HealthChoice Illinois Contract Access-to-Care Standards

Network Adequacy Standards

Contractor's Provider Network must include all necessary Provider types, including primary care Providers, Behavioral Health Providers, OB/GYNs, dental care Providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely Covered Services to Enrollees in accordance with the standards outlined herein. For each Provider type, Contractor must provide access to at least ninety percent (90%) of Enrollees within each county of the Contracting Area within the prescribed time and distance standard required, with the exception of pharmacy services, which must provide one hundred percent (100%) coverage to Enrollees.

Time and Distance Standards	Urban Areas (Non-Rural)	Rural Areas
Primary Care Provider Access	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.	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.
Behavioral Health Provider Access	Access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence.	Access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.
OB/GYN Access	Access to at least two (2) OB/GYN Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence.	Access to at least one (1) OB/GYN Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.
Dental Access for Children	Access to at least one (1) dentist, who serves Children, within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence.	Access to at least one (1) dentist, who serves Children, within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.
Hospital Access	Access to at least one (1) hospital within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence.	Access to at least one (1) hospital within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.
Other Specialist Provider Access	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.	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.
Pharmacy Access	Access to at least one (1) pharmacy within a fifteen (15)–mile radius of or fifteen (15)–minute drive from the Enrollee's residence.	Access to at least one (1) pharmacy within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.

LTSS Provider Types in Which Enrollee Travels to Provider	Access to at least two (2) LTSS Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence.	Access to at least two (2) LTSS Providers within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

* Exceptions to the time and distance standards may be considered and approved at the discretion of the Department. Exception requests must be submitted to the Department in writing.

* An Enrollee may elect to travel beyond the distance standards when the Enrollee exercises choice in selecting a Provider. The free exercise of such choice by the Enrollee will not negatively impact the results of any reporting by Contractor on access to care.

Accessibility of Provider Locations

Contractor must ensure Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities. Contractor shall collect sufficient information from Providers to assess compliance with the Americans with Disabilities Act (ADA). As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, Contractor shall include within its Provider Network, Provider locations that are able to accommodate the needs of individual Enrollees.

Appointments

Contractor shall require that time-specific appointments for routine preventive care are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. 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. Enrollees with problems or Complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of operation that are no less than the hours of operation offered to Persons who are not Enrollees.

Contractor shall ensure that an initial appointment for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions is available within ten (10) Business Days from the date of request for an Enrollee. Follow-up appointments for outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions shall be available within twenty (20) Business Days from the date of request for an Enrollee. The Contractor will not be held responsible if the Enrollee or provider voluntarily chooses to schedule an appointment outside of these required timeframes.

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.

Choice of PCP

Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP. Contractor shall provide direct access to a WHCP for routine and preventative women's healthcare Covered Services when a female Enrollee's PCP is not a WHCP.

Specialists as PCPs

Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special healthcare needs the option of choosing a specialist to be their PCP. Such Enrollees or their Providers may request a specialist as a PCP at any time. Contractor shall contact the Enrollee promptly after the request to schedule an assessment. Contractor's medical director will approve or deny requests after determining whether the Enrollee meets criteria and whether the specialist is willing to fulfill the role and all the obligations of a PCP.

Homebound

If an Enrollee is homebound or has significant mobility limitations, Contractor shall provide access to primary care through home visits by Providers to support the Enrollee's ability to live as independently as possible in the community.

Primary Care Provider-to-Enrollee Ratio

Contractor's maximum primary care Provider panel size shall be as set forth below. If Contractor does not satisfy the primary care Provider requirements set forth below, Contractor may demonstrate compliance with these requirements by demonstrating that Contractor's full-time-equivalent primary care Provider ratios exceed ninety percent (90%) of the requirements set forth below, and that Covered Services are being provided in a manner that is timely and otherwise satisfactory. Contractor shall comply with Section 1932(b)(7) of the Social Security Act.

For the Families and Children Population and ACA Adult Enrollees, Contractor's maximum primary care Provider panel size shall be one-thousand eight-hundred (1,800) Enrollees. An additional maximum of nine hundred (900) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one-hundred percent (100%) full-time equivalent employee or contractor.

For Seniors and Persons with Disabilities Enrollees, Contractor's maximum primary care Provider panel size shall be six hundred (600) Enrollees. An additional maximum of three hundred (300) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant, and APN who is one hundred percent (100%) full-time equivalent employee or contractor.

Family Planning

Contractor shall demonstrate that its network includes sufficient Family-Planning Providers to ensure timely access to Covered Services as provided in 42 CFR §438.206.

Parity in Mental Health and Substance Use Disorder Benefits

Contractor may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder Covered Services.

Contractor will not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Enrollees (whether or not the benefits are furnished by the same MCO).

When an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), Contractor shall provide mental health or substance use disorder benefits to the Enrollee in every classification in which medical/surgical benefits are provided.

Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

Contractor may not impose any non-quantitative treatment limitation (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

Contractor shall establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits. Contractor shall provide the necessary documentation, reporting, and analyses in the format and frequency required by the Department.

*Failure to meet access and Provider ratio standards- If the Department determines that Contractor has not met the Provider-to-Enrollee access standards established above, the Department will send Contractor a notice of noncompliance. If Contractor has not met these requirements by the end of the thirty (30)–day period following the notice, the Department may, without further notice:

- impose a performance penalty of up to US $50,000;
- impose an enrollment hold on Contractor; or
- impose both