C/O: HealthSmart Management Services Organization, Inc.
PO Box 6300, Cypress, CA 90630-0063
Phone: (714) 947-8600; Provider Services Fax: (714) 947-8708

Access and Availability Standards

We are committed to ensuring patients receive health care services in a timely manner applicable for the patient's condition. Our access and availability standards are based on the Department of Managed Health Care (DMHC) regulatory and National Committee for Quality Assurance.

Participating providers are responsible for offering members access to covered services 24/7. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. Providers are also required to meet appointment access standards as described below.

After-Hours Calls:

- The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be immediately directed to dial 911 or to proceed directly to the nearest hospital emergency room.
- If staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct members with emergency healthcare needs to dial 911 or go directly to the nearest hospital emergency room. The message must also give members an alternative contact number so they can reach the primary care physician (PCP) or on-call provider with medical concerns or questions.
- Non-English-speaking members who call their PCP after hours should expect to get.
  language-appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed directly to the nearest hospital emergency room.

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- In a nonemergency situation, members should receive instruction on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter. All calls taken by an answering service must be returned.

Appointment Access

Note: The next available appointment date and time can be either In-Person or by *telehealth* services.

Healthcare providers must make appointments for members from the time of request as follows:

General Appointment	
Emergency Examination	Immediate Access – 24/7
Urgent (sick) Examination	Within 48 hours of request, excluding holidays and weekends, if authorization is not required OR within 96 hours of request, excluding holidays and weekends, if authorization is not required OR within 96 hours of request, excluding holidays and weekends, if authorization is required, or as clinically indicated.
Routine Primary Care Examination (Non-urgent)	Within 10 Business Days of Request
Non-Urgent consults/specialty referrals	Within 15 Business Days of Request
Non-Urgent care with Non-Physician mental health provider or substance use disorder provider (where applicable)	Within 10 Business Days of Request
Non-Urgent follow-up care with non-physician mental health provider or substance use disorder provider	Within 10 Business Days of Request
Non-Urgent Ancillary	Within 15 Business Days of Request
Mental Health Appointment, Non-Physician	Within 10 Business Day of Request

S8221

Effective since July 1, 2022, non-physician mental health/substance use disorder appointments are subject to the timely access standards outlined in the chart above. This bill also requires that all health plans ensure that enrollees who are undergoing a course of treatment for an ongoing mental health or substance use disorder condition can schedule a follow up appointment with their non-physician mental healthcare or substance use disorder provider **within 10 business days of the prior appointment.**

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Services for Members under the age of 21 years	
Initial Health Assessment	
Children from Birth to 20 years of age	Within 120 days of Enrollment
Preventive Care Visits	Within14 days of Request
Services for Members 21 years of age and older	
Initial Health Assessments	Within 120 days of Enrollment
Preventive Care Visits	Within 14 days of Request
Routine Physicals	Within 30 days of Request
Prenatal and Postpartum Visits	
1st and 2nd Trimester	Within 7 Days of Request
3rd Trimester	Within 3 days of Request
High-Risk Pregnancy	Within 3 days of Identification
Postpartum	Between 21 and 56 Days after Delivery
Long-Term Services and Support	
Skilled Nursing Facility	❖ Rural and Small Counties – Within 14 Business Days of Request. ❖ Medium Counties – Within 7 Business Days of Request ❖ Dense Counties – Within 5 Business Days of Request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	❖ Rural and Small Counties – Within 14 Business Days of Request. ❖ Medium Counties – Within 7 Business Days of Request ❖ Dense Counties – Within 5 Business Days of Request
Community Base Adult Services (CBAS)	Capacity CANNOT decrease in aggregate statewide below April 2012 Level

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Specialists

The following guidelines are in place for our specialists:

- For urgent care, the specialist should see the member within 96 hours of receiving the request.
- For routine care, the specialist should see the member within 15 business days of receiving the request.
- A copy of the medical records and/or results of the visit should be sent to the PCP's office to allow continuity of care.

Wait times

- When a provider's office receives a call from a member during regular business hours as well as after hours for assistance and possible triage, the provider or another healthcare professional must either take the call or call the member back **within 30 minutes** of the initial call.

- When a member arrives on time to an appointment, the member should be seen within 15 minutes of the scheduled appointment.

- When members and/or prospective members call a physician's office, they should not be placed on hold for longer than IO minutes.

Interpretation services

When a provider's office receives a call from a member, the provider's office should know where to contact a telephone interpreter to communicate in the member's preferred language.

Noncompliance

Please ensure that you comply with the standards described; compliance with these standards is a contractual requirement. If We or a health plan finds that your office is non-compliance it can result in corrective action.