PURPOSE

Embright recognizes the importance of providing timely access to appointments and care as a key aspect of delivering high quality member services and ensure access to needed care.

POLICY

This policy describes the access standards that Embright has established and communicated for primary care, high-volume and high-impact specialty care practitioners, and behavioral health practitioners. The policy also describes the methodology and process used by Embright in the annual analysis of data to measure performance against these standards. The information from that annual analysis is then used in identifying opportunities for improvement and intervening with practitioners.

Standards are quantified in a specific number of hours or days, or the number or percentage of complaints about access to each type of appointment stated in the factors. The measure of performance must reflect the standard. For example, if the standard is hours or days, then the measure of performance must be hours or days.

DEFINITION

CAHPS	Consumer Assessment of Healthcare Providers and Systems. A set of standardized surveys that measure patient satisfaction with the experience of care.
Clinical Integration Committee (CIC)	The Committee is advisory to the Board of Managers ("Board"). Based on recommendations, status updates and other briefings from Company management, the Committee will make recommendations to the Board regarding certain care integration activities or will make decisions where the Board has delegated decision-making authority.
HEDIS	Healthcare Effectiveness Data and Information Set. A set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans.
Emergency care	A sudden or acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe a health condition exists that require immediate medical attention and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunctions of a bodily organ or part, or would place the person's health in serious jeopardy.
Urgent acute care	While not considered life threatening, it cannot comfortably be delayed. Providers must have a system in place to evaluate the needs of members calling or presenting at the office that enables them to identify conditions requiring urgent and emergent care.
Member	A person insured or otherwise provided coverage by a health insurance organization.

PROCEDURE

I. Appointment Access

All providers who oversee the members health care are responsible for providing the following appointments to Embright members in the timeframes noted.

A. Primary Care Appointment Access Standards

PRIMARY CARE PHYSICIAN

Type of Care	Appointment Wait Time	Performance Measure
Emergency care	Immediately	
Urgent care appointments	Within 24 hours	
Preventative care appointments	Within 42 calendar days	
Non-urgent, routine appointments for symptomatic conditions	Within 7 calendar days	
Non-urgent, routine appointments for asymptomatic conditions	Within 30 calendar days	Days from request to appointment is 30 calendar or less in 90% of tested attempts or 90% of members report that they are able to get an appointment as soon as they need it.
Office wait time	1-30 minutes	

B. Specialty Care Appointment Access Standards

Type of Care	Appointment Wait Time	Performance Measure
Urgent, symptomatic appointments	Within 24 hours	
Non-urgent, specialty referral appointments	Within 30 calendar days	Survey indicates that members can obtain access to an appointment within 30 calendar days 90% or greater of requests. Provider has 5 or less member complaints a year about appointment access.

C. Behavioral Healthcare Access Standards

BEHAVIORAL HEALTH

Type of Care	Appointment Wait Time	Performance Measure
Non-Life threatening emergency care	Within 6 hours of request or directed to the nearest emergency room	Practitioner has process, communications and staff procedures that direct members with non-life threatening emergencies to the emergency room. Practitioner has protocols for addressing suicidal and life-threatening situations.
Urgent care appointments	Within 48 hours of request	90% of sites surveyed have slots for urgent care within 48 hours. and Provider has less than 5 member complaints regarding urgent care access a year.

Routine initial and follow-up office visits	Within 10 business days of request	90% of sites surveyed have slots for routine initial visits within 10 business days. and Provider has less than 5 member complaints regarding routine care access a year.

D. After Hours Care

a. All providers must have back-up (on call) coverage after hours or during the provider's absence or unavailability.

b. Providers must provide coverage 24 hours a day, 7 days a week that includes an answering service or a recorded message directing members to a provider for after-hours care.

i. Answering service should be able to contact the on-call provider or another designated network provider.

ii. Call forwarding to provider's home or other location.

iii. On-call pager.

iv. Recorded phone message, delivered in the language of each of the major population group served by the provider, with instructions that direct the member to a provider for live instructions of after-hours care. Direction to another recording is not acceptable.

v. The service or recorded message should instruct members with a life-threatening emergency to hang up and call 911 or go to the nearest emergency room.

II. Monitoring Access for Compliance with Standards:

Embright collects data and conducts an annual analysis of network access performance against standards. The Senior Provider Network Manager is responsible for compiling the results in an annual report that includes recommendations. The results and recommendations are presented to the Clinical Integration Committee. In addition, all access to care standards are reviewed and approved by the Clinical Integration Committee on an annual basis.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Clinical Integration Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Clinical Integration Committee.

A. Primary Care Access Analysis

Embright measures primary care performance against access standards using a mix of the following sources:

a. If available, results of the HEDIS/CAHPS 5.0H survey (results provided by payor partners). The CAHPS questions that are used include the following:

   - (CAHPS question) In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?

   - (CAHPS question) In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

b. Site-specific surveys regarding access to offices of practitioners providing primary care

c. Complaint data from Embright member services and payor partners

Data is collected and analyzed both at the individual practitioner level as well as at the organizational level. This allows Embright to address issues and opportunities either directly with the practitioner or with the organized group that oversees the practitioner. If an issue is identified at the organizational level (i.e., primary care practitioners and practices may be grouped together), Embright conducts a practitioner-level analysis (by individual primary care practitioner) across all primary care practitioners and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.

Surveys and audit tests (e.g. “secret shopper” data collection approaches) are designed to be either 100% audits or statistically valid samples. The approach is detailed in the annual report. If the data that is used is self-reported, Embright supplements the information with complaint data to ensure a balanced perspective is provided and member identified concerns are addressed.

Embright conducts both quantitative and qualitative analyses on annual basis. The quantitative analysis provides an assessment of performance against the accessibility standards and the qualitative analysis provides insight into the performance results. The qualitative analysis may also identify root causes, barriers and issues that are then addressed in the recommendations section of the annual report.

B. Specialty Care Access Analysis

Embright measures specialty care performance against the access standards for high-volume specialists and high-impact specialists in order to determine if access to appointments is sufficient and if not what interventions need to be planned. The standards are set and reviewed by Embright and then analysis is conducted annually using a mix of the following sources:

a. Statistically valid member surveys

b. Relevant results of the HEDIS/CAHPS 5.0H survey (results provided by payor partners). The CAHPS questions that are used include the following:

   - (CAHPS question) In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?

   - (CAHPS question) In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

c. Site-specific surveys regarding access to offices of practitioners providing primary care

d. Complaint data from Embright member services and payor partners

Data is collected and analyzed both at the individual practitioner level as well as at the organizational level. This allows Embright to address issues and opportunities either directly with the practitioner or with the organized group that oversees the practitioner. If an issue is identified at the organizational level (i.e., specialist care practitioners and practices may be grouped together), Embright conducts a practitioner-level analysis (by individual specialist) across all specialists in the organization and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.

Surveys and audit tests (e.g. "secret shopper" data collection approaches) are designed to be either 100% audits or statistically valid samples. The approach is detailed in the annual report. If the data that is used is self-reported Embright supplements the information with complaint data to ensure a balanced perspective is provided and member identified concerns are addressed.

Embright conducts both quantitative and qualitative analyses on annual basis. The quantitative analysis provides an assessment of performance against the accessibility standards and the qualitative analysis provides insight into the performance results. The qualitative analysis may also identify root causes, barriers and issues that are then addressed in the recommendations section of the annual report.

C. Behavioral Health Access Analysis

Embright measures specialty care performance against the access standards for behavioral health practitioners in order to determine if access to appointments is sufficient and if not what interventions need to be planned. The standards are set and reviewed by Embright and then analysis is conducted annually. The annual analysis and report of behavioral health providers includes a separate analysis of prescriber and non-prescriber availability.

The data collection and analysis approach may use a mix of the following data sources:

a. Statistically valid member surveys

b. Practitioner site surveys

c. Claims data analysis

d. Relevant results of the HEDIS/CAHPS 5.0H survey (results provided by payor partners). The CAHPS questions that are used include the following:

  - (CAHPS question) In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?

  - (CAHPS question) In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

e. Site-specific surveys regarding access to offices of practitioners providing primary care

f. Complaint data from Embright member services and payor partners

Data is collected and analyzed both at the individual practitioner level as well as at the organizational level. This allows Embright to address issues and opportunities either directly with the practitioner or with the organized group that oversees the practitioner. If an issue is identified at the organizational level (i.e., behavioral health practitioners and practices may be grouped together), Embright conducts a practitioner-level analysis (by individual practitioner) across all behavioral health practitioners in the organization and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.

Surveys and audit tests (e.g. “secret shopper” data collection approaches) are designed to be either 100% audits or statistically valid samples. The approach is detailed in the annual report. If the data that is used is self-reported Embright supplements the information with complaint data to ensure a balanced perspective is provided and member identified concerns are addressed.

Embright conducts both quantitative and qualitative analyses on annual basis. The quantitative analysis provides an assessment of performance against the accessibility standards and the qualitative analysis provides insight into the performance results. The qualitative analysis may also identify root causes, barriers and issues that are then addressed in the recommendations section of the annual report.

III. Communication:

The appointment access standards are available in the provider manual, which is distributed to all Embright providers. Providers can also access the provider manual at https://embright.com.

REGULATION

NCQA HP 2020 NET 2: Accessibility of Services

REVISION

Revision Date	Revision