Access to Care Standards: Q&A

Question: Why do we have to meet access to care standards?

Access Standards are based upon Federal Regulations. The following is an excerpt from the Code of Federal Regulations (CFR) 438

Sec. 438.206 Availability of services.

   (a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.

   (1) Timely access. Each MCO, PIHP, and PAHP must do the following:
   (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
   (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
   (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

The State of Kansas requires all ValueOptions providers to meet the following standards

Level of Urgency	Referral/Assessment	Treatment
Emergent	Immediate	Immediate
Urgent	24 hours	48 hours from assessment
Urgent Block Grant Priority Populations (not meeting 24 hour need)	48 hours	48 hours from assessment
Routine	14 days	14 days from assessment

Measurement is in calendar days. Holidays and weekends are not a reason for not meeting access standards.

Question: At what point do we begin measuring the access standards?

At the point that the client first seeks care either by walk in or over the phone. If a message is left on an answering machine, the initial contact date starts when the message was left, not when the call was returned.

Question: What questions do we ask in order to determine urgency?

Emergent

Ask the client the following:

Are you in distress? (Are you having physical problems right now, or do you feel like you might hurt yourself or someone else?)

> *If yes, the caller would be transferred to a clinician for assistance, and the clinician will decide whether to rate the treatment need as Emergent, Urgent or Routine.*
> - If caller is determined to be at risk of self harm or harm to others, or is a detox risk, the member requires immediate assistance and intervention, and is referred to a hospital or detox setting. The need is rated as Emergent.

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Urgent

Ask the client the following:

Have you been drinking or gotten high within the last 24 hours, or do you plan to within the next 24 hours?

Are you currently hospitalized, or have you been discharged within the past 24 hours from a hospital or residential setting where you received treatment for alcohol, drugs or mental health?

If yes, the caller would be considered to have an urgent need and the urgent appointment standards would need to be followed.

Need is also considered to be urgent for the following priority populations:
- Pregnant women;
- Women with dependent children;
- Individuals diagnosed with HIV;
- Intravenous drug users;
- Clients with special health care needs;
- SRS clients (Family Preservation, Foster Care, etc.); and
- Individuals who are involuntarily committed.

For Block Grant priority populations, the standards is 48 hours from initial call to assessment **IF** the client does not meet the need for a 24 hour urgent appointment

Routine

All other calls not considered emergent/urgent would be considered routine.

Question: I have several questions regarding these standards. Will there be training?

Yes. ValueOptions is currently asking for volunteers to sit on a provider committee to work through access to care work flows and implementation. The committee will begin in March. Once the committee has finalized its plans, communication and training via webinar will take place. If you need assistance prior to the training, please contact sheree.marzka@valueoptions.com

Question: How will the access data be captured?

KCPC enhancements are in progress and will be used to gather data. These fields will be mandatory. Please see the screen shots below for details.

Initial contact date: the date the client first called/walked in to receive services during the episode of care.
Assessment offered date: the first date you offered the client an appointment for an assessment
Scheduled date: the date an assessment was scheduled for. This date is used to capture member choice.
Assessment type: emergent, urgent or routine according to the definitions above

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