **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.[11]

I. **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.

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

K. **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.

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

M. **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

[7] 28 CCR § 1300.67.2.2(b)(5)
[8] 28 CCR § 1300.67.2.2(b)(6)
[9] California Health and Safety Code (Health & Saf. Code) § 1345(i)
[10] 28 CCR § 1300.67.2.2(b)(10)
[11] 28 CCR § 1300.67.2.2(b)(11)

to all of the basic health care services.[12,13,14]

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

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

P. **Urgent Prenatal Visit** – These are health care services needed to diagnose and/or treat actual or perceived prenatal conditions that are of sufficient severity that care is needed urgently but are not emergency medical conditions.

Q. **Urgent Visit** – These are health care services to address an urgent non-emergency medical conditions.

R. **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.

PROCEDURES:

A. **Access Standards for Clinical Services**

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

Primary Care Provider (PCP) and Obstetrics/Gynecology (OB/GYN) Primary Care	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do not require prior authorization	Within 48 hours of request
Urgent visit for services that do require prior authorization	Within 96 hours of request
Not emergency or urgently needed, but the enrollee requires medical attention[15]	Within 7 business days of request
Non-urgent (routine) visit	Within 10 business days of request

[12] 28 CCR § 1300.67.2.2(b)(3)
[13] CA Health & Saf. Code § 1345(b)(5)
[14] CA Health & Saf. Code § 1367.03(e)(3)
[15] 42 CFR § 422.112 (a)(6)(B)

9. ACCESS STANDARDS

A. Access Standards

Initial health assessment[16,17]	Within 120 calendar days of enrollment
Initial Preventive Physical Exam	30 days (complete the exam within 120 days of the Member's enrollment and annually thereafter)
Follow up exam	As directed by Physician

Specialist	
Type of Appointment	**Timeframe**
Emergency	Immediate disposition of Member to appropriate care setting
Urgent visit for services that do <u>not</u> require prior authorization	Within 48 hours of request
Urgent visit for services that do require prior authorization	Within 96 hours of request
Urgent prenatal visit	Within 48 hours of request
Non-urgent (routine) visit	Within 15 business days of request
Non-urgent visit for ancillary services (for diagnosis or treatment of injury or other health condition)	Within 15 business days of request
Initial Prenatal Visit	Within 2 weeks of request
Non-Urgent (routine) prenatal care	Within 2 weeks of request
Follow up exam	As directed by Physician

a. <u>Shortening or Expanding Appointment Times</u> – 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.

b. <u>Preventive Care</u> – 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.

[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Member under Twenty-One (21) Years of Age
[17] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 6, Services for Adults

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. Please see Policy MA_9B, "Missed Appointments."

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 must limit average wait time to two (2) minutes. Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person. Calls received after normal business hours (Monday-Friday, 8am-8pm and Saturday-Sunday, 8am-5pm) are returned within one (1) business day. Calls received after midnight are responded to the same business day.

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.

3. Time or Distance Standards – Time or distance standards apply to OB/GYN primary care services only if a Member elects to use the OB/GYN as a PCP. IEHP does not require OB/GYNs to act as PCPs, regardless of how they are utilized.

a. Proximity of PCPs and OB/GYN Primary Care to Members – IEHP network PCPs must be located within 10 miles or 15 minutes travel time from assigned Members' residence, as applicable, based on geographic regions.[18]

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 30 miles or 60 minutes travel time from assigned Members residence, as applicable, based on geographic regions.

[18] CMS Medicare-Medicaid Plan (MMP) Application & Annual Requirements, CY 2020 MMP Health Service Delivery Network Adequacy Standards Criteria Reference Table

~~b.~~c. Proximity of Behavioral Health Providers – IEHP network Clinical Psychologists must be located within 30 miles and 45 minutes travel time from assigned Members' residence, as applicable, based on geographic regions. IEHP network Clinical Social Work Providers must be located withing 20 miles and 30 minutes travel time from assigned Members' residence, as applicable, based on geographic regions.

~~c.~~d. Proximity of Hospital – IEHP network hospitals must be located within 30~~)~~ miles or 45 minutes travel time from assigned Members' residence.[19]

~~d.~~e. 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.

4. Provider Shortage – If timely appointments within the time or distance standards required are not available, then the IPA shall refer the Member to or assist in locating available and accessible contracted Provider in neighboring service areas to obtain the necessary health care services in a timely manner appropriate for the Member's needs. The IPA shall arrange and authorize as appropriate specialty services from specialists outside IEHP's contracted network if unavailable within the network, when medically necessary for the Member's condition or when time or distance standards as established by regulators are not met and at no cost to the Member. It is important to note that IEHP or its IPAs may not meet Time or Distance Standards and are not utilizing Telehealth to meet compliance for certain zip codes or specialties due to a lack of available Providers with whom to contract in those specific areas; or when a significant change occurs in the Network and no longer meet time or distance standards, but must have Alternative Access Standards as approved by DHCS. Please see Policy MA_14D, "Pre-Service Referral Authorization Process" for more information.

5. Telehealth Services[20]

   a. IEHP utilized Telehealth Providers to meet time or distance standards, as well as to provide Members with access to necessary health care services, except for General Surgery, Orthopedic Surgery, Physical Medicine, Rehabilitation, and Hospital services. IEHP must submit documentation to the Department of Health Care Services (DHCS) before using these Telehealth Providers.

   b. The use of Telehealth Providers to meet time or distance standards does not absolve IEHP's responsibility to provide Members with access to in-person services if the Member prefers.[21,22,23]

   c. IEHP must provide transportation to a network Provider and meet timely access

[19] CMS Medicare-Medicaid Plan (MMP) Application & Annual Requirements, CY 2020 MMP Health Service Delivery Network Adequacy Standards Criteria Reference Table
[20] Welf. & Inst. Code § 14197 (f)(1-2)
[21] Welf. & Inst. Code § 14197 (e)(1)(A)
[22] Welf. & Inst. Code § 14197 (e)(4)
[23] Welf. & Inst. Code § 14132.72 (f)

standards for medically necessary services when a Member is offered a Telehealth visit but request an in-person visit.

d. If IEHP is unable to arrange for an in-person visit with a network Provider, IEHP must authorize OON services and provide transportation to the appointment as needed.

e. IEHP may use third-party corporate Telehealth Providers due to a Member's choice to use Telehealth or in-person services, IEHP cannot auto-assign a Member to a third party corporate Telehealth Providers.[24]

f. Telehealth services must be consistent with the criteria outlined in the state and federal laws and regulations and contractual requirements. Please see Policy MA_18P, "Virtual Care" for more information.

6. Minimum Hours On-Site – The PCP must be on site and available for Member care a minimum of 16 hours per week, or meet the criteria identified in Policies MA_6D, "Residency Teaching Clinics" and MA_6E, "Rural Health Clinics."

7. 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:

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. 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, seven (7) days a week through its Nurse Advice Line (NAL). 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 that 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.

[24] Health and Safety Code § 1374.141 (a)

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

8. 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.

   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 same staff member or Physician with whom the Member wishes to speak with, 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 – 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.

9. 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. Please see Policy 14C, "Emergency Services" for more information.

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

information regarding needed follow-up, if any. PCPs are responsible for obtaining any necessary medical records from such a visit and arranging any needed follow-up care.

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

C. **Special Access Standards**

1. Sensitive Services for Adults – Providers and Practitioners must have procedures to ensure that minors and adults have access to sensitive and confidential services as outlined in Policy 9D, "Access to Sensitive Services."

2. Access for People with Disabilities – All IEHP facilities and Practitioners are required to maintain access in accordance with the requirements of Title III of the Americans with Disabilities Act of 1990. Each PCP office is assessed to identify if barriers to Member care exist during facility site reviews. Areas audited include but are not limited to: designated parking spaces, wheelchair access, and restroom access for wheelchair users, handrails near toilets, and appropriate signage. If a Provider/Practitioner's office or building is not accessible to Members with disabilities, an alternative access to care must be provided. See Policy MA_9C, "Access to Care for People with Disabilities."

3. Access and Interpretation Services for People are Deaf or Hard-of-Hearing and/or with Limited English Proficiency – All IEHP network Providers, including network Pharmacy and Vision Practitioners, must provide services to Members with limited English proficiency in the Member's primary language. See Policies MA_9H1, "Cultural and Linguistic Services – Foreign Language Capabilities" and MA_9D1, "Access to Care for People with Disabilities - Members Who Are Deaf or Hard-of-Hearing."

4. Access Standards for Behavioral Health Services – The following information delineates the access standards for availability of services to IEHP DualChoice Members for Behavioral Health care and after-hours emergency services.

   a. Appointment standards:

Behavioral Health	
Type of Visit	**Timeframe**
Life-threatening emergency	Immediate disposition of Member to appropriate care setting
Non-life-threatening emergency	6 hours, or go to the ER
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

Behavioral Health	
Type of Visit	**Timeframe**
Not emergency or urgently needed, but the enrollee requires medical attention[25]	Within 7 business days 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 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[26]	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

b. 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.

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, including accessibility, availability, continuity of care, and network capacity 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.[27]

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 PCP 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

[25] 42 CFR § 422.112 (a)(6)(B)
[26] 28 CCR § 1300.67.2.2
[27] 28 CCR § 1300.67.2.2(d)(2)(D)

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 take action on Providers that are not meeting access standards to bring them into compliance.

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

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

   Using the DMHC PAAS methodology and tools, IEHP reports on the health plan's overall rate of compliance for each of the time elapsed standards, and that of each IPA in Riverside and San Bernardino Counties (See "DMHC Provider Appointment Availability Survey Methodology" and "DMHC Appointment Availability Survey Tools" found on the IEHP website[28]). 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 the 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) and the Department of Managed Health Care (DMHC).

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 afterhours triage, screening, and advice standards by reviewing triage call center reports. On at least an annual basis, the QI Subcommittee reviews and makes recommendations

[28] https://www.iehp.org/en/providers/provider-resources?target=forms

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 Director and the IEHP website. Please see Policy 6B, "Physical Accessibility Review Survey" for more information.

9. **Access and Interpretation Services for People are Deaf or Hard-of-Hearing and/or with Limited English Proficiency** – The Quality Management Department monitors compliance with these standards through these FSR/MRR survey questions:

   Facility Site Review Questions

   a. There is 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) review process for individually identified Providers.

D. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures. Please see Policy MA_25A3, "Delegation Oversight – Corrective Action Plan Requirements" for more information regarding the CAP process.

9. ACCESS STANDARDS

A. Access Standards

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2024	

9. ACCESS STANDARDS

B. Missed Appointments

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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 per Provider instruction; 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 if applicable.
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. Please see Policy 18L, "Provider Charging Members."

B. Monitoring

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

9. 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 or at the discretion of IEHP. Please see Policy 6A, "Facility Site Review and Medical Record Review Requirements and Monitoring" for more information.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

~~INLAND EMPIRE HEALTH PLAN~~		
~~Chief Approval:~~ *~~Signature on file~~*	**~~Original Effective Date:~~**	~~September 1, 1996~~
~~Chief Title:~~ ~~Chief Medical Officer~~	**~~Revision Date:~~**	~~January 1, 2023~~

9. ACCESS STANDARDS

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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]

A.

~~A.~~B. IEHP prohibits discrimination against Members on the basis of disability or Limited English Proficiency (LEP).[2,3] All IEHP Providers contracted to provide care to Members are required to provide and maintain access to facilities and services to individuals with disabilities.[4]

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.[5,6]

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.
3. Miniature horses that have been individually trained to do work or perform tasks for people with disabilities by IEHP in accordance with ADA regulation standards. Service animals are working animals, not pets.[7]

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

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10, Access Rights
[2] Title 42 United States Code (USC) § 12132
[3] 42 USC § 18116 et. seq
[4] 42 USC § 12182
[5] Title 28 Code of Federal Regulations (CFR) § 35.104
[6] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Service Animals, 2/24/20
[7] Ibid.

site review of PCP sites. This survey is repeated every three (3) years thereafter. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements" for more information.

B. **Providers who are anticipating modification to their facilities must meet Americans with Disabilities Act Accessibility Guidelines (ADAAG).**[8]

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.[9,10]

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-~~1916-2~~504~~054~~ or view the ADAAG online: http://www.access-board.gov/adaag/html/adaag.htmhttps://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[11]

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.[12]

   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.[13]

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

[8] 28 CFR part 36, subpart D, "New Construction and Alterations"
[9] 42 USC § 12101
[10] 24 CFR § 570.614
[11] 28 CFR § 35.136
[12] 28 CFR § 35.136(f)
[13] 28 CFR § 35.136(a)

demonstrates that the presence or use of a service animal would pose a health risk in certain parts of the institution directly involved.[14]

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.[15]
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.[16]
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).[17]
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:[18]
        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;

[14] 28 CFR § 35.136(g)
[15] Americans with Disabilities Act (ADA), 2010 Revised Requirements, Service Animals
[16] 28 CFR § 35.136(e)
[17] 28 CFR § 35.136(d)
[18] ADA, 2010 Revised Requirements, Service Animals

- Oncology units;
- Psychiatric units;
- Isolation areas;
- Medication storage areas; and
- Clean or sterile supply areas.

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. This includes assistive listening systems, sign language interpreters, captioning, written communication, and electronic format.
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 IPA; 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 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 Member's medical record.
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 ~~the~~ IEHP through its Provider ~~Relations Team~~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.
9. Grievances and Member requests for disenrollment mentioning inadequate access for people with disabilities are carefully analyzed and ~~researched~~ 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.
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.[19]

[19] 28 CCR § 1300.67.04

3. IEHP is responsible for the cost of the interpretation services for PCP and outpatient visits.[20]
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.[21,22] Contracted Urgent Care Facilities and SNFs are responsible for the cost, maintenance, and connectivity (Wi-Fi, Cellular, LAN) of IEHP-approved VRI equipment. (See ~~the~~ Attachment "~~Attachment/~~Video Remote Interpretation Approved Devices and Technical Specifications" found in the IEHP website.[23] ~~in IEHP Portal).~~
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

[20] Ibid.
[21] 28 CCR § 1300.67.04
[22] Ibid.
[23] https://www.iehp.org/en/providers/provider-resources?target=forms

(such as braille, large-size print, secure electronic, or audio formats) by contacting IEHP Member Services.[24]

~~7.~~ IEHP consults with stakeholders with disabilities to continuously evaluate and maintain accessibility of services for Members with disabilities. See Policy 2H – "Persons with Disabilities Workgroup (PDW)."

7.

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[24] Health Plan Management System (HPMS) Memo, "California MMPs: Application of APL 22-002 to Final Contract Year 2022 Marketing Guidance for California Medicare-Medicaid Plans"

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9. ACCESS STANDARDS

D. Access to Services with Special Arrangements

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and IPAs ensure 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.[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. Please see Policy 10K, "Family Planning Services."
2. **Sexually Transmitted Infection (STI) Prevention Care, Diagnosis and/or 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 STI within his or her scope of practice. Please see Policy 10G, "Sexually Transmitted Infection Services."
3. **HIV Testing and Counseling** – Members may access confidential HIV testing and counseling services without prior authorization within IEHP's network and from an out-of-network LHD or any qualified family planning Provider.[2][3,4] Please see Policy 10H, "HIV Testing and Counseling."
4. **Immunization** – Immunizations are preventive services not subject to prior authorization requirements.[5] Please see Policy 10B, "Adult Preventive Services."
5. **American Indian Health Services Programs –** American Indian Members may access

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

contracted and non-contracted American Indian Health Service Programs.

B. 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 IPA's network.
2. **Abortion Services** - Abortions are not a covered Medicare procedure except when:[6]
   a. The pregnancy is the result of an act of rape or incest; or,
   b. The woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
   c. Prior authorization is required for non-emergency abortions.

   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.[7]
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 IEHP Behavioral Health Program. Please see Policy 12D1, "Behavioral Health – Behavioral Health Services."
4. **Substance Use (Drug or Alcohol) Disorder Treatment Services**:
   a. Hospitalization is covered for medically necessary detoxification for alcoholism or other drug use. Authorization must be obtained prior to admission.
   b. Medicare covers substance use disorder treatment in outpatient treatment centers that have agreed to participate in the Medicare program.
5. For more specific information regarding authorization requirements and other details, see Sections 10, "Medical Care Standards" and 14, "Utilization Management."

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

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

E. Members may obtain information regarding access to care and assistance with scheduling appointments for sensitive services through IEHP Member Services at (877) 273-4347 or their PCP's office. Assistance is provided with complete confidentiality.

F. Periodic monitoring of Provider compliance is performed through review of encounter data and medical record review. See Policy 6A, "Facility Site Review and Medical Record Review

[6] Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD), Abortion, 6/19/06
[7] California Health & Safety Code § 123420

Survey Requirements and Monitoring," for more information.

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E. Open Access to Obstetrical or Gynecological Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs must allow 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 IPA to which they are assigned and use their assigned Hospital for facility-based services.[2]

PROCEDURES:

A. FPs participating under this policy must be credentialed by IPAs in accordance with IEHP 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 10, "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
[2] Ibid.

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 their IPA 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 14D, "Pre-Service Referral Authorization Process". OB/GYNs or FPs can meet this requirement by providing this information to the Member's IPA, which will then be forwarded to the PCP.[3]

[3] CA Health & Saf. Code § 1367.695

9. ACCESS STANDARDS

E. Open Access to Obstetrical or Gynecological Services

E. OB/GYNs and FPs providing care to Members under this policy are encouraged to either contact the IPA when initiating treatment, or to provide appropriate clinical information when submitting claims to their IPA to ensure timely and appropriate processing of claims.

F. IEHP and its IPAs are required to 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.

G. OB/GYNs and FPs providing care to Members under this policy must first appeal denied or disputed claims to the IPA. If the appeal is denied, claims appeal should be directed to IEHP at:

Inland Empire Health Plan
Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

H. If IEHP determines that the IPA has denied payment for services rendered under this policy, IEHP will reimburse the Provider and adjust capitation to the IPA.

I. IEHP and its IPAs should have a structure in place to monitor compliance with this policy. Processes should include, but not limited to, review of denied OB/GYN services, review of Member and Provider grievances, review of Provider appeals and denial of OB/GYN Provider claims.

J. IEHP will perform ongoing monitoring to assure compliance with these requirements. Persistent failure to comply with these requirements will result in negative action against the IPA, up to termination of the IEHP-IPA contract.

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

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F. Cancer Treatment Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs ensure Members access to medically necessary screening and treatment services for cancer according to nationally recognized clinical criteria. [1]

B. IEHP does not require prior authorization or cost-sharing for preventive services.[2] This includes cancer screenings that are United States Preventive Services Task Force (USPSTF) Part A and B recommendations.

PROCEDURES:

Cancer Treatment

A. IEHP contracts define physician and other professional services as the responsibility of the IPA. This responsibility includes payment of services accessed by Members under this policy.

B. IEHP requires Members to obtain all care and services for cancer screening or diagnostic testing from credentialed IEHP Providers (including Physicians, Surgeons, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, or other Providers of service) within the IPA to which they are assigned.

C. IEHP and its IPAs may require prior authorization for the following referral requests related to cancer services, but the services must be provided if medically necessary:

1. Surgical treatments;
2. Chemotherapy;
3. Radiation therapy; and
4. Treatments for complications related to cancer treatments.

D. For reconstructive surgery or prosthetic devices necessary to restore symmetry to a Member after surgical resection of cancer, IEHP and its IPAs can subject the request to prior authorization process.

E. IEHP requires Members obtaining care and services for cancer to receive services from the Member's assigned Hospital.

Clinical Trials

A. A Member's treating Physician, who is providing covered health care services may determine

[1] California Health and Safety Code (Health & Saf. Code) § 1367.665
[2] CA Health & Saf. Code 1367.002

that participation in a clinical trial has a meaningful potential to benefit the Member diagnosed with cancer. The treating Physician may request for authorization and if approved, coverage must be provided for all routine Member care costs related to a clinical trial for a Member who is accepted into a clinical trial. The clinical trial endpoint must not be defined exclusively to test toxicity but must have a therapeutic intent.[3]

1. Routine costs in clinical trials include:[4]
    a. Health care services typically provided in the absence of a clinical trial;
    b. Health care services required solely for the provision of the investigational drug, item, device or service;
    c. Health care services required for the clinically appropriate monitoring of cancer treatment;
    d. Health care services provided for the prevention of complications arising from the cancer clinical trial; and
    e. Health care services needed for the reasonable and necessary care arising from the complications of the cancer clinical trial.
2. Routine costs of a clinical trial do not include the following:
    a. Drugs or devices that have not been approved by the FDA and that are associated with the clinical trial;[5]
    b. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the clinical trial;
    c. Items or services provided solely for data collection and analysis needs and that are not used in the clinical management of the Member; [6]
    d. Health services associated with the cancer clinical trial that are otherwise specifically excluded from coverage under the Member's health plan; [7] and
    e. Health services customarily provided by the research sponsors free of charge for the Member in the clinical trial. [8]

B. IEHP and its IPAs can direct all services noted above to contracted in-network Providers whose scope of practice includes these services. If an appropriately qualified Provider is not available within the IPA network, arrangements must be made for the Member to receive care from an appropriately qualified Provider outside the IPA network.

C. IEHP and its IPAs are required to reimburse Providers rendering care to Members under this policy according to the guidelines above using appropriate claims review and processing

[3] CA Health & Saf. Code § 1370.6(a)
[4] CA Health & Saf. Code § 1370.6(d)(4)
[5] CA Health & Saf. Code § 1370.6(d)(5)
[6] ~~CA Health & Saf. Code § 1370.6(d)(5)~~Ibid.
[7] Ibid.
[8] Ibid.

standards. Please see Policy 20A, "Claims Processing" for more information.

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F. Cancer Treatment Services

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G. Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Transportation services for IEHP DualChoice (HMO D-SNP) Members are covered as a Medi-Cal benefit. IEHP provides both Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services for all prior authorized services and Medicare and/or Medi-Cal covered services within San Bernardino and Riverside counties.[1]

DEFINITIONS:

A. Non-Emergency Medical Transportation (NEMT) – Transportation to one's IEHP or Delegate-approved medical appointment by ambulance, litter van, wheelchair van, or air.

B. Non-Medical Transportation (NMT) – Roundtrip transportation to one's IEHP or Delegate approved medical appointment by private car, taxi or bus, when the Member has reasonably exhausted other transportation resources.

C. Private Conveyance – Transportation via a privately owned vehicle arranged by the Member. This can include the Member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft.[2]

PURPOSE:

A. To ensure that Members have transportation access to necessary medical and behavioral health services.

PROCEDURES:

General Information

Member Rights and Responsibilities

A. Members requiring NEMT ~~or NMT~~ should contact IEHP Member Services Department (877) 273-4347 at least five (5) business days prior to requested service to ensure transportation is arranged in a timely matter. ~~or IEHP's~~ NMT members should contact IEHP's Transportation Broker Call the Car at (855) 673-3195 at least ~~five (5) business days~~ 48 hours prior to requested service. The exceptions to the five (5) business days policies above are:

1. Dialysis;

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008, Supersedes APL 17-010, "Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses"
[2] Ibid.

2. Pharmacy;
3. Urgent Care;
4. Wound Care;
5. Cancer Treatment (radiation/chemotherapy);
6. Pre-Op Appointments;
7. Surgery;
8. Follow Up appointment from a recent Hospital Discharge;
9. Transplant~~; and~~
10. Fracture.
11. Infectious Disease (Including HIV)
12. Dental
13. Pain Management
14. COVID testing and vaccines.
~~10.~~15. Laboratory and Radiology (related to pre-op, urgent or STAT requests)

B. Please note this is not an all-inclusive list. If a NEMT or NMT Member has justification for why IEHP or CTC needs to transport them under five (5) business days or 48 hour time frame, the Member may call IEHP's Member Services Department at (877) 273-4347 or CTC at (855) 673-3195 .

C. Members must contact IEHP within 24 hours when transportation services are no longer required or canceled. ~~Members may receive written communication from IEHP UM for failure to notify IEHP after three (3) incidences.~~

IEHP Responsibilities

A. IEHP or its Delegate coordinates with transportation Provider to ensure we meet timely access standards when providing NEMT and NMT.[3] See Policy 9A, "Access Standards" for more information.

B. IEHP makes its best effort to provide and coordinate NEMT and NMT for services not covered by the health plan, including but not limited to specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS~~)~~ delivery system.[4]

C. IEHP has designated its Manager of Transportation Services as the Plan's transportation liaison, who ensures that authorizations are processed during and after business hours.

[3] DHCS APL 22-008
[4] Ibid.

Providers and Members may call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides through the following avenues. Calls and requests will be routed directly to the Plan's transportation liaison, as appropriate:

1. For Providers - Provider Call Center at (866) 223-4347; and
2. For Members - Member Services Department at (877) 273-4347/(800) 718-4347 (TTY).
3. Neither IEHP nor the Transportation Broker modify the PCS form after the PCP or treating Physician has prescribed the form of transportation, unless multiple modalities were selected.[5]

D. IEHP bears authorization and financial responsibility for transportation services.

E. IEHP shares the PCS form or communicates the approved mode of NEMT and dates of service to the Transportation Broker.[6]

Coverage and Limitations

A. IEHP will provide NEMT/NMT services to the Member and one (1) attendant.[7]

B. There are no limits in receiving NEMT/NMT services as long as the trip is validated to meet the guidelines stipulated in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008.

C. Members may ~~only~~ travel ~~between home address on file and the~~ to medical/mental health facility, within the San Bernardino and Riverside counties, unless the service is not available within the two (2) counties.

1. Transportation will be provided to Members whose access to medically necessary services are beyond the required time and distance standards. Please see Policy 9A, "Access Standards" for more information.

D. Transportation to a Member's home setting from facility or hospital is also covered when medical transportation by ambulance, litter van or wheelchair transportation are required due to Member's medical and physical condition.

E. NEMT and NMT will be arranged to locations that meet the Member's needs ~~and that are closest to their home address on file. For example, pharmacy requests should be no more than five (5) miles away from the home address on file and requests to a laboratory should be no more than ten (10) miles away from the address on file. The only exception is when service is not available within the mileage range described above.~~

F. Members may only be transported to the IEHP contracted Urgent Care within their region of residence.

[5] DHCS APL 22-008
[6] Ibid.
[7] Ibid.

G. IEHP will not provide transportation services to:

1. Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) Meetings;
2. Social Security Income (SSI) evaluations;
3. ~~3.~~ Workman's Compensation Appointments;
4. ~~4.~~3. ~~IEHP Community Resource Center (CRC) unless a class has been scheduled through the Health Education Department;~~
5. ~~5.~~4. Any service that is not covered by IEHP; and/or
6. ~~6.~~5. A Medicare Fee For Services (FFS) Member traveling out of San Bernardino/Riverside Counties.

H. IEHP and CTC can direct all NEMT and NMT 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 vendor outside the IEHP network.

I. Requests for NEMT ~~or NMT~~ that do not adhere to APL 22-008 may be denied or partially approved. In this event, a Notice of Action is sent to the Member and requesting Practitioner. This notification must include rationale for denial alternative transportation recommendations, and information on how to appeal the decision.[8]

~~I.~~J. Requests for NMT that do not adhere to APL 22-008 may be canceled. In this event, an IEHP Transportation Services team member will contact the Member by phone.

Travel Expenses

A. IEHP covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for Members receiving medically necessary covered services and their accompanying attendant, including living MOT donors.[9]

B. IEHP covers the salary of the accompanying attendant determined to be necessary, as well as if the attendance is not a family member.[10]

C. IEHP will provide retroactive reimbursement for transportation-related travel expenses. The Plan may also consider to pre-payment, as appropriate.[11]

Enrollment of NEMT/NMT Providers

[9] DHCS APL 22-008
[10] Ibid.
[11] Ibid.

9. ACCESS STANDARDS

G. Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses

A. All NEMT and NMT Providers must comply with Medi-Cal enrollment requirements.[12]Providers that continue to be non-compliant with these requirements may be subject to disciplinary action, including the issuance of corrective action plan, leading up to termination of contract.

B. IEHP will allow NEMT and NMT Providers to participate in its network for up to 120 calendar days, pending the outcome of the enrollment process. IEHP will track the 120-day timeframe and will terminate its contract with the Provider upon notification from DHCS that the Provider has been denied enrollment in the Medi-Cal program, or upon expiration of the one 120-day period.[13]

Major Organ Transplants

A. IEHP provides NEMT or NMT services to individuals, who may not be enrolled in IEHP Medi-Cal but serve as living organ donor for an IEHP Member.[14]

   1. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor has the ability to get to the hospital for the MOT.

   2. IEHP allows an attendant for the donor if the Plan determines than an attendant to accompany the donor is necessary.

Non-Emergency Medical Transportation (NEMT)

Prior Authorization

A. NEMT services are a covered Medi-Cal 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 or pharmacy prescriptions prescribed by the Member's Provider and those authorized by Medi-Cal Rx.[15]

B. NEMT services are subject to prior authorization. IEHP will authorize the appropriate modality prescribed by the Member's PCP or treating Provider on the Physician Certification Statement (PCS) form.~~[16]~~ This PCS form, which has been approved by DHCS and includes components required by DHCS to arrange for NEMT services,~~.~~[17] is available on the secure IEHP Provider portal and IEHP website.[18]

[12] Ibid.
[13] DHCS APL 22-008
[14] Ibid.
[15] Ibid.

[17] Ibid.
[18] https://www.iehp.org/en/providers/provider-resources?target=forms

1. This certification statement remains in effect for 12 months from date of the Practitioner's signature.[19]
2. The PCS form must be completed before NEMT can be provided. Contracted Providers may submit the form electronically through the secure IEHP Provider portal.
3. Non-contracted providers may fax the completed and signed form to IEHP at (909) 912-1049.[20]
4. IEHP can authorize NEMT requests telephonically when the Member requires a covered medically necessary service of urgent nature and a PCS form could not have reasonably been submitted beforehand. The Member's Provider however, must submit a PCS form post-service for the telephone authorization to be valid.[21]
5. IEHP ensures that a copy of the PCS form is on file for all Members receiving NEMT services and that all fields are filled out by the Provider. Additionally, IEHP has developed a process to capture data from the PCS form and report to DHCS, as required.[22]

C. For covered services requiring recurring appointments, IEHP authorizes NEMT for the duration of the recurring appointments, not to exceed 12 months.[23]

D. Prior authorization is not 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 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.[24]

1. To ensure timely transfer following an inpatient stay at the acute level of care, NEMT services must be provided within three (3) hours of the Member or Provider's request. If NEMT services are not provided within the three (3) hour timeframe, the acute care hospital may arrange, and IEHP will cover, out-of-network NEMT services.[25]

E. IEHP authorizes the lowest cost type of NEMT that is adequate for the Member's medical needs if multiple modalities are selected by the Member's Provider in the PCS form.[26]

[19] DHCS APL 22-008
[20] https://www.iehp.org/en/providers/provider-resources?target=forms
[21] Title 22 California Code of Regulations (CCR) § 51323(b)(2)(A)
[22] DHCS APL 22-008
[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.

F. IEHP ensures door-to-door assistance is being provided for all Members receiving NEMT services.[27]

G. IEHP informs Members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT Provider is late or does not arrive at the scheduled pick-up time, the Member is asked to call IEHP so an urgent NEMT ride may be authorized to ensure the Member does not miss their appointment.

Non-Medical Transportation (NMT)

A. IEHP does not require prior authorization for NMT services. These services are a covered Medi-Cal benefit when a Member needs to obtain medically necessary services, including those not covered by the health plan, such as, but not limited to, specialty mental health, substance use disorder, dental, and other benefits delivered through the Medi-Cal FFS delivery system, including pharmacy services provided to Members through Medi-Cal Rx. Therefore, IEHP will not apply utilization controls or time or distance standards for NMT to carved-out services not authorized or arranged by the Plan.[28]

B. IEHP informs Members that they must arrive within ~~fifteen (~~15~~)~~ minutes of their scheduled appointment. If the NMT Provider is late or does not arrive at the scheduled pick-up time, the Member is asked to call IEHP so the health plan may provide alternate NMT or allow the Member to schedule alternate out-of-network NMT and reimburse for out-of-network NMT.[29]

C. Members may be issued a Single or monthly bus pass for transportation if all the following criteria are met:

~~1. Transit is available;~~

~~2. Trip is less than 150 minutes in total duration (roundtrip);~~

1. Transit is available. ~~Bus stop is no more than one (1) mile walking distance from the Member's address on file.~~

2. CTC will provide a daily bus pass if the member has less than four appointments in a month. A monthly bus pass will be issued if member has more than four (4) appointments in a month. CTC will validate appointments before bus pass is issued to the member.

3. Live within ¾ mile from a bus line

4. Appointment is ¾ mile from a bus line.

5. Member does not have mobility limitations.

[27] Ibid.
[28] DHCS APL 22-008
[29] California Welfare & Institutions Code § 14132(ad)(2)(A)(i)

~~3.~~ Treatment type is not: Dialysis, Chemotherapy or Radiation

~~D.~~6. ~~Members who utilize the benefit everyday will be issued a 31-day or a 30-day bus pass, depending on where they live.~~

~~E.~~D. With the exclusion of dialysis, standing orders for NMT will not be arranged for more than 30 days at a time.

~~F.~~E. IEHP will provide gas mileage reimbursement consistent with the Internal Revenue Service (IRS) rate for NMT services provided by private conveyance arranged by the Member for medical purposes when:[30]

1. Member attestation is received by phone, electronically or in-person that all other transportation resources available have been exhausted;
2. The driver can provide proof of a valid driver's license, valid vehicle registration and valid vehicle insurance; and
3. The trip has been prior authorized by IEHP.

Monitoring

A. IEHP does not delegate the following responsibilities to its Transportation Broker:[31]

1. Monitoring and oversight of network Providers and subcontractors;
2. Grievance and appeals resolution;
3. Enrollment of NEMT or NMT Providers as Medi-Cal providers; or
4. Utilization management functions, including the review of PCS forms.

B. IEHP ensures its Transportation Broker and Providers meet regulatory and contractual requirements. Monitoring activities are performed no less than quarterly and may include but not be limited to:[32]

1. Enrollment status of NEMT and NMT Providers;
2. Non-modification of the level of transportation service outlined in the PCS form.~~; and~~ Modifications to the level of transportation will need to be reviewed and approved by IEHP.
3. Providing door-to-door assistance for Members receiving NEMT services;
4. NEMT and NMT Providers arriving within 15 minutes of scheduled time for appointments;
5. No show rates for NEMT and NMT Providers.

[30] DHCS APL 22-008
[31] Ibid.
[32] DHCS APL 22-008

Continued non-compliance will result in intervention, including but not limited to Broker/Provider education, issuance of a corrective action, freezing to new authorizations, leading up to termination of contract.

C. Transportation Brokers are required to have a process that identifies specific NEMT or NMT Providers, including the name of drivers based on service date, time, pick-up/drop-off location, and Member name, including a process for Members to be able to identify specific drivers in a grievance.[33]

D. Members who are found to have misused the transportation benefit will be reported to IEHP Compliance Department and will receive a formal written warning from ~~IEHP~~ compliance. Members ~~and~~ will be expected to correct their behavior. If the behavior is not corrected, IEHP will report the continued non-compliance as a potential incident of Fraud, Waste or Abuse (FWA) to the Department of Health Care Services Program Integrity Unit (DHCS PIU).

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[33] Ibid.

9. ACCESS STANDARDS

H. Cultural and Linguistic Services

1. Language Assistance Capabilities

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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.

B. IEHP provides oral and written Member information in the threshold languages designated by the Centers for Medicare and Medicaid Services (CMS), in accordance with federal and state regulations.[1]

DEFINITIONS:

A. Threshold Language - The Centers for Medicare and Medicaid Services (CMS) defines threshold language as any primary language of at least 5% of the individuals in a plan's service area.[2]

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.[3]

PROCEDURES:

A. IEHP and its network of Providers must provide written materials to Members in designated threshold languages.[4]

B. **Provider Language Capability**

1. All IEHP network Providers including, but not limited to, IPAs, 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 Limited English Proficient (LEP) or non-English speaking.[5]

2. IEHP lists all language capabilities of Providers and/or their staff in the Provider Directory.

[1] Title 42 Code of Federal Regulations (CFR) §438.10(d)
[2] Title 42, Code of Federal Regulations (CFR) § 422.2267(a)(2)
[3] Title 28, California Code of Regulations (CCR) § 1300.67.04(c)(2)(A)
[4] 42 CFR § 422.2267(a)(2)
[5] California Health and Safety Code (Health & Saf. Code) § 1367.04

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.[6] See Policy 9H2, "Cultural and Linguistic Services - Language Competency Audits" for more information.
4. Providers must provide written materials to Members in designated threshold languages.[7]

C. **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.[8]
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.
    a. Sign language interpretation must be provided in accordance with Policy 9C1, "Access to Care for People with Disabilities - Members Who Are Deaf or Hard of Hearing."
3. IEHP arranges interpreter services requested by Members and Providers for face-to-face interpretation services. Providers may use face-to-face interpreters when requested at least five (5) working days before the medical appointment or telephonic interpretation services to meet the language requirement. These interpretation resources are available to Members twenty-four (24) hours a day/seven (7) days a week.[9,10]
    a. Interpreter services are scheduled by calling IEHP Member Services at (877) 273-IEHP (4347), or (800) 718-4347 for TTY users.
    b. Emergent and urgent interpreter service requests under five (5) business days are subject to interpreter availability.
4. IEHP has contracted with Pacific Interpreters to provide telephonic interpretation services to Members twenty-four (24) hours a day, seven (7) days a week. IEHP Members and Providers may access these services 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 twenty-four (24) hour Nurse Advice Line at (888) 244-IEHP (4347), or (866) 577-8355 for TTY users to

[6] 28 CCR § 1300.67.04(d)(9)(C)
[7] 42 CFR §438.10(d)(3)
[8] 28 CCR § 1300.67.04(c)(2)(G)(iv)
[9] 22 CCR § 53853(c)
[10] 28 CCR § 1300.67.04

access interpretation services.

c. IPAs must submit material requiring transcription to an alternative format~~ting~~ to IEHP within 24 hours of an identified need. IEHP will send any alternative format letters requests to the ~~Member~~Vendor.

D. Members have the right to request an interpreter at no charge for discussions of medical information and behavioral health information at key points of contact.[11]

E. 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.[12]

F. Providers should document the Member's requests for or refusal of interpreter services in their medical record.[13]

G. Members have the right to file a complaint or grievance if their linguistic needs are not met. 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.

H. Members who do not select a PCP at the time of enrollment are assigned to a PCP Language compatibility is one of the factors in the PCP assignment. See Policy 3B, "Primary Care Provider Assignment" for more information.

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[11] 28 CCR § 1300.67.04(c)(1)(G)
[12] CA Health & Saf. Code § 1367.04
[13] 28 CCR § 1300.67.04(c)(1)(C)

9. ACCESS STANDARDS

H. Cultural and Linguistic Services

1. Language Assistance Capabilities

	☐ DMHC	☐ NCQA
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~~**Chief Approval:** *Signature on file*~~	~~**Original Effective Date:**~~	~~January 1, 2007~~
~~**Chief Title:** Chief Medical Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~

9. ACCESS STANDARDS

H. Cultural and Linguistic Services
2. Language Competency Study

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

A. IEHP surveys the capability of its Providers to provide services in threshold languages. Threshold languages for Riverside and San Bernardino Counties, as defined by the California Department of Health Care Services (DHCS) are English, Spanish, Chinese (including Mandarin and Cantonese), and Vietnamese.

B. IEHP surveys on an annual basis all Primary Care Providers (PCPs), and High-volume Specialist offices that have been identified as having the ability to speak Spanish, Chinese (including Mandarin and Cantonese), and Vietnamese. These Providers are listed in the IEHP Provider Directory as having threshold language speaking capabilities.

PROCEDURES:

A. On an annual basis, IEHP surveys threshold language-speaking Providers for language capability. The technique utilized for assessing targeted language competency within the Provider site includes, but is not limited to the following steps:

1. The survey will be sent to all PCP and High-Volume Specialist offices via fax and/or email, with return response due within ten (10) business days. The survey will inquire about:

    a. Who in the office speaks the threshold language (Doctor/clinical staff and office staff, doctor/clinical staff only and non-clinical staff only);

    b. How many staff in the office speak the threshold language; and

    c. Confirmation that answering machine or answering service used when the office is closed include threshold language-speaking options.

2. If IEHP does not receive a response from the Provider regarding the threshold language inquiry, the Provider will be included in the second round of faxes/emails, with a response due date of ten (10) business days.

3. If the Provider still does not respond, IEHP will conduct phone calls to the Provider offices to conduct the survey telephonically. The telephones surveys will be conducted within a two (2) week period.

    a. Providers who do not demonstrate adequate threshold language-speaking capabilities are listed in the Provider Directory and portals as not meeting the language capability requirements and are provided resources to expand and improve language assistance

services for individuals with limited English proficiency (LEP), to ensure compliance with State and Federal law.[1]

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[1] Health and Safety Code § 1367.04

9. ACCESS STANDARDS

H. Cultural and Linguistic Services

3. Non-Discrimination

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

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

B. IEHP and its Delegates may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in IEHP DualChoice on the basis of any factor that is related to health status, including but not limited to medical condition, including mental as well as physical illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.[2,3]

C. IEHP will not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. IEHP will not terminate the enrollment of an eligible individual based on an adverse change in their health.[4]

DEFINITION:

A. Discrimination – For the purpose of this policy, discrimination may include but is not limited to the following:

1. Denying any Member any covered services;
2. Providing the Member any covered service which is different, or is provided in a different manner or at a different time from that provided to other Members, except where medically indicated;
3. Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any covered service;
4. Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed

[1] Department of Health Care Services (DHCS) State Medicaid Agency Contract (SMAC), Exhibit E, Attachment 2, Provision 25, Discrimination Prohibitions
[2] Title 42 Code of Federal Regulations (CFR) § 422.110(a)
[3] California Government Code (Gov. Code) § 11135(a)
[4] DHCS SMAC, Exhibit E, Attachment 2, Provision 25, Discrimination Prohibitions

by others receiving any covered service, treating a Member or a beneficiary eligible for enrollment into IEHP DualChoice differently from others in determining whether they satisfy any admission, enrollment, quote eligibility, membership, or other requirement or condition, which individuals must meet in order to be provided any covered service;

5. The assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identify, sexual orientation, or identification with any other persons or groups defined in California Penal Code Section 422.56;
6. Failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and
7. Failing to ensure meaningful access to programs and activities for LEP Members and potential Members.

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] See Policy 16A, "Member Grievance Resolution Process" for more information.

~~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.

[5] Title 45 CFR Part 92
[6] DHCS SMAC, Exhibit E, Attachment 2, Provision 27, Discrimination Grievances

9. ACCESS STANDARDS

H. Cultural and Linguistic Services

3. Non-Discrimination

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~~**Chief Title:** Chief Medical Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~

9. ACCESS STANDARDS

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs 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;[3,4] or
3. Declaration of a public health emergency by the Secretary of Health and Human Services.[5,6]

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.[7]

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.[8]

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.[9]

D. Public Health Emergency – The Secretary of DHHS may determine that a disease or disorder

[1] California Health and Safety Code (Health & Saf. Code) § 1368.7(a)
[2] CA Insurance Code (Ins. Code) § 10112.95
[3] Medicare Prescription Drug Benefit Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.12
[4] Medicare Managed Care Manual, "Chapter 4: Benefits and Beneficiary Protections," Section 150
[5] Medicare Prescription Drug Benefit Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.12
[6] Medicare Managed Care Manual, "Chapter 4: Benefits and Beneficiary Protections," Section 150
[7] CA Government Code (Gov. Code) § 8558
[8] https://www.fema.gov/disaster-declaration-process
[9] Ibid.

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.[10]

PROCEDURES:

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:[11,12]

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 enrollees; and
3. Summarizing actions the plan has taken or is in process of taking to ensure the health care needs of enrollees are met.

D. IEHP performs the following to support its IPAs and Providers in ensuring 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 IPAs, 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.

[10] https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx
[11] Department of Managed Health Care (DMHC) All Plan Letter (APL) 19-007 (OPL), "Governor's Declarations of Emergency
[12] CA Health & Saf. Code § 1368.7(b)

b. IPAs/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 works with its IPAs to ensure that Members maintain access to medically necessary health care services, equipment, and covered drugs by:[13,14]

1. Relaxing prior authorization requirements for medically necessary drugs and services;
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. ~~IEHP's Behavioral Health and Care Management (BH & CM) will e~~Encouraging Members to maintain routine care via all applicable means including telehealth visits.;[15]
6. ~~5.~~ 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, access to prescription;
7. ~~6.~~ Suspending prescription refill limitations and allowing an impacted Member to refill their prescriptions at an out-of-network pharmacy; and
8. ~~7.~~ In case of the issuance of a presidential major disaster or emergency declaration, allowing an affected Member to obtain the maximum extended day supply, if requested and available at the time of refill.[16,17]

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.

~~G. IEHP's Behavioral Health and Care Management (BH & CM) will encourage Members to maintain routine care via all applicable means including telehealth visits. IEHP will encourage Members~~

[13] CA Health & Saf. Code § 1368.7(b)
[14] CA Ins. Code § 10112.95
[15] CY 2024 Readiness Checklist for Medicare Advantage Organizations, Prescription Drug Plan Sponsors, 1876 Cost Plans, and Medicare-Medicaid Plans
[16] Medicare Prescription Drug Benefit Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.12
[17] Medicare Managed Care Manual, "Chapter 4: Benefits and Beneficiary Protections," Section 150

9. ACCESS STANDARDS

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

~~H.~~G. At the request of IEHP, IPAs must provide the following, at minimum, to demonstrate their compliance with these requirements:

1. Identified point(s) of contact to support these efforts;
2. Policies and procedures; and
3. Regular updates on any actions taken to ensure access to care for impacted Members.

9. ACCESS STANDARDS

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2020	
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