



California Society of Dermatology & Dermatologic Surgery

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FREQUENTLY ASKED QUESTIONS: TIMELY ACCESS REGULATIONS

New Department of Managed Health Care (DMHC) regulations, intended to ensure that health plan enrollees have access to needed health care services in a “timely manner,” could have a profound affect on California Dermatologists and their patients. Similar, though less extensive regulations were promulgated by the Department of Insurance (DOI) in 2008 and already apply to insurers and contracted PPOs and IPAs in the state. The new regulations stem from legislation (AB 2179) enacted in 2002 that allows the DMHC director to impose various legal remedies which may include a combination with civil, criminal and other administrative proceedings.

The director also has the authority to evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department. Moreover, the director has the authority to determine whether a health care service plan has knowingly abused the requirements, so that it indicates a general business practice. In addition, contracting providers are also included and must abide by the requirements.

The FAQs developed here will help you better understand compliance and enforcement provisions of these new regulations:

For more information, please contact CalDerm or go to:
<http://wpsso.dmhc.ca.gov/regulations/docs/regs/20/1261420231445.pdf>

FAQs:

Q1: How, specifically, will this affect my practice?

A1: These regulations will require each plan to “ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes”:

24/7: Triage or screening availability by telephone

30 minutes: Waiting time limit for telephone triage

10 minutes: Waiting time limit to speak to plan rep during normal business hours

48 hours: Limit for urgent care appointments not requiring prior authorization

96 hours: Limit for urgent care appts requiring prior auth. (including specialists)

10 business days: Limit for non-urgent primary care appointments

15 business days: Limit for non-urgent appointments with specialists

10 business days: Limit for non-urgent appts with a mental health care provider

15 business days: Limit for non-urgent appointments for ancillary services

Q2: Do the regulations affect all PPO and HMO contracted physicians, or HMO contracted physicians only?

A2: It affects PPO and HMO contracted physicians.

Q3: What will trigger enforcement?

A3: Enforcement by DMHC and/or DOI will be triggered by a pattern of violations or a particularly bad one. In the case of a patient making a complaint to an insurer, it will be the insurer's responsibility to have internal processes, sanctions, etc. Patients may also complain directly to the DMHC or DOI which may also trigger enforcement activity.

Q4: How will enforcement be carried out?

A4: Enforcement by DMHC would be against the health plans and insurers (rather than providers directly) and, in the case of DMHC can be as tough or lenient as the Director believes is warranted. Penalties against the physician will likely be contractual and be part of a plan's (or other insurance company's) policies agreed to by providers.

Q5: Will the timeliness of the services that I provide create a new professional standard or care or create a new cause of action against me?

A5: No. These regulations do not establish new professional standards of practice for physicians or other providers, nor do they create a new cause of action or a defense to liability.

Q6: What would the penalties be against physicians?

A6: DMHC would not be charged with penalizing physicians. Because it is "delegated," the plan would be penalized, the plan would pass the pain along to the physician or group. The role of the DOI, and its enforcement teeth, are a bit less defined. DOI must report to the legislature on progress and PPO/IPA adherence. But, the enabling legislation gives less enforcement power to the DOI Commissioner than it does the DMHC Director.

Q7: What would the penalties be against physicians?

A7: DMHC would not be charged with penalizing physicians. Because it is "delegated," the plan would be penalized, the plan would pass the pain along to the physician or group.

Q8: What do telephone triage and triage waiting time mean?

A8: Telephone triage means the "assessment of an enrollee's health concerns and symptoms via communication 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 an enrollee for purposes of determining the enrollee's need for care."

Telephone waiting time is the interval in which the patient waits to speak by telephone with that physician, nurse or other qualified professional.

Q9: Can a plan negotiate with DMHC for the purpose of obtaining alternative procedures related to timely access?

A9: Plans are permitted to request DMHC approval for alternative time-elapsed standards or alternatives to time-elapsed standards.

Q10: How inclusive are the timely access requirements, i.e., at what stage of a patient's care do they commence?

A10: The requirements are to ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section

Q11: Does the timely access mandate also need to be a consideration when follow up care is required?

A11: Yes, when it is necessary for a provider or an enrollee to reschedule an appointment, the appointment is required to be "promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice"

Q12: What if interpreter services are needed at the time of a patient's appointment?

A12: Interpreter services must be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Q13: What if a patient/enrollee needs specialty services from specialists that are not contracted within the patient's health plan network?

A13: The patient/enrollee's plan must arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the patient/enrollee's condition. (Patient/Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles.)

Q14: What should be utilized as the health plan's guidelines when developing timely access procedures?

A14: The plans must establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure a physician's compliance with the regulations' "clinical appropriateness standard."

Q15: What quality control/assurance monitoring systems will be implemented?

A15: The quality assurance monitoring systems will include: Tracking and documenting network capacity and availability; annual enrollee experience survey; annual provider survey; quarterly evaluation of information available to the plan regarding accessibility, availability and continuity of care; advanced access (open scheduling) programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access.

Q16: What if you are a physician providing services through a preferred provider organization network?

A16: For that portion of the network that plans provide services through a preferred provider organization network, the plan can demonstrate compliance by annually monitoring the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area. This would include monitoring patient/enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsd standards.

Q17: How do the timely access requirements impact standing referrals to specialists?

A17: The provisions allow for but do not require standing referrals to specialists for chronic conditions to be scheduled in advance.

Q18: How do timely access requirements address geographic areas of the state where there is a shortage of providers, physicians, and other health care services?

A18: Plans operating in areas of the state where there is a shortage of one or more types of providers may comply with time-elapsd standards by referring enrollees to, or, in the case of PPOs, by assisting enrollees to locate to available and accessible contracted providers in neighboring service areas.

Q20: What important timelines are imposed on the plans that physicians need to be aware of?

A20: There are three (3) important time lines to take note of: (1) in 12 months: plans must implement the policies, procedures and systems (2)9 months: plans must disclose how it will comply with these regulations

(3) By March 31, 2012, and by March 31 of each year thereafter: plans must file a report with DMHC showing compliance, non-compliance or the degree of compliance. These reports will be made public through the DMHC and the Office of Patient Advocate (OPA) annual report card allowing the public to compare degree of compliance between plans.

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