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Policy Name: Measuring Accessibility of Medical Services	Policy Number: PS-6
Business Segment: HealthCare	
Initial Effective Date: 07/21/06	**Policy Committee Approval Date(s):** 4/27/21; 11/9/21; 11/8/22; 7/11/23; 9/12/23; 5/14/24
Replaces Policies: NA	

Purpose:
To establish a national methodology for measuring the accessibility of medical care services in order to ensure that Cigna customers (Commercial HMO Products*, Commercial Insured Products*, and Individual and Family Plans) can obtain such services in a timely manner. This Policy and Procedure establishes the national accessibility standards and documents the valid national methodology for assessing performance against those standards.

Policy Statement:
Contracted providers are required to provide customers access to appointments for regular and routine, urgent/emergent, and after-hours care. This Policy applies to all members across all markets for both Commercial and Individual Family Plans. National accessibility standards are followed, unless a state requirement is stricter than the national standard(s), in which case the state standard will be used. These state requirements are noted in Attachment A.

A. Primary Care Provider (PCP) Accessibility is assessed through results from the NCQA CAHPS® Participant Survey and Qualified Health Plan Enrollee Experience Survey, along with an assessment of access complaints received from customers. The surveys include specific questions related to accessibility.

B. High-Volume Specialty Care and High-Impact Specialty Provider (SCP) types identified according to Cigna's Availability of Practitioners methodology will have a statistically valid sample surveyed at the practitioner-level practice self-reported access data. This is supplemented by an analysis of complaints received from customers of these SCP types. Practitioners surveyed can participate in either Commercial or IFP networks.

C. Practice-specific performance will be assessed through customer complaints about access to specific Providers

Definitions:
For purposes of this policy, "customer" means an individual participant or member.

HMO Products: Customers insured in the HMO, HMO/POS, HMO Open Access, and HMO POS Open Access products.

Insured Products: Customers insured in the PPO, EPO, OAP, OAP IN, Network, Network POS, Network Open Access, Network POS Open Access, LocalPlus®, Cigna Connect, and Cigna SureFit® products.

CAHPS® (Consumer Assessment of Healthcare Providers and Systems): A registered trademark of the Agency for Healthcare Research and Quality (AHRQ), which is a public–private initiative developed to survey customers' experiences.

Medical Primary Care Provider (PCP): A physician duly licensed to practice medicine who is contracted with Cigna to provide covered services in the field of General Medicine, Internal Medicine, Family Practice, and Pediatrics and has agreed to provide primary care services to Cigna Contract customers in accordance with Cigna Program Requirements. Unless specified by state mandate and contractually agreed to by the Provider and Cigna, Obstetricians and Gynecologists are defined as specialty care providers only and cannot act as PCPs. See Attachment B for state mandates allowing additional Providers to provide primacy care services.

Medical Specialty Care Provider (SCP): A physician, who has advanced education and training in one clinical area of practice, who is duly licensed to practice medicine and who is contracted with Cigna to provide specialty care services to Cigna Contract customers in accordance with Cigna Program Requirements.

- A High-Volume SCP provides services to the largest segment of the membership, inclusive of the OB/GYN Specialty.
- A High-Impact SCP treats conditions with high mortality and/or high morbidity rates and may require significant resources for appropriate treatment. An Oncologist is one High-Impact SCP type.

State/Federal Compliance: State-specific mandates will override national standards when applicable. For state-specific Network accessibility requirements, please refer to the Compliance Common Bulletin named "Provider Networks: Network Adequacy and Service Area' Common Bulletin." This bulletin can be found by going to iComply, (link at end), and clicking on the View Common Bulletins hyperlink. These state requirements are noted in Attachment A.

Procedure(s):
Annually, Cigna measures accessibility of care to PCP, and High-Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics outlined below. Cigna uses the continuous quality improvement (CQI) process to identify opportunities for improvement. . Provider surveys are performed annually for high-volume & high-impact specialists, and for states which are specified in Attachment A. Standards apply to existing patients unless otherwise noted.

CQI Process

A. Collect/measure data
B. Evaluate results
C. Identify possible root causes or barriers
D. Select opportunities
E. Plan/implement intervention/corrective actions
F. Determine intervention effectiveness

Accessibility Standards and Metrics

A. Medical:
   1. Emergency: Immediately
      - Medical, surgical, hospital, and related health care services and testing, including ambulance services, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.
   2. Urgent: Within 24 hours. (Urgent medical needs are those that are not emergencies but require prompt medical attention, such as symptomatic illness and infections.)
      - Medical, surgical, hospital, and related health care services and testing which are not Emergency Services but have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where the customer ordinarily receives and/or is scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Provider's recommendation that the customer should not travel due to any medical condition.
   3. Regular and Routine Care: Within 14 days, or within the timeframe specified by the treating physician
      - Preventive and primary care for non-urgent conditions. Non-urgent conditions are conditions that do not substantially restrict normal activity but could if left untreated (e.g., chronic disease).
   4. After-hours care: Provider provides 24-hour coverage
      - There is a Provider on call twenty-four (24) hours a day to provide emergency and urgent medical care for all customers

PROCEDURE Measurement and Reporting		
1a	The NCQA CAHPS® Survey is administered on a national basis to Cigna customers with HMO Products* and Insured Products*on an annual basis. The Qualified Health Plan Enrollee Survey is administered on a national basis to Cigna customers enrolled in an Individual Family Plan through the Marketplace.	Quality and Market Research
1b	Both surveys include questions that assess: • satisfaction with timeliness for regular, routine, urgent and emergency care • satisfaction with lead times for regular, routine, urgent and emergency care	Quality and Market Research

1c	Results from both surveys should be used in conjunction with customer complaints about access to determine if there are problems with specific Providers, groups or geographic areas	Quality
1d	A statistically valid sample of specialty practices for identified High-Volume SCP and High-Impact SCP types is assessed annually through a web-based national survey for self-reported accessibility data. This is supplemented by an analysis of complaints received from customers on these specialty types.	Quality and Market Research
Evaluating Results		
2a	Quality Management works with Provider Strategy and Engagement to evaluate market/state and practice-specific performance (based on customer complaints about access to a specific) against the established standards to determine if any interventions are required.	Quality Provider Strategy and Engagement
2b	Goals for the percent of customers satisfied for each measurement are determined by the appropriate Quality Committee.	Quality Committee
2c	Market/Statewide performance (as measured by the responses to the CAHPS® Participant Satisfaction Survey and Qualified Health Plan Enrollee Survey) should be compared against goals for the percent of customers satisfied to determine if interventions are required.	Quality and Provider Strategy and Engagement
2d	Quality and Provider Strategy and Engagement evaluate state/market level CAHPS® scores and any customer complaints about access to a specific Provider to determine if any states/markets do not meet standards.	Quality and Provider Strategy and Engagement

2e	If Market/State performance against the established standards is below the established goals, Provider Strategy and Engagement may conduct additional studies to measure/access practice-specific performance against the standard, if appropriate.	Provider Strategy and Engagement
Corrective Action Plans		
3	If intervention is required, Provider Strategy and Engagement directs the improvement effort, including follow-up evaluation to determine the effectiveness of the intervention. Suggested interventions include the following: • Expansion of the network • Work with individual Provider practices to improve their scheduling systems • Target specific specialty or geographic area for special recruitment efforts • Recommend that certain Providers close or open their panels	Provider Strategy and Engagement

Applicable Enterprise Privacy Policies:
https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures:
PS-8 Measuring Availability of Practitioners and Providers
HM-OPS-023 Prudent Layperson
CA Language Assistance Program Policy (See California Language Assistance Program Overview (CALAP) - Iris (cigna.com))
MH-NET-021 Responding to Noncompliant Provider Behavior

Links/PDFs:
'Common Bulletin: Provider Networks: Network Adequacy and Service Area.' This bulletin can be found by going to iComply, and clicking on the View Common Bulletin hyperlink.
https://icomply.lpa.cigna.com/icomply/pages/default2.aspx

State-Specific Addenda:
- Attachment A – Comparison of State Appointment Standards to Cigna Standards
- Attachment B – State Mandates for Additional Primary Care Provider Types

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Attachment A - Comparison of State Appointment Standards to Cigna Standards
*Indicates requirements that are **more stringent** than Cigna standard

Centers for Medicare and Medicaid Services (CMS) require Qualified Health Plan's (QHP) meet the following criteria:

- Beginning with the 2025 plan year, CMS will implement appointment wait time standards.
- The appointment wait time standards will apply to the specialties included in the table below.
- The appointment wait time standards measure the number of business days between when an individual requests an appointment and when the first in-person appointment is available.
- These standards apply to appointments for both new and existing patients.
- Requirements is meeting the requirement 90 percent of the time.

Provider/Facility Specialty Type	Appointments Must Be Available Within
Primary Care (Routine)	15 business days
Specialty Care (Non-Urgent)	30 business days

Arizona (HMO)

- Preventive Care within 60 days
- Routine Care within 15 days
- Specialty Care within 60 days of the enrollee's request or sooner if medically necessary

California

- The following CAHPS® questions are used to monitor compliance with CA requirements.

Access Standard/Requirement	CAHPS® Question
• Urgent care – authorization required – 96 hrs	CAHPS® Q4
• Urgent care – no authorization required – 48 hrs	CAHPS® Q4
• Non-urgent primary care – 10 bus days*	CAHPS® Q6

- **PROVIDER SATISFACTION SURVEY QUESTION –** The following question has been added to the Provider satisfaction survey (fielded nationally) for CA Providers, in order to assess a Provider's satisfaction with a plan/delegated Provider's referral and authorization requirements that can impact timely access to services. The results of this question are incorporated into the annual CA Access report.

  The state 'Timely Access to Non-Emergency Health Care Services Regulation' requires health care service plans to maintain an adequate Provider network to ensure patients receive timely care as appropriate for their condition. Based upon this standard, please indicate whether you are satisfied with the following: [using a scale of 1–4, 4 being very satisfied and "not applicable"].

  a. The referral and/or prior authorization process necessary for your patients to obtain covered services
  b. Access to urgent care

c. Access to non-urgent primary care
d. Access to non-urgent specialty services
e. Access to non-urgent ancillary diagnostic and treatment services

Once the CA CAHPS® Access reports have been produced by the national team, the California Provider lead for Accessibility monitoring will update the report with member complaints by network (to be obtained from the CA Grievance Officer), the Industry Collaborative Effort's Provider Appointment Availability Survey Results (which must be broken out by Provider group, to derive a "rate of compliance"), the Provider satisfaction survey question (noted above) results, and OAP/PPO Provider monitoring to measure availability of office hours one night a week until 10:00 p.m. or a half-day on Saturday. Opportunities for improvement will be identified, and a Corrective Action Plan developed with leaders from network management, the General Managers (or their delegate[s]), and at least one Medical Director. The Provider Services Access lead will present the full CA Access report annually to the Service Advisory Committee. The report will be filed with the Department of Managed Health Care (DMHC) (HMO regulator) annually in March, by the regulatory compliance reporting team.

- Urgent care appointments for services that do not require prior authorization within 48 hours
- Urgent care appointments for services that require prior authorization within 96 hours
- Non-urgent appointments for primary care within 10 business days
- Non-urgent appointments with specialist physicians within 15 business days
- Non-urgent appointments with a non-physician mental health or substance use disorder care provider within 10 business days
- Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition within 15 business days
- The applicable waiting time for a particular appointment may be extended if the referring or treating provider, or the health professional providing triage or screening services, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person
- Preventive care services and periodic follow-up care including but not limited to standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, or mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice.
- Provide 24 hours per day, 7 days per week of triage or screening services by telephone:
    a. in a timely manner and with waiting times that do not exceed 30 minutes, and
    b. that can be provided by insurer-operated telephone triage or screening services, telephone medical advice services, contracted primary care and mental health or substance use disorder care provider network, or other method that is consistent with requirements.
- Insurers shall ensure that, during normal business hours, the waiting time for a covered person to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the covered person's questions and concerns shall not exceed ten (10) minutes, or that the covered person will receive a scheduled call-back within 30 minutes
- Review and evaluate, no less frequently than quarterly, the information available to the insurer regarding accessibility, including but not limited to information obtained through covered person and provider surveys, covered person grievances and appeals, and triage or screening services.

(1)

- Rescheduling Appointments: In the event that an appointment needs to be rescheduled, the provider is required to follow the above standards.
- Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Colorado

Access to Service/Waiting Time Standards

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical,	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met > 90% of the time
Prenatal Care	Within 7 calendar days	Met > 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hours a day,7 days a week by answering service or instructions on how to reach a physician	Met > 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met > 90% of the time
Specialty Care – non-urgent	Within 60 calendar days	Met > 90% of the time

Connecticut

- An annual Connecticut-specific Provider survey will be conducted to measure the following performance measures and the time frame achieved 90% of the time.

- Appointment Wait Times:

Type of Appointment	Timeframe Requirement
Urgent Care	Within 48 hours
Non-Urgent Appointments for Primary Care	Within 10 business days
Non-Urgent Appointments for Specialist Care	Within 15 business days
Non-Urgent Appointments for Non-Physical Mental Health	Within 10 business days
Non-Urgent Appointments for Ancillary Services	Within 15 business days

Florida

- HMO
  - Emergency: Immediately

- Urgent: Within 24 hours*
- Routine symptomatic: Within 2 weeks
- Routine non-symptomatic: As soon as possible. Also, within 1 hour of scheduled appointment time seen for professional evaluation*

- Insured
  - Hours of operation of exclusive providers and availability of after-hour care must reflect usual practice in the local area. Emergency care must be available 24 hours a day, 7 days a week

District of Columbia

appointment wait times for qualified in-network providers, carriers shall:

- establish the standards listed below for appointment wait times for services within the network

SERVICE TYPE	TIME FRAME
First appointment with a new or replacement Primary Care physician	within 7 business days
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment	within 7 business days
First appointment with a new or replacement provider for Prenatal Care treatment	within 15 business days
First appointment with a new or replacement provider for Specialty Care treatment	within 15 business days

- maintain and publicize a toll-free number to assist covered persons with identifying provider appointment availability within timeframe.
- must track call center statistics (# of call received, issues addressed, call resolution) for reporting purposes
- must have at least twenty percent (20%) of available essential community providers in each plan's service area participate in the plans network.

Kansas

- Sufficiency may be established based on appointment waiting times

Maine

- Analyze against the Cigna standards annually for:
  - Regular and routine care appointments;
  - Urgent care appointments;
  - After-hours care; and
  - Member services by telephone

Maryland

Each provider panel shall meet the waiting time standards for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.

Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider's license, certification, or other authorization.

A semi-annual Maryland-specific Provider survey will be conducted to measure the following performance measures.

Waiting Time Standards	
Urgent care for medical services	72 hours
Routine primary care	15 calendar days
Preventive visit/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Inpatient urgent care for mental health services	72 hours
Inpatient urgent care for substance use disorder services	72 hours
Outpatient urgent care for mental health services	72 hours
Outpatient urgent care for substance use disorder services	72 hours
Non-urgent mental health care	10 calendar days
Non-urgent substance use disorder care.	10 calendar days

Missouri (HMO)

- For all provider types:
  - Routine care without symptoms: Within 30 days from the time that the enrollee contacts the provider
  - Routine care, with symptoms: Within 1 week/5 business days from time that enrollee contacts the provider*
  - Urgent care: Within 24 hours from the time that the enrollee contacts the provider*
  - Emergency care: Available 24/7; immediately
  - OB care:

- Within 1 week for 1st or 2nd trimester;*
- Within 3 days for 3rd trimester
- Emergency obstetrical care is subject to the same standards as emergency care except that an obstetrician must be available 24 hours per day, 7 days per week for enrollees who require emergency obstetrical care.

- Mental Health: 24/7 access to a licensed physician therapist via phone.

New Hampshire

- For PCP services, the carrier must ensure that covered persons may obtain an initial appointment with an in-network provider within:
  - 48 hours for urgent care; and
  - 30 days for other routine care, including an initial or evaluation visit

New Jersey

- Emergency: Immediately
- Urgent: Within 24 hours of notification of PCP or carrier (PCP: 24/7 triage services)*
- Routine appointment: Within 2 weeks
- Routine physicals: Within 4 months

New Mexico

- Emergency: Immediately
- Urgent: Within 48 hours of notification to PCP or carrier
- PCP: 24/7 triage services
- Routine appts: As soon as possible*
- Routine physicals: Within 4 months

North Carolina

- An annual North Carolina-specific Provider survey will be conducted to measure the following performance measures. This survey will request that the Provider's office respond to specific questions that will be used to assess the appointment waiting time availability by the Provider types specified below. The survey results will be reported in the filing corresponding to the calendar year in which the survey was performed.
- Medical Provider Survey:

Provider Type	**Routine** (Symptomatic Regular and Routine Care)	**Urgent**	**Emergency****
Performance Goal*	70%	80%	100%
Primary Care Physician (includes Family Practice, Internal Medicine and General Practice)	Within 14 calendar days	Within 48 hours	Immediately
Pediatrician	Within 14 calendar days	Within 48 hours	Immediately

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Provider Type	**Routine** (Symptomatic Regular and Routine Care)	**Urgent**	**Emergency****
Obstetrician/Gynecologist (Pre-natal care standards)	• 1st trimester: Within 14 calendar days • 2nd trimester: Within 7 calendar days • 3rd trimester: Within 3 calendar days	Immediately	Immediately
Specialist , Including gynecology only practices	Within 14 calendar days	Within 48 hours	Immediately
Non-Physician (	Within 14 calendar days	Within 48 hours (if applicable	N/A

* Performance Goal is determined by appropriate Quality Committee

**Emergency standard is measured by asking whether provider offices have 24/7 coverage arrangements to address emergencies. The emergency standard may not be applicable to all specialties and/or practices.

- Must measure survey results separately for the following legal entities/products:
  - Cigna HealthCare of North Carolina, Inc.
  - Connecticut General Life Insurance Company, Inc. – POS
  - Connecticut General Life Insurance Company, Inc. – PPO
  - Cigna Health and Life Insurance Company, Inc. – POS
  - Cigna Health and Life Insurance Company, Inc. – PPO
- Results must include explanation/corrective action for any results falling below goals

Rhode Island

- Emergency: Immediate
- Urgent: 24 hours*

Tennessee

- Emergency Care (including ambulance service): 24 hours a day, 7 days per week. Must be able to obtain emergency care at any available emergency care facility. Also, must be available (as well as urgent services) when outside usual service area.
- Urgent Care: Same day or within 24 hours based on physician assessment of need;
- Routine care: Required to have written standards, but not specified what standard must be;

- Specialty Care Appointments: Available in a "timely manner."
- Office Waiting Times: Required to have written standards, but not specified what standard must be;
- After-Hours Consultation and Callback Time: Must be available and accessible by telephone from PCP or on-call designee whenever the PCP's office is closed. Must be a reasonable callback response time and must be documented as a written standard.

Texas

- An annual Texas-specific Provider survey will be conducted to measure the following performance measures.
- Emergency care must be available and accessible 24 hours per day, seven days per week, without restrictions on where the services are rendered.
- Urgent care within 24 hours for medical a*
- Routine care within 3 weeks for medical
- Preventive services within 2 months for a child (earlier if needed for specific services) and 3 months for an adult.
- Network adequacy must be assessed using Texas's appointment availability standards

Vermont

- Emergency: Immediately
- Urgent: Within 24 hours*
- Non-emergency or non-urgent care: Within 2 weeks for initial treatment
- Preventive care (physicals): Within 90 days
- Routine lab, x-ray, optometry, and other routine services: Within 30 days*

Virginia

- Emergency: Immediately
- Urgent: Within 24 hours*
- Routine physicals: Within 60 days
- Routine appointments: Within 2 weeks

West Virginia

- **Appointment Wait Time Standards: At least 90 percent of health carrier's providers must meet the following wait time standards:**

Service Type	**Time Frame**
Primary Care – Routine	Within 15 business days
Specialty Care – non-urgent	Within 30 business days

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Attachment B – State Mandates for Additional Primary Care Provider Types

State mandates state that the following Providers may provide primary care services to Cigna Contract customers in accordance with Cigna Program Requirements in the states listed below:

- **Obstetricians and Gynecologists:** California, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, Oregon, Utah, West Virginia, Wyoming
- **Nurse Practitioners**: Arizona, California, Colorado, Connecticut, Florida, Hawaii, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon (if specializes in women's health), Rhode Island, Tennessee, Texas, West Virginia, Wyoming
- **Physician Assistants**: Arizona, California, Colorado, Florida, Hawaii, Iowa, Louisiana, Massachusetts, Minnesota, New Jersey, New Mexico, Oregon (if specializes in women's health), Rhode Island, Tennessee, Texas, Vermont, Wyoming
- **Certified Nurse Midwives**: Arizona, Florida, Hawaii, Iowa, Louisiana, Maryland, New Jersey, New Mexico, New York, Oregon (if specializes in women's health), Rhode Island, Texas, West Virginia
- **Naturopaths**: New Hampshire, Oregon (if specializes in women's health), Vermont
- **Chiropractors**: Illinois