ACCESS TO CARE FINAL RULE:

The Kentucky Department of Medicaid Services, in order to meet the requirements of 42 CFR 447.203, proposes to implement an Access to Care Monitoring Review Plan (ACMRP) for the Fee for Service (FFS) Medicaid population. As of August 1, 2016, the total Kentucky Medicaid population was 1.3 million, with approximately 10 percent in Fee for Service, mostly in Long Term Care and Waiver programs. This plan for the identification and interpretation of the access to care needs of Kentuckians participating in the FFS program will align with existing measures used to ensure access that are already in place for the managed care population. The specific requirements that the plan will address include:

- The extent to which beneficiaries' needs are met;
- Availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;
- Changes in beneficiary utilization of covered services in each geographic area;
- Characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations, as well as individuals with disabilities; and
- Actual or estimated levels of provider payment available from other payers, including other public and private payers, and by provider type along with the geographic area of service.

DMS proposes to release a Request for Proposal (RFP) and obtain an External Quality Review Organization (EQRO) Vendor to meet these requirements within the structure of the Code of Federal Regulations Chapter 42 Part 447, 80 FR 67576.

Proposed Scope of Work

The EQRO Vendor shall:

A. Review and evaluate DMS Compliance with State and Federal access standards. In addition to reviewing the operational areas in this section, the Vendor shall also be responsible for reviewing all other applicable sections as required by 42 CFR 447.203. The compliance review shall follow CMS Protocols.

B. Work with DMS to review and validate the methodology to be utilized to ensure compliance with access standards. This process shall include:

1. Establishing Compliance Thresholds (Review Criteria Tools),
2. Performing Preliminary Reviews;
3. Conducting Site Visits;
4. Compiling and Analyzing Findings;
5. Meeting on-site with DMS to discuss findings immediately after conclusion of activities; and
6. Issuance of Results to DMS in writing within 45 days.

C. Schedule a conference call with DMS staff prior to the annual review to describe the process (both document review and on-site interviews) and detail the topics to be reviewed. Review criteria/tools shall be submitted to DMS for approval no later than 60 days after contract start. Once approved by DMS, on-site reviews will start the first week of December.

D. Perform partial quarterly reviews and a full compliance review annually. The Vendor shall complete a full compliance review; make recommendations for remediation of non-compliant findings.

These reviews shall include, but not be limited to:

1. Assessing DMS compliance with state and federal standards and requirements in the following operational areas:

   a. Quarterly- No less than quarterly, the Vendor shall from all available sources of information, conduct a "desk review" of compliance in the operational areas listed in i - viii below. The vendor shall provide DMS with a summary of the desk review no later than 45 days after end of the quarter being reviewed. The EQRO shall discuss any compliance deficiencies with DMS to facilitate resolution.

   b. Annually, the Vendor shall assess compliance with Medicaid and KCHIP regulations, including all operational areas listed i - xiii below. DMS requires the Vendor to submit the results of the annual compliance review to DMS by March 1.

   Operational Areas:

   i. Availability and access of services;

   ii. Continuity and coordination of care;

   iii. Coverage and authorization of services;

   iv. Establishment of provider networks;

   v. Enrollee rights;

   vi. Pharmacy;

   vii. Enrollment and disenrollment;

   viii. Grievance systems;

   ix. Sub-contractual relationships and delegation;

   x. Use of practice guidelines;

   xi. Health information systems-per the vendor protocols, States must assess the information system capabilities. The State must ensure that it maintains a health information system that collects, analyzes, integrates, and reports data for areas including, but not limited to; utilization, grievances, appeals, and disenrollment for other than loss of Medicaid eligibility. The EQRO shall annually assess the strength of the information system capabilities to include processing, collecting and reporting data;

   xii. Mechanisms to detect under and over-utilization of services; and

   xiii. Mechanisms to detect fraud and abuse;

   xiv. Fiscal Management including restructuring of rates or supplemental payments.

2. Ensuring that the Annual Compliance Review references the following three required main sources of information to determine compliance with regulatory and contract requirements:

a. Document review;

b. Interviews with DMS personnel;

c. Analysis of available data sources including MMIS data, call logs, fee schedules and recommendations from the Kentucky Medicaid Advisory Council.

E. Access and Availability Surveys

1. The selected Vendor will conduct telephonic surveys to assess availability and access to providers. Surveys of primary care providers and selected specialists, dentists, and behavioral health providers shall be conducted annually. Other provider types, including obstetrics and home health providers will be surveyed on an as needed basis.

The access and availability surveys shall involve phone calls to a sample of provider offices/sites. An average of 250 completed calls shall be conducted annually. Physician phone numbers are provided by DMS using the most recent Provider Network submission. The Vendor will select the sample and make the phone calls following several different scenarios: to determine access and availability for specific appointment standards including routine appointments, non-urgent but sick appointments, and after hours calls. Specific tasks included in these Access and Availability Surveys will include:

a. Assisting in the development of, and revisions to, the methodology used to conduct the survey;

b. Selecting random sample of providers from data provided by DMS;

c. Preparing and updating as necessary scripted scenarios for surveys (approved by DMS);

d. Conducting the telephone surveys using scripted scenarios;

e. Preparing and submitting preliminary and final reports;

f. Working with DMS to correct discrepancies that are discovered.

2. Make additional calls if DMS does not achieve an 80% pass rate in satisfying the standards for access and availability. Once DMS has had an opportunity to implement a plan of action, the Vendor shall make these additional calls to verify corrective action has been implemented with providers. The Vendor is responsible for completing the follow up calls and including the results of findings in the annual activity report.

3. Identify workforce shortages by Medicaid region annually;

4. Add providers to the survey roster whenever the reimbursement rate for the services they provide are being considered by the Department for restructuring;

5. Provide DMS with discrepancies that are identified during the survey, such as name and address changes or incorrect phone numbers for use in auditing provider network submissions.

6. Submit an annual survey findings report by June 1 annually.

F. Validation of Provider Network Submissions

DMS must meet all applicable provider panel requirements required by CMS in order to ensure access to medically necessary Medicaid covered services and adherence to provider capacity requirements.

The Vendor shall:

1. Audit the provider panel information submitted to verify the accuracy of the data, which will ensure that the DMS is meeting provider capacity requirements (i.e. access standards). In addition, this will ensure accuracy of the provider listings in the provider directory. Services shall include, but not be limited to:

    a. Audit of the DMS provider directories both in print as well as online searchable directories;

    b. Conduct provider telephone surveys. The vendor will be required to contact a sample of the providers to verify if information submitted is accurate according to the contracted provider;

    c. Recommend the information set or data fields to be validated.

    d. Develop the data collection tool and analysis plan.

    e. Identify the random sample of providers to be reviewed.

2. Submit a report of the findings in a PDF and Word format biannually (December 30 and June 30 each year).

G. Individual/Case Review

Medicaid members have the right to file a complaint with the DMS regarding a potential quality of care concern. DMS is responsible for the intake, tracking and resolution of all complaints or grievances filed. Internal Cabinet for Health and Family Services employees perform case reviews for the Department whether the complaint is filed with the Ombudsman, received in writing from the member or via the provider or member hotlines.

DMS will perform a review of all quality of care complaints filed to determine whether a complete case review occurred or if a quality issue has not been addressed or significant findings remain. The Vendor shall:

1. Function as an independent reviewer and as such assist DMS in resolving specific medical/quality of care complaints on a timely basis.

2. Develop and implement a formal process for the identification of appropriate clinicians to respond to member's specific medical issues within timeframes identified by the Department for the review and submission of medical determinations or opinions.

3. Perform case reviews when concerns arise from other sources other than a complaint filed with the Long Term Care Ombudsman. It is estimated that there would be no more than 40 total requests per contract year.

4. Develop a process for identifying increases in volume of complaints, no matter the source, that are focused in a particular geographic region. Once identified, the EQRO will provide the Department statistical information to assist in identifying the type of care and services that are the subject of the complaints. Those services will be added to the surveys performed in the Access and Availability Surveys detailed in G above in a rolling manner.

5. Submit a Case Summary report for each case reviewed within 30 calendar days following review, to include the following:

a. An analysis of the information and rationale for the determination,

b. Identification of the discipline of the individual(s) reviewing the case,

c. Determination of whether or not a quality of care issue exists,

d. Results from the case review, and

e. Recommendations to resolve any issues found.

6. Maintain a record of the input and response of the State in each instance for no less than three (3) years after resolution of the complaint.

Summary

Kentucky Medicaid intends to use this continuous quality improvement process to identify opportunities to improve performance and outcomes for members in the Fee for Service Medicaid system. As issues are identified in a particular service area, DMS will develop action plans to address concerns access to care needs and apply appropriate interventions. Further, DMS will be responsible for maintaining the information gathered via the activities of the EQRO as well as that garnered through public, provider and member comments and complaints. DMS also understands that the most current access monitoring review plan and these comments will need to be submitted along with any SPA proposed that will reduce or restructure rates.

Appendix A – Definitions.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Standardized survey of members' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

External Quality Review (EQR): The analysis and evaluation, by an EQRO, of aggregated information on timeliness, access, and quality of health care services furnished to Medicaid enrollees by each contracted managed care entity and other related activities performed by an EQRO.

External Quality Review (EQR)-related activities: Validation of performance improvement projects; validation of performance measures; and reviews to determine compliance with standards for access to care, structure and operations, and quality measurement and improvement.

External Quality Review Organization (EQRO): Refers to an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR, other EQR-related activities as set forth in §438.358, or both.

Appendix B – Report Table Examples for Access and Availability

Table 1: Calls per Call Type and Provider Type

Table 1 displays the number of providers allocated to each combination of call type as well as the proportion of providers for each category (**Table 1**)

Call Type (% of Calls per Call Type)	Type of Provider (% of Calls per Provider)			Total (100%)
	PCPs (50%)	(30%)	(20%)	
Routine calls (xx%)				
Non-urgent calls (xx%)				
After-Hours calls (1xx%)				
Total (100%)				

Table 2A: Contact Made by Provider Type for Routine Calls

Table 2 A and B displays the sample breakdown by provider type among the providers comprising the survey samples by call type. The number of providers for the routine and non-urgent calls would be identical.

Provider Type	# Providers Surveyed	# Contact Made	Contact Rate
PCP			
Other Provider Type to be identified			
Other Provider Type to be identified			
Total			

Table 2B: Contact Made by Provider Type for Non-urgent Calls

Provider Type	# Providers Surveyed	# Contact Made	Contact Rate
PCP			
Other Provider Type to be identified			
Other Provider Type to be identified			
Total			

Table 3A: Reasons Contact was Not Made for Routine Calls

Table 3A displays the reasons that the providers in the routine category could not be contacted.

Reason Not Able to Contact Provider	n	%
Telephone company message phone out of order		
Answering machine/Voice mail system*		
Number called was a residence or non-doctor business		
Constant busy signal*		
No answer*		
Wrong telephone number		
Answering service*		
Put on hold > 10 minutes*		
Total		**100.0%**

* These calls occurred on the 4th attempt, since these reasons required multiple attempts.

Table 3B: Reasons Contact was Not Made for Non-urgent Calls

Table 3B displays the reasons that the providers in the non-urgent category could not be contacted

Reason Not Able to Contact Provider	n	%
Telephone company message phone out of order		
Answering machine/Voice mail system*		
Number called was a residence or non-doctor business		
Constant busy signal*		
No answer*		
Wrong telephone number		
Answering service*		
Put on hold > 10 minutes*		
Total		

* These calls occurred on the 4th attempt, since these reasons required multiple attempts.

Table 4A: Compliance by Provider Type for Routine Calls

Table 4A displays the compliance rate for each provider type among the providers for analysis for routine calls.

Plan/Provider Type	Providers Surveyed	Appointments within 30 days	Compliance Rate
PCP			
Other Provider Type to be identified			
Other Provider Type to be identified			
Total			

Table 4B: Compliance by Plan and Provider Type for Non-urgent Calls

Table 4b displays the compliance rate for each provider type among the providers for analysis for Non-urgent calls

Plan/Provider Type	Providers Surveyed	Appointments within 48 hours	Compliance Rate
PCP			
Other Provider Type to be identified			
Other Provider Type to be identified			
Total			

Table 5A: Most Common Reasons Appointment Not Made for Routine Calls

Reason Appointment Not Made	n	%
Provider practice restricted to specialty care		
Provider not at site and no alternative provider available		
Provider not accepting new patients		
Provider not a plan participant		
Must complete health questionnaire before appointment can be made		
Staff required previous medical records		
Staff not scheduling any appointments at this time		
Provider required referral		
Instructed to go to emergency room		
Total		**100.0%**

Table 5B: Most Common Reasons Appointment Not Made for Non-urgent Calls

Reason Appointment Not Made	n	%
Provider practice restricted to specialty care		
Provider not at site and no alternative provider available		
Provider not accepting new patients		
Provider not a plan participant		
Must complete health questionnaire before appointment can be made		
Staff required previous medical records		
Staff not scheduling any appointments at this time		
Provider required referral		
Instructed to go to emergency room		
Total		**100.0%**

Table 6: Most Common Reasons for Non-compliance for After-Hours Calls

Reason for Non-compliance	n	%
Told to leave message; provider to call back within unspecified timeframe		%
No after-hours phone number given		
Wrong number		
Provider not covered by answering service		
No live voice at second number		
Disconnected/not in service		
Provider no longer at site		
Not answered (> 11 rings)		
Provider not a plan participant		
Instructed to go to emergency room/hospital		
On hold for more than 10 minutes		
Other		
Total		**100.0%**

Table 7: Compliance Summary by Call Type and Provider Type

Table 7 displays the compliance results by provider type

Call Type	Provider Type	Providers Surveyed	Compliant	Compliance Rate
Routine	PCP			
	Other to be Identified			
	Other to be Identified			
	Total Routine			
Non-urgent	PCP			
	Other to be Identified			
	Other to be Identified			
	Total Non-urgent			
After-Hours	PCP			
	Other to be Identified			
	Other to be Identified			
	Total After-Hours			

Appendix C: ***Access and Availability Survey Requirements and Scenarios***

After Hours Care

To evaluate after-hours phone arrangements by PCPs in Network and ensure that the acceptable arrangements are implemented:

A. Acceptable:

(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.

B. Unacceptable:

(1) Office phone is only answered during office hours;
(2) Office phone is answered after hours by a recording that tells Members to leave a message;
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and
(4) Returning after-hours calls outside of thirty (30) minutes.

Routine and Urgent Care

Provider Program Capacity Demonstration

To assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance members and to ensure Members have access to medically-necessary services. Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services shall be available within 48 hours of request.

A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.

Scenarios

Surveyor Telephone Scripts

Code	**ROUTINE APPOINTMENT SCENARIOS**
INTERNISTS/FAMILY PRACTICE	
A1	Smokes 2 packs per day, coughing a lot, requesting help to stop smoking.
A2	Overweight, weighs about 200lbs. (female), needs help to lose weight, (height is 5'2 ½"); or male who weighs 275lbs., is 5'9 ½".
A3	Heartburn and Insomnia: When I eat dinner and go to bed I can't sleep because of heartburn. It has been going on for about 3 weeks. (No other symptoms).
A4	High-blood pressure and is running out of medication. (1 month of medication left takes Atenolol, 1 pill in the morning –50 mg)
A5	Diabetic and haven't had a check-up in over a year.
A6	History of high cholesterol and has not had blood checked in over a year.
OB/GYN	
B7	New member that moved from downstate to upstate (or vice versa) and has not had a GYN check-up in over two years. Request a routine GYN check-up (i.e. Pap test, breast exam, etc.).
B8	I'm in my late 40's and have been experiencing sweating and "hot flashes". I think I may be starting menopause. (DOB: March 27,1968)*
B9	I am sure I am pregnant. I've missed my last period, and haven't been seen by an OB doctor yet. I need to schedule a prenatal care visit.
PEDIATRICIAN	
C11	New member seeking immunizations (shots) for 6 month-old daughter. (DOB: May 8, 2014)
C12	Needs physical for 13 year-old son. (DOB: January 4, 2002- 8th grade)

C13	New member seeking physical for 8 year-old as she is overweight. (DOB: Jan. 11, 2007)
C14	New member, who just moved into the area, seeking a pediatrician appointment for a 12 month-old boy. (DOB: January 12, 2014)

Code	URGENT APPOINTMENT SCENARIOS
INTERNISTS/FAMILY PRACTICE	
D13	I feel all stuffed up and my hearing is muffled. This is the 2nd day I have pain and it's getting worse. I also have a fever of 100.5.
D14	I have a funny taste in my mouth all the time and lately when I blow my nose the mucous is green.
D15	Bad back ache and the pain goes into my right leg.
D16	Coughing a lot, day and night- thought it was a cold, but it's 2 weeks now, (mucous is yellow). (Did not take temperature).
D18	I've had diarrhea for the past two days. I didn't feel so well after I got take-out food two nights ago. No one else who ate with me is sick. I am able to drink but I don't feel like eating. No abdominal pain.
OB/GYN	
E18	Vaginal discharge (yellow and odorous).
E19	Pain and cramping in the lower left side. I thought it was gas but the pain has not gone away.
E20	I'm in my 20's or 30's and have experienced some vaginal bleeding (after intercourse). My last period was two weeks ago.
E21	Eight (8) months pregnant and I've never been seen by a doctor.
PEDIATRICIAN	
F22	Six (6) year old daughter has been vomiting and has diarrhea for 2 days. (DOB: February 13, 2008)
F25	Thirteen (13) year old son played basketball a couple of days ago, and now complains about pain when he lifts his right arm or when he picks up anything with his right arm. There is no indication that he fell or had a trauma. (DOB: May 21, 2001)
F27	Ten (10) month old son who is not eating, only drinking- for a day. (DOB: March 5, 2014)
F28	Six (6) year old son complains of pain in his knees and difficulty walking for a week. The pain has not gone away and he keeps telling me it hurts. (DOB: March 1, 2008)

After Hours calls do not have a specific scenario, but must meet criteria in contract language above to be considered compliant.

Appendix D: Attachment: KY Routine Appointment Data Sheet FFS Draft

PROVIDER ACCESS AND AVAILABILITY STUDY
PRIMARY CARE PHYSICIAN (PCP)
ROUTINE APPOINTMENT AVAILABILITY DATA ENTRY SHEET

Surveyor Last Name_____ Plan Name:_____ Scenario ID: _____ Phone: _____

Provider Name:_____ Provider Category: _____

Address: _____ Sample ID: _____

CALL 1: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)
2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)
3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____
4. Appt Date:___/___/___ Appt Time___:___AM/PM
5. Appt within 30 days of call:
   [ ] Yes (Go to #7) [ ] No
6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No
7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____*
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

CALL 2: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)
2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)
3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____
4. Appt Date:___/___/___ Appt Time___:___AM/PM
5. Appt within 30 days of call:
   [ ] Yes (Go to #7) [ ] No
6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No
7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____*
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

Appointment cancelled? [ ] Yes [ ] No Initials _____

Appendix D: Attachment: KY Routine Appointment Data Sheet FFS Draft

PROVIDER ACCESS AND AVAILABILITY STUDY
PRIMARY CARE PHYSICIAN (PCP)
ROUTINE APPOINTMENT AVAILABILITY DATA ENTRY SHEET

CALL 3: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)
2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)
3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____
4. Appt Date:___/___/___ Appt Time___:___AM/PM
5. Appt within 30 days of call:
   [ ] Yes (Go to #7) [ ] No
6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No
7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____*
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

CALL 4: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)
2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)
3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____
4. Appt Date:___/___/___ Appt Time___:___AM/PM
5. Appt within 30 days of call:
   [ ] Yes (Go to #7) [ ] No
6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No
7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____*
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

Appointment cancelled? [ ] Yes [ ] No Initials _____

Appendix E: Attachment: KY Urgent Appointment Data Sheet FFS Draft

PROVIDER ACCESS AND AVAILABILITY STUDY
PRIMARY CARE PHYSICIAN (PCP)
URGENT APPOINTMENT AVAILABILITY DATA ENTRY SHEET

Surveyor Last Name_____ Plan Name:_____ Scenario ID: _____ Phone: _____

Provider Name:_____ Provider Category: _____

Address: _____ Sample ID: _____

CALL 1: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)

2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)

3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____

4. Appt Date:___/___/___ Appt Time___:___AM/PM

5. Appt within 48 hours of call:
   [ ] Yes (Go to #7) [ ] No

6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No

7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____ *
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

CALL 2: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)

2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)

3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____

4. Appt Date:___/___/___ Appt Time___:___AM/PM

5. Appt within 48 hours of call:
   [ ] Yes (Go to #7) [ ] No

6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No

7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____ *
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

Appendix E: Attachment: KY Urgent Appointment Data Sheet FFS Draft

PROVIDER ACCESS AND AVAILABILITY STUDY
PRIMARY CARE PHYSICIAN (PCP)
URGENT APPOINTMENT AVAILABILITY DATA ENTRY SHEET

Appointment cancelled?	[ ] Yes	[ ] No	Initials _____

Appendix E: Attachment: KY Urgent Appointment Data Sheet FFS Draft

PROVIDER ACCESS AND AVAILABILITY STUDY
PRIMARY CARE PHYSICIAN (PCP)
URGENT APPOINTMENT AVAILABILITY DATA ENTRY SHEET

CALL 3: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)

2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)

3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____

4. Appt Date:___/___/___ Appt Time___:___AM/PM

5. Appt within 48 hours of call:
   [ ] Yes (Go to #7) [ ] No

6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No

7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____*
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

CALL 4: DATE ____/____/____ TIME: ____/____ AM/PM

1. Able to make contact:
   [ ] Yes [ ] No (Go to Part A)

2. Able to make appt:
   [ ] Yes [ ] No (Go to #7 Then to Part B)

3. Appt with:
   [ ] Designated Provider
   [ ] Alternate Provider_____

4. Appt Date:___/___/___ Appt Time___:___AM/PM

5. Appt within 48 hours of call:
   [ ] Yes (Go to #7) [ ] No

6. *Attempt to make earlier appt*:
   [ ] Yes [ ] No

7. Contact person's name _____

NEED TO RECALL FOR [ ] ADULT [ ] CHILD SCENARIO

Remember to Cancel Appointment

PART A - Reason No Contact Made

[ ] No answer *
[ ] Put on hold >10 min *
[ ] Answering machine/Voice mail system *
[ ] Answering Service *
[ ] Wrong telephone number New #_____*
[ ] Constant busy signal *
[ ] Telephone company message indicating phone out of order *
[ ] Number called was a residence or non-doctor business *

PART B - Reason No Appt Made

[ ] Provider not accepting new patients (closed panel)
[ ] Provider not a plan participant
[ ] Provider practice is restricted to specialty care
Specialty: _____
[ ] Provider required referral
[ ] Provider required info that surveyor could not provide
Info requested: _____
[ ] Staff not scheduling any appointments at this time
[ ] Staff required previous medical records
[ ] Provider not at site and no alternative provider available
[ ] Instructed to go to Emergency Room
[ ] Patient must complete health form before appointment can be made

Appointment cancelled? [ ] Yes [ ] No Initials _____

KY Access and Availability PCP Survey DATE										
Routine Calls				APPENDIX F: Call Dispostions						
No.	IPRO #	Provider Category	Name	NPI	Phone #	New Phone #	Failure Reason	Plan Response	Date of Change	Other Response
Providers who could not be contacted and reasons										

KY Access and Availability PCP Survey DATE

Routine Calls **APPENDIX F: Call Dispostions**

No.	IPRO #	Provider Category	Name	NPI	Phone #	New Phone #	Failure Reason	Plan Response	Date of Change	Other Response