Access to Care

Harvard Pilgrim understands the importance of helping our members stay healthy and assisting those members with chronic or complex conditions in getting the resources and care they need to have the best quality of life possible. While all programs are voluntary, the following summarizes some of the assistance that is provided to our members.

CMS requires that the hours of operation of its practitioners are convenient for and do not discriminate against members.

Practitioners must provide coverage for their practice 24 hours a day, seven days a week with a published after-hours telephone number (to a practitioner's home or other relevant location), pager or answering service, or a recorded message directing members to a provider for after-hours care instruction.

Note: Recorded messages instructing members to obtain treatment via emergency room for conditions that are not life threatening are not acceptable. In addition, primary care providers must provide appropriate backup for absences.

Accessibility of services is measured by the timeliness of appointments and in-office waiting times for routine, urgent and emergency care. Each practitioner must ensure that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds.

Providers and their office staff are not allowed to discriminate against members in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. It is necessary that a provider's office can demonstrate they accept for treatment any member in need of health care services they provide.

CMS delegates the responsibility to assess and monitor compliance to Harvard Pilgrim as it is our responsibility to ensure our members receive care based on CMS regulations. If it is determined that a practitioner does not meet access standards, the non-compliant practitioner must submit a corrective action plan within 30 days of receipt of notification from Harvard Pilgrim.

Advance Directive

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Advance Directives may differ among states.

Each member (age 18 years or older and of sound mind), should receive information regarding Advance Directives. These directives allow the member to designate another person to make medical decisions on the member's behalf should the member become incapacitated. Information regarding Advance Directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members' medical records. Providers shall not, as a condition of treatment, require a member to execute or waive an Advance Directive.

Medical Management

The provider's participation agreement with Harvard Pilgrim requires compliance with our medical management programs. Harvard Pilgrim designed medical management programs to ensure that the treatment members receive is covered according to the medical necessity guidelines. Medical management programs also encourage cost effective and appropriate use of the health care delivery system.

Medical Management programs include CMS approved:

- Case management
- Disease management

Objectives of the programs are to:

- Promote efficient use of health care resources
- Define and agree upon appropriate standards of care

Payment for services remain subject to CMS regulations, payment conditions, benefit exclusions, member eligibility, and the member's benefit plan as approved by (CMS) and medical necessity. Therefore, denials may occur because the benefit plan does not cover a service or the member is not eligible at the time a service is provided.

Harvard Pilgrim recommends that providers verify coverage, benefits, contract eligibility and limitations for all patients prior to providing services.

Case Management

Case Management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' health care benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes.

The goals of case management are to:

- Support and encourage individual accountability for health and wellness (self-care management)
- Promote the efficient use of health care benefits
- Improve member satisfaction with the health plan and health care system
- Maximize health and functional outcomes
- Help members coordinate services that meet their needs and navigate through the health care system

Harvard Pilgrim understands the importance of case management and is collaborating with CMS to ensure members who qualify for this service receive the necessary care to improve health outcomes.

Disease Management

Harvard Pilgrim understands the importance of Disease Management and is collaborating with CMS to ensure prospective members who qualify for disease management education and services related to chronic conditions such as: hypertension, hyperlipidemia, coronary artery disease (CAD), diabetes, chronic obstructive pulmonary disease (COPD) and asthma receive the necessary care to improve health outcomes.

Harvard Pilgrim awaits the identification of members for this program through health risk assessments or claims data analysis. Harvard Pilgrim anticipates the program's goal to be the assistance in managing their conditions through education.

Utilization Management & Quality Management Programs (UM/QM)

Harvard Pilgrim has UM/QM programs that include consultation with requesting providers when appropriate. Under the terms of the contract for participation with the Plan‘s network, providers agree, in addition to complying with state and federal mandated procedures, to cooperate and participate in the Plan‘s UM/QM programs, including quality of care evaluation, peer review process, evaluation of medical records, provider or member grievance procedures, external audit systems and administrative review.

Further, to comply with all final determinations rendered pursuant to the proceedings of the UM/QM programs, all participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section.

Compliance is monitored on an ongoing basis and formal audits are conducted annually.

Continuity of Care

Members undergoing active treatment

Harvard Pilgrim will provide coverage for members receiving active treatment using prior authorization at a minimum to include:

- Approval of a prior authorization request for treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual member's medical history, and the treating provider's recommendation; and
- A minimum 90-day transition period for any active course(s) of treatment when a member has enrolled in Harvard Pilgrim after starting a course of treatment, even if the service is provided by an out-of-network provider. This includes members new to Harvard Pilgrim. Harvard Pilgrim must not disrupt or require reauthorization for an active course of treatment for new members for a period of at least 90 days.

Terminated Provider

Harvard Pilgrim will provide coverage for continued services to members undergoing a course of treatment by a provider that no longer participates with the Plan, if the following conditions exist at the time of contract termination:

- Such care is medically necessary. Continued care is allowed through the completion of treatment, until the member selects another treating provider, or until the next open enrollment period – not to exceed six (6) months after the termination of the provider's contract.
- Continuation of care through the postpartum period for members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated with a terminated treating provider.

For continued care under this subsection, the Plan and terminated provider continue to abide by the same terms and conditions as existed in the terminated contract. However, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant. This subsection does not apply to providers terminated from the Plan for cause.

Accessibility Requirements

Providers shall provide or arrange for the provision of medical advice to members on a timely basis. Advice must be available 24 hours a day, seven days a week via a telephone response. Providers are not obligated to provide any health service not normally provided to others, or services for which they are not authorized by law to provide.

Timeliness Requirements

Category	Standard
Preventive Care Appointment or Immunization	Within 30 business days of a member's request
Scheduled Appointments	Within 7 business days and within 30 minutes of member's arrival
Routine/Well Care Appointment	Within 30 business days of a member's request
Urgently Needed Services	Immediately
Emergency Care	Immediately
After-Hours Care	24 hours a day, seven days a week

Telephone Responsiveness	• During office hours, a provider or designee will assess the member according to patient care needs. • Providers should give a timely response to incoming phone calls. • Providers must answer calls in six rings or less. • Providers can only put members on hold two minutes or less.

Harvard Pilgrim collects and performs an annual analysis of access and availability data, and measures compliance to required thresholds. The analysis can include access to:

- Well care
- Sick care
- Urgent care, and/or
- After-hours care

After-Hours Services

The Primary Care Provider or covering provider must be available after regular office hours to offer advice and to assess any conditions, which may require immediate care. This includes referrals to the nearest Urgent Care Center or Hospital Emergency Room in the event of a serious illness. To assure accessibility and availability, the Primary Care Provider must provide one of the following:

- 24-Hour answering service
- Answering system with an option to page the Provider
- An advice nurse with access to the PCP or on-call provider

Closing Provider Panel

When closing membership panel to new Plan members, providers must:

- Submit a request in writing, 90 days prior to closing the Membership panel
- Maintain the panel open to all Plan members who were provided services prior to closing the panel
- Submit a written notice of the re-opening of the panel, to include a specific effective date

Harvard Pilgrim will assist providers in providing communication to Members with disabilities or language services. Please contact Harvard Pilgrim Provider Services to arrange services for the deaf, blind, or those who need a language interpreter.

Provider Participating with Telemedicine

If Harvard Pilgrim Stride[SM] (HMO) and Stride[SM] of New Hampshire (HMO) has approved a provider to provide telemedicine services to its members, the provider is required to have protocols in place to prevent fraud waste and abuse. The provider must implement telemedicine fraud waste and abuse protocols that address the following:

- Authentication and authorization of users
- Authentication of the origin of the information
- The prevention of unauthorized access to the system or information
- System security, including the integrity of information that is collected, program integrity and system integrity
- Maintenance of documentation about system and information usage

Provider Information Changes

Prior notice is required for any of the following changes:

- Tax identification number
- Group name or affiliation
- Physical or billing address
- Telephone or facsimile number

Minimum Requirements

- Maintain medical records for at least 10 years from the date of service unless a longer time period is required
- Store medical records in a secure location using an efficient tracking process for ease of retrieval
- Show either a patient name or ID on each page
- Ensure medical records are dated, legible and signed
- Maintain current problem lists
- Prominently display allergies/adverse reactions
- Prominently note current medications and dosage
- Describe recommended immunizations and preventive health care
- Include initials and date that the primary care provider received and reviewed a consultation report and labs/radiology results
- Include a statement as to whether the member executed an advance directive

Medical Record Keeping Practices

The patient medical record serves as legal documentation of services received and allows for evaluation of continuity and coordination of care. Harvard Pilgrim requires providers to maintain timely and accurate medical, financial and administrative records related to services rendered to Harvard Pilgrim Medicare Advantage members. Providers are responsible for keeping medical records for a period of no less than 10 years.

Confidential Member Information & Release of Medical Records

All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with the HIPAA Privacy and Security Rules established on April 14, 2003. All providers practice personnel must be trained on privacy and security rules. The Practice should ensure that there is a Privacy Officer on staff, that a policy and procedure is in place for confidentiality of member‘s protected health information and that the practice is following procedure or obtaining appropriate authorization from members to release protected health information.

All members have a right to confidentiality. Any health care professional or person who directly or indirectly handles the member or his/her medical record must honor this right. Every practice is required to post their Notice of Privacy Practice in the office or provide a copy to members.

Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Confidential Information includes:

- Any communication between a member and a provider
- Any communication with other clinical persons involved in the member‘s health, medical and mental care

Included in this category are:

- All clinical data, i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number, etc.
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem

- Any communicable disease (such as AIDS) or HIV testing protected under federal or state law

When a member enrolls in the Plan, his/her signature on the enrollment form automatically gives the health care provider permission to release his/her medical record to the Plan, other providers in the Plan network who are directly involved with the member's treatment plan and agencies conducting regulatory or accreditation reviews.

Before any individual not working for the Plan can gain access to the member's medical record, written authorization must be obtained from the member, member's guardian or his/her legally authorized representative (except when there is a statute governing access to the record, a subpoena or a court order involved). Disclosures without authorization or consent may include, but are not limited to armed services personnel, attorneys, law enforcement officers, relatives, third party payers, and public health officials.

Written Policies

Each provider must have policies and procedures as indicated here:

Policy Required	Recommendations
Advance Directives	• Make information available • Document discussion in medical record • Keep copies • Notify hospital upon admission • Harvard Pilgrim network providers must document in a prominent place in medical record if individual has executed an advance directive [422.128(b) (1) (ii) (E)]
Communicable Disease Reporting	• Report communicable diseases as required by the State Health Department • Report within one day • Define reporting responsibilities • Address completion and submission of forms
Confidentiality and Security of Medical Records	• Have confidentiality policy for handling health information and medical records that meets state and federal requirements, including release of information • Review the confidentiality policy and procedures with staff at least annually • Ensure timely access for members to their records and information
Foreign Language Translation and Services for the Hearing Impaired	• Provide assistance for both situations • Make available an interpreter for phone calls and face-to-face interactions • Notify member and his or her family that you provide an interpreter • Identify resources
Medical Emergency	• Have mechanism in place for responding. • Identify medical emergency code. • Identify who directs activities. • Identify who determines if you call 911.
Medication Management	• Have mechanism in place for procuring, storing, controlling and distributing medications. • Address narcotics, even if to note they are not kept on site. • Address recalls. • Address emergency and sample drugs. • Explain sign-out log. • Address prescription pad accessibility.
Communication	Develop, implement and sustain an efficient communication protocol between primary care provider and medical specialists, including behavioral health specialists, to ensure effective coordination of care.

PUBLICATION HISTORY

10/15/13	original documentation
12/15/14	reviewed; no changes
01/01/16	updated referral/authorization table
01/25/16	added the *universal home health services prior authorization form* link and fax info to referral/authorization table
02/26/16	updated the authorization submission information to inpatient rehabilitation facilities and skilled nursing facilities
10/15/16	updated prior authorization and referral chart
05/03/17	removed electronic discharge submission information
06/25/19	removed referral and authorization information and placed into separate documents
09/17/21	removed RN-24/7 section
01/01/23	reviewed; administrative edits
01/01/24	updated timeliness requirements section to align with CMS Final Rule 2024