Provider Access & Appointment Standards Reference Guide

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MA Plan
Access & Appointment Standards (42 CFR)

Service Type	Standard / Timeframe
Urgently needed services or emergency	Immediately
Non-emergency, but requires medical attention	Within 7 business days
Routine and preventive care	Within 30 business days
Continuous monitoring of access & wait times	MA organization must ensure provider network meets standards; corrective action if standards not met
Coverage rules, practice guidelines, payment policies, utilization management	Must allow **individual medical necessity determinations**
Provider consideration	Beneficiary input must be incorporated into proposed treatment plan
Convenience & non-discrimination	Provider hours must be convenient to the population served; no discrimination against Medicare enrollees
24/7 availability	Plan services must be available 24 hours/day, 7 days/week when medically necessary
Urgently needed services or emergency	Immediately
Non-emergency, but requires medical attention	Within 7 business days
Routine and preventive care	Within 30 business days
Continuous monitoring of access & wait times	MA organization must ensure provider network meets standards; corrective action if standards not met

Source: [eCFR :: 42 CFR 422.112 -- Access to services.]

HIV-SNP Plan

Access & Appointment Standards (Section 15, Model Contract)

Service Type	Standard / Timeframe
Emergency care	Immediately upon presentation at service delivery site
CPEP, inpatient MH, inpatient detox, crisis intervention	Immediately upon presentation
Urgent care	Within 24 hours of request
Urgently needed SUD/MH outpatient (rehab, stabilization, ACT, PROS clinic, OTPs)	Within 24 hours of request
Non-urgent “sick” visit	Within 48–72 hours, as clinically indicated
Routine non-urgent, preventive care	Within 4 weeks of request
Specialist referrals (not urgent)	Within 4–6 weeks of request
Behavioral health specialist referrals (not urgent)	Continuing Day Treatment, Intensive Psych Rehab, Residential SUD treatment: within 2–4 weeks; PROS (non-clinic): within 2 weeks
Initial prenatal visit	1st trimester: within 3 weeks; 2nd trimester: within 2 weeks; 3rd trimester: within 1 week
Adult baseline/routine physicals	Within 12 weeks of enrollment; HIV SNP: within 4 weeks
Well child care	Within 4 weeks of request
Initial family planning visits	Within 2 weeks of request
MH/SUD follow-up after hospital discharge or incarceration release	Within 5 days of request, or as clinically indicated
Non-urgent MH/SUD outpatient clinic (incl. PROS clinic)	Within 1 week of request
Initial PCP visit for newborns	Within 2 weeks of hospital discharge; HIV SNP: within 48 hours or by following Monday if Friday discharge
Provider visits for LDSS work ability assessments	Within 10 days of request
Behavioral Health Home & Community Based Services	Standards per Appendix T (HARP & HIV SNP specific)
24-hour access requirement	Must ensure 24/7 access to care via PCPs/OB-GYNs; after-hours calls may not be routinely referred to ER

Source: Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan Model Contract Chapter 15, page 152

Medicaid Advantage Plus (MAP) Plan

Access and Appointment Standards (Member Handbook)

Service Type / Situation	Standard / Timeframe
Emergency care	Immediately upon presentation
Urgent care (non-emergency)	Within 24 hours of request
Non-urgent “sick” visit	Within 48–72 hours (as clinically indicated)
Routine / preventive PCP visits	Within 4 weeks of request
Adult baseline / routine physicals	Within 12 weeks of enrollment
Prenatal care – 1st trimester	Within 3 weeks of request
Prenatal care – 2nd trimester	Within 2 weeks of request
Prenatal care – 3rd trimester	Within 1 week of request
Well-child care	Within 4 weeks of request
Initial family planning visits	Within 2 weeks of request
Initial PCP visit after plan enrollment	Within 3 months of enrollment
Follow-up after MH or SUD ER / inpatient discharge	Within 5 days of request
Non-urgent MH / SUD outpatient clinic visit	Within 1 week of request
Specialist referrals (non-urgent)	Within 2–4 weeks of request
Urgent specialist referral (pregnancy related)	Within 72 hours of request
Newborn PCP visit after hospital discharge	Within 2 weeks of discharge
Service authorization – expedited	Within 3 business days of request
Service authorization – regular	Within 3 business days after all info received, not to exceed 14 calendar days

Source: NEW YORK STATE MEDICAID MANAGED CARE MODEL MEMBER HANDBOOK, Part 1: How to Get Regular Care

MLTC Partial Cap Plan

Access and Appointment Standards

Service Type / Situation	Standard / Timeframe
Emergency care	Immediately upon presentation
Urgent care (non-emergency)	Within 24 hours of request
Non-urgent “sick” visit	Within 48–72 hours (as clinically indicated)
Routine / preventive PCP visits	Within 4 weeks of request
Adult baseline / routine physicals	Within 12 weeks of enrollment
Prenatal care – 1st trimester	Within 3 weeks of request
Prenatal care – 2nd trimester	Within 2 weeks of request
Prenatal care – 3rd trimester	Within 1 week of request
Well-child care	Within 4 weeks of request
Initial family planning visits	Within 2 weeks of request
Initial PCP visit after plan enrollment	Within 3 months of enrollment
Follow-up after MH or SUD ER / inpatient discharge	Within 5 days of request
Non-urgent MH / SUD outpatient clinic visit	Within 1 week of request
Specialist referrals (non-urgent)	Within 2–4 weeks of request
Urgent specialist referral (pregnancy related)	Within 72 hours of request
Newborn PCP visit after hospital discharge	Within 2 weeks of discharge
Service authorization – expedited	Within 3 business days of request
Service authorization – regular	Within 3 business days after all info received, not to exceed 14 calendar days

Please note: As detailed in the IPRO 2023_mltc_atr_report.pdf, MLTCP plans are subject to the same regulations as Medicaid Advantage Plus plans:

> The State of New York codified Managed Long-Term Care access standards that align with these federal requirements, and identified additional state-specific standards. The Department of Health enforces managed care plan adoption of these standards in the *Medicaid Managed Long-Term Care Partial Capitation Model Contract*, the *Medicaid Advantage Plus Model Contract*, the *Program of All-Inclusive Care for the Elderly Model Contract, New York State Public Health Law Article 44*, and *Title 10 of the New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*.

Suggestions for Tracking Provider Compliance

1. Review call center logs for provider access complaints.
2. Conduct mystery shopper calls for appointment availability.
3. Track grievances and resolutions for CMS reporting.
4. Maintain audit trail of network adequacy and corrective actions.

Updated 10.07.2025