Timely Access to Care

2024

Humana
Healthy Horizons®
in Ohio

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Introduction

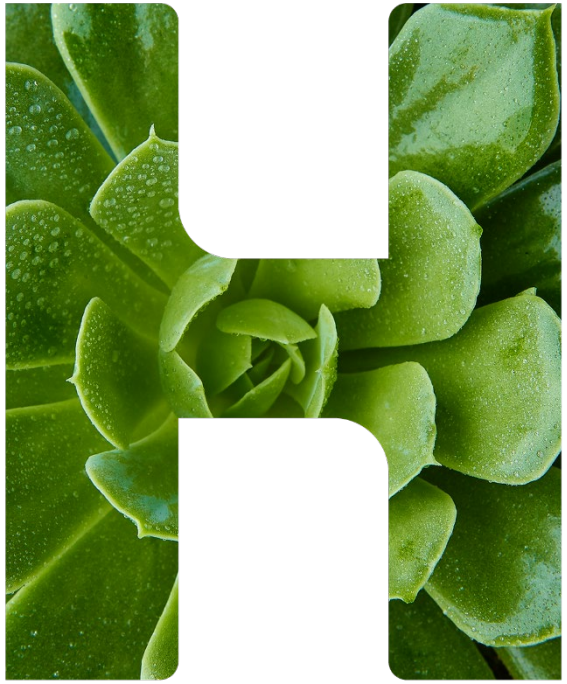
Humana Healthy Horizons® in Ohio members rely on us and providers to partner and deliver the **right care** at the **right time**.

That means providing timely access to care.

Training objectives

Understand how timely access to care is measured through the Appointment and Availability Survey.

- What is it?
- Why is it important?
- How does it work?
- How is it measured?



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Appointment and Availability Survey

Background and methodology

To ensure regulatory and accreditation compliance, Humana Healthy Horizons must monitor and track contracted providers' ability to provide timely access to care to Humana Healthy Horizons members.

The National Committee for Quality Assurance (NCQA) and state regulators developed access to care standards Humana Healthy Horizons must abide by as an operating health plan.

The Appointment and Availability Survey enables Humana Healthy Horizons to confirm providers are meeting these standards. If a provider does not meet a standard, Humana Healthy Horizons supports improvement efforts through a partnership to remove barriers to care.

Purpose

To ensure members have access to healthcare they need when they need it

Objective

To identify potential gaps in our members' ability to access timely care and work with providers to reduce timely access barriers

Data collection process

- Vendor survey of network providers provides unbiased and accurate identification of access barriers.
- Humana Healthy Horizons defines the data set and survey questions.
- Vendor provides results to Humana Healthy Horizons using a standard Ohio Department of Medicaid (ODM) template.
  - Group quotas ensure statistically valid samples.
  - Providers are selected randomly.
  - 3 outreach attempts are made using an approved script.

Why is the Appointment and Availability Survey important?

The survey measures our ability to maintain healthcare access and availability standards for our members, fulfill network requirements, identify potential gaps, and work toward their resolution.

Regulatory requirements

Humana Healthy Horizons is required to meet standards set by state and contract requirements and follow protocol set by agencies such as NCQA.

Patient experience and satisfaction

Monitoring access to care through the audit helps ensure Humana Healthy Horizons members have a positive healthcare experience, which will likely be reflected in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Improve patient health outcomes

Monitoring access to care through the survey helps to ensure members are getting the appropriate care as soon as needed.

Reduce unnecessary emergency department visits

Ensuring standards are met and following the audit protocol helps inform members where they should go to receive the level of care they need.

Appointment and Availability Survey

Humana Healthy Horizons ensures compliance with timely access to care and appointments by measuring 3 sets of access standards:

Primary care provider (PCP) and specialist appointment availability

Audit of randomly selected PCPs' and specialist providers' ability to schedule a timely appointment when a member calls during operating hours

Behavioral health appointment availability

Audit of randomly selected behavioral health prescribing and nonprescribing providers' ability to schedule a timely appointment when a member calls during operating hours

Dental appointment availability

Audit of randomly selected dental providers' ability to schedule a timely appointment when a member calls during operating hours

Telehealth does not replace provider choice and/or member preference for in-person service delivery.
Note: Additional telehealth information is available at **Humana.com/OHTelehealth.**

Appointment standards

Type of visit	Description	Minimum standard
Emergency service	Emergency services are needed to evaluate, treat or stabilize an emergency medical condition.	24 hours, 7 days a week*
Urgent care (includes medical, behavioral health and dental services)	Urgent care is provided for a nonemergent illness or injury with acute symptoms that require immediate care. Examples include sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, nonresolving headache. Also includes acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	Within 24 hours, 7 days a week
Behavioral health, non-life-threatening emergency	This is a non-life-threatening situation in which a member exhibits extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral health, routine care	Routine care involves requests for routine mental health or substance abuse disorder treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
Child and Adolescent Needs and Strengths (CANS) initial assessment	A CANS initial assessment is an assessment for the purposes of Ohio Resilience through Integrated Systems and Excellence (OhioRISE) eligibility.	Within 72 hours of identification

At a minimum, members should be provided appointments for care within the time frames listed.

* For emergency situations, care must be available 24 hours a day, 7 days a week.

Appointment standards (cont'd.)

Type of visit	Description	Minimum standard
American Society of Addiction Medicine (ASAM) Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	This involves initial screening, assessment and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	These type of services are needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days a week*
Primary care appointment	This type of care is provided to prevent illness or injury. Examples include routine physical examinations, immunizations, mammograms and Pap tests.	Within 6 weeks
Nonurgent sick primary care	This type of care is provided for a nonurgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal care: first or second trimester	This type of care is provided to a member while the member is pregnant to keep member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal care: third trimester or high-risk pregnancy		Within 3 calendar days
Specialty care appointment	Specialty care is care provided for a nonemergent/nonurgent illness or injury requiring consultation, diagnosis and/or treatment from a specialist.	Within 6 weeks
Dental appointment	This involves nonemergent/nonurgent dental services, including routine and preventive care.	Within 6 weeks of request

At a minimum, members should be provided appointments for care within the time frames listed.

* For emergency situations, care must be available 24 hours a day, 7 days a week.

Appointment availability requirements for comprehensive primary care practices

- Comprehensive primary care (CPC) practices must offer **at least one alternative to traditional office visits** to increase access to the patient care team and clinicians in ways that best meet the needs of the population (e.g., virtual visits, phone visits, group visits, home visits, alternative location visits, or expanded hours in the early mornings, evenings and weekends).
- CPC practices must provide **access to a PCP who can access the member's medical record within 24 hours** of initial request.
- The practice also **must make the member's clinical information available** through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other clinicians outside the practice when the office is closed.

Member access to out-of-network providers

If the provider network is unable to provide medically necessary covered services in a timely manner, Humana Healthy Horizons covers these services adequately and promptly through an out-of-network provider as long as the current provider network is unable to provide the services.

- Cost to the member shall be no greater than it would be if the services were furnished by a network provider.
- Prior authorization is required.

More detail on this process can be found in the clinical section of the **Humana Healthy Horizons in Ohio Provider Manual**.

Provider engagement outreach following the Appointment and Availability Survey

Following the annual Appointment and Availability Survey, Humana's Provider Engagement team will contact providers who failed to meet standards.

The Provider Engagement team will:

- Share survey results, identify opportunities for improvement and provide support as needed
- Notify providers they will be resurveyed after 6 months
- Educate providers that a second failure of the survey will result in the development and implementation of an improvement plan

Providers who met appointment availability standards during the annual Appointment and Availability Survey will not receive any outreach.

How to prepare for the survey

- Ensure your understanding of the appointment and availability standards.
  - Prepare by keeping staff at your practice up-to-date with the appointment and availability standards.
  - Make sure everyone understands what happens if you do not meet the standards. Humana Healthy Horizons will work with you so you have the tools and resources to improve.
- Keep your information current.
  - Advance notice of status changes, such as a change in address or phone, or when adding or removing a provider from your practice, helps maintain current records which is critical for accurate claims processing.
- Know the timely access standards and where to find them.
  - Appointment standards are available on slides 9 and 10, and in our **Humana Healthy Horizons in Ohio Provider Manual**. Consider posting and displaying a copy of these standards in your office where it is easy to reference throughout the day.
- Check in regularly with your Humana Healthy Horizons Provider Engagement representative to get the support you need.
  - Talk to your Provider Engagement representative about your timely access procedures.
  - Review known barriers and ask for support.

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