

**Table 2. Access Provisions**

State	Time and distance standards			Appointment wait-time standards for adults			After-hours care	Disability access*	Language access*
	Primary care	Specialty care	Pediatric-specific standards	Primary care	Specialty care	Nonemergent urgent care			
AZ	X <sup>1</sup>	X <sup>2</sup>		X <sup>3</sup>	X <sup>4</sup>	X <sup>5</sup>	X <sup>6</sup>	X <sup>7</sup>	X <sup>8</sup>
CO	X <sup>9</sup>			X <sup>10</sup>	X <sup>11</sup>	X <sup>12</sup>	X <sup>13</sup>		X <sup>14</sup>
CT**									X <sup>15</sup>
FL	X <sup>16</sup>	X <sup>17</sup>	X <sup>18</sup>	X <sup>19</sup>		X <sup>20</sup>	X <sup>21</sup>		X <sup>22</sup>
IL	X <sup>23</sup>	X <sup>24</sup>		X <sup>25</sup>		X <sup>26</sup>	X <sup>27</sup>	X <sup>28</sup>	X <sup>29</sup>
KY	X <sup>30</sup>	X <sup>31</sup>		X <sup>32</sup>	X <sup>33</sup>	X <sup>34</sup>			X <sup>35</sup>
MD***	X <sup>36</sup>	X <sup>37</sup>		X <sup>38</sup>	X <sup>39</sup>	X <sup>40</sup>	X <sup>41</sup>	X <sup>42</sup>	X <sup>43</sup>
MA <sup>^</sup>	X <sup>44</sup>	X <sup>45</sup>		X <sup>46</sup>	X <sup>47</sup>	X <sup>48</sup>	X <sup>49</sup>	X <sup>50</sup>	X <sup>51</sup>
MN	X <sup>52</sup>	X <sup>53</sup>		X <sup>54</sup>	X <sup>55</sup>	X <sup>56</sup>	X <sup>57</sup>		X <sup>58</sup>
MO <sup>^</sup>	X <sup>59</sup>	X <sup>60</sup>		X <sup>61</sup>		X <sup>62</sup>	X <sup>63</sup>		X <sup>64</sup>
NJ	X <sup>65</sup>	X <sup>66</sup>		X <sup>67</sup>	X <sup>68</sup>	X <sup>69</sup>	X <sup>70</sup>		X <sup>71</sup>
OH	X <sup>72</sup>				X <sup>73</sup>		X <sup>74</sup>		X <sup>75</sup>
PA	X <sup>76</sup>	X <sup>77</sup>	X <sup>78</sup>	X <sup>79</sup>	X <sup>80</sup>	X <sup>81</sup>	X <sup>82</sup>	X <sup>83</sup>	X <sup>84</sup>
RI <sup>^</sup>	X <sup>85</sup>			X <sup>86</sup>		X <sup>87</sup>	X <sup>88</sup>		X <sup>89</sup>
SC	X <sup>90</sup>	X <sup>91</sup>		X <sup>92</sup>	X <sup>93</sup>	X <sup>94</sup>	X <sup>95</sup>	X <sup>96</sup>	X <sup>97</sup>
TN	X <sup>98</sup>	X <sup>99</sup>		X <sup>100</sup>	X <sup>101</sup>	X <sup>102</sup>	X <sup>103</sup>		X <sup>104</sup>
VA <sup>^</sup>	X <sup>105</sup>						X <sup>106</sup>	X <sup>107</sup>	X <sup>108</sup>
WA	X <sup>109</sup>			X <sup>110</sup>		X <sup>111</sup>	X <sup>112</sup>		X <sup>113</sup>
WV	X <sup>114</sup>	X <sup>115</sup>		X <sup>116</sup>		X <sup>117</sup>	X <sup>118</sup>	X <sup>119</sup>	X <sup>120</sup>
<b>Total</b>	<b>18/19</b>	<b>13/19</b>	<b>2/19</b>	<b>16/19</b>	<b>10/19</b>	<b>16/19</b>	<b>17/19</b>	<b>8/19</b>	<b>19/19</b>

**Notes:**

\* We based our assessment of access provisions on affordability, availability, geographic accessibility, accommodation, and acceptability.<sup>121</sup> If a provision fit within these categories, it was included as an access requirement. If however, language included a focus on establishing a baseline threshold requirement for the network of providers, then the clause was included in Table 1. Disability access reflects provisions that are in addition to mandatory compliance with the Americans with Disabilities Act.

\*\* Connecticut operates a single Administrative Service Organization for physical health, which is the sole Contractor and provider of services in the state, and thus, their model contract does not provide for some of the network requirements that would be found in typical managed care contracts.

\*\*\* Maryland’s boilerplate contract language is based heavily on and structured upon MD’s regulations regarding managed care; therefore the footnotes below reflect regulatory citations.

<sup>^</sup> This state had only published an RFP for its contracts so the chart reflects provisions of the RFP instead of actual contract language.

All data in the footnotes is actual boilerplate language from the contracts and RFPs unless otherwise noted.

<sup>1</sup> AZ Model Contract Sec. D. 26. Network Development. Network Development and Management Plan: The Contractor shall develop and maintain a Network Development and Management Plan to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services [42 CFR 438.207(b)(2)]. The submission of the Network Management and Development Plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor’s provider network. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Network Development and Management Plan must include the requirements outlined in ACOM Policy 415. The Contractor shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population. In accordance with the requirements specified in ACOM Policy 436, the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing in Pima and Maricopa Counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a MultiSpecialty-Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Policy 436.

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<sup>2</sup> AZ Model Contract Sec. D. 26. Network Development. Network Development and Management Plan: The Contractor shall develop and maintain a Network Development and Management Plan to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services [42 CFR 438.207(b)(2)]. The submission of the Network Management and Development Plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Network Development and Management Plan must include the requirements outlined in ACOM Policy 415. The Contractor shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population. In accordance with the requirements specified in ACOM Policy 436, the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing in Pima and Maricopa Counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a MultiSpecialty-Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Policy 436.

<sup>3</sup> AZ Model Contract Sec. D. 32. APPOINTMENT STANDARDS. For Primary Care Provider Appointments, the Contractor shall be able to provide: a. Immediate Need appointments the same day or within 24 hours of the member's phone call or other notification b. Urgent care appointments within 2 days of request c. Routine care appointments within 21 days of request.

<sup>4</sup> AZ Model Contract Sec. D. 32. APPOINTMENT STANDARDS. For Specialty Provider Referrals, the Contractor shall be able to provide: a. Immediate Need appointments within 24 hours of referral b. Urgent care appointments within 3 days of referral c. Routine care appointments within 45 days of referral.

<sup>5</sup> AZ Model Contract Sec. D. 32. APPOINTMENT STANDARDS. For Primary Care Provider Appointments, the Contractor shall be able to provide: a. Immediate Need appointments the same day or within 24 hours of the member's phone call or other notification b. Urgent care appointments within 2 days of request c. Routine care appointments within 21 days of request.

<sup>6</sup> AZ Model Contract Sec. D. 26. Network Development. The Contractor is required to have available non-emergent after-hours physician or primary care services within its network. If the Contractor's network is unable to provide medically necessary services required under Contract, the Contractor shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted.

<sup>7</sup> AZ Model Contract Sec. D. 7. Accommodating ACHHS Members. The Contractor must ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the Contractor must provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills. The Contractor must provide accommodations to members and individuals with disabilities at no cost to afford such persons an equal opportunity to benefit from the covered services.

<sup>8</sup> AZ Model Contract Sec. D. 17. Member Information. The Contractor shall make interpretation services available to its members free of charge including: written translation of vital materials in prevalent non English languages in its service area, availability of oral interpretation services in all languages, use of auxiliary aids such as TTY/TDY and American Sign Language.

<sup>9</sup> Rocky Mountain HMO FY 2017-2018 Contract (hereafter Rocky Mountain Contract) Sec. 4.2. The Contractor's PCMP Network shall have a sufficient number of PCMPs so that each Member has a PCMP and each Member has their choice of at least two (2) PCMPs within their zip code or within thirty (30) minutes of driving time from their location, whichever area is larger. For rural and frontier areas, the Department may adjust this requirement based on the number and location of available providers.

<sup>10</sup> Rocky Mountain Contract Sec 4.2. The Contractor's PCMP Network shall be sufficient to ensure that appointments will be available to all Members: Within ten (10) calendar days of a Member's request for non-urgent, symptomatic care. Within forty-five (45) calendar days of a Member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedules.

<sup>11</sup> Rocky Mountain Contract. Sec. 4.2.4. The Contractor's PCMP Network shall be sufficient to ensure that appointments will be available to all Members: Within forty-eight (48) hours of a Member's request for urgent care. Within ten (10) calendar days of a Member's request for non-urgent, symptomatic care. Within forty-five (45) calendar days of a Member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedules.

<sup>12</sup> Rocky Mountain Contract Sec 4.2. The Contractor's PCMP Network shall be sufficient to ensure that appointments will be available to all Members: Within forty-eight (48) hours of a Member's request for urgent care.

<sup>13</sup> Rocky Mountain Contract Sec. 4.2. The Contractor's PCMP network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. The Contractor will determine the appropriate requirements for the number of extended hours and weekend availability based on the needs of the Contractor's Region, and submit these requirements to the Department for approval. The Contractor shall assess the needs of the Contractor's Region on a regular basis, no less often than quarterly, and submit a request to the Department to adjust its requirements accordingly. At a minimum, the Contractor's PCMP network shall provide for twenty-four (24) hour a day availability of information, referral and treatment of emergency medical conditions.

<sup>14</sup> Rocky Mountain Contract Sec. 5.2. The Contractor shall provide interpreter services at no cost for all interactions with Members or Clients when there is no bilingual or multilingual Member of the Contractor available who speaks a language understood by a Member.

<sup>15</sup> General ASO Contract. Sec. Q.2. Throughout the term of the Contract, the Contractor's member services staff shall provide non-clinical information to Members and when appropriate provide immediate access to clinical staff for care related assistance. The Contractor shall: Q.2.1. Staff member services with competent, diverse professionals including Spanish speaking individuals in order to best serve the needs of Members; Q.2.2. Make special provisions for Members and their families who have limited English proficiency, or are hearing or vision impaired. Q.2.2.1. Oral informing techniques may include face-to-face contact, other media, including TDD/TY and sign language services; Q.2.3. Ensure that Member information is clearly communicated in a manner that is culturally sensitive.

<sup>16</sup> ATTACHMENT II EXHIBIT II-A MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM (hereinafter FL MMA Exhibit II-A) Sec. VI. Provider Network Standards Table. 30 mins; 20 miles.

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<sup>17</sup> FL MMA Exhibit II-A Sec. VI. Provider Network Standards Table. For example: In urban areas, Cardiology, 50 minutes, 35 miles; Oncology, 80 minutes, 60 miles; Pulmonology, 60 minutes, 45 miles. In non-urban areas: Cardiology, 75 minutes, 60 miles; Oncology, 90 minutes, 75 miles; Pulmonology, 75 minutes, 60 miles.

<sup>18</sup> FL MMA Exhibit II-A Sec. VI. Provider Network Standards Table. 50 mins; 35 miles. For non-urban, 75 mins; 60 miles.

FL MMA Exhibit II-A Sec. VI. Provider Network Standards Table. For pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.

<sup>19</sup> FL MMA Exhibit II-A Sec. VI.A.8. The Managed Care Plan must assure that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis, as follows: (1) Urgent Care — within one (1) day of the request; (2) Sick Care — within one (1) week of the request; and (3) Well Care Visit — within one (1) month of the request.

<sup>20</sup> FL MMA Exhibit II-A Sec. VI.A.8. The Managed Care Plan must assure that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis, as follows: (1) Urgent Care — within one (1) day of the request; (2) Sick Care — within one (1) week of the request; and (3) Well Care Visit — within one (1) month of the request.

<sup>21</sup> FL MMA Exhibit II-A, Section VI. The Managed Care Plan shall ensure the following: (1) The PCP provides, or arranges for coverage of services, consultation or approval for referrals twenty-four hours per day, seven days per week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number.

<sup>22</sup> FL Managed Care Contract. Sec. IV.B.1.d. In accordance with Title VI of the Civil Rights Act of 1964, the Managed Care Plan shall provide language assistance services, including the provision of foreign language interpreter and translation services and auxiliary aids and services to enrollees to achieve effective communication.

Sec. IV.B.3.b. The Managed Care Plan is required to notify its enrollees of the availability of oral interpretation services and to inform them of how to access such services. Oral interpretation services are required for all Managed Care Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services.

<sup>23</sup> IL Model Contract Sec. 5.8.1. Primary care Provider access. Contractor shall ensure an Enrollee has access to at least two (2) primary care Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence in an urban setting. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) primary care Provider within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

<sup>24</sup> IL Model Contract Sec. 5.8. Contractor shall ensure an Enrollee has access to at least one (1) specialty services Provider within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) specialty services Provider within a ninety (90)-mile radius of or ninety (90)-minute drive from the Enrollee's residence.

<sup>25</sup> IL Model Contract. Sec. 5.8.4 After hours. Primary care and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable.

<sup>26</sup> IL Model Contract. Sec. 5.8.3. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day after the request.

<sup>27</sup> Sec. 5.8.4 After hours. Primary care and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable.

<sup>28</sup> IL Contract. 2.8 PROVIDER SITE ACCESS All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the needs of individual Enrollees.

IL Model Contract. Sec. 5.8.8. For Seniors and Persons with Disabilities Enrollees, Contractor's maximum primary care Provider panel size shall be six hundred (600) Enrollees.

<sup>29</sup> Sec. 5.21. Basic information. "Basic information" as used herein shall mean information regarding: 5.21.1.13 names, locations, telephone numbers, and non-English languages spoken by current Network Providers, including identification of those who are not accepting new Enrollees.

5.21.2 Obligation to provide basic information. Contractor shall provide basic information to the following Participants, and shall notify such Participants that translated materials in Spanish and other prevalent languages are available and how to obtain them, once a year.

5.21.4.1 Interpretive services. Contractor shall make oral interpretation services available free of charge in all languages to all Potential Enrollees, Prospective Enrollees, or Enrollees who need assistance understanding Key Oral Contacts or Written Materials. Contractor must include in all Key Oral Contacts and Written Materials notification that such oral interpretation services are available and how to obtain such services. Contractor shall conduct Key Oral Contacts with a Potential Enrollee, Prospective Enrollee, or Enrollee in a language the Potential Enrollee, Prospective Enrollee, or Enrollee understands. If a Participant requests interpretive services by a family member or acquaintance, Contractor shall not allow such services by anyone who is under the age of eighteen (18). Contractor shall accept such Participant's verification of the age of the individual providing interpretive services unless Contractor has a valid reason for requesting further verification.

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5.21.4.3 Alternative methods of communication. Contractor shall make Key Oral Contacts and Written Materials available in such alternative formats as large print, Braille, sign language provided by interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, audio CDs, TDD/TTY, video relay interpretation, or video relay services, and in a manner that takes into consideration the special needs of those who are visually impaired, hearing impaired, or with limited reading proficiency. Contractor shall inform Potential Enrollees, Prospective Enrollees, and Enrollees, as appropriate, that information is available in alternative formats and how to access those formats. Contractor must provide TDD/TTY service upon request for communicating with Potential Enrollees, Prospective Enrollees, and Enrollees who are deaf or hearing impaired. Contractor shall arrange interpreter services through Contractor's Enrollee services department when necessary (such as for Provider visits or consultations). These services will be made available at no cost to the Enrollee.

5.21.4.4 Translated materials. Translated Written Materials and scripts for translated Key Oral Contacts require Prior Approval and must be accompanied by Contractor's certification that its certified translator confirms the translation is accurate and complete, and that the translation is easily understood by individuals with a sixth (6th)- grade reading level and is culturally appropriate. Contractor's first submittal of the translated materials to the Department for Prior Approval must be accompanied by a copy of the Department's approval of the English version and the required translation certification. Contractor shall make all Written Materials distributed to English-speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Department in accordance with Section 1557 of the Affordable Care Act. Where there is a prevalent single-language minority within the low-income households in the relevant DHS local office area, which for purposes of this Contract shall exist when five percent (5%) or more of such households speak a language other than English, as determined by the Department according to published Census Bureau data, Contractor's Written Materials provided to Potential Enrollees, Prospective Enrollees, or Enrollees must be available in that language as well as in English.

<sup>30</sup> Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: Contractor shall provide PCP delivery sites that are no more than thirty (30) miles or thirty (30) minutes from Member residence in urban areas. Contractor shall provide PCP delivery sites that are no more than forty-five (45) miles or forty-five (45) minutes from Member residence in "non-urban" areas.

<sup>31</sup> Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes.

<sup>32</sup> Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: Appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services.

<sup>33</sup> Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: Appointment and waiting times for Specialists shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care.

<sup>34</sup> Commonwealth of Kentucky - Master Agreement Modification. Section 29.7. Provider Program Capacity Demonstration: Appointment and waiting times, not to exceed forty-eight (48) hours from date of a Member's request for Urgent Care.

<sup>35</sup> Commonwealth of Kentucky- Master Agreement Modification. Sec. 23.1. Appropriate foreign language and/or oral interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education and otherwise comply with 42 CFR 438.10(d).

<sup>36</sup> COMAR 10.09.64.05. Documentation that enrollees will have access to primary care services, including pharmacy, obstetrics/gynecology and diagnostic laboratory services, within a reasonable distance of their places of residence, demonstrated by showing the availability of these services in: (a) Urban areas, within a 10-mile radius; (b) Rural areas, within a 30-mile radius; and (c) Suburban areas, within a 20-mile radius.

<sup>37</sup> COMAR 10.09.66.06.B. Except as provided in §C of this regulation, to meet the geographical access standard established by this regulation, an MCO shall provide the services listed in §A(1) —(4) of this regulation: (1) In urban areas, within 10-miles of each enrollee's residence; (2) In rural areas, within 30 miles of each enrollee's residence; and (3) In suburban areas, within 20 miles of each enrollee's residence. C. If an MCO can otherwise demonstrate to the Department's satisfaction the adequacy of its provider network notwithstanding its inability to meet the requirements of §B of this regulation, the Department may, in its discretion, approve the network if special circumstances exist which, considered along with the overall strength of the MCO's network, establish that the Department's approval of the network will enhance recipients' overall access to quality health care services in the area to be served.

<sup>38</sup> COMAR 10.09.66.07. Requests for routine and preventative primary care appointments shall be scheduled to be performed within 30 days of the request.

<sup>39</sup> COMAR 10.09.66.07. Requests for routine specialist follow-up appointments shall be scheduled to be performed within 30 days of the initial authorization from the enrollee's primary care provider, or sooner as deemed necessary by the primary care provider, whose office staff shall make the appointment directly with the specialist's office.

<sup>40</sup> COMAR 10.09.66.07. Individuals requesting urgent care shall be scheduled to be seen within 48 hours of the request.

<sup>41</sup> COMAR 10.09.66.04. A. An MCO shall develop and make available either electronically or by hard copy to all of its PCP and specialty care providers a Medicaid requirements manual, including periodic updates as appropriate, and shall: (3) Inform the MCO's primary and specialty care providers of their responsibility to provide or arrange for medically necessary accessible health care services that are continuous, comprehensive, and coordinated for each enrollee, including: (a) Preventive health services; (b) Primary acute medical care; (c) Chronic medical care; (d) Consultation, referral, and follow-up in areas including medical specialties and child dental care; (e) Referral for ancillary and support-related services including but not limited to: (i) Drug therapies, (ii) Diagnostic tests, (iii) Medical supplies, (iv) Durable medical equipment, and (v) Case management when appropriate for complex conditions; (f) 24-hour per day, 7-day per week provider coverage for medically necessary services; (g) Maintenance of a medical record, including records of referral arrangements and outcomes of those referrals; and (h) Detection of mental health problems or substance use disorder during routine or follow-up screening, to be treated either through the MCO or referred to the behavioral health ASO for services.

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<sup>42</sup> COMAR 10.09.66.01. Access Standards: Addressing Enrollees' Individualized Needs. A. An MCO shall provide access to health care services and information A. An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, regardless of gender, sexual orientation, or gender identity, including, but not limited to, the delivery of services and information to enrollees: (1) In a culturally sensitive manner; (2) At an appropriate reading comprehension level; (3) In the prevalent non-English languages identified by the State; and (4) In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it.

B. Special Access. (1) An MCO shall on request make interpretation services available free of charge to each enrollee and potential enrollee who: (a) Does not speak English; or (b) Is hearing impaired. (2) As a part of its initial application, a prospective MCO shall describe, for the Department's consideration, what special access provisions the applicant has made to fulfill the requirements of this section.

COMAR 10.09.64.06. An MCO applicant shall include in its application the following information or descriptions: K. Documentation of access provisions to address the needs of enrollees who: (1) Do not speak English; (2) Are deaf; or (3) Have one or more physical, mental, or developmental disabilities.

<sup>43</sup> COMAR 10.09.64.06. [An MCO applicant shall include in its application the following information or descriptions:] Documentation of access provisions to address the needs of enrollees who: (1) Do not speak English; (2) Are deaf; or (3) Have one or more physical, mental, or developmental disabilities.

COMAR 10.09.65.02.G.3. Conditions for Participation. G. An MCO: (3) Shall prepare and make available all publications, including, but not limited to, provider directories, enrollee handbooks, health education materials, and informational brochures: (a) In a culturally sensitive manner, (b) At an appropriate reading comprehension level, and (c) In the prevalent non-English languages, identified by the State.

COMAR 10.09.66.01 Access Standards: Addressing Enrollees' Individualized Needs. A. An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, regardless of gender, sexual orientation, or gender identity, including, but not limited to, the delivery of services and information to enrollees:

(1) In a culturally sensitive manner; (2) At an appropriate reading comprehension level; (3) In the prevalent non-English languages identified by the State; and (4) In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it. B. Special Access. (1) An MCO shall on request make interpretation services available free of charge to each enrollee and potential enrollee who: (a) Does not speak English; or (b) Is hearing impaired. (2) As a part of its initial application, a prospective MCO shall describe, for the Department's consideration, what special access provisions the applicant has made to fulfill the requirements of this section.

<sup>44</sup> Massachusetts Model MassHealth Managed Care Contract, Sec. 2.9.C. The PCP network shall include a sufficient number of PCPs to offer each Enrollee a choice of at least two appropriate PCPs with open panels. An appropriate PCP is defined as a PCP who:

Is located within 15 miles or 30 minutes travel time from the Enrollee's residence.

<sup>45</sup> MassHealth Managed Care Contract, Sec. 2.9.C. For all other specialist providers, the Contractor must demonstrate to EOHHS that these specialist providers are available within 20 miles or 40 minutes travel time from the Enrollee's residence.

<sup>46</sup> MassHealth Managed Care Contract, Sec. 2.9.B. Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care, unless an appointment is required more quickly to assure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule.

<sup>47</sup> MassHealth Managed Care Contract, Sec. 2.9.B. Within 48 hours of the Enrollee's request for Urgent Care; Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and Within 60 calendar days for Non-Symptomatic Care.

<sup>48</sup> MassHealth Managed Care Contract, Sec. 2.9.B. Within 48 hours of the Enrollee's request for Urgent Care.

<sup>49</sup> Sec.2.9.C. The Contractor shall develop and maintain a network of Primary Care Providers (PCP network) that ensures PCP coverage and availability throughout the Regions 24 hours a day, seven days a week.

<sup>50</sup> MA ACO Model Contract. Sec. 2.3 Administration and Contract Management.2.a. The following roles shall be Key Personnel: (7) The Contractor's Disability Access Coordinator, whose responsibilities shall include, but may not be limited to: Ensuring that the Contractor and its Providers comply with federal and state laws and regulations pertaining to persons with disabilities. Such requirement shall include monitoring and ensuring that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Enrollees with physical or mental disabilities;

<sup>51</sup> MassHealth Managed Care Contract Sec. 2.5 Care Delivery, Care Coordination, and Care Management. A.1.d. Care that is Linguistically and Culturally Competent. The Contractor shall regularly evaluate the population of Enrollees to identify language needs, including needs experienced by Enrollees who are deaf or hard of hearing, and needs related to health literacy, and to identify needs related to cultural appropriateness of care (including through the Care Needs Screening as described in Section 2.5.B). The Contractor shall identify opportunities to improve the availability of fluent staff or skilled translation services in Enrollees' preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care.

<sup>52</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec. 6.13. No more than thirty (30) miles or thirty (30) minutes distance for all Enrollees, or the STATE's Generally Accepted Community Standards.

<sup>53</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec. 6.13. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

Sec. 6.13.5 Dental, Optometry, Lab, and X-Ray Services. (A) Transport Time. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

<sup>54</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec. 6.13. Not to exceed forty-five (45) days from the date of an Enrollee's request for routine and preventive care and twenty-four (24) hours for Urgent Care.

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<sup>55</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec. 6.13. Appointments for a specialist shall be made in accordance with the time frame appropriate for the needs of the Enrollee, or the Generally Accepted Community Standards.

<sup>56</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec. 6.13. Not to exceed forty-five (45) days from the date of an Enrollee's request for routine and preventive care and twenty-four (24) hours for Urgent Care.

<sup>57</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec. 6.14. The MCO shall make available to Enrollees access to Medical Emergency Services, Post-Stabilization Care Services and Urgent Care on a twenty-four (24) hour, seven-day-per-week basis. The MCO must provide a twenty-four (24) hour, seven day per week MCO telephone number that is answered in-person by the MCO or an agent of the MCO. This telephone number must be provided to the STATE. The MCO is not required to have a dedicated telephone line.

<sup>58</sup> Minnesota Model Contract for Medical Assistance and Minnesotacare Services. Sec 6.1. The MCO shall provide sign and spoken language qualified interpreter services, as defined in 45 CFR § 92.4, that assist Enrollees in obtaining services covered under this Contract, to the extent that interpreter services are available to the MCO or its subcontractor when services are delivered. The intent of the limitation, above, is that the MCO should not delay the delivery of a necessary health care service, even if through all diligent efforts, no interpreter is available. This does not relieve the MCO from using all diligent efforts to make interpreter services available. The MCO is not responsible to provide interpreter services for services provided through fee-for-service

<sup>59</sup> 20 CSR 400-7.095. 10 miles from urban area, 30 miles for non-urban area.

<sup>60</sup> 20 CSR 400-7.095. 25 miles. For non-urban area 100 miles.

<sup>61</sup> MO RFP November 2017. Sec. 2.5.3. Routine care with physical or behavioral symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): Appointments within one (1) week or five (5) business days whichever is earlier. Routine care without physical or behavioral symptoms (e.g. well child exams, routine physical exams): Appointments within thirty (30) calendar days.

<sup>62</sup> MO RFP November 2017. Sec. 2.5.3. Urgent care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): Appointments within twenty-four (24) hours.

<sup>63</sup> MO RFP November 2017. Sec. 2.5.1. b. The health plan shall provide an accommodation, if needed, to ensure all members equal access to twenty-four (24) hours per day health care coverage.

<sup>64</sup> MO RFP. Sec. 2.14.4 Interpreter Services: The health plan shall make interpreter services available to potential enrollees and require the health plan make those services available free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.

<sup>65</sup> NJ Model contract referencing N.J.A.C. 11:24-6.2, 20 miles or 30 minutes; 2017 Contract Sec. 4.8.8. 90% of the enrollees must be within 6 miles of 2 PCPs and 2 PCDs in an urban setting. 85% of the enrollees must be within 15 miles of 2 PCPs and 2 PCDs in a non-urban setting.

<sup>66</sup> NJ Model contract referencing N.J.A.C. 11:24-6.2. 60 minutes, 45 miles.

<sup>67</sup> NJ Model Contract. Sec. 5.12. Symptomatic Acute Care. Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention. Routine Care. Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.

<sup>68</sup> NJ Model Contract. Sec. 5.12. Specialist Referrals. Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Urgent Specialty Care within twenty-four (24) hours of referral

<sup>69</sup> NJ Model Contract. Sec. 5.12. Urgent Care. Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening.

<sup>70</sup> Sec 4.8.2. The PCP shall provide twenty-four (24) hour, seven (7) day a week access.

<sup>71</sup> Sec. 5.9.1. The enrollee shall be assigned to a PCP whose office is within the travel time/distance standards, as defined in Article 4.8.8. If the language and/or cultural needs of the enrollee are known to the Contractor, the enrollee shall be assigned to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts.

4.8.4 PROVIDER DIRECTORY REQUIREMENTS A. The Contractor shall prepare a provider directory which shall be presented in the following manner. Ten (10) hard copies of the Contractor's up-to-date provider directory shall be provided to the HBC and two (2) hard copies and one (1) CD format shall be provided to DMAHS at least every six months or within 30 days of an update, whichever is earlier. Up-to-date, web-based provider directories shall also be maintained with updates made no later than every 30 days. Primary care providers who will serve enrollees listed by • County, by city, by specialty • Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); telephone number; fax number if available; office hours at each location; indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP.

Sec. 5.8.1.D. The Contractor shall make its written information available in the prevalent non-English languages in each service area of operation. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. NJ FamilyCare compiles a list of prevalent non-English languages, and makes it available to MCOs, including through their website.

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Sec. 5.8.2 ENROLLEE NOTIFICATION/HANDBOOK Prior to the effective date of enrollment, the Contractor shall provide each enrolled case or, where applicable, authorized person, with a bilingual (English/Spanish) Member handbook and an Identification Card. The handbook shall be written at the fifth grade reading level or at an appropriate reading level for enrollees with special needs. The handbook shall also be available in prevalent languages and on request in other languages and alternative formats, e.g., large print (a font size no smaller than 18 point), Braille, audio formats for enrollees with sensory impairments or in a modality that meets the needs of enrollees with special needs. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee.

Sec. 5.14. The Contractor shall provide documentation regarding the availability of and access procedures for services which ensure physical and communication access to: providers and any Contractor related services (e.g. office visits, health fairs); customer service or physician office telephone assistance; and, interpreter, TDD/TT services for individuals who require them in order to communicate. Document availability of interpreter, TDD/TT services. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. The Contractor shall provide twenty-four (24)-hour access to oral interpreter services free of charge for all enrollees/potential enrollees including the deaf or hard of hearing at provider sites within the Contractor's network, either through telephone language services or in-person interpreters to ensure that enrollees are able to communicate with the Contractor and providers and receive covered benefits.

<sup>72</sup> OH Model Contract, Appendix C. 30 miles or MCP must provide transportation.

<sup>73</sup> OH Model Contract, Appendix H. MCPs must ensure that all nonPCP network providers follow community standards in the scheduling of routine appointments.

<sup>74</sup> APPENDIX H.1. Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. MCPs must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. MCPs must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply ... The MCP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable.

<sup>75</sup> Appendix C. The MCP must make oral interpreter services for all languages available free of charge to all members and eligible individuals pursuant to 42 CFR Section 438.10(c)(4). The MCP must comply with the requirements specified in OAC rules 5160-26-03.1, 5160-26-05, and 5160-26-05.1 for providing assistance to LEP members and eligible individuals.

<sup>76</sup> PA Model Contract Exhibit AAA(1). Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available.

<sup>77</sup> PA Model Contract Exhibit AAA(1). i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural): General Surgery Cardiology Obstetrics & Gynecology Pharmacy Oncology Orthopedic Surgery Physical Therapy General Dentistry Radiology. ii. For the following provider types, the PH-MCO must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone: Oral Surgery Urology Nursing Facility Neurology Dermatology Otolaryngology. iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

<sup>78</sup> PA Model Contract Exhibit AAA(1). Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

<sup>79</sup> PA Model Contract Exhibit AAA(1). Routine appointments must be scheduled within ten (10) Business Days.

<sup>80</sup> PA Model Contract Exhibit AAA(1). For specialty referrals, the PH-MCO must be able to provide for: i. Emergency Medical Condition appointments immediately upon referral. ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral. iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types: Otolaryngology Orthopedic Surgery Dermatology Pediatric Allergy & Immunology Pediatric Endocrinology Pediatric Gastroenterology Pediatric General Surgery Pediatric Hematology Pediatric Infectious Disease Pediatric Nephrology Pediatric Neurology Pediatric Oncology Pediatric Pulmonology Pediatric Rehab Medicine Pediatric Rheumatology Pediatric Urology Dentist. iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

<sup>81</sup> PA Model Contract Exhibit AAA(1). Urgent Medical Condition cases must be scheduled within twenty four (24) hours.

<sup>82</sup> PA Model Contract, Sec. V. S. 3. It is the responsibility of the PH-MCO to have coverage available directly or through its PCPs, who may have on-call arrangements with other qualified Providers, for urgent or emergency care on a twenty-four (24) hour, seven (7) day-a-week basis. The PH-MCO must not use answering services in lieu of the above PCP emergency coverage requirements without the knowledge of the Member. For Emergency or Urgent Medical Conditions, the PHMCO must have written policies and procedures on how Members and Providers can make contact to receive instruction for treatment. If the PCP determines that emergency care is not required, 1) the PCP must see the Member in accordance with the time frame specified in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, under Appointment Standards, or 2) the Member must be referred to an urgent care clinic which can see the Member in accordance with the time frame specified in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, under Appointment Standards.

<sup>83</sup> PA Model Contract Exhibit AAA(3), Sec. 1. n. ADA Accessibility Guidelines. The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance. The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections. If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier. The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

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<sup>84</sup> PA Model Contract Sec. V.F.4. Limited English Proficiency (LEP) Requirements. During the Enrollment Process, the PH-MCO and/or the Department's Enrollment Specialists must seek to identify Members who speak a language other than English as their first language. Upon a Member's request, the PH-MCO must provide, at no cost to Members, oral interpretation services in the requested language or sign language interpreter services to meet the needs of the Members.

PA Model Contract Exhibit GG. The PH-MCO must provide language interpreter services when requested by a Member, at no cost to the Member.

PA Model Contract. Sec. V. R.2. 2. Provider Education The PH-MCO must demonstrate that its Provider Network is knowledgeable and experienced in treating Members with Special Needs. The PH-MCO must submit an annual Provider Education and Training workplan to the Department that outlines its plans to educate and train Network Providers. The format for this workplan will be designated by the Department through its Operations Reporting requirements found on the HealthChoices Intranet. This training plan can be done in conjunction with the SNU training requirements as outlined in Exhibit NN, Special Needs Unit, and must also include Special Needs Recipients, advocates and family members in developing the design and implementation of the training plan. The PH-MCO must submit in its annual plan the PH-MCO process for measuring training outcomes including the tracking of training schedules and Provider attendance. At a minimum, the PH-MCO must conduct the Provider training for PCPs and dentists, as appropriate, and include the following areas: a. EPSDT training for any Providers who serve Members under age twenty-one (21). b. Identification and appropriate referral for mental health, drug and alcohol and substance abuse services. c. Sensitivity training on diverse and Special Needs populations such as persons who are deaf or hard of hearing; how to obtain sign language interpreters and how to work effectively with sign language interpreters. d. Cultural Competency, including: the right of Members with LEP to engage in effective communication in their language; how to obtain interpreters, and; how to work effectively with interpreters. e. Treating Special Needs populations, including the right to treatment for individuals with disabilities. f. Administrative processes that include, but are not limited to: coordination of benefits, Recipient Restriction Program, Encounter Data reporting and Dual Eligibles. g. Issues identified by Provider relations or Provider hotline staff in response to calls or complaints by Providers. h. Issues identified through the QM process. i. Identifying and making referrals to the PH-MCO SNU. j. Guidance to providers on the process to submit materials to the PH-MCO to make utilization review and Prior authorization review decisions about members. Submitted materials may include but not be limited to letters of medical necessity. k. Information to providers on the complaint, grievance and appeal process including but not limited to expectations should a provider represent a member at a grievance review. l. Information on PIP such as the Provider Pay for Performance (P4P) outlined in Exhibit B(3) and how providers may benefit from participation in these programs.

<sup>85</sup> RI July 2016 RFP. Sec. 3.2.4.2. Bidder shall develop, maintain and monitor a network that is geographically accessible on a timely basis to the population to be served including a PCP, whose office is located within twenty (20) minutes or less travel time from the member's home. Members may, at their discretion, select PCPs located farther from their homes.

<sup>86</sup> RI July 2016 RFP. Sec. 3.2.4.2. Bidder agrees to make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

<sup>87</sup> RI July 2016 RFP. Sec. 3.2.4.2. Bidder shall make services available within twenty-four (24) hours for treatment of an Urgent Medical Condition including a mental health or substance use condition.

<sup>88</sup> RI July 2016 RFP. 3.2.4.2 Access to Services – Service Accessibility Standards. The Bidder will establish and implement mechanisms to ensure that network providers comply with access and timely appointment availability requirements. Contractor will monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply. Bidder must assure that service accessibility standards are fully in place for persons with special needs. Service accessibility standards include: Twenty-Four Hour Coverage: Bidder shall provide access to medical and behavioral health services either directly or through its PCPs, to Members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, Bidder must have a back-up plan for instances where the PCP is not available. Bidder must also have written policies and procedures describing how Members and providers can contact the Bidder to receive instructions for treatment of an emergent or urgent medical problem.

<sup>89</sup> RI RFP. 3.2.7 Member and Provider Services. Contractor must ensure that services are provided in a culturally competent manner to all Members. Specifically, Contractor (1) must give the concerns of Members related to their racial and ethnic minority status full attention beginning with the first contact with a Member continuing throughout the care process, and extending to evaluation of care; (2) must make interpreter services available when language barriers exist and are made known to Contractor, including the use of sign interpreters for Members with hearing impairments and the use of Braille for Members with vision impairments; and (3) as appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its Member population; (4) develop policies and procedures for the provision of language assistance services, which includes but is not limited to interpreter and translation services and effective communication assistance in alternative formats.

<sup>90</sup> SC 2016 Contract referencing South Carolina Managed Care Policy and Procedure Manual, Sec. 6.1 General Requirements (Provider Network Adequacy Determination Process), available at [https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20July%202015\\_Final\\_Post%2006-29-15.pdf](https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20July%202015_Final_Post%2006-29-15.pdf). For Providers acting in the capacity of a primary care physician the standard is 90% of the Managed Care eligible population in the county must have access to at least one (1) PCP within thirty (30) miles and within forty-five (45) minutes or less driving time.

<sup>91</sup> SC 2016 Contract referencing South Carolina Managed Care Policy and Procedure Manual, Sec. 6.1 General Requirements (Provider Network Adequacy Determination Process), available at [https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20July%202015\\_Final\\_Post%2006-29-15.pdf](https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20July%202015_Final_Post%2006-29-15.pdf). For Providers acting as specialists the standard is 90% of the Managed Care eligible population in the county must have access to the required specialist within fifty (50) miles and within seventy (75) minutes or less driving time.

<sup>92</sup> SC 2016 Contract. 6.2.1.3. Routine visits scheduled within four (4) weeks.

<sup>93</sup> SC 2016 Contract. 6.2.1.3. For specialty referrals, provide for: Emergent visits immediately upon referral. Urgent medical condition care appointments within forty-eight (48) hours of referral or notification of the Primary Care Physician Scheduling of appointments for routine care (non-symptomatic) within four (4) weeks and a maximum of twelve (12) weeks for unique specialists.

<sup>94</sup> SC 2016 Contract. 6.2.1.3. Urgent, non-emergent visits within forty-eight (48) hours.

<sup>95</sup> SC 2016 Contract. 6.2.1.3.6. Provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system.



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<sup>96</sup> South Carolina Managed Care Policy and Procedure Manual, Sec. 6.1 General Requirements (Provider Network Adequacy Determination Process), available at [https://mspcdhhs.gov/managedcare/sites/default/files/MCO%20July%202015\\_Final\\_Post%2006-29-15.pdf](https://mspcdhhs.gov/managedcare/sites/default/files/MCO%20July%202015_Final_Post%2006-29-15.pdf). An initial onsite review by the MCO is required of all Primary Care Physicians and OB/GYN physicians acting as Primary Care Physicians, prior to the completion of the initial credentialing process. The MCO must assess the quality, safety, and accessibility of all office sites (including part-time or satellite offices) where care is delivered. MCO staff conducting the on-site review must be trained and qualified to perform the review(s). The MCO is required to send SCDHHS training policies and personnel qualifications for staff conducting on-site reviews. The following, at a minimum, must be included in the assessment: • Physical/handicapped accessibility, well lit waiting room, adequate seating • Physical appearance that is safe and sanitary • Adequate waiting rooms and public bathrooms • Adequate examination rooms to include size and appearance • Posting of office hours • Availability of appointments • Adequate patient record-keeping system which is compliant with state and federal requirements including, but not limited to, a secure and confidential filing system, legible file markers, and a process for quickly locating records.

<sup>97</sup> SC July 2016 Contract. Sec. 3.14.3. Make available a Provider Directory to all Medicaid Managed Care Members. The Provider Directory shall include the office hours, age groups, telephone numbers of, and non-English languages spoken by current CONTRACTOR providers.

Sec. 3.15.6. [Contractor shall] Ensure that where at least five (5) percent or more of the resident population of a county is non-English speaking and speaks a specific foreign language, materials will be made available in that specific language to assure a reasonable chance for all Medicaid Managed Care Members to understand how to access the CONTRACTOR and use services appropriately.

Sec. 3.16.2 [Contractor shall] Develop written policies and procedures for providing language interpreter and translation services to any Member who needs such services, including but not limited to: (a) Members with limited English proficiency, and (b) Members who are hearing impaired in accordance with 42 CFR 438.10; Provide interpreter and translation services free of charge to Members. Ensure interpreter services are available—this includes in-person interpreters, sign language or access to telephonic assistance, such as the AT&T universal line; Make all written materials available in alternative formats and in a manner that takes into consideration the Member's special needs, including those who are visually impaired or have limited reading proficiency; Notify all Members and, upon request, potential enrollees that information is available in alternative formats and how to access those formats; Provide written information available in the prevalent non-English languages identified by the Department in particular service areas.

<sup>98</sup> TN 2017 Contracts (BCBS, Amerigroup, United, and Volunteer plans all contain same language) Attachment III. Primary Care Physician or Extender: Distance Urban: 20 miles; Distance Rural: 30 miles.

<sup>99</sup> TN 2017 Contracts Attachment IV. The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that: (1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy. Cardiology. Dermatology. Endocrinology. Otolaryngology, Gastroenterology. General Surgery, Nephrology. Neurology. Neurosurgery. Oncology/Hematology. Ophthalmology. Orthopedics. Psychiatry (adult). Psychiatry (child and adolescent), and Urology; and (2) The following access standards are met: Travel distance does not exceed 60 miles for at least 75% of non-dual members and travel distance does not exceed 90 miles for ALL non-dual members

<sup>100</sup> TN 2017 Contracts Attachment III. Appointment/Waiting times: Usual and customary practice, not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

<sup>101</sup> TN 2017 Contracts Attachment III. Referral appointments to specialists shall not exceed 30 days for routine care or 48 hours for urgent care.

<sup>102</sup> TN BlueCare 2017 Contract Attachment III. Appointment/Waiting times: Usual and customary practice, not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

<sup>103</sup> TN 2017 Contracts Attachment III. In general, contractor shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, Professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24/7 basis.

<sup>104</sup> TN Contracts. Sec. A.2.18.2. The CONTRACTOR shall provide language assistance services, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as auxiliary aids free of charge to members and/or the member's representative.

TN 2017 Contracts Section A.2.18.3. Contractor shall: Assist the member in identifying contract providers that may be selected by the member to provide personal care visits, attendant care, respite or community-based residential alternative services, as applicable, that are able to assign staff who are linguistically competent in the member and primary caregiver's primary spoken language or in sign language, or other forms of effective communication assistance, including auxiliary aids or services, or who can facilitate non-verbal forms of communication, including the use of assistive technology.

<sup>105</sup> VA 2017 RFP Sec. 4.4.6 Travel Time and Distance Enrollee Travel Time Standard For urban areas, each enrollee shall have a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). For rural areas, each enrollee shall have a choice of at least two (2) providers of each service type located within no more than sixty (60) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard.

Travel time standards only apply to the enrollee's travel time. Travel time standards only apply to the time an enrollee must travel to receive a service. Time standards do not apply to providers who travel to provide a service (e.g., home health). Enrollee Travel Distance Standard Each enrollee shall have a choice of at least two (2) providers per service type located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. Travel distance standards only apply to the distance an enrollee must travel to receive a service. Travel distance standards do not apply to providers who travel to provide a service (e.g., home health).

<sup>106</sup> VA 2017 RFP Sec. 3.5 Call Center. A specific process shall be in place, for hospitals that have elected to refer patients with nonurgent/emergent conditions to alternative settings for treatment, whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The 24/7 nurse triage line may be utilized for this purpose. The total number of calls

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received pertaining to patients in EDs needing assistance in accessing care in an alternative setting shall be tracked and reported. Reporting requirements for the 24/7 ED assistance line will be finalized in the MEDALLION 4.0 Contract.

Sec. 3.9.3. Provider Network Adequacy and Standards. To alleviate emergency department visits, Contractors shall be required to have a network of providers to cover after-hours urgent care services for members. Transportation to these services shall be required if medically necessary.

<sup>107</sup> VA 2017 RFP. Sec. 4.4.5. Access Standards. Offerors shall consider the following when establishing and maintaining its networks: ... 6. The ability of network providers to communicate with limited English proficient enrollees in their preferred language; 7. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for MEDALLION 4.0 enrollees with physical or mental disabilities...

<sup>108</sup> VA 2017 RFP. Sec. 4.4.5. Access Standards. Offerors shall consider the following when establishing and maintaining its networks: ... 6. The ability of network providers to communicate with limited English proficient enrollees in their preferred language; 7. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for MEDALLION 4.0 enrollees with physical or mental disabilities...

<sup>109</sup> WA Apple Health Model Contract. Sec. 6.9. 2 within 10 miles for urban area; 25 miles non-urban area.

<sup>110</sup> WA Apple Health Model Contract. Sec. 6.7. Preventive office visits shall be available within 30 calendar days. Non-urgent, symptomatic office visits shall be available within 10 calendar days.

<sup>111</sup> WA Apple Health Model Contract. Sec. 6.7. Within 24 hours.

<sup>112</sup> Where medically necessary. Sec. 6.3. referencing 42 CFR 438.206.

WA Apple Health 2017 Model Contract. Sec. 6.5. Contractor shall have the following services available on a 24/7 basis by telephone: Medical or mental health advice; triage for emergent, urgent, or routine care; authorization of emergent and urgent cases.

<sup>113</sup> TN BlueCare 2017 Contract Sec. 3.3. Contractor shall ensure equal access for all Enrollees and Potential Enrollees when oral or written language communications creates a barrier to access, such as free interpreter services at any provider for a covered service and emergency services.

<sup>114</sup> WV Model Contract Sec. 2.1.2 Availability and Access Standards. This network must include a panel of primary care providers from which the enrollee may select a personal primary care provider. Requirements for adequate access state that: Routinely used delivery sites, including PCPs' offices and the offices of frequently used specialists, must be located within thirty (30) minutes travel time; Basic hospital services must be located within forty-five (45) minutes travel time; and Tertiary services must be located within sixty (60) minutes travel time. The intent of these standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program. BMS will periodically publish specific network standards that define which provider types are considered "frequently used specialists" in each county or region, based on a comparison to the traditional Medicaid program or other criteria as defined by BMS. Exceptions to these standards will be permitted where the travel time standard is better than what exists in the community at large.

<sup>115</sup> WV Model Contract Sec. 2.1.2 Availability and Access Standards. This network must include a panel of primary care providers from which the enrollee may select a personal primary care provider. Requirements for adequate access state that: Routinely used delivery sites, including PCPs' offices and the offices of frequently used specialists, must be located within thirty (30) minutes travel time; Basic hospital services must be located within forty-five (45) minutes travel time; and Tertiary services must be located within sixty (60) minutes travel time.

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<sup>116</sup> WV Model Contract Sec. 2.1.2. Availability and Access Standards. The MCO must have standards for timeliness of access to care and member services that take into account the urgency of the need for services and that meet or exceed such standards as may be established by BMS. The MCO must also regularly monitor its provider network's compliance with these standards, and take corrective action as necessary. Current BMS standards for timeliness state that: Routine cases other than clinical preventive services, must be seen within twenty-one (21) days (exceptions are permitted at specific times when PCP capacity is temporarily limited); EPSDT services must be scheduled in accordance to EPSDT guidelines and the EPSDT Periodicity Schedule; An initial prenatal care visit must be scheduled within fourteen (14) days of the date on which the woman is found to be pregnant; and MCOs should encourage SSI members to schedule an appointment with a PCP or specialist who manages the member's care within forty-five (45) days of initial enrollment. If requested by the member or provider, the MCO should schedule or facilitate an appointment with the member's PCP.

<sup>117</sup> WV Model Contract Sec. 2.1.2. Availability and Access Standards. The MCO must have standards for timeliness of access to care and member services that take into account the urgency of the need for services and that meet or exceed such standards as may be established by BMS. The MCO must also regularly monitor its provider network's compliance with these standards, and take corrective action as necessary. Current BMS standards for timeliness state that: Emergency cases must be seen immediately or referred to an emergency facility; Urgent cases must be seen within forty-eight (48) hours.

<sup>118</sup> WV Model Contract Sec. 2.1.2. Availability and Access Standards. When Medically Necessary, the MCO makes services available 24 hours a day, seven days a week. The MCO must establish a mechanism to ensure that providers comply with the access standards set forth in this contract.

<sup>119</sup> WV Model Contract. Sec. 2.1.2. The MCO must ensure that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. The MCO must also ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

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Sec. 3.7.4 Disabled Access The MCO must comply with the Americans with Disabilities Act (ADA); the ADA's requirements apply to both the MCO and its providers. All facilities are readily accessible to, and usable by, individuals with disabilities, and auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the ADA.

<sup>120</sup> WV Model Contract Sec. 3.7.1 Communication Barriers The MCO is required to provide oral interpretive services for languages on an as-needed basis. These requirements extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the MCO and providers and receive coverage benefits. Oral interpretative services must be provided free of charge to enrollees and potential enrollees and must be available for all non-English languages. The MCO must also provide audiotapes for the illiterate upon request. BMS will periodically review the degree to which there are any prevalent language or languages spoken by Medicaid beneficiaries in West Virginia (cultural groups that represent at least five (5) percent of the Medicaid population). Within ninety (90) days of notification from BMS, the MCO will make written materials available in prevalent non-English languages in its service areas. At the current time, there is no data to indicate that West Virginia has any Medicaid populations that meet this definition. The MCO must notify enrollees and potential enrollees of the availability of oral interpretation services for any language and written materials in prevalent non-English languages. The MCO must also notify enrollees and potential enrollees of how to access such services.

<sup>121</sup> See Penchansky R, Thomas JW. The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care*. 1981;19(2):127-40.