Appointment Availability Standards

Aetna Better Health® of California

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Provider Relations will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the California Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

The tables below has appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), and high volume Participating Specialist Providers (PSPs).

**Please note that follow-up to ED visits must be in accordance with ED attending provider discharge instructions.*

Emergency	Urgent	Non-Urgent	Specialty	Mental health
Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Services that do not require prior authorization within forty- eight (48) hours; for services that do require prior authorization within 96 hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week.	Non-urgent sick care within 10 business days of request or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	Specialty care consultation, including nonurgent, within 15 business days of request or as clinically indicated.	You can expect to be seen by the provider within ten (10) business days

Prenatal Care -- Members will be seen within the following timeframes:

- First prenatal visit within 10 business days
- Within their first trimester within 14 days
- Within the second trimester within 7 days
- Within their third trimester within 3 days
- High risk pregnancies within 3 days of identification of high risk by Medi-Cal or maternity care provider, or immediately if an emergency exists.

Physicals -- This is regular care to keep you and your child healthy. Call your provider to make an appointment for preventive care. You can expect to be seen within ten business days. Examples: of preventive care are checkups, shots and follow up appointments.

Ancillary Services -- For the diagnosis or treatment of injury, illness, or other health condition, within 15 business days of request.

Waiting Time –

- Scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room
- If a provider is delayed, patients must be notified immediately.
- If the wait is anticipated to be more than 90 minutes, the patient must be offered a new appointment.
- Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Please note: Pursuant to Health & Safety Code § 1367.27(j)(2), if a provider who is not accepting new patients is contacted by an member or potential member seeking to become a new patient, the provider shall direct the member or potential member to both Aetna Better Health of California for additional assistance in finding a provider and to the DMHC to report any inaccuracy with the plan's directory or directories.

Telephone Accessibility Standards

Aetna Better Health® of California

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available, or having on-call arrangements in place with other qualified participating Aetna Better Health of California providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and emergent health care issues are held to the same accessibility standards regardless if after hours coverage is managed by the PCP, current service provider, or the on-call provider. All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via email) between members, their PCPs, and practice staff.

Providers must return calls within 30 minutes. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all the following situations:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable:	Unacceptable:
• Telephone is answered by provider, office staff, answering service, or voice mail. • The answering service either: ○ Connects the caller directly to the provider ○ Contacts the provider on behalf of the caller and the provider returns the call ○ Provides a telephone number where the provider/covering provider can be reached • The provider's answering machine message provides a telephone number to contact the provider/covering provider.	• The answering service: ○ Leaves a message for the provider on the PCP's/covering provider's answering machine ○ Responds in an unprofessional manner • The provider's answering machine message: ○ Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. ○ Instructs the caller to leave a message for the provider. • No answer • Listed number no longer in service • Provider no longer participating in the contractor's network • On hold for longer than ten (10) minutes • Answering Service refuses to provide information for after-hours survey • Telephone lines persistently busy despite multiple attempts to contact the provider

**Providers must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.*