COLORADO
Department of Health Care Policy & Financing

Network Adequacy Plan
Instructions and Narrative Report

RAE Name	**Health Colorado, Inc.**
RAE Region #	**4**
Reporting Period	[SFY20-21 07/01/2021 – 06/30/2022]
Date Submitted	**July 30, 2021**
Date Resubmitted	**September 8, 2021**
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Instructions: The RAE's Annual **Network Adequacy Plan** should be submitted (on or by July 31 each year) to the Department via MoveIT, be no more than 10 pages in length, and include for both its PCMP and Behavioral Health Network, how the RAE will:

- Maintain and monitor a network of appropriate providers supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract for Members across all ages, levels of ability, gender and cultural identities, including those with limited English proficiency, that includes:
  - Adult and pediatric primary care providers;
  - OB/GYNs;
  - Adult and pediatric mental health providers;
  - Substance use disorder providers;
  - Psychiatrists;
  - Child psychiatrists;
  - Psychiatric prescribers; and
  - Family planning providers.
- Ensure accurate provider information is available to members.
- Make available to Members accurate and timely provider information including:
  - Name, address, telephone, email and website;
  - Ability to provide physical access, reasonable accommodations, and accessible equipment;
  - Capacity to accept new Medicaid Members;
  - Cultural and language expertise (including ASL); and
  - After-hours and weekend appointment availability.
- Calculate and monitor Network Provider counts, time/distance results, ratios, timeliness standards or other access to care metrics including the geographic location of providers in relationship to where Medicaid Members live. (Please describe the software package(s) and/or processes that your MCE uses.)
- Determine the number of behavioral health providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region.
- Ensure its network of providers and other health neighborhood and community resources meet the needs of the Member population in the Contractor's Region.

Network Adequacy Plan Narrative

Provider networks are key to delivering the right balance of quality, accessibility, and control of cost. The objective of Health Colorado, Inc. (HCI) is to develop and support a comprehensive network of providers to deliver high quality services to address the health needs of members in the communities we serve. HCI continuously monitors both primary care medical providers (PCMPs) and behavioral health (BH) provider networks to ensure that services provided are inclusive of member age, levels of ability, gender identities, and cultural identities, including those with limited English proficiency. We seek to recruit and expand relationships with providers who have demonstrated experience providing care using a patient-centered medical home model, cultural background, licensure level, and meet criteria for participation in the network. The 2020 pandemic forced the expansion of all telehealth services and HCI intends to continue to focus on the advancement of telehealth services to support and fill gaps within the continuum of care.

Fiscal Year 2021 Goals:

1- HCI's goal for FY 2021 was to meet the time/distance standards for both physical health and behavioral health networks by provider type across all counties within the region one hundred percent (100%) of the time.

HCI monitored primary care and behavioral health networks on a quarterly basis through its GeoAccess analysis to measure time and distance standards at each county within the region. HCI consistently meets this goal in areas with established practices eligible to join the network.

For behavioral health, HCI consistently met most access to care standards for members residing within rural and frontier counties in the region during the fiscal year. The exception was treatment providers for Substance Use Disorder (SUD) outpatient services, as well as SUD inpatient and residential services. Furthermore, psychiatric units in acute care facilities within standard distance and ratio are limited for all RAE 4 rural and frontier counties. Within urban counties, the majority of members (more than eighty percent, 80%) meet access. However, in rural and frontier counties there is no facility within the time and distance. Given the rural and frontier nature of RAE 4, members may seek treatment outside of RAE 4 region for services such as Medication-Assisted Treatment (MAT), residential care, and SUD Intensive Outpatient (IOP).

For PCMPs, HCI contracted with five (5) new PCMP practices during the fiscal year. HCI contracted with three (3) PCMPs located in Pueblo County in the last two quarters. The providers are SOCO Primary Care Clinic, Steel City Pediatrics, and Comfort Care Family Practice. Additionally, HCI contracted with San Luis Valley Behavioral Health Group (SLVBHG) in Alamosa County that opened a PCMP location in early 2021. Furthermore, HCI contracted with Summit Primary Care (SPC) in Pueblo. HCI expects SPC will complete affiliation into the network in August 2021. The success of the recruitment of additional providers is a result of HCI review of the Enrollment Summary Report and community partners referrals.

Despite this increase in PCMPs in Pueblo County, HCI's coverage in this county remained at ninety-nine (99%) percent of standards. Since the majority of the practitioners are in the city of Pueblo, Health First Colorado (formerly Medicaid) members residing on the southern border of the county (which would

more accurately define as a rural community than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are no available PCMPs to meet the requirement. As a result, one (1%) percent of HCI members residing in Pueblo County do not have two (2) providers within the time and distance standard.

HCI was challenged in reaching the one hundred (100%) percent goal by the limited number of providers who have chosen to practice in the rural and frontier areas. RAE 4 is comprised of one (1) urban county and nine (9) rural and nine (9) frontier counties. HCI conducted a review of behavioral health providers within the region under Department of Regulatory Agency (DORA) Registry, as well as a review of the MCO Affiliate Reports, and a survey to all Department of Human Services Directors to identify regional CORE providers with behavioral health licensures. The analysis showed the limited availability of independent practitioners in the region:

- The majority ninety (90%) percent of the providers identified through this process are part of Community Mental Health Centers (CMHCs) and are already in the network.
- No additional SUD providers were found for recruitment in counties of need. HCI has contracts or is contracting with existing SUD providers. There is a need for expansion and to focus on start-up programs. Any "brick and mortar" approach will likely be cost prohibitive for the providers, themselves.
- Some providers identified provided Applied Behavior Analysis (ABA) services, which is not a RAE covered service. Therefore, we are evaluating coverage potential and will work with Health Care Policy and Financing (HCPF) to address this issue for whole health needs.
- Obstetricians and Gynecologists in HCI's counties generally do not perform primary care services including those that are part of contracted organizations. The PCMPs refer to obstetricians and gynecologists as a specialty, not as part of primary care. Therefore, the primary care network does not reflect these practitioners within the region.

2- HCI's goal in FY 2021 was to increase the percentage of primary care and behavioral health providers within the region that meet the appointment availability standards for new and existing members by ten (10%) percent by the end of the fiscal year.

The audits conducted for PCMP locations in the first quarter versus the fourth quarter of fiscal year 2021, HCI achieved an overall improvement:

Metric	First Quarter	Fourth Quarter	Goal Status
Availability within standards for a new Medicaid member	45%	74%	Met
Availability within standards for an established Medicaid member	45%	91%	Met
Offered same day appointments	45%	100%	Met
Met all the standards	45%	70%	Met

The HCI behavioral health network found an overall reduction in the appointment availability standards from first to fourth quarter auditing:

Metric	First Quarter	Fourth Quarter	Goals Status
Availability within standards for a new Medicaid member	24%	21%	Not Met

Availability within standards for an established Medicaid member	32%	24%	Not Met
Met all the standards	24%	21%	Not Met

Providers reported throughout the year reduced capacity and full caseloads due to high demand and members continuing to engage in services. HCI is outreaching and reviewing with providers expectations of availability of appointments and expectations for providers audited the fourth quarter in an effort to improve in the new fiscal year. HCI has been conscientious in outreach, unfortunately, some of the full caseloads are due to limited space and face-to-face capacity within offices and the comfortability and willingness for members to attend appointments with individuals based on who is or is not vaccinated.

3- HCI's goal in FY 2021 was to increase the number of primary care and behavioral health providers that use telehealth services by 10% by the end of the fiscal year.

HCI exceeded its goal to increase telehealth services available within its PCMP and BH provider networks. At the beginning of the fiscal year, twenty-one (21) PCMP practices reported offering telehealth services, a total of one hundred and two (102) PCMP practice locations offered telehealth services in some capacity. Almost a four hundred (386%) percent increase in telehealth services available for members. Similarly, HCI experienced a steady increase in the reporting of telehealth services for BH care. At the end of the fiscal year, sixty-four (64) providers reported offering telehealth services. This is a two hundred and twenty (220%) percent increase of BH providers offering these services from the twenty (20) providers reported in the first quarter report.

In addition to the fiscal year 2021 goals reported above, HCI developed the provider network for the new SUD benefit implemented on January 1, 2021. HCI developed a statewide network of twenty-four (24) contracted providers with sixty-six (66) service locations across all licensure levels except ASAM level 3.3 due to the limited licensed facilities. Of the contracted providers, sixteen (16) providers with thirty (30) service locations completed credentialing within the fiscal year. Network staff are supporting contracted facilities to complete Health First Colorado enrollment and credentialing applications. Facilities are: Mental Health Partners, Sobriety House, Valley Hope Association, Regents of the University Colorado (ARTS), Mile High Behavioral Health Care, Peak View Behavioral Health, Denver Health Hospital Authority, and Community Reach Center. An additional four (4) providers (CeDAR, Northpointe Colorado, SummitStone Health Partners, and West Pines Behavioral Health) are currently negotiating contracts. HCI will continue to monitor utilization, network access, and provider Medicaid enrollment to determine the need to recruit additional SUD providers into the network.

Although HCI was not able to make a true twelve (12) month network comparison due to Network Adequacy Reporting requirement changes, the above listed successes demonstrate HCI has a tailored network largely composed of specialty providers located in areas where members request services. HCI will continue to monitor and enhance the network to ensure members have a full continuum of care by seeking additional opportunities to contract with providers for network development.

Behavioral Health Network Expansion

HCI has an existing statewide network of BH providers that complies with the network time and distance standards for all ages, levels of ability, gender identities, and cultural identities, including those with limited English proficiency. The network includes contracts and relationships with essential community providers including CMHCs, Federally Qualified Healthcare Centers (FQHCs), school-based health

centers, Rural Health Centers (RHCs), and community safety-net clinics, to include those that are staffed with providers that offer adult and pediatric mental health and psychiatry, SUD facilities, and psychiatric prescribers. HCI's network also includes private/non-profit providers and SUD providers in the region. HCI actively recruits providers to join the RAE 4 network to ensure adequacy and access without barriers.

To meet the needs of Health First Colorado members the funding available to support efforts are an integral and limiting factor of the FY2022 plan. HCI has utilization and membership eligibility has increased significantly in the last fiscal year. HCI must ensure Medicaid funds are used wisely and targeted in areas that truly have enough demand to be financially sustainable to expand services. Value-based payment alternatives will be considered to assess increased demand as a strategy to incentivize quality providers to offer services in the region or expand the current footprint to better meet member needs. To the extent that SUD services are expanded and demonstrate that these services save costs by providing care in lieu of hospitalization, but that are not accounted for administratively in the SUD risk corridor established for inpatient and residential care, the available funding will be limited.

HCI's Network expansion priorities for fiscal year 2022 are as follows:

1. Increase in-region partnerships to enhance services and improve care coordination for members with Intellectual and Developmental Disabilities (IDD), children in the child welfare system, members involved in the justice system, and those that are unstable for housing.
2. Expand integration for behavioral health and physical health services.
3. Enhance cultural competency and peer specialist services to improve access for special populations.
4. Expand and sustain telehealth access throughout the region for specialty services and members located in rural and frontier areas.
5. Expand intensive behavioral health to include Assertive Community Treatment (ACT), IOP, and MAT services.

HCI plans to build on network development strategies used in previous years, such as monitoring, State provider rosters, as well as utilization and single case agreement (SCA) data. HCI will enhance efforts including but not limited to:

1. Collaborate with providers and community partners to ensure health equity and the integration of services including physical health, behavioral health, and support services as well as the engagement of these members in care plans and extended care coordination. This will include County Department of Human Services (DHS) and Department of Corrections (DOC).
2. Offer training opportunities for staff to build cultural competency and develop peer specialist resources in partnership with subject matter experts.
3. Enhance specialty care relationships through meaningful and measurable care compacts with specialists, leveraging e-consults, and telemedicine. HCI will continue to work on enhancing hospital relationships to address transitional care and enhance care coordination efforts, and further enhance community partnerships to address social determinants of health.
4. Evaluate telehealth utilization based on geographic and specialties to support expansion and sustainability of quality telehealth services, intended to increase access, particularly IOP, and provide additional member choices in rural and frontier areas.
5. Explore local resources for respite models as an alternative to inpatient or residential services for short-term interventions.

HCI will continue to evaluate the regional network through utilization data and geographic mapping to identify where access could be expanded by adding providers, enhancing benefits, or expanding current provider services, and addressing gaps in care that may be narrowed, resulting in demonstrable higher quality of care. These evaluations also consider whether there is enough patient demand to make expanding access for certain services feasible.

All recruitment and contracting activities will be closely monitored to track progress towards network development and to provide early detection of any barriers to contract for these services. This will ensure HCI's BH network has the range of services available for RAE 4 members. HCI will measure the progress of the expansion of the behavioral health network for the areas outlined in this plan. This will be completed by monitoring the change in providers that render services or increased capabilities within the region from the start to the end of the fiscal year. Additionally, HCI will track changes, barriers, and lessons learned in the implementation of the expansion plan.

In the event that there are less than two (2) practitioners that meet the BH standards within the defined area for members in rural and frontier counties, HCI may recommend to HCPF to remove the time/distance requirements for those members as outlined in the contract between HCPF and HCI.

Primary Care Network Development

HCI maintains and monitors a PCMP network that includes provider types and areas of expertise for adult, pediatric, OB/GYNs, and family medicine. HCI contracts with providers within the region that meets criteria to qualify as a PCMP.

HCI recognizes the improvement in the time/distance standard for adults and pediatric population was in part due to updates in the network adequacy requirements which allowed practitioners that serve both adults and pediatric patients to not only be categorized as family practitioners. HCI successfully advocated with other RAEs to HCPF and HSAG to update the requirements to more accurately depict HCI's network, particularly in rural and urban counties where practitioners tend to serve all ages. HCI will continue to identify opportunities to improve network adequacy reporting that represents RAE 4's primarily rural and frontier region.

HCI evaluated our regional network through utilization data and geographic mapping. Based on this information, HCI's network development priorities for fiscal year 2022 are as follows:

1. Expand access to gynecology and OB/GYN providers of all levels, including physicians and physician assistants particularly in rural and frontier counties.
2. Sustain telehealth access available throughout RAE 4 for primary care services and members.

HCI plans to strengthen the PCMP network in areas of need and ensure that the network has a sufficient number of providers to serve members based on the maximum distance for county classification. In the new fiscal year, HCI will:

1. Target practices eligible for HCPF Alternative Payment Model (APM) and required to be in-network with the RAE.
2. Review the DORA Registry and Enrollment Summary Report to identify providers with licensures that meet primary care provider criteria.

3. Leverage community connections through Program Improvement Advisory Committee and Health Neighborhood Collaborative to obtain information on potential providers within the region, with particular attention to those in the frontier and rural counties.

Once HCI identifies a potential PCMP, HCI will recruit the provider by educating providers on the benefits of joining the network. They include the following which are detailed in the Practice Support Plan FY 2022 (please reference as needed):

1. Receive Per Member Per Month (PMPM) payment based on the practice's attribution which may provide a consistent monthly payment to support/offset non-revenue generating activities necessary to ongoing work in support of PCMP functions.
2. Obtain practice support, member-level health data, and help coordinating both medical and non-medical care for your Members.
3. Eligible to receive additional payments for attributed Health First Colorado Members and for supporting important quality health outcomes and participating in practice transformation efforts.
4. For PCMPs eligible for the HCPF Alternative Payment Model (APM), will receive specialized practice support to achieve selected measures.

HCI will continue evaluate access to care for members, surveying providers/stakeholders to understand where to expand services. Furthermore, HCI will continue to support PCMPs to strengthen telehealth access throughout the region. PCMPs increased use of telehealth services during the fiscal year as a result of COVID-19 pandemic. HCI will work with these providers to sustain the access of the service as an option to reach members.

All recruitment and contracting activities will be closely monitored to track progress towards network development and to provide early detection of any barriers to contract for these services. Success in network development will be determined by assessing the number/percent of providers that meet access to care standards quarter over quarter. Additionally, telehealth volume can be assessed to determine changes in visit volume. In the event that there are less than two (2) practitioners that meet the PCMP standards within the defined area for members in rural and frontier counties, HCI may suggest to HCPF to remove the time/distance requirements for those members as outlined in the contract between HCPF and HCI.

Provider Network Monitoring

HCI conducts a geographic access (GeoAccess) mapping analysis for time and distance starting from the member's residence and driving to the closest available provider based on the county classification. HCI also calculates the provider-to-member ratios at the regional and county level by provider type. HCI uses the latest Quest Analytics, an industry-standard application for the analysis.

Appointment Availability

Access to care standards, set by the State of Colorado require all participating primary care and BH providers to have availability for members within seven (7) days of request, and urgent access availability within 24 hours from initial identification need. Provider contracts require hours of operation of all network providers to be convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially insured or publicly insured, fee-for-service individuals).

HCI conducts outbound calls to monitor compliance to access standards. Providers that do not demonstrate compliance receive education and are monitored for improvement. Providers that do not demonstrate improvement may be subject to a Corrective Action Plan (CAP). Providers are required to submit a written response within thirty (30) days of request and HCI will review the CAP to ensure it addresses the requirements and follow up with providers to track CAP progress. Providers will be audited within ninety (90) days from the acceptance of the CAP to demonstrate improvement in meeting access to care standards. Providers that are non-compliant are recommended for review to the Quality Oversight Care Committee (QOCC). Non-compliance is determined by not submitting a CAP; not submitting a CAP within stated timeframes or continuing to fail audits. Based on the QOCC review, determination may include panel closures, suspension of referrals, continuation of the CAP, or other activities deemed appropriate up to termination from the network.

During the previous fiscal year, when performing the audits, HCI found that most providers were not offering in office services. Instead most were performing services via telehealth. HCI determined that telehealth counted as providing access which helped providers meet the measure. However, understanding that resources and staffing during this time were already stressed due to the national COVID Pandemic, HCI opted for a process where providers helped ensure a member is able to access the services they need via our call center or other links to care. HCI did not want to place providers on a CAP that potentially further stresses their resources. Instead, HCI focused on supporting the providers and updating their provider profile to reflect changes in their practices (i.e. telehealth or phone number changes). Following the audit, providers received written notification of results, which included an outline of the standards. Outreach was also done for providers, offering supports, education on the standards, and other resources as needed. This ensured accurate provider contact information on file for Member and audit utilization. During FY 2022, HCI will issue Corrective Action Plans (CAPs) to providers who continuously do not meet the access to care standards.

Access for new members is an important part of maintaining a network that serves all members. Patient centered access and continuity of care is a key component of Practice Transformation efforts. HCI will continue to educate providers to notify HCI on changes to capacity to accept new members. For PCMPs, HCI updates the State's portal and monthly reports. For all providers, the next update to the provider directory will reflect the changes. HCI's call center staff in the Member and Family Services Department assist members that need help finding a provider. Staff assist members and/or family members to find a provider that meets specific needs and demographics. Members are asked their preference for a male/female provider and if there is a need for a bilingual provider. Members are also asked if they need the provider to have a specialty such as working with a specific diagnosis. HCI staff searches for a provider based on all of the member preferences. If the specific member has complex issues, a referral for care coordination is completed to help the member with scheduling appointments, transportation, or other assistance. Further, Member Services staff may assist if there is a need for access or availability issues for the member. Staff will assist to find an out-of-network provider and complete an SCA. Any other provider related concerns are directed to Provider Relations for outreach and education.

Accessible Facilities

HCI utilizes provider data to identify provider locations as accessible in the provider directory and to count the number of providers that meet the requirements in the network adequacy analysis. HCI monitors if there are sufficient providers in the network with the ability for physical access, reasonable

accommodations, and accessible equipment for members with physical or other disabilities. During Fiscal Year 2021, HCI had five hundred and seventeen (517) behavioral health practice locations and ninety-five (95) PCMP locations reporting physically accessible facilities, based on fourth quarter data. This was a slight increase in physically accessible facilities from the beginning of the fiscal year. Based on first quarter data, HCI had five hundred and five (505) behavioral health practice locations and ninety-four (94) PCMP locations reporting physically accessible facilities. Although there is no specific standard to determine a sufficient number of providers with accessible facilities, HCI relies on member feedback obtained through Member and Family Services Department. HCI did not receive member complaints with provider location not having physically accessible accommodations.

HCI conducts ongoing phone outreaches to providers that do not have a Council for Affordable Quality Healthcare (CAQH) profile to validate information in the provider directory. HCI offers trainings on the RAE 4 website (www.healthcoloradorae.com) to educate providers on how to directly update demographic information through the provider portal and CAQH, to include reporting physical access and/or accessible equipment information for practice locations. HCI integrates data from CAQH to maintain accurate records for network providers in through HCI's administrative service organization (ASO) Beacon system, which populates the provider directory and network adequacy analysis.

After-hours and Weekend Availability

During the previous fiscal year, PCMPs reporting expanded hours decreased slightly from thirty-five (35.2%) percent in first quarter to thirty-two (32.3%) percent in fourth quarter. This may be attributed in part to PCMPs challenges in ramping up services after COVID-19 pandemic to include workforce shortages. BH practitioners reported a slight increase in expanded hours from twenty-six (25.91%) percent in the first quarter and twenty-nine (28.6%) percent in the fourth quarter. The increase in the number of individual behavioral health practitioners with expanded availability was primarily in facilities or large provider groups. HCI is working with providers to leverage telehealth services to expand hours and increase access to care.

Cultural Expertise

HCI continues to seek new training content related to cultural inclusivity. While we request providers to complete a cultural competency training, we are also working to access additional training content. Successful training sessions will be assessed through post-training surveys on skills learned with follow-up surveys on the application of those skills.

HCI obtains information of providers with cultural expertise through provider self-reporting. This is determined through language and specialty availability. BH providers report competencies during initial credentialing and re-credentialing. PCMPs report cultural competency during contracting and through assessments of practices. Providers are able to update information through ASO provider portal, which then populates the provider directory.

Health Neighborhood Partners

In the Population Management Strategic Plan FY 2022, HCI detailed the Population Management Strategic framework comprised of five (5) main components: Care Coordination, Practice Transformation, Member Engagement, Quality Management, and Data Analytics and Reporting (please reference for further details). A component of the Population Management Strategic Plan FY 2022 is the Enhanced Health Neighborhood.

The Health Neighborhood forum (renamed "The Collaborative") is an opportunity to work together on shared initiatives in RAE 4 communities to address barriers and gaps in the system of care and align activities as a means of strengthening relationships in the healthcare system. HCI strives to develop communication channels to share and exchange information with community agencies and providers for collaboration and engagement in initiatives to optimize member health and well-being. The Collaborative serves as a method to engage community partners in a meaningful way while identifying services and supports for members. Invitations are sent to the following types of agencies: physical and behavioral health providers, hospitals, Long Term Services and Support providers, public health, home health, and hospice providers, DentaQuest, Single Entry Points, and Area Agency on Aging. RAE 4 also includes the Interagency Oversight Groups, Collaborative Management Program programs; Special Supplemental Nutrition Program for Women, Infants, and Children, Nurse-Family Partnership, Faith-Based Agencies, Community Centered Boards, Department of Human Services, Homeless Shelters in addition to local community agencies that assist with high fidelity wrap-around social support services.

The Collaborative meetings are held quarterly and have been incorporated into the regional PIAC meeting rotation as many of the participants are the same. Topics from previously held meetings include wellness, prevention, and related services and supports, wellness and resilience for children during the pandemic, and future topics planned include presentation on eConsult. Additionally, HCI ensures our network of providers are meeting the needs of RAE 4 members through the Population Management Strategic Plan, which incorporates both member and provider engagement strategies to improve the overall health and wellness of the RAE membership.

Behavioral Health Providers Accepting Certifications

HCI conducted annual surveys of CMHCs to confirm acceptance of certifications and will continue to monitor changes in BH providers. The information resulted in identifying seven (7) CMHCs that accept mental health certifications, including Solvista Health and Southeast Health Group, servicing in RAE 4. Furthermore, North Range Behavioral Health, Mental Health Partners, The Center for Mental Health, Mind Springs Health, and Diversus Health are located outside of RAE 4. In the new fiscal year, HCI will work with CMHCs to seek opportunities to increase acceptance of mental health certifications.

Data Management

Data management of the provider network is key to accurately report the network and assess the capacity and gaps of the network. HCI's approach to targeted solutions include detailed explorations of data to pinpoint and create effective solutions including Root Cause Analysis, Plan-Do-Study-Act (PDSA), and/or A3 performance improvement methodologies. These methods can be applied to Network Adequacy challenges. Success measures include improvements in data quality and/or reductions in errors, speed of correcting data issues, and the speed to which provider data is updated.

HCI identified improving provider data as one of HCI's top strategic priorities for FY 2021 and going forward for FY 2022. Beacon is working on a multi-year investment with targeted completion date of end of 2022 for a Unified Provider Database (UPD). The system is expected to help improve both provider data quality and increase accuracy to updates in provider data. As part of the project, Beacon will be deploying CAQH 2.0. In the short term, Beacon has launched multiple data quality improvement initiatives focused in three (3) work streams:

1. Improving initial data quality.
2. Improving analytics and reporting on data quality.

3. Interrogating RAE 4 data to identify data quality issues and correct data quality issues.

HCI has completed multiple data corrections and continues to do so. Ongoing, HCI is conducting provider outreach and education to promote more timely provider updates regarding NPI updates, Accepting New Patients, and Office Hours. This component will be ongoing to maintain data quality.

Provider Directory

HCI provider information available on the HCI website provider directory at: www.healthcoloradorae.com/members/find-a-provider/. The provider directory includes name, address, telephone number, email address, and website, if available. Members may also contact Member Services Department to request a hard copy of the provider directory or electronic format by calling 888-502-4185.

The provider directory includes information for providers compliant with American with Disabilities standards, which includes physical access, reasonable accommodations, and accessible equipment. In addition, the provider directory details the provider's capacity to accept new Medicaid members, offer cultural and language expertise (including ASL), after hours, and weekend appointment availability.

The provider directory is maintained and updated continuously to ensure it is the most accurate based on the information available. Providers are expected to maintain their demographic and practice information in the HCI system and notify HCI when changes occur. HCI reinforces this requirement through provider training, during provider meetings, and electronic communications. The provider directory on the HCI website is updated monthly.

For a Primary Care Medical Provider, they submit an Adds, Change, and Deletes form to Provider Relations with changes on their practice or rendering provider's demographics as changes occur. HCI conducts a review of PCMPs demographic data during practice transformation assessments and educates them on how to submit changes in their practice. Additionally, when HCI identifies a change, Provider Relations contacts the provider to verify the information and submit the appropriate change.

For behavioral health providers, HCI uploads CAQH data which is mined for updated demographic information which is then reflected in the behavioral health provider's profile. Should a behavioral health provider updates their CAQH profile, that information is gathered and the HCI system is updated, overriding what is currently in the system. Each email sent to a provider from Provider Relations includes a reminder to providers to attest their CAQH information on a regular basis, even when updates are not needed. This helps to maintain the correct information in the system and the provider directory. Providers may also make changes directly into the system through the Provider Portal or by contacting Provider Relations with a change, which is submitted internally for data entry update. Finally, when HCI identifies a change, Provider Relations contacts the provider to verify the information and assists them to submit the appropriate change.

A new addition to the provider directory process is the implementation of internal quality improvement process leveraging a PDSA, an iterative, four (4) stage problem solving model used for improving process. HCI believes this approach will ensure the provider directory and accessibility is accurate and distributed to key stakeholders.