No. UM AA-001	Network Adequacy and Member Access to Care	
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Committee Approval: 1/18/22 Previous Versions: see revision history on last page		
DMHC TAG: Access and Availability NCQA Standards NET 1, 2		

NETWORK ADEQUACY POLICY

Network adequacy refers to the breadth of services offered by Canopy Health's physicians, the distance that members would travel to access covered health care services within the Canopy Health service area, and the clinical safety of that travel time.

Methodology to Assess Geographic Network Adequacy

Canopy Health uses a "zip code inventory" to weight the zip codes where our current members live and potential future members are most likely to live. Canopy Health then compares these zip codes to the addresses of Canopy Health's physicians, hospitals and emergency departments. Using the software analytic logic through Quest Analytics, Canopy Health monitors for gaps in the geographic distribution of PCPs and specialists. Where such provider or care center gaps are found, Canopy Health works with each IPA to fill them. Network adequacy analysis is also conducted if substantial changes occur in the composition and/or geographic distribution of network providers available to members.

Network adequacy evaluates the following elements:

1. **Types of providers**: primary care physicians and medical and surgical specialists, including high volume and high impact specialists. Canopy Health is not delegated to offer behavioral health care and so does not evaluate behavioral health care provider network adequacy.
    - **Primary care physicians include family practice, general practice, internal medicine, pediatric and obstetric/gynecologic physicians**
    - High volume specialists include other specialists who treat high

volumes of members

- High impact specialists include oncologists and may include other specialists who treat conditions with high mortality and morbidity rates or require significant resources

2. **Ratio of healthcare providers to members**:
   - Physicians overall – at least 1 full time physician per 1,200 members
   - Primary care physicians (PCPs) -- at least 1 full time PCP per 2,000 members
   - High volume specialists - at least one per 5,000 members
3. **Type of facilities in Canopy Health's Network**: acute care hospitals, emergency care facilities; skilled nursing facilities; laboratories. Canopy Health is not delegated for Retail Pharmacy services.
4. **Time and distance from a member's home or workplace to specific types of providers and facilities:**
   - PCPs - must be located within 30 minutes or 15 miles of a member's home or workplace, per CA Title 28 CCR §1300.51 (d)(H)(i); CA Title 28 CCR §1300.67.2.1(a); CA Title 28 CCR §1300.67.2.2.(c)(7)(A).
   - Specialists of all types, including high volume and high impact - must be located within 30 miles or 60 minutes of a member's home. This conforms to NCQA network adequacy standard NET 1 C, which indicates that the "group" (in this case, Canopy Health) must define its own measurable standard for network adequacy for specialty care access; DMHC does not specify a standard for specialty care access but requires that basic health care services and specialized health care services shall be readily available and accessible.
   - Acute inpatient and emergency services - must be located within 30 minutes or 15 miles of a member's home or workplace, per CA Title 28 CCR §1300.51(d)(H)(ii); CA Title 28 CCR §1300.67.2.1(a); CA Title 28 CCR §1300.67.2.2.(c)(2) and (7); and
   - Ancillary services (defined as laboratory, pharmacy and similar services and goods dispensed by order or prescription from the PCP) - must be available "within a reasonable distance" from the prescribing or ordering provider

Network adequacy is tracked by:

- Member experience, complaints and appeals about network adequacy for non-behavioral healthcare services
- Claims for out of network services
- Other standards required by the California Department of Managed Care ("DMHC") or the National Committee for Quality Assurance (NCQA) Network Management Standards

MEMBER ACCESS TO CARE POLICY

DEFINITIONS

Canopy Health complies with federal and state requirements and NCQA Standards for timely access to care, including CA Title 28 CCR §1300.67.2.2.

"Advanced access" means:

- provision of an appointment with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested.
- advance scheduling of appointments later, if the enrollee prefers not to accept the appointment offered within the same day or next business day.

  The providers referenced here are within the Canopy Health network, either in individual practices, or a medical group or IPA to which the enrollee is assigned.

"**Ancillary service**" includes, but is not limited to, providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers" as defined by HSC §1323(e)(1).

"Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group or IPA and completing any other condition or requirement of the plan or its contracting providers.

"Health care service plan" or **"specialized health care service plan"** means either of the following: any person who either 1) arranges for provision of health care services for enrollees or 2) pays for or reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

"High-volume specialist" includes obstetrics/gynecology and may include other specialists who treat many members.

"High-impact specialists" includes oncologists and other specialists whose presence in the community are critical to meet membership needs.

"Mental Health Care Provider (MHCP)" includes Medical Doctors and Doctors of Osteopathy with specialties in addictionology or psychiatry, clinicians licensed by the state for the independent practice of psychology (including Master's Degree Psychologist, if permitted in the state where the psychologist practices, California requires a PhD in psychology to be licensed for independent practice), and Master's Level Clinicians: counselors, therapists, social workers, licensed professional examiners and nurses who are licensed or certified to practice independently according to state laws in their practice location. Marriage and Family Therapists and Licensed Clinical Social Workers are licensed or certified to practice independently in California.

"Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services as defined by HSC §1345(i).

"Provider Group" means a delegated medical group, independent practice HSC §1373.65(g).

"Preventive care" means 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 to all the basic health care services required HSC §1345(b)(5) and §1300.67(f).

"Specialist" is defined as a residency-trained, board-certified or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA).

"Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and enrollee constitutes telemedicine for the purposes of this policy and procedure.

"Triage" or **"screening"** 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 who may need care, to determine the urgency of the enrollee's need for care.

"Triage or screening waiting time" means the time waiting 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 an enrollee who may need care.

"Urgent care" means health care for a condition which requires prompt attention when the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function consistent with HSC §1367.01(h)(2.

Canopy Health's quality assurance **and** utilization review mechanism**s monitor** and evaluat**e members'** timely access to various types of care**,** including PCPs,

specialists, ancillary support services, and **recommended** preventive health services. Canopy Health supports all Health Plan, medical group and IPA processes that are necessary to authorize and obtain covered health care are completed in a timely manner appropriate for the member's condition.

STANDARDS FOR TIMELY ACCESS TO CARE

Canopy Health, through its delegated medical groups and IPAs, provides access for primary care services, and specialty care services as specified in Title 28 §1300.67.2.2(c). Canopy Health's parent health plans provide behavioral health care services using their contracted behavioral health provider network. Required timeframes for members to get appointments depend on the type of appointment and provider requested, detailed here:

Appointment Type	**Timeframe** ^see exceptions below
Urgent Care (if prior authorization not required by the health plan)	48 hours
Urgent Care (if prior authorization required by the health plan)	96 hours
Non-urgent care doctor appointment (PCP)	10 days
First prenatal visit for a pregnant member	Within 10 days of request
Non-urgent care doctor appointment (specialist)	15 days
Non-urgent care mental health appointment (non-physician)	10 days
Non-urgent care appointment (ancillary provider)	15 days

^ Exceptions to the Timeframes for Appointment Availability

- **Preventive Care Services and Periodic Follow-Up Care**: 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 provider 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, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

- **Extending Appointment Waiting Time when not Detrimental**:
  The waiting time for an appointment may be extended if a longer waiting time will not have a detrimental impact on the health of the patient, as determined by either the referring or treating licensed health care provider or the health professional providing triage or screening services while acting within the scope of his or her practice and consistent with professionally recognized standards of practice. Such determination must be documented in the relevant record.

- **Advanced Access**: The appointment availability standard listed above for primary care may be met if the PCP's office provides "advanced access." This means offering an appointment to a patient with a PCP, nurse practitioner or physician's assistant the same or next business day after an appointment is requested, or on a later date if the patient declines the appointment offered the same or next business day and prefers to wait for a later appointment with a specific contracted provider.

Appointment Rescheduling: When a provider or enrollee must reschedule an appointment, that rescheduled appointment shall be made promptly and in a timeframe that is appropriate for the member's health care needs and ensures continuity of care, consistent with the objectives of HSC §1367.03.

Provision of Telehealth Services

When telehealth services are provided those services must comply with all requirements as established in HSC § 1367(e)(2) and BPC § 2290.5 including:

- The health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient

for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent must be documented.

- A patient must not be precluded from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.
- All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.
- All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services.

Telephone Access for Triage or Customer Service

- Canopy Health through its delegated medical groups and IPAs and their providers, contracted health plans and internal processes, provides telephone triage 24 hours a day, seven days per week for immediate clinical support of everyday health issues and questions. The triage or screening waiting time does not exceed 30 minutes. Registered nurses may respond to calls, and they may: provide protocol-based advice for minor injuries and illnesses, identify emergency health situations, explain medications, and prepare patients for doctor visits.

Interpreter services

Interpretation services are offered in any language requested by a member, whether or not the language is identified as one of the health plan's threshold languages, per HSC 1367.04 and Section 1300.67 of Title 28. The range of services available in these languages must be appropriate for the chosen point of contact between the member and Canopy Health or its Network providers and vendors. Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services so that interpreter services are available during the appointment.

Obtaining services outside a member's home service area

If one Canopy Health service area has a shortage of a specialty or service, providers may refer members elsewhere within the Canopy Health Network. If the specialty or service is not available within the Canopy Health network, providers may refer members to non-network providers. Utilization Management departments within the member's home IPA will approve such services and will arrange contracts when necessary to ensure timely, medically necessary care. Member costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles.

After Hours/Emergency Services

Canopy Health supports the delegated IPAs in maintaining after-hours access. All Canopy Health participating providers must be available either directly or indirectly through medical call coverage arrangements 24 hours a day, seven days a week, responding within 30 minutes after the member calls. Acceptable means for providing after-hours access are:

- an answering service that offers to call or page the physician or on-call physician;
- a recorded message that directs the patient to call the answering service and the phone number is provided; or
- a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

Canopy Health supports the delegated medical groups and IPAs in maintaining 24/7/365 availability of urgent and emergency medical care through contracts with urgent care centers, ambulances, and acute care hospitals.

Canopy Health is not delegated to provide behavioral healthcare. The health plans with which Canopy Health contracts will contract, oversee, and affiliate with behavioral health practitioners, programs, and facilities to provide services to members that require urgent or emergent mental health care. These services include crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area, 24 hours a day, 7 days a week. Canopy Health and its participating Medical Groups and IPAs are responsible for fees related for

involuntary psychiatric (5150) hospitalizations for patients admitted to acute care non-psychiatric hospitals, as per their contractual Division of Financial Responsibility (DOFR).

Access to Inpatient Services

Canopy Health contracts directly with acute care inpatient providers, including those providing emergency and advanced trauma services, for adult and pediatric members. All contracted primary care providers are within 30 minutes or 15 miles of the facilities contracted with Canopy Health. Members have access to all participating network hospitals across Canopy Health for emergency services 24 hours a day, seven days a week. Access to inpatient services for elective services is dependent on the enrollee's admitting physician and where he/she has privileges in a Network participating hospital. Referrals to specialty physicians are facilitated by the enrollee's primary care physician; however, enrollees may request referral to any Network participating specialty physician. Inpatient access for enrollees is not limited by geography or "dyad" (a dyad is specified by Canopy Health as the local hospitals and the medical groups and IPAs commonly referring patients to those facilities). Inpatient access is not by influenced by payment mechanism (fee-for-service or capitation).

Access to Behavioral Health Services

Canopy Health is not delegated to provide Behavioral Healthcare services. Enrollees access behavioral health services through the behavioral health provider network contracted with their health plan to provide behavioral health services for the enrollees.

Communication about Guidelines Regarding Accessibility

Guidelines regarding access standards are distributed by Canopy Health, its participating providers and/or contracted health plans via the web, policy and procedure documents, or other recognized methods.

Assessing Compliance with Accessibility Policies

Canopy Health, along with its medical groups and IPAs conducts accessibility monitoring and tracking to document capacity to meet all federal and state

regulations. Canopy Health's upstream health plans assess appointment access and availability and after-hours access in its provider networks as well as patient satisfaction with accessibility. Survey results, when provided by the upstream health plan, are reviewed by Canopy Health Utilization Management Committee.

High Volume and High Impact Specialists Monitoring

Canopy Health provides adequate availability and accessibility to high volume and high impact specialist physicians for their members by:

- supporting the delegated medical groups and IPA UM Committee's efforts to identify gaps
- identifying specialties with the highest claims number by unique member claims
- identifying specialists whose care have the highest impact on patient care e.g. oncologists
- reviewing of Canopy Health's Provider Roster annually to ensure an adequate number and geographic distribution of specialists to meet the unique needs of the membership.

Canopy Health collects and analyzes data annually from its medical groups and IPAs, as well as Health Plan grievances and appeals, to measure delegates' performance against the current regulations and standards for timely access to various types of care (routine care, urgent and after-hours care) and to high impact and high-volume specialists. Canopy Health will monitor problems that develop, including telephone inaccessibility, delayed appointment dates, wait times for appointments, other barriers to accessibility, and any problems or dissatisfaction identified through complaints from contracting providers or grievances from subscribers or enrollees. These reports are reviewed by Canopy Health Quality Management Committee on an annual basis. Responses may include:

- contracting with new providers, through Canopy Health or its delegated IPAs and medical groups, depending on whether Canopy Health or the IPAs bear financial risk for the service offered by that specialist. The cost of care for the member will not be greater than it would have been if the care was furnished within the network.
- conducting an annual enrollee experience survey

- conducting an annual provider survey to solicit from physicians' perspective and concerns regarding compliance with the standards. Access to care for non-physician mental health providers is the responsibility of the parent health plans' contracted behavioral health vendor
- reviewing and evaluating information shared by upstream health plans from their access, availability, and continuity of care surveys or their grievances and appeals or other communications to Canopy Health Quality Management Committee

Revision History:

Version Date	Edited By	Reason for Change
7/18/16	M. Durbin	Creation date
11/10/16	M. Durbin	Consolidates certain sections of Exhibit I-5 and J-13 pertaining to timely access to care into a single, standalone policy, adds clarifying definitions within the policy, adds supplemental details regarding (a) how access is assessed and the corrective action plans instituted as necessary; (b) appointment rescheduling requirements; (c) compliance monitoring; (d) access to inpatient services; (e) behavioral health services; and (f) telemedicine
12/19/17	A. Kmetz	Updated in response to WHA pre-delegation audit in areas including: documenting CH shall establish and maintain provider networks, QA monitoring systems processes sufficient to ensure compliance with clinical appropriateness standard, high-volume and high impact specialist definitions, monitoring plans and after-hours response definition and monitoring
12/22/17	M Durbin	Wordsmithing, formatting changes
1/19/18	M. Durbin	Updated the extending appointment wait times paragraph per DMHC filing requirements per MWE

02/13/18	A. Kmetz	Expanded description for identification of high volume and high impact providers to address issues noted in WHA's pre-delegation review.
4/13/18	A. Kmetz	Removed/replaced the timeliness standards directly from the DMHC website. Changed the description of how Canopy Health provides oversight of access and availability to reflect the current practice. Added high volume specialist access to care standards.
4/17/18	M. Durbin	Specified that the entity contracted with OON network providers (Canopy Health or IPA) depends on who bears financial risk for that service.
4/24/18	M. Durbin	Combined AA 001 and AA 002 P & P: Network Adequacy Policy and Timely Access to Care Policy, removed redundancies.
7/18/18	M. Durbin	Updated to include DMHC TAGs and NCQA standards and remove references to providing Telemedicine per Health Net request
7/1/19	R. Scott	Corrected content and references to specific regulation per DMHC request.
6/1/20	R. Scott	Revised network adequacy tracking and specified that upstream health plans are responsible for monitoring compliance with access and availability. Added section with DMHC requirements describing provision of telehealth.
10/1/21	R. Scott	Removed reference to Canopy Health Customer Service (call center) which was closed as of 4/1/21. Clarified upstream health plan responsibility for UM patient satisfaction survey with access.