CORPORATE POLICY & PROCEDURE

	Policy Name: Network Adequacy
Department: Provider Network	Policy Number: PN7
Version: 5	Creation Date: 1/15/2018
Revised Date: 6/28/18, 7/15/19, 10/2/19, 6/9/21	Review Date:
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☒ Umpqua Health Network
Signature: Approved By: Michael A. von Arx, Chief Administrative Officer	Date: 6/23/2021

POLICY STATEMENT

Umpqua Health Alliance (UHA) and Umpqua Health Network (UHN) are committed to members receiving adequate access to care. UHA maintains and monitors a network of participating providers that is supported with written agreements and has sufficient capacity and expertise to provide adequate, timely, geographic, and medically appropriate access to covered services as required by the Coordinated Care Organization (CCO) Contract, 42 Code of Federal Regulation (CFR) §§ 438.68 and 457.1230, Oregon Administrative Rules (OAR) 410-141-3515 , Oregon Revised Statute (ORS) 414.609 and other applicable law, to members across the age span from child to older adult, including full benefit dual eligible (FBDE) members.

PURPOSE

This policy outlines UHA's approach in defining and identifying its network adequacy and network needs to which all UHA providers shall adhere. UHA reviews network adequacy monthly during the Network Performance Committee.

RESPONSIBILITY

Provider Network

DEFINITIONS

Contracted Hospital: Under Exhibit G of the CCO Contract this term means a hospital that is a subcontractor.

Contract Year: The twelve-month period during the term that commences on January 1 and runs up to and through the end of the day on December 31 on each calendar year.

Fully Dual Eligible or Full Benefit Dual Eligible (FBDE): For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the OHA for full medical assistance coverage.
I/DD: Intellectual Disability as defined in OAR 411-320-0020(21) and/or Developmental Disability as defined in OAR 411-320-0020(11).

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

Non-Contracted Hospital: Under Exhibit G of the CCO Contract this term means a hospital that is not a subcontractor.

PROCEDURES

General

1. UHA will anticipate access needs in its provider network and will employ or subcontract, as required under 42 Code of Federal Regulation (CFR) 438.206 and under CCO Contract Exhibit B, Part 4 and any other applicable provisions of the CCO Contract, enough providers to meet the needs of UHA's members in all categories of service, and types of service providers, such that members have timely and appropriate access to services.
2. UHA ensures all UHA members receive the right care at the right time and place, using a patient-centered, trauma informed approach in accordance with the Oregon Administrative Rules (OAR) 309-019-0135 and 410-141-3515, CFRs and Coordinated Care Organization Contract (CCO) Contract.
3. UHA shall make covered services available 24 hours a day, seven (7) days a week, when medically appropriate per CCO Contract.
4. Provider Network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.
5. UHA prioritizes timely access to care for prioritized populations per OAR 410-141-3515 and as outlined in PN8 - Monitoring Network Availability and PN9 - Monitoring Network Access.
6. If necessary, UHA may contract with providers located outside of its defined service area to ensure access to an adequate provider network.
7. UHA utilizes a multi-faceted approach to evaluate its network adequacy.
8. Specifically, UHA uses the following means to assess its network:
    a. Provider availability requirements.
    b. Time and distance standards.
    c. Member-to-Primary Care Provider (PCP) ratio.
    d. Grievance analysis.
    e. Special requests and accommodations.
    f. Utilization trends.
    g. Requests for out-of-network services.
    h. Requests for second opinions.
    i. Community Needs Assessment.

j. Consumer Assessment of Health Care Providers and System (CAHPS) access to care and satisfaction survey results.

9. UHA will assess its network adequacy at least quarterly, and the results will be utilized to help guide its Provider Network Department of the network needs (42 CFR § 438.206).

Monitoring Overview

1. UHA will monitor its provider network capacity based on at a minimum, the following factors:
    a. Anticipated Medicaid enrollment and anticipated enrollment of full benefit dual eligible (FBDE) individuals;
    b. An appropriate range of preventative and specialty services for the population enrolled or expected to be enrolled in the service area;
    c. The expected utilization of services, also taking into consideration the physical, oral, and behavioral health care needs of members;
    d. The number and types (in terms of training, experience, and specialization) of providers required to provide services under its CCO Contract;
    e. There are, in accordance with 42 Code of Federal Regulations (CFR) § 438.14(b)(1), a sufficient number of Indian health care provider (IHCP) participating providers to ensure all eligible American Indian/Alaskan Native (AI/AN) members receive, from such IHCPs, timely access to all of the services required to be provided under its CCO Contract;
    f. The geographical location of participating providers and members considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities;
    g. Data collected from UHA's grievance and appeal system;
    h. Data collected from UHA's monitoring of wait time to appointment;
    i. Any deficiencies in network adequacy or access to services identified through the course of self-audit, reviews conducted by the Oregon Health Authority's (OHA) External Quality Review Organization (EQRO), monitoring conducted by OHA, or audits conducted by any other State or Federal agency;
    j. The provider network is sufficient in number and areas of practice and geographically distributed in a manner that the covered services provided in its CCO Contract are reasonably accessible to members, as stated in ORS 414.609;
    k. The number of providers who are not accepting new members; and
    l. The number of members assigned to patient-centered primary care homes (PCPCH).

Delivery System Network (DSN) Provider Monitoring and Reporting Requirements

1. UHA will provide OHA with a quarterly DSN provider report no later than 30 days following the end of each calendar quarter. In addition, UHA shall update such reports

any time there has been a change in UHA's provider network including terminating a provider or upon expiration of a provider agreement, and at OHA request. UHA will utilize the DSN Provider Capacity and Narrative Report template located on CCO Contract Forms Website to create such quarterly report, which, once completed will be provided to OHA via Administrative Notice (see PN12 - Delivery Service Network Workflow).

a. All of UHA's providers shall be included in the DSN Provide Report. Notwithstanding the foregoing, in order to include a provider and contracted facilities in its quarterly DSN provider, such provider whether employed subcontracted, shall have agreed to provide services to both Medicaid and fully dual eligible members.
b. Providers listed in DSN Provider Report will be categorized by provider taxonomy code.
c. For PCPCH, information should include the certification tier and the number of members assigned to the network participating as PCPCH.

Provider Availability Requirements

1. UHA's following providers shall meet the availability requirements as outlined in the CCO Contract and UHA's policy PN8 - Monitoring Network Availability policy (see policy PN8 – Monitoring Network Availability for requirements):
    a. PCPs.
    b. Specialists.
    c. Dental and Oral Health Care Providers.
    d. Behavioral Health Providers.
    e. Non-Emergency Medical Transportation (NEMT).

Time and Distance Standards

1. UHA shall ensure that its network is meeting the following time and distance access standards, as outlined in UHA's PN9 - Monitoring Network Access policy.
    a. PCPs are required to meet the following time and distance standards.
        i. Average travel time for member to PCP: 30 minutes urban/60 minutes rural (OAR 410-141-3515(7); or
        ii. Average distance for member to PCP: 30 miles urban/60 miles rural (OAR 410-141-3515(7).
    b. Specialists are required to meet the following time and distance standards, in accordance with OAR 410-141-3515(7).
        i. Dental and oral care – within 60 minutes or 60 miles of member.
        ii. Endocrinology – within 60 minutes or 60 miles of member.
        iii. Gynecology (OB/GYN) – within 60 minutes or 60 miles of member.
        iv. Infectious diseases – within 60 minutes or 60 miles of member.

v. Oncology (medical/surgical) – within 60 minutes or 60 miles of member.
vi. Oncology (radiation/radiology) – within 60 minutes or 60 miles of member.
vii. Mental health – within 60 minutes or 60 miles of member.
viii. Pediatrics – within 60 minutes or 60 miles of member.
ix. Cardiology – within 60 minutes or 60 miles of member.
x. Rheumatology – within 60 minutes or 60 miles of member.
xi. Hospitals - within 60 minutes or 60 miles of member.
xii. Outpatient dialysis – within 60 minutes or 60 miles of member.
xiii. Inpatient psychiatric facility services – within 60 minutes or 60 miles of member.

Member-to-PCP Ratio

1. UHA shall ensure that its network is meeting the following member-to-PCP ratio, which has been determined based on the information supplied in the Office of Inspector General report on State Standards for Access to Care in Medicaid Managed Care. Generally speaking, UHA utilizes the following guidelines when assessing member-to-PCP ratio:
    a. UHA's member-to-PCP ratio shall not exceed 1,500 members per PCP.
    b. No clinic shall have greater than 1,500 members per PCP.

Grievance Analysis

1. UHA shall review all member grievances that relate to access and availability using the following process:
    a. When a grievance is received, it shall be categorized based on grievance type. The following are the grievance categories for access:
        i. Provider's office is unresponsive, not available, difficult to contact for appointment or information.
        ii. Plan unresponsive, not available, difficult to contact for appointment or information.
        iii. Provider's office is too far away, not convenient.
        iv. Unable to schedule appointment in a timely manner.
        v. Unable to be seen in a timely manner for urgent/emergent care.
        vi. Provider's office closed to new patients.
        vii. Referral or second opinion denied/refused by provider.
        viii. Referral or second opinion denied/refused by plan.
        ix. Provider not available to give necessary care.
        x. Eligibility issues.
        xi. Female or male provider preferred, but not available.
        xii. Non-emergent medical transportation (NEMT) not provided, late pick up with missed appointment, no coordination of services.

xiii. Dismissed by provider as a result of past due billing issues.
xiv. Dismissed by clinic as a result of past due billing issues.

b. The number of grievances for each category shall be aggregated by quarter.
c. The grievances shall be reviewed for trends.
    i. Individually, each category shall be reviewed for trends, such as decreases or increases in the number of that grievance or grievances originating from a particular provider, specialty, or office.
    ii. The total number of grievances in aggregate shall be reviewed for trends, such as increases or decreases in the number of grievances or similar grievances, or grievances originating from a particular provider, specialty, or office.

Special Requests and Accommodations

1. UHA shall review all member special requests and accommodations that relate to access and availability using the following process:
    a. UHA's Customer Care Department shall maintain a log of alternate format materials (MS5 – Requests for Interpreter or Alternative Format). Clinical Engagement also assists in special requests and accommodations related to a disability or interpretation services.
    b. The alternate format log shall be reviewed for any requests related to special requests and accommodations, including, but not limited to, those for Braille, large print, audiotape, oral presentation, and electronic format and telephone interpretation service to callers with Limited English Proficiency (LEP).
    c. The interpretation requests received by Clinical Engagement shall also be reviewed.
    d. The alternate format log and interpretation requests shall be reviewed for trends, including, but not limited to, the following:
        i. A high number of requests for a provider that speaks a particular language.
        ii. A high number of requests for a service or accommodation that cannot be serviced or accommodated locally.

Hospital Network Adequacy

1. UHA shall develop and maintain an adequate hospital network for a full range of services to sufficiently meet the needs of UHA's members.
    a. UHA monitors contracted hospitals and non-contracted hospitals.
    b. UHA will report on hospital admissions and paid amounts at contracted hospitals and hospital admissions at non-contracted hospitals.
    c. The Hospital Adequacy Report will also include UHA's total outpatient costs at both contracted and non-contracted hospitals.

d. UHA will report on the following standards in Key Performance Indicators (KPI) reported to the Compliance Department at least quarterly:
    i. A minimum of 90% of UHA's total inpatient admissions, excluding all outpatient services with contracted hospitals; and
    ii. A minimum of 90% of UHA's total dollars paid for all outpatient services, excluding amounts paid for inpatient admissions for all contracted hospitals.
    iii. If the standards are not adequately met, the Compliance Department will determine the reasoning and if necessarily, will issue a corrective action plan (CO21- External Risk Response) until the required thresholds are met.
    iv. In instances where the percentage of non-contracted hospital services are below the benchmarks or the OHA's review of UHA's annual report of hospital admission by diagnosis related groups (DRG) indicates UHA's hospital network is not adequate, OHA will determine if UHA has made good faith effort to contract with the appropriate hospital(s) and OHA may modify the benchmark calculation, if necessary. The determination of good faith is based of CCO Contract Exhibit G(5)(b)fbde(2).

e. UHA shall monitor, document and provide a Hospital Adequacy Report to OHA using the Hospital Adequacy Report Template located on the CCO Contract Forms website.
    i. The Hospital Adequacy Report shall be provided to OHA via administrative notice by March 31 of each Contract Year which reflect the monitoring and documentation undertaken in the previous contract year.

Utilization Trends

1. UHA's Utilization Management Committee shall review utilization for trends that indicate access and availability issues. UHA's utilization analysis may include, but is not limited to, the following:
    a. Utilization by specialty.
    b. Utilization by office.
    c. Utilization by provider.
    d. Expected utilization versus actual utilization.
    e. Anticipated enrollment.

Requests for Out-of-Network Services

1. UHA shall review referrals for out-of-network referrals by provider type.
    a. Referral requests for each provider type shall be aggregated and reviewed.

Requests for Second Opinions

1. UHA shall review the number of requests for out-of-network second opinions.
    a. Requests for each provider type shall be aggregated and reviewed.

Community Needs Assessment

1. UHA shall review its Community Health Improvement Plan, Community Health Assessment and Transformation and Quality Strategy for trends and issues related to access and availability to ensure UHA's provider network is capable of providing integrated and coordinated physical, oral health, behavioral health, and substance use disorders treatment services and supports as required under the CCO Contract

CAHPS Access to Care and Satisfaction Survey Results

1. For 2016, two (2) of the OHA CCO Incentive Metrics were directly related to access and availability that were a part of the CAHPS survey. Those two (2) metrics were CAHPS Composite – Access to Care and CAHPS Composite – Satisfaction with Care. OHA established a pass/fail benchmark for UHA.
2. UHA shall review the results of the two (2) CCO Incentive Metrics and compare them with the benchmark established by OHA to provide a broad picture of access as a whole.

Network Adequacy Study

1. UHA shall perform a Network Adequacy Study at least annually based on the information ascertained from reviewing the above.
2. UHA's Network Adequacy Study shall include a summary of recommendations and observations based on the results of the network analysis, which may include, but is not limited to, the following:
    a. No action be taken.
    b. Areas of improvement such as processes for assessing the network.
    c. Recruiting or contracting priorities.

Network Adequacy and/or Access to Services Deficiencies

1. UHA shall monitor for deficiencies through the Network Adequacy Study and in compliance with the OAR 410-141-3515 under this policy by using geomapping to identity potential gaps in the network. Key Performance Indicators (KPI's) are implemented to monitor UHA's approach in defining and identifying its network adequacy and network needs to which all UHA providers shall adhere. UHA sends out Access to Care Surveys requesting our providers to respond documenting the average wait times for new and routine appointment. The providers shall also verify if they screen for new patients, differentiate appointment scheduling based on the type of insurance, have call coverage for nights, weekends or vacations and 24-hour phone instructions or an answering service to direct patients to call 911 or go to the emergency room. UHA identifies utilization trends to make timely informed decisions.

a. UHA will encourage its current providers to identify barriers to access.
b. UHA identifies areas for remediation and recommends improvement strategies.
    i. UHA may request technical support from OHA to assist with its efforts.
c. These actions include care coordination and establishing contracting outside of UHA's service area.

Behavioral Health Dashboard Monitoring

1. This dashboard is used to monitor UHA's network in order to assess availability in the following categories:
    a. Community Mental Health Programs (CMHP) or licensed behavior health treatment program under OAR 309-008-0100.
    b. Primary Care Integration.
    c. Prescribing Capabilities.
    d. Niche/Specialized Provider.
    e. Generalized Services.
2. The dashboard is updated quarterly by the Provider Network Department for all behavioral health providers.
3. If UHA lacks provider capacity to provide Wraparound, UHA shall notify OHA and develop a plan to increase provider capacity.
    a. Lack of capacity may not be a basis to allow members who are eligible for Wraparound supports to be placed on a waitlist.
    b. No member on a waitlist for Wraparound may be without such services for more than 14 days.

Assertive Community Treatment

1. UHA will ensure network adequacy in contracting with the following specific provider types (OAR 410-141-3515(17):
    a. Providers of residential chemical dependency treatment services and notify the OHA within 30 days of executing new contracts.
    b. Any dental care organizations necessary to provide adequate access to oral services in the area where members reside.
2. UHA will assess the needs of its membership and make available supported assertive community treatment services when members are referred and eligible (OAR 410-141-3515(18).
    a. UHA shall report the number of individuals who receive supported assertive community treatment services, within five (5) business days of request by OHA. When no appropriate provider is available, UHA shall consult with the OHA and develop an approved plan to make supported assertive community treatment services available.

b. If 10 or more members in a CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive assertive community treatment for more than 30 days, CCOs shall take action to reduce the waitlist and serve those individuals by:
    i. Increasing team capacity to a size that is still consistent with fidelity standards; or
    ii. Adding additional assertive community treatment teams; or
    iii. When no appropriate assertive community treatment provider is available, UHA shall consult with the OHA and develop an approved plan to increase capacity and add additional teams.

Subcontractors Monitoring

1. For those services to which UHA has delegated to a subcontractor, the subcontractor shall comply with the requirements outlined in the CCO Contract and the access to care OARs:
    a. Primary care providers are required to meet the following access to care OARs:
        i. OAR 410-141-3515(11)(a)(A);
        ii. OAR 410-141-3515(11)(a)(B); and
        iii. OAR 410-141-3515(11)(a)(C).
    b. Specialist providers are required to meet the following access to care OARs:
        i. OAR 410-141-3515(11)(c)(A); and
        ii. OAR 410-141-3515(11)(c)(C).
    c. Oral care providers are required to meet the following access to care OARs:
        i. OAR 410-141-3515(11)(b)(A);
        ii. OAR 410-141-3515(11)(b)(B); and
        iii. OAR 410-141-3515(11)(b)(C).
    d. 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.
2. If any of the above access to care standards does not comply with OAR 410-141-3515 or as outlined within this policy, UHA shall proactively work to identify ways to assure either its network or a particular provider meet the availability standards.
    a. If the average wait 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.
        i. If there are no additional in-area providers of that specialty, the Provider Network Department shall work to contract with 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.
3. If any activities have been subcontracted, UHA will also describe its oversight and monitoring procedures to ensure compliance with the requirements of the CCO Contract

(CO10 - Evaluation of Subcontractor and CO35 – Subcontractor – General Requirement Standards).

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 to the CO21 – External Risk Response. The activities of a risk response will vary depending on the issue and severity.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
N/A	N/A	N/A	N/A	N/A