Humboldt IPA

UTILIZATION MANAGEMENT AND CREDENTIALING POLICY

ACCESS TO HEALTHCARE SERVICES

Purpose: To set standards for appropriate, timely access to healthcare services for all health plan members and procedures for monitoring compliance with those standards.

Policy: The IPA network clinicians provide access to health plan members in a timely manner as identified by the patient's medical condition and service requested. The IPA monitors compliance with this policy and takes corrective action as needed.

Medical Access Standards

- *Emergency* (Serious condition requiring immediate intervention): Immediate
- *Urgent* Care appointments that do not require prior authorization(Condition that could lead to a potentially harmful outcome if not treated, and/or requires immediate attention because of symptom severity): Within 48 Hours
- Urgent Care appointments that do not require prior authorization(Condition that could lead to a potentially harmful outcome if not treated, and/or requires immediate attention because of symptom severity): Within 96 Hours
- *Non-Urgent, Routine Primary Care* (non-urgent, symptomatic): Within 10 business days of request
- *Preventive Care* (non-urgent, asymptomatic - includes physical exams): Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.
- *Consult/Specialty Referral:* 15 business days of request
- *Non*-Urgent, Ancillary Services (diagnosis or treatment of injury, illness or other health conditions): Within 15 days of request.
- *Office Wait Time*: Within 30 Minutes. The applicable waiting time for a particular appointment may be extended only if the referring or treating licensed health care provider, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
- *After Hours Availability*: Members will have access to healthcare professionals by telephone 24 Hours/Day. After hours calls will be managed by a telephone system or answering service. Members, who feel they have a serious acute medical condition, will be instructed to seek immediate care by calling 911 or going to nearest emergency room. Members who need to speak to a physician will be given instructions on how to contact a physician and the expected time frame (30 minutes) during which they will be able to speak with a physician.
- Telephone logs will be monitored and maintained. After hours calls will be documented in the patient record.
- *Call Wait Times*: <30 Seconds to be answered by a non-recorded voice
- *Call Abandonment Rate*: <5%

- *Full-time SCP to Member Ratio:* 1:1,200

Behavioral Health Access Standards

- *Life Threatening Emergency:* Immediately
- *Non-Life Threatening Emergency:* Within 6 hours
- *Urgent (that does not require prior authorization):* Within 48 hours
- *Urgent Care (that requires prior authorization):* Within 96 hours
- *Routine:* Within 10 business days of request (non-MD's)
- *Routine: Within 15 business days (MD/DO)*
- *Office Appointment Wait Time:* Members will not have to wait longer that 15 minutes after their scheduled appointment
- 24 hours/day; 7 days/week availability and accessibility required
  - For MD/DO – Answering service, pager, or answering machine with instructions on immediately reaching a practitioner or the on-call practitioner
  - For non-MD/DO – Answering machine/service, or pager
  - Answering machine/services must provide instructions for directing patient to emergency care
- *Call Wait Times*: <30 Seconds to be answered by a nonrecorded voice
- *Call Abandonment Rate*: <5%
- Minimum 20 hours of office practice per week

Ready Access**:** The IPA allows PCPs to refer patients to all local in-plan specialists without pre-authorization.

Direct Access, General**:** Member may self-refer to the following: Allergy, Dermatology, OB/GYN and Ear/Nose/Throat. Members should expect to receive at a minimum an evaluation and consultation during the direct access visit(s.)

Direct Access to OB/GYN: Members may directly access in-network OB/GYN practitioners for OB/GYN services. Utilization protocols and terms and conditions of this access will be the same as those usually applied to physician services and will not be more restrictive.

Open Access for Behavioral Health: HMO members may directly access or self-refer to any of the contracted behavioral health care practitioners within the HMO Health Plan Network. The IPA is only delegated for credentialing of behavioral health practitioners.

Second Opinions: Per CA Health & Safety Code 1383.15(a) (5), members may request a second opinion (see *Second Opinions Policy* for details).

Telephone Advice Service: The IPA does not provide centralized telephone advice services.

Physician Incentive Program**:** The IPA's Quality Improvement program will include continuous monitoring of the potential effects of any incentive plan on access/quality of care. This monitoring will include assessment of the results of member satisfaction surveys and UM data to identify patterns of possible underutilization of services that may be related to the incentive plan.

Language Standards

In addition, the IPA provides readable, easily understood (at 8th grade level) information to health plan members instructing them on how to obtain primary and specialty care. If 10% or more of the population speaks a language other than English, member information will be provided in that language. Access to healthcare services information will include:

1) how to obtain information about practitioners who are contracted with the IPA,

2) how to obtain primary care services, including points of access,
3) how to obtain specialty care, hospital and behavioral health services,
4) how to obtain care after normal office hours,
5) how to obtain in area emergency care, including the IPA's policy on when to directly access emergency care or use 911 services.

Interpreter Services

Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations 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.

Procedures:

Customer Service Representatives (routinely):

When a member complaint is received regarding access to care, customer service representatives (CSR) will immediately contact the member's practitioner to identify any perceived or real barriers to timely access. When appropriate, the CSR will advocate for the member. The member will also be advised that they may place an official complaint against the practitioner by contacting their health plan's grievances and appeals department.

Credentialing Manager (annually):

- Identifies contracted primary care providers (PCP) within the network, assesses them via member complaint review and member satisfaction surveys, and verifies that the contracted health plan's definition of PCP to member ratio (1:2,000) and geographic distribution is reasonable, given the number of contracted PCPs and assigned members.
- Identifies contracted specialty care providers (SCP) within its network, establishes quantifiable and measurable standards for the needed number and geographic distribution of SCPs and SCP to member ratio (1:1,200), and assesses via complaint review and member satisfaction surveys that the standards are adequate and reasonable, given the number of contracted SCPs and assigned members.
- Identifies contracted behavioral health practitioners within its network, establishes quantifiable and measurable standards for needed number and geographic distribution of behavioral health practitioners, and assesses via complaint review and member satisfaction surveys that the standards are adequate and reasonable, given the number of contracted behavioral health practitioners and assigned members.
- Updates and reviews the list of multilingual practitioners in the network. Practitioner's multi-lingual language proficiency is identified at the time of credentialing/recredentialing and is assessed and analyzed against the annual Needs Assessment. Proficiency in a language other than English is recorded in the credentialing database, Intellicred and a list of multilingual practitioners is available for Customer Service staff to assist members with identifying multilingual practitioners upon request.
- Identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations.
- Identifies or reconfirms the list of identified qualifying physicians, which is made available to UM staff.

Quality Management Department (annually):

- Conducts a Cultural and Linguistic Needs Assessment based on the IPA's patient population. This assessment is done using public data on Humboldt County. Threshold languages are identified and interpreters are identified and their skills assessed. Interpreter services are provided at key points of contact. Signs and written materials are translated into threshold languages. The IPA will, upon request, provide member information on a recorded audio cassette for the visually impaired. Translation services in Spanish are provided by IPA staff. Translation services for other non-threshold languages, including sign language, are accomplished through communication with a family member, or through the services of a local interpreter (see attachment).

- Evaluates linguistic services (via analysis of grievances/complaints and member satisfaction) and QI measures instituted, as needed.
- Trains staff regarding the importance of providing clinically competent and culturally appropriate services. The IPA will provide services in a culturally competent manner to all members, including those with limited or non-English proficiency or reading skills, and those with diverse cultural or ethnic backgrounds. The IPA will provide services in a nondiscriminatory manner and make a public declaration (i.e., via posters, member handbooks, newsletters or mission statement) of commitment to nondiscriminatory behavior. The provision of health services is not influenced by member color, ancestry, national origin, religion, citizenship status, gender identity and gender expression, age (40 and older), sexual orientation, sex (including pregnancy, childbirth, and related medical conditions), genetic information, marital status, status as victim of domestic violence, assault, or stalking, medical conditions, AIDS/HIV, disability (physical or mental), political affiliations or activities, military or veteran status, or source of payment. The IPA will accept for treatment any patient in any of the health care services that they provide. The IPA will address member and practitioner allegations of discrimination through the grievance process.
- The IPA will annually collect and analyze its access compliance data to measure its performance against its access standards (may utilize data collected by the contracted health plan). The IPA will identify and implement opportunities and interventions for access improvement and measure the effectiveness of those interventions.

Approval	Signature	Date
Candy Stockton, M.D. Chief Medical Officer	*Signature on file*	
Rosemary DenOuden Chief Executive Officer	*Signature on file*	

DOCUMENT HISTORY

Status	Date	Action
Approved	7/2005	Approved by QMAC
Revised	9/2005	Added Translation attachment
Approved	5/2006	Approved by QMAC
Approved	3/2007	Approved by QMAC
Approved	1/2008	Approved by QMAC
Reviewed	5/2008	
Revised	8/2008	Revised timeliness of callbacks
Approved	7/2009	Approved by QMAC
Approved	7/2010	Approved by QMAC
Approved	2/2011	Approved by QMAC
Approved	2/2012	Approved by QMAC
Approved	4/2014	Approved by QMAC
Approved	2/2015	Approved by QMAC
Reviewed	3/2017	
Reviewed	1/2018	
Reviewed	1/2019	
Reviewed	1/2020	
Updated	12/2020	Removed the word 'Prudent' when referring to the layperson
Reviewed	2/2021	

Appropriate Emergency Room Utilization

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency.

If a member considers a medical condition to be an emergency, they should be instructed to call 911 or go to the nearest hospital emergency room immediately. HMO Health Plan (e.g., BCC or BSC) covers emergency services that are necessary to screen and stabilize a condition. No authorization or pre-certification is needed if the enrollee reasonably believes that an emergency medical condition exists. Once the condition is stabilized, the member or family member should contact their physician for authorization of any additional service. A member should be directed to call the telephone number on the back of their HMO Health Plan ID card with any questions.

A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately. Examples of medical emergencies include:

- Severe pain
- Chest pains
- Heavy bleeding
- Sudden weakness or numbness of the face, arm, or leg on one side of the body
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Active labor

California law requires health plans to follow the "layperson" standard in providing directions for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any " layperson" would have considered the situation to be an emergency. A "layperson" is a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is necessary. Therefore, HMO Health Plans expect every PPO and HMO practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or go directly to the emergency room. If emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted at a later date. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller believes they are experiencing an emergency.

Requests for payment cannot be denied for failure to obtain a prior approval when the approval would be impossible or could seriously jeopardize the life or health of the claimant.

Humboldt IPA
Medical Care Access Audit Summary Sheet (GOAL = 100%)

Auditor Name_____________________________ Month___________________ Year___________

PCP/SCP Name____________________________ PH#______________________________________

PCP/SCP Address____

Encounter ID	Wait Time for Emergent	Wait Time for Urgent	Routine Primary Care	Office Wait Time	After Hours Care	Call Wait Time
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Total Achieved Criteria						
Total Encounters						
Total Encounters Meeting Standard						
% Achieved						
Average Achieved Criteria						
Data Collection Source: **a. Office Patient Schedule** **b. Provider Office Personnel** **c. Patient Survey** **d. Computer data** **e. Direct Observe** **e. Other**						
For Urgent Care Only Insert who the patient was seen by: **a. Assigned PCP** **b. Another PCP** **c. UCC**						

Humboldt IPA
Behavioral Health Access Audit Summary Sheet (GOAL = 100%)

Medical Group Name___________________________ Month_________________ Year__________

Address____

BH Practitioner Name___________________________ PH#__________________________________

BH Practitioner Address____

Data Collector____

Encounter ID	Emergent	Urgent	Routine	Call Wait Time	Call Abandonment Rate
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
Total Achieved Criteria					
Total Encounters					
Total Encounters Meeting Standard					
% Achieved					
Average Achieved Criteria					
Data Collection Source **a. Office Patient Schedule** **b. Provider Office Personnel** **c. Patient Survey** **d. Computer data** **e. Direct Observation** **e. Other**					
For Urgent Care Only Insert who the patient was seen by: **a. Assigned PCP** **b. Another PCP** **c. PA** **d. UCC**					

DEFINITIONS FOR CONDUCTING AN ACCESS AUDIT

Primary Care Practitioner	Those providers responsible for primary health care. Specialties include: Family Practice, General Practice, Pediatrics, Internal Medicine, and OB/GYN. Nurse Practitioners and Physician Assistants, under the direction of the primary physician, may also be included.
Specialist	Those providers responsible for specialty (non-primary) care. Specialties include: OB/GYN, Orthopedics, General Surgery, Cardiology, Oncology and Dermatology.
Behavioral Health Practitioner	Practitioners providing BH services
Encounter	Patient visit to/with an appropriate provider for each criterion.
Sample Size	Sample size should be based on the MG/IPA population, audit timeframes, HMO requirements, etc. Example: If you are conducting semi-annual audits, for each audit 25% of the MG/IPA primary care and 25% of the specialist providers might be audited, with the goal to audit all providers within a two (2) year period.

INSTRUCTIONS FOR SCORING ACCESS AUDIT

- Use one sheet per practitioner/provider
- Total Achieved Criteria – Add 1. Thru 10.
- Total Encounters – Add 1. thru 10.
- Total Encounters Meeting Standard – Add Encounters Meeting Standard
- % Achieved – Total # of Encounters Meeting Standard divided by Total # of Encounters
- Average Achieved Criteria – Achieved Criteria divided by Total # of Encounters

INSTRUCTIONS FOR EVALUATION OF ACCESS AUDIT RESULTS

Findings from this study should be compared with the previous study to determine if an improvement or a decline in performance has occurred. Findings from Member Grievance data and Member Satisfaction Surveys should be incorporated into these findings. Assess the overall compliance rate for access standards and determine if there are areas where there is opportunity for improvement. The review should include identifying practitioner-specific issues and systemic trends.

After determining if there are any negative trends or issues, the appropriate departments should look at opportunities for improvement. Examples of appropriate departments include QM, UM, and Credentialing/Provider/Practitioner Relations. Areas should be targeted according to the findings, resources and priorities of the organization. Access issues should be included as part of the practitioner's Quality Profile during recredentialing.

Develop an action plan based on the findings and identified opportunities for improvement. Actions may include but are not limited to, practitioner in-services, recommendations for increased staffing, development of policies and procedures to address the specific areas, extending office hours, and follow-up audits. Actions should be developed according to the findings, resources and priorities of the organization. The action plan should include target dates and responsible individuals, as well as monitoring and follow-up to determine if the actions are achieving the desired goals.