<table>
<tr><td colspan="2">SUBJECT: Accessibility of Services and Provider Administrative Service Standards</td><td>Policy No.</td></tr>
<tr><td colspan="2">BUSINESS OWNER: Quality Improvement</td><td>Page 1 of 9</td></tr>
<tr><td colspan="2">APPROVED BY: Accreditation Team</td><td>APPROVED BY ACCREDITATION TEAM: 11/15/2021</td></tr>
<tr><td colspan="2" rowspan="3">Joshua Plavin, MD
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Vice President and Chief Medical Officer</td><td>EFFECTIVE: 7/19/2004</td></tr>
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<tr><td colspan="2"></td><td>APPLIES TO: All Lines of Business</td></tr>
<tr><td colspan="3">REGULATORY / ACCREDITATION LINKS:
2022 NCQA HP Standards and Guidelines: NET 1B-D; NET 2A-C, & ME 7C-F
Vermont Rule H-2009-03: 5.1B</td></tr>
<tr><td colspan="3">POLICY LINKS:
Blue Cross Quality of Care and Risk Investigation Policy
PCP Selection Criteria Policy
Availability of Network Practitioners Policy
Claims Appeal policy
Complaints policy</td></tr>
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I. DEFINITIONS

- **Regular and Routine Appointments:** First-contact visits and continuing care for persons with undiagnosed signs, symptoms or health concerns, not limited by problem origin, organ system or diagnosis.

- **After Hours Care:** Access to a primary care or obstetric practitioner for questions and concerns must be available to members during closed office hours. After-hours access via telephone or after-hours clinic meets the intent of this policy.

- **Preventive and Routine Physical Examinations and Routine Mental Health and Substance Use Disorder (MHSUD) Office Visits**: Services including well visits, health promotion, disease prevention, health maintenance, counseling, patient education, self-management support, care planning and the on-going maintenance of chronic illnesses.

- **Emergency Medical Condition:** The sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in one or more of the following:
  - Placing the member's physical or mental health in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
  - In the situation of a pregnant member, this pertains to both mother and unborn child

- **Urgent Care:** Those health care services that are necessary to treat a condition or illness, including MHSUD conditions, of an individual that if not provided promptly (within 24 hours or a period consistent with the medical exigencies of the case) presents a serious risk or harm.

- **Non-Life-Threatening Emergency:** A situation where clinical evidence shows that a person requires immediate care, but lack of care would not lead to death.

- **High-Volume Specialties and High-Impact Specialties:** Blue Cross considers obstetrics and gynecology (OB/GYN) a high-volume specialty and oncology/hematology a high-impact specialty. In addition, Blue Cross may choose to monitor and analyze additional practitioner specialties if network changes or other conditions warrant further review.

II. POLICY

Blue Cross and Blue Shield of Vermont (Blue Cross) requires that covered health care services are accessible to members on a timely basis from network practitioners. This policy describes the expected standards for accessing care. Blue Cross network providers must meet these access and service standards for Blue Cross members.

Blue Cross evaluates compliance with this policy using CAHPS results, ECHO results, member complaint data, after-hours audits, and appointment availability audits. In addition, Blue Cross quality improvement staff investigate member complaints and quality of care risk investigations about access and service, and work with providers to make improvements.

A. Waiting Times Standards

Blue Cross requires network practitioners providing **MEDICAL SERVICES** to adhere to the following standards for Blue Cross members:

- 24 hours or a time frame consistent with the medical urgency of the case for urgent care
- 14 days for non-emergency, non-urgent care
- 90 days for preventive care (including routine physical examinations)
- 30 days for routine laboratory, imaging, general optometry and all other routine services

Blue Cross requires **MHSUD PRACTITIONERS** to adhere to the following access standards:

- Care for a non-life-threatening emergency within six hours
- Urgent care within 48 hours
- Initial visit for routine care within 10 business days
- An appointment for a routine follow-up visit within seven business days

B. Service Standards for Network Practitioners

In addition to the waiting time standards above, Blue Cross sets service standards for PCP, high-volume specialties, high-impact specialties and MHSUD practitioner offices. Blue Cross intends for providers to use the following standards as a general approach to providing adequate access and continuity of care to members. Blue Cross understands that individual and unforeseen circumstances may result in deviations from these standards.

If a member's plan requires selection of a primary care provider, the member's selected primary care practice shall maintain scheduling capacity to see Blue Cross members for at least one routine preventive visit annually.

- Primary care practitioners shall be on-site and available for member care a minimum of 16 hours per week.
- Primary care practices shall be open with a staff practitioner available to see members at least 24 hours per week.
- Wait time to see the scheduled practitioner shall not exceed 15 minutes beyond the scheduled appointment. If office staff expects a wait to exceed 15 minutes beyond the scheduled appointment, the staff notifies the patient and offers to schedule an alternate appointment. If a wait time exceeds 15 minutes beyond the scheduled appointment, the office offers to schedule an alternative appointment.
- Wait time to get a routine prescription renewal from a PCP, high-volume specialist, high-impact specialist or prescribing MHSUD provider shall not exceed three business days.
- A return telephone call back from the practitioner or delegate for a non-urgent problem shall not exceed two business days.

C. Accepting Blue Cross Members as Primary Patients

Providers cannot hold members liable for any costs associated with provider pre-screening of members as an approach to practice management. If a provider's status reads as "accepting new patients," the provider cannot reject the member. When providers have concerns related to successfully caring for a member, the provider may set clear boundaries related to the care they will provide. Providers should facilitate member referrals for the care they are unable to provide.

D. After-Hours Care Standards for PCP and High-Volume Specialty Offices

Blue Cross requires PCPs and high-volume specialties to provide 24-hour, seven-day-a-week access to members by means of an on-call or referral system. Practitioners should return any after-hour telephone calls from members regarding urgent problems in a reasonable time not to exceed two hours of receipt.

1. **The provider's telephone service should do one of the following**:

- Transfer the member to an answering service or phone number where physician is available to answer
- Transfer the member to an after-hours clinic that is open any time the PCP, high-volume specialty or high-impact specialty office is closed
- Provide a recording that indicates the provider's pager number or phone number where they may be reached
- Provide a recording with the telephone number for the provider's answering service or an on-call provider who will answer the call within a specified time

2. The provider's recorded message must provide the following information:

- Instructions for emergencies
- A statement that the office is closed
- The phone number of the covering or on-call provider
- A statement that indicates whether the member will reach an answering service, pager or the on-call physician at the number provided within a specified time
- A message during closed office lunch hours stating when the office will re-open and how to reach a provider urgently

3. The provider's answering service must:

- Provide a statement that the member reached an answering service, not the provider office
- Note the caller's contact information
- The name of the on-call provider and the time within which the member can expect a return call

4. Unacceptable After-Hours Phone Coverage:

- Recording that provides only information on when the office is open
- Recording that only instructs the caller to go directly to the ER, an urgent care center or to dial 911
- Recording that only directs the caller to an after-hours clinic with limited hours of coverage
- Recording that directs the caller to leave a message without indicating that the message will trigger a callback from a provider within a specified time

E. After-Hours Care Standards for MHSUD Provider Offices

Blue Cross expects all MHSUD practitioners to work with patients to develop an individualized crisis plan to outline options for crisis care during and after typical office hours. Blue Cross encourages these crisis plans to identify opportunities for members to access care from the MHSUD practitioner as a first course of action in the event of a non-life threatening emergency; Blue Cross also advises all MHSUD practitioners to direct, members with a non-life-threatening emergency to go directly to their local emergency room or to the appropriate emergency services available if the MHSUD practitioner is not available to provide care..

III. Methodology for Analyzing Practitioner Availability

A. Measurement of Member Accessibility of Services: PCPs, High-Volume Specialties, High-Impact Specialties and MHSUD providers

Blue Cross evaluates access by collecting data and performing aggregate analysis on the following:

1. **CAHPS Survey**
   This standard survey provides a measure of members' satisfaction with access to the network that Blue Cross can compare to national and regional benchmarks. We will look at the trends for prior years and set goals each year aligning with the quality work plan.

2. **ECHO Behavioral Health Member Satisfaction Survey Results**
   This standard survey provides a measure of members' satisfaction with access to the network that Blue Crosscan trend over time. We will look at the trends for prior years and set goals each year aligning with the quality work plan.

3. **Geo-access Reports**
   Geo-access provides reports of average travel time for Blue Cross members to see a PCP, high-volume specialty, high-impact specialty and MHSUD practitioner. Blue Cross's performance goals for the number of practitioners in the network are defined in the Availability of Network Practitioners Policy.

4. **Member Complaints and Quality of Care Risk Investigations**
   Blue Cross monitors the number of member complaints and quality of care risk investigations received on a semi-annual basis. More than three complaints or risk investigations within eighteen months related to access results in a practice-level analysis to assess whether there is a system issue the practice should address. Common areas of access-related complaints include:
   a. Difficulty obtaining an appointment
   b. Office wait time

c. Office hours
d. Difficulty after hours
e. Telephone access

5. After Hours Telephone Audit

Blue Cross annually conducts an audit of network, high-volume specialties, high-impact specialties, and MHSUD practices by phoning the offices after normal business hours. At a minimum, Blue Cross audits a random selection of PCP and MHSUD offices that represent all areas of Vermont and contiguous counties geographically during a sample period, and all high-volume and high-impact specialty offices. Blue Cross compares results for accessing a provider after hours against the Blue Cross's established standards. Blue Cross notifies the practices who do not meet the standards, requests a corrective action plan, and performs a re-audit within six months.

6. Appointment Availability Audit:

Blue Cross conducts an annual audit of network high-volume specialty and high-impact specialty providers to determine availability of urgent and routine appointments. This may be done by phoning during normal business hours, by mail or by electronic survey. Blue Cross compares results for accessing a provider against Blue Cross's established standards. Blue Cross notifies the practices who do not meet the standards, requests a corrective action plan and performs a re-audit within six months.

Additionally, if the organizational level data (i.e., CAHPS and ECHO surveys) reveals issues with accessing PCP or MHSUD providers, a practitioner level analysis is performed from a statistically valid sample that represents all geographic areas of Vermont and contiguous counties during a sample period. The audit and any necessary follow up is performed in the same manner as the audit for high-volume and high-impact specialties.

Blue Cross supplements the information listed above with quality of care cases, out of network appeals, and other relevant satisfaction data as available.

B. Performance Improvement Plans (PIP): PCP, high-volume specialty, high-impact specialty, and MHSUD practitioner performance that falls below Blue Cross requirements will result in one or more of the following actions:

- Notification of poor performance results to the provider office
- A site visit by the Blue Cross (consistent with the *Blue Cross Site*

Visit and Medical Record Keeping Policy)

- Provider education on the Blue Cross accessibility standards and a request for a corrective action plan
- Repeat audit within six months of results notification
- Report to the network quality and credentialing committee if the Blue Cross requests for performance improvement are ignored or if practice performance does not improve over two reporting periods
- Disciplinary actions as recommended by the network quality and credentialing committee

IV. Reporting

The quality department analyzes and reports on the PCP, high-volume specialty, high-impact specialty and MHSUD data separately. The MHSUD data is further categorized by prescribers and non-prescribers. Each report compares results to Blue Cross thresholds and presents findings and recommended actions to the clinical quality committee semi-annually using the following format:

A. Semi-annual reports include:

- Member complaints and quality of care risk investigations for previous six months
- Follow-up on any actions taken

B. Annual Member Access Analysis and Reports include:

- Member complaints annual totals
- Quality of care risk investigations annual totals
- CAHPS/ECHO results
- Follow-up on any actions taken
- Access report—after hours audit results
- Access-related out-of-network appeals
- Access-related educate and pay cases
- Access report—appointment availability audit results for high-volume specialties and high-impact specialties
- Geoaccess information
- Directory validation—providers accepting new patients
- If an appointment availability audit is required for PCP and/or MHSUD providers, the results of this audit will be included.

V. Distribution of Policy to Providers

Blue Cross distributes this policy and office site criteria to network practitioners and appropriate staff members. The quality improvement department facilitates publication of these criteria in the provider manual that is available on the Provider Resource Center.

VI. Biennial Review

The Accreditation Team (AT) reviews this policy biennially and as needed to ensure consistency with current business practice and to incorporate the latest regulatory and accreditation standards.