

<b>SUBJECT:</b>	Availability of Network Practitioners	<b>Policy No.</b>	
		<b>Reference:</b> S:\QI\Policies\QI Policies	
<b>BUSINESS OWNER:</b>	Quality Improvement	<b>Page 1 of 8</b>	
<b>APPROVED BY Accreditation Team:</b> Date: 12/6/2021		<b>EFFECTIVE:</b> 08/02/2004	
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Joshua Plavin, MD MPH, MBA Vice President and Chief Medical Officer, BCBSVT		<b>NEXT REVIEW DATE:</b> 12/2023	
		<b>APPLIES TO:</b> All Lines of Business	
<b>REGULATORY / ACCREDITATION LINKS:</b> 2022 HPA Standards and Guidelines/Elements: NET 1 State of Vermont Rule H 2009-03 Standards: 5.1(A) ; 6.3 (A)			

## I. DEFINITIONS

**Primary Care Practitioner (PCP):** A network practitioner whom members in managed care health plans may select to manage their care. Practitioners are eligible to be PCPs if they have a specialty in family practice, internal medicine, general practice, and pediatrics. In addition, certain naturopaths, geriatric specialists, nurse practitioners, physician assistants, and Advance Practice Registered Nurses (APRN) may carry patient panels as a PCP.

**Specialty Care Practitioner (SCP):** A network practitioner who is not considered a primary care practitioner.

**Mental Health Practitioner:** A network practitioner who has a specialty in psychiatry, psychology, clinical social work or mental health counseling.

**Substance Use Disorder Practitioner:** A network practitioner who has a specialty in psychiatry, psychology, clinical social work or substance use disorder counseling.

**Behavioral Health Practitioner:** A network practitioner who meets the definition of either a mental health or substance use disorder practitioner.

## II. POLICY

Blue Cross Blue Shield of Vermont (Blue Cross) ensures that:

- A) its networks have sufficient numbers and types of primary care, specialty care and behavioral health practitioners to ensure adequate geographic access, and;
- B) its networks meet the needs and preferences, including the linguistic and cultural needs and preferences, of the Blue Cross membership.

### ***A. Geographic Access***

**Network Availability Standards:** The Plan's standards for network availability are:

- Members have a choice of at least two age-appropriate PCPs, who are accepting new patients, within 30 minutes travel time.
- Among high-volume specialties, members have a choice of at least one network practitioner within 60 minutes travel time.

- Among high-impact specialties, members have a choice of at least one network practitioner within 60 minutes travel time.
- Among certain specialties, including cardiac catheterization laboratory, major trauma treatment, neonatal intensive care, and open-heart surgery, members have a choice of one network practitioner within 90 minutes travel time.
- Members have a choice of at least one mental health practitioner within 30 minutes travel time.
- Members have a choice of at least one substance use disorder practitioner within 30 minutes travel time.

**Performance Goals:** The Plan's performance goals for network availability are:

- At least 90 percent of the Plan's membership is within 30 minutes travel time from two age-appropriate network PCPs, and at least 80 percent of the membership is within 30 minutes travel time from two age-appropriate network PCPs who are accepting new patients. This is monitored by each specialty that is eligible to be a PCP and in the aggregate.
- At least 90 percent of the membership is within 60 minutes travel time from at least one practitioner from each of the specialties that have been selected for monitoring.
- At least 90 percent of the membership is within 90 minutes travel time from at least one practitioner that have been selected for monitoring for the following specialty services: cardiac catheterization laboratory, major trauma treatment, neonatal intensive care, and open heart surgery. (Rule H2009-03)
- At least 90 percent of the Plan's membership is within 30 minutes travel time from one mental health practitioner for each of the following categories: psychiatry, psychology-doctoral level, and master level clinical social work and other master level practitioners and all mental health practitioners in the aggregate.
- At least 90 percent of the Plan's membership is within 30 minutes travel time from one substance use disorder practitioner for each of the following categories: psychiatry, psychology-doctoral level, master level clinical social work and other master level practitioners, and all substance use disorder practitioners in the aggregate (Rule H-2009-03).

**Travel Time Specification:** When calculating member travel time to practitioners the following travel speed specifications must be used:

- Urban areas- 25 mph;
- Suburban areas- 40 mph;
- Rural areas- 50 mph.

**Reporting:** A separate report is required for each specialty requested and for each network. Each report should include rates for each Vermont county and an aggregate total for the entire state.

**Criteria for determining which specialties to monitor for geographic distribution:** Blue Cross monitors PCPs, high-volume specialties and high-impact specialties. Specialties that serve as PCPs will be monitored by specialty and as an aggregate. Family Practice will include general practice, naturopaths, APRN, nurse practitioners, physician assistants, and geriatrics due to relatively small number of providers in these other specialty categories.

Blue Cross considers obstetrics and gynecology (OB/GYN) a high-volume specialty and oncology/hematology a high-impact specialty. Annual monitoring will be conducted on OB/GYN and oncology/hematology practitioners. In addition, Blue Cross may choose to monitor and analyze additional practitioner specialties if network changes or other conditions warrant further network review.

**Frequency of geographic access analysis:** Blue Cross assesses its conformance to network geographic access standards at least once every twelve months.

## ***B. Number of Practitioners***

**Network Availability Standards:** Blue Cross' standards for adequate number of practitioners are:

- The number of age-appropriate PCPs that are accepting new patients equals a ratio of one for every 2,000 or less members.
- The number of high-volume specialists that have been selected for monitoring equals a ratio of one for every 2,500 or less members.
- The number of psychiatrists equals one for every 5,000 or less members.
- The number of psychologists-doctoral level equals one for every 1,500 or less members.
- The number of master of social work and other master level behavioral health practitioners equals one for every 1,500 or less members.

**Performance Goals:** Blue Cross' performance goals for the number of practitioners in the network are:

- At least one age-appropriate PCP that is accepting new patients per 2,000 members. This is monitored by each specialty that is eligible to be a PCP..
- At least one specialty practitioner of each high volume specialty that has been selected for monitoring per 2,500 members.
- At least one psychiatrist per 5,000 members.
- At least one psychologist-doctoral level per 1,500 members.
- At least one master of social work or other master level behavioral health practitioner per 1,500 members,

### ***C. Linguistic and Cultural Needs and Preferences***

**Criteria for action:** At least annually, Blue Cross analyzes data on member linguistic and cultural needs and preferences and makes changes in the network as needed. Blue Cross assesses potential member needs using information about the cultural, racial, ethnic, and linguistic characteristics of the population residing in the service area.

These needs are assessed through:

- CAHPS survey results on respondent race and ethnicity
- US Census data on resident language preference and race distribution for the Blue Cross service area
- Data on member linguistic needs based on customer service language translation requests
- Member expressed needs regarding practitioners who meet their ethnic, racial, cultural, or linguistic needs through analysis of member complaints and other available data

Practitioner network composition is assessed through:

- Reporting of race and ethnicity data reported through CAQH
- Reported practitioner languages spoken data

**Threshold for action on linguistic needs of Plan membership:** Blue Cross will take appropriate action when membership or US census data for Vermont shows five percent or more of the population speaks a single language other than English.

### **Frequency of linguistic and cultural needs and preferences**

**analysis:** The Plan assesses its conformance to network adequacy standards at least annually.

### III. PROCEDURES

#### ***A. Monitoring Geographic Distribution***

1. Each year the quality improvement department (QI) will use internal reporting to identify the specific network practitioners to include in the network availability analysis. Separate member level reports are used to identify member's ages and zip codes to facilitate Geoaccess reporting. Geoaccess software programs are used to monitor geographic adequacy of the network. Geoaccess provides reports of average travel time for members to see a PCP, specialist and behavioral health practitioner. The QI department requests Geoaccess reports from the Blue Cross and Blue Shield Association (BCBSA) for each identified specialty and for PCPs. The timing of these reports should coincide with the required reporting for the annual Rule H 2009-03 data submission.
2. The QI department uses the Geoaccess reports to compare the network practitioner availability results against the performance goals. Also reported is the number of practitioners with closed panels (accepting only existing patients) as a percentage of all PCPs. The results are reported in the *Practitioner Availability Analysis* to the Quality Council. If additional research is necessary, a workgroup may be convened to conduct further preliminary analysis to identify factors contributing to not meeting the goals. This research should include further analysis of other practitioners in the area to determine if there are practitioners that are not currently within our networks. The workgroup identifies corrective actions to bring the performance up to standard.
3. The results, analysis and corrective actions are documented in the QI Program Evaluation on an annual basis.

#### ***B. Monitoring the Number of Practitioners***

1. Each year the QI department will use the same reporting described above to monitor the number of network practitioners.
2. The QI department will analyze the data to produce ratios of the number of providers per member for each of the monitored specialties. The ratio of providers to members will be compared to the standards and performance goals described above. The results are reported in the *Practitioner Availability Analysis* to the Quality Council.
3. If additional research is necessary a workgroup may be convened to conduct further analysis to identify factors contributing to not meeting the goals. The research should include further analysis of other practitioners in the state to

determine if there are practitioners that are not currently within our networks. The workgroup identifies corrective actions to bring the performance up to standards.

4. The results, analysis and corrective actions are documented in the QI Program Evaluation on an annual basis.

### ***C. Monitoring Linguistic and Cultural Characteristics***

1. Each year, the QI department uses U.S. census data to gather available demographic data about the cultural, racial, linguistic, and ethnic composition of membership.
2. Each year, the QI department gathers and analyzes practitioner data regarding:
  - a. Languages spoken other than English
  - b. Practitioner ethnic distribution
  - c. Open practitioner panel compared to member demographics
3. Complete tables 1, 2, 3, 4 and 6 in the *Practitioner Availability Analysis* based on US Census data, CAHPS data and religious composition data from Pew Research Center.
4. Identify gaps between member cultural, ethnic, racial, and linguistic needs and network capability to address member cultural needs.
5. Summarize the results and corrective actions in the *Practitioner Availability Analysis*. The completed *Practitioner Availability Summary* is presented to the Quality Council as described in step 2 of the Monitoring Geographic Distribution procedure above.

## **IV. BIENNIAL REVIEW**

This policy and procedure will be reviewed by Accreditation Team and updated every 24 months to ensure that it is consistent with current business practice and to incorporate the latest regulatory and accreditation standards.

## **V. DEPARTMENT OF FINANCIAL REGULATION FILING**

The Plan submits physician availability reports to the Department of Financial Regulation (DFR) as part of the annual filing required by Vermont Rule H 2009-03.