CORPORATE POLICY & PROCEDURE

	Policy Name: PN8 - Monitoring Network Availability
Department: Provider Network	Policy Number: PN8
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Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☒ Umpqua Health Network
Approved By:	Date: Not Set

POLICY STATEMENT

Umpqua Health Alliance (UHA) and Umpqua Health Network (UHN) are committed to providing a network of available providers that ensures geographic and physical access to its members and potential members for all populations including specialty behavioral health services in accordance with Oregon Administrative Rules (OAR) 309-019-0135 and 410-141-3515 and the Coordinated Care Organization (CCO) Contract.

PURPOSE

To ensure that UHA's network of providers is adequately available to serve UHA's members as required in the Oregon Administrative Rules (OARs), Code of Federal Regulation (CFR) and CCO Contract. This policy outlines how UHA will monitor the availability of UHA's providers and their training. These monitoring methods will be reviewed monthly during the Network Performance Committee.

RESPONSIBILITY

Provider Network

DEFINITIONS

Behavioral Health Services: Medically appropriate services rendered, or made available, to a recipient for treatment of a behavioral health diagnosis.

I/DD: Intellectual Disability as defined in OAR 411-320-0020(21) and/or Developmental Disability as defined in OAR 411-320-0020(11).

Key Performance Indicators (KPIs): Specific elements identified by UHA (CO7 – Monitoring Policy) to track progress on whether required elements are being met.

PROCEDURES

Key Performance Indicator (KPI) Monitoring

1. UHA will monitor monthly the following availability standards as further outlined in PN7 – Network Adequacy policy:
    a. Primary Care Providers.
        i. Urgent care shall be seen within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840 (OAR 410-141-3515(11)(a)(B).

ii. Well care (aka routine) shall be seen within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 (OAR 410-141-3515(11)(a)(C).
iii. Follow-up visit following an ER visit or post hospital discharge is done within 72 hours (TC1 – Transitional Care for Acute Care).

b. Specialists.
   i. Urgent care shall be seen within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840 (OAR 410-141-3515(11)(a)(B).
   ii. Well care (aka routine) shall be seen within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 (OAR 410-141-3515(11)(a)(C).

c. Oral Health Care Providers – Children and Non-Pregnant Individuals
   i. Emergency oral care shall be seen or treated within 24 hours (OAR 410-141-3515(11)(b)(A).
   ii. Urgent oral care shall be seen within one (1) week or as indicated in the initial screening in accordance with OAR 410-123-1060 (OAR 410-141-3515(11)(b)(B).
   iii. Routine oral care shall be seen within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) weeks appropriate. (OAR 410-141-3515(11)(b)(C).

d. Oral and Dental Care Providers – Pregnant Individuals
   i. Time frame for Emergent Dental Care – Seen or treatment within 24 hours;
   ii. Time frame for Urgent Dental Care – within one (1) week;
   iii. Time frame for Initial Screening or Routine Dental Care – within four (4) weeks, unless there is a documented special clinical reason that would make access longer than four (4) weeks appropriate.

e. Behavioral Health Providers for Other Populations.
   i. Routine Non-Urgent Behavioral Health Appointments.
      1. Shall be seen for an intake assessment within seven (7) days from the date of request;
      2. A second appointment within 14 days of assessment; and
      3. Four (4) appointments (including second appointment) within 48 days.
      4. Appointments shall be therapeutic in nature and expand beyond administrative activities.
   ii. Urgent Behavioral Health Care for all populations shall be provided immediately (OAR 410-141-3515(11)(c)(A)).

f. Specialty Behavioral Health Providers for Priority Populations.
   i. Assessment and intake timeframe requirements:
      1. Pregnant Women, women with children, unpaid caregivers, families, and children ages birth through five (5) years shall be provided with an immediate assessment and intake.
         a. If interim services are necessary due to capacity restrictions, treatment at an appropriate level of care shall commence within 120 days from placement on a waitlist.
      2. Veterans and their families shall be provided with an immediate assessment and intake.
         a. If interim services are necessary due to capacity restrictions, treatment at an appropriate level of care shall commence within 120 days from placement on a waitlist.
      3. Individuals with HIV/AIDs or tuberculosis shall be provided with an immediate assessment and intake; Individuals at risk of first episode psychosis and I/DD population shall be provided with an immediate assessment and intake;
         a. If interim services are necessary due to capacity restrictions, treatment at an appropriate level of care shall commence within 120 days from placement on a waitlist.
      4. IV drug users shall be provided with an immediate assessment and intake.
         a. Admission is required within 14 days of request, or, if interim services are necessary due to capacity restrictions, admission shall commence within 120 days from placement on a waitlist.
      5. Those with opioid use disorders shall be provided with an assessment and intake within 72 hours.
      6. Those requiring medication assisted treatment shall be provided with an assessment and induction of no more than 72 hours with efforts to do such as soon as possible; additionally, those requiring medication assisted treatment shall also have access to:
         a. Assist such members in navigating the health care system and utilize community resources such as hospitals, peer support specialists, and the like, as needed until assessment and induction can occur;
         b. Ensure providers provide interim services daily until assessment and induction can occur and barriers to medication are removed;

i. UHA or its provider shall, in no event, require members to follow a detox protocol as a condition of providing such members with assessment and induction;

c. Provide such members with an assessment that includes a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into consideration the results of such assessment and the potential risks and harm to the member in light of the presentation and circumstances; and

d. Provide no less than two (2) follow-up appointments to such members within one (1) week after the assessment and induction.

7. Children with serious emotional disturbance.

a. UHA will ensure that periodic social-emotional screening for all children birth through five (5) years is conducted in the primary care setting and ensure any concerns revealed by the screening are addressed in a timely manner (OAR 410-141-3515(11)(c)(B)(vi) and CCO Contract Exhibit M, Section 19(l)).

ii. If a timeframe cannot be met due to lack of capacity, the member shall be placed on a waitlist and provided with interim services within 72 hours of being put on a waitlist. Interim services shall be comparable to the original services requested based on the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDs testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135.

g. Non-Emergent Medical Transportation (NEMT).

i. UHA ensures members have access to safe, timely, appropriate NEMT services in accordance with OAR 410-141-3920.

1. UHA's NEMT subcontractor shall submit monthly KPIs on performance elements in order to routinely monitor the quality of the call center (CO29 – NEMT Quality Assurance Program and Plan). In addition, an annual subcontractor audit is performed in accordance with policy CO10 – Evaluation of Subcontractors.

2. If any of the above access to care standards does not comply with OAR 410-141-3515. or PN7 - Network Adequacy policy, UHA shall proactively work to identify ways to assure either its network or a particular provider meets the availability standards.

a. If the average waiting time for a particular specialty is not met for most of the providers within that specialty, the Provider Network Department shall work to determine how to increase access to care.
    i. If there are no additional in-area providers of that specialty, the Provider Network Department shall work to contract out-of-area providers of that specialty to increase availability.
    ii. If additional in-area providers of that specialty are identified, the Provider Network Department shall work to contract with those in-area providers.

Monitoring

UHA will monitor access and availability in several ways, including, but not limited to, the following:

1. Behavioral Health Dashboard Monitoring
    a. This dashboard is used to monitor UHA's network to assess availability in the following categories:
        i. Community Mental Health Programs (CMHP) or licensed behavior health treatment program under OAR 309-008-0100.
        ii. Primary Care Integration.
        iii. Prescribing Capabilities.
        iv. Niche/Specialized Provider.
        v. Generalized Services.
    b. The dashboard is updated quarterly by the Provider Network Department for all behavioral health providers.
2. Access-to-Care Surveys
    a. Survey of appointment timeframes with its participating network providers;
        i. Survey of appointment timeframes with its participating network providers;
            1. Access to Care surveys is emailed out the designated point of contact at each contracted provider's office at the end of each quarter of the calendar year, to the following provider service categories:
                a. Primary Care Providers (PCP).
                b. Specialists.
                c. Behavioral Health.
                d. Adapt dba Compass Behavioral Health (CMHP).
                e. Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC).
                f. Oral Healthcare Organization (DCO).

2. Survey is customized to each provider service category. The survey questions address specific access and availability standards as required in the OARs including ensuring sufficiency of language services and physical access for members with disabilities.
3. Providers are asked to return the surveys by the date specified in the survey request letter.
    a. To receive the best turnaround response time, the following reminders will be sent:
        i. Two (2) weeks prior to the delivery deadline, an email will be sent to remind providers of the upcoming deadline.
        ii. A week prior to the delivery deadline, a Provider Services Representative will call each office who have not returned their survey to request they be returned by the deadline.
4. Completed surveys are incorporated into the KPI reporting periods.

b. Secret Shopper Calls
    i. Calls will be performed randomly on an as-needed basis or as areas in need of improvement are identified through member concerns received through the Customer Care Department or through the grievance process.
        1. Scripts are created based on the specific thresholds the service provider is required to meet.
        2. Upon call completion the information collected is reviewed with the Chief Administrative Officer (CAO). The CAO will determine if further action is required.
            a. Data collected may be utilized by the Network Performance Workgroup to identify potential gaps and provide recommendations for the Contracting Workgroup.

c. Monthly Geomapping
    i. UHA utilizes a geomapping software, Quest Analytics, to run routine reports comparing geographical location of providers, by specialty and location, with the member's primary home address identified in the monthly member list to determine the travel time and distance members are in compliance for access time and distances for the following health care services:
        1. Primary Care Providers (PCP).
        2. Specialists.
        3. Behavioral Health

4. Substance Use Disorders Services.
5. Oral Health Care Providers
6. Ancillary Providers
7. Hospital
8. Obstetrician-Gynecologist
9. Pharmacy

d. Grievance Monitoring
   i. UHA has internal grievance and appeal procedures under which members have the right to file grievance at any time for any matter other than an appeal or contested case hearing. When grievance is received, it is categorized and reviewed for trends related to access barriers including, but not limited to, the following:
      1. Provider's office unresponsive, not available, difficult to contact for Plan unresponsive, not available, difficult to contact for appointment or information.
      2. Provider's office too far away, not convenient
      3. Unable to schedule appointment in a timely manner.
      4. Unable to be seen in a timely manner for urgent/emergent care
      5. The provider's office is closed to new patients.
      6. Referral or 2nd opinion denied/refused by provider.
      7. Referral or 2nd opinion denied/refused by plan.
      8. Provider not available to give necessary care
      9. Eligibility issues
      10. Female or male provider preferred, but not available
      11. NEMT not provided, late pick up w/missed appointment, no coordination of services
      12. Dismissed by provider because of past due billing issues
      13. Dismissed by clinic because of past due billing issues.

e. Subcontractors Monitoring
   i. For those services to which UHA has delegated to a subcontractor, the subcontractor shall comply with the access to care OARs.
      1. Primary care providers are required to meet the following access to care OARs:
         a. OAR 410-141-3515(11)(a)(A);
         b. OAR 410-141-3515(11)(a)(B); and
         c. OAR 410-141-3515(11)(a)(C).
      2. Specialist providers are required to meet the following access to care OARs:
         a. OAR 410-141-3515(11)(c)(A); and

b. OAR 410-141-3515(11)(c)(C).

3. Oral health care providers are required to meet the following access to care OARs:
    a. OAR 410-141-3515(11)(b)(A);
    b. OAR 410-141-3515(11)(b)(B); and
    c. OAR 410-141-3515(11)(b)(C).
4. Behavioral health providers are required to meet the following access to care OAR 410-141-3515(11)(c)(A) and CCO Contract Exhibit B, Part 4, Section 2 and Exhibit M.

ii. If any of the above access to care standards does not comply with OAR 410-141-3515 or PN7 - Network Adequacy policy, UHA shall proactively work to identify ways to assure either its network or a particular provider meets the availability standards.

1. If the average waiting time for a particular specialty is not being met for most of the providers within that specialty, the Provider Network Department shall work to determine how to increase access to care.
    a. If there are no additional in-area providers of that specialty, the Provider Network Department shall work to contract out-of-area providers of that specialty to increase availability.
    b. ii. If additional in-area providers of that specialty are identified, the Provider Network Department shall work to contract with those in-area providers.

Corrective Action Process

1. The corrective action process can be found in the Provider Handbook.

Provider Training

1. The Provider Network Department will provide annual training, literature, and onsite provider guidance. Training and literature provided to the providers includes, but is not limited to:
    a. Motivational interviewing.
    b. Trauma informed care.
    c. Culturally and Linguistically Appropriate Services (CLAS).
2. Training will be assigned to providers following the Network Performance Committee's review of the above-mentioned monitoring methods, to remediate areas of concern or if a provider is not meeting contractual requirements. The training will be:
    a. Customer Service;

b. CIM access;
c. Inteligenz;
d. A review of policy and procedures;
e. Prior authorization guidelines;
f. Training books; and
g. A power point of the presentation for the providers to reference and share with their staff.

3. Documentation of provided trainings will be retained in accordance with policy CO23 – Record Retention and Destruction.

External Risk Response Process

1. In the event during the monitoring process, it is determined a provider is out of compliance with this policy, Provider Network will notify UHA's Compliance Department.
    a. UHA's Compliance Department will either assign a Notice of Opportunity (Notice), Opportunity Plan (OP), or a Corrective Action Plan (CAP) to remediate the provider's area of non-compliance, in accordance with the CO21 – External Risk Response. The activities of a risk response will vary depending on the issue and severity.
        i. A CAP will be assigned to providers who do not meet the required threshold for appointment timeframes as follows (CO7 – Monitoring):
            1. Below, but within 5% of the threshold requirement for two (2) or more consecutive reporting periods.
            2. Below and greater than 5% of the threshold requirement for one (1) or more consecutive reporting periods.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Provider Network	Secret Shopper Calls	SOP-PN8	4/27/22	1