Colorado Access

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Introduction

Colorado Access (COA) is dedicated to empowering our members with access to timely and appropriate health care, and delivering comprehensive choice to Members as they seek out providers and resources that best meet their needs. Building upon a history of partnership, engagement, and network development, COA is well positioned, currently, to meet or exceed the network adequacy standards established by the Regional Accountable Entity (RAE) contracts for Regions 3 and 5, and excited about opportunities to grow and improve our network in the coming years. While not comprehensive, this Network Adequacy Plan articulates the overarching approach that COA will employ toward cultivating and supporting viable provider participation, thus helping to expand options for Members.

This report is written within context of Section 9.8.1., and subsequent paragraphs, of the RAE contracts for Regions 3 and 5, and will address questions specific to those paragraphs. COA will submit a Network Adequacy Report, on a quarterly basis, to help track and validate the successes and challenges of the strategies outlined in the pages that follow. As always, COA is happy to provide further information and clarification to the Department upon request.

Contract Citation 9.5.1.1.

> ***How [will the Contractor] maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members including those with limited English proficiency and members with physical or mental disabilities?***

Colorado Access has extensive experience in developing and supporting a provider network dedicated to servicing members of Health First Colorado (Colorado's Medicaid program). The vigorous provider networks we established during our tenure as a Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) are the foundation of our RAE network. Though slightly different in how they transitioned, our initial focus for RAE network development has centered on effectively forwarding our previous providers into our current network—and maintaining sufficient support for providers during the transition.

Primary Care Medical Provider Network (PCMP)

COA targeted all providers in our previous RCCO networks, for Regions 3 and 5, to become part of our RAE primary care network. Due to programmatic differences between the RCCO and RAE platforms, COA developed and executed new contracts with these providers. We achieved a 100% success rate in re-contracting each of the 100 targeted primary care providers.[1]

Building on this foundation, COA will has added 27 additional PCMPs in the past year. We use various resources to further target potential additions and grow our network of

[1] This number represents ***provider*** participation and is not reflective of the total number of ***practice sites***. The number of practice sites is significantly higher, as will be indicated in subsequent reporting.

providers. COA has a dedicated provider contracting team that responds to inquiries and requests to participate in our network on a daily basis. These requests consistently arise from:

- Interested physical health providers;
- Extensive outreach by our Provider Relations team;
- Requests from contracted providers such as UC Health;
- Referrals by community partners;
- Inquiries from members and referrals by our Customer Service team;
- Partnership with the Department and Health First Colorado Enrollment to outreach and contract with providers that have been requested by Members, but who are not yet participating in our network.

In addition, COA continually monitors provider to member ratios within our regions to identify areas that need prioritization for targeted provider outreach. It is important to note, however, that COA is dedicated to contracting with any willing and appropriate provider to become part of our primary care network, regardless of their location.

To become part of our network, COA requires all primary care medical providers (PCMPs) to complete a comprehensive provider application, and to sign a Professional Provider Agreement (PPA).[2] All PCMPs have a newly revised agreement that obligates them to the PCMP requirements as outlined in our RAE contract with the State of Colorado. The PPAs are used to assess each provider's readiness to meet the general primary care needs of our members and to accommodate members with special needs. In addition to other data, the Provider application (Appendix 1) seeks information on:

- Extended office hours;
- Additional languages spoken and interpretation services offered;
- ADA compliance and necessary equipment available for Medicaid enrollees with physical or mental disabilities;
- Cultural competency training, and other data fields that we require be completed before processing their application.

Information reported on the Provider application is populated into our credentialing software and sorted to aid us in determining what aspect of our network can meet the needs of special populations and how to best develop and implement programming to increase access to these services across our regions.

Behavioral Health Provider Network

Colorado Access has a long standing and vibrant state-wide behavioral health network with greater than 6,900 providers. In preparing for the transition from BHO to RAE, Colorado Access determined that our existing BHO contracts would maintain legal force once COA began operations as a RAE. This means that Behavioral Health provider contracts that were executed with ABC Denver and ABC NE are still valid under the RAE. Therefore, COA did not need to re-execute contracts with providers who were already contracted with us

[2] Please see Appendix 1

under the BHO. Our credentialing, claims processing and utilization management procedures remain the same as when operating as the BHO. Future amendments will apply to all contracts, whether executed prior to or after July 1, 2018.

As such, our network of behavioral health providers continues uninterrupted and is the footing for our RAE efforts to ensure adequate access to behavioral health services for our members. This existing network includes contracted relationships with every Community Mental Health Center in the state, hospital systems, behavioral health providers who are integrated with PCMPs, IMD's, and independent behavioral health providers, statewide. Colorado Access continues to contract with behavioral health providers. The Contracting team continues to contract with behavioral health providers statewide, in an ceffort to offer a comprehensive network to expand member access to services.

Updated methodology for member attribution and specified obligations within the RAE contract, however, require focused attention to ensure an operationally adequate network, regardless of the total number of providers under contract. COA will work to address these challenges by offering consistent training to behavioral health providers that underscores the implications of site-based attribution and the best way to navigate eligibility, claims, and billing issues within the RAE system. Conducted by our Provider Relations team and supported by Provider Contracting and Behavioral Health Operations teams, trainings provided in various formats, including:

- Provider forums and open houses, with appropriate COA staff to answer questions and direct further inquiry;
- Creation of webinars to address issues that impact numerous providers;
- In-depth one-on-one trainings and meetings with providers who request and need them;
- Extensive communications through our provider newsletters and other email platforms.

COA is working with all previously contracted behavioral health providers, as well as any newly contracted providers, to complete the new Provider Application, in order to better understand our network's capacity to meet the needs of special populations and to better direct future training and programmatic priorities. As noted above, the Provider Applications are used to assess each provider's readiness to meet the needs of our members and to accommodate members with special needs.[3]

Our Provider Application asks providers if they are able to "effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities." We interpret "cognitive disabilities" to mean mental disabilities. If the Department has different guidance, please let us know, and we will incorporate that into our PPA.
Under the RAE contract, Colorado Access will be responsible for administering the behavioral health program for the region previously administered by Behavioral Healthcare Incorporated (BHI). As part of our plan to ensure network adequacy under the RAE, COA

[3] Please see Appendix 1

has outreached former BHI providers who were not previously a part of our network. Currently, COA has finalized contracts with 56 out of 59 of these "non-PAR" providers.

Additionally, COA will ensure continuity of care by offering single-case agreements when needed and appropriate to any behavioral health provider, statewide (and out-of-state when necessary), who would like to render services to one of our members. We have developed relationships with personnel from the various RAEs and will act upon referrals from those RAEs on an ad-hoc basis to ensure adequate services for our members.

Each potential new behavioral health provider will be required to execute a contract with COA, complete the Provider Applicaton, and pass credentialing requirements, before becoming an active participant in our provider network. These written agreements and documents will support growth and maintenance of the network and highlight areas of service—especially for special needs populations—that require further attention within our regions. As with the primary care network, COA will continually analyze provider to member ratios to assess areas of our regions for outreach prioritization. Claims data will be reviewed to analyze utilization patterns and help direct contracting efforts. We will work with our our care managers, community partners, such as Interagency Oversight Groups, disparate health alliances, counties and local public health agencies, and internal governance groups to identify areas of need and frame outreach from our Provider Relations and Provider Contracting teams.

Integrated Care and Telehealth

Colorado Access currently has **eight** fully integrated practices in our network, and are planning to grow that core network. As a part of that strategy, we developed an assessment tool that will include questions to evaluate providers on their infrastructure preparedness, as a way to stratify those most prepared for imbedded behavioral health. This assessment will allow our Practice Transformation team to determine the ongoing technical assistance needs of these practices. We will be responsive to any practice who indicates an interest in learning more about becoming a Medicaid provider under the regional organization structure of the Accountable Care Collaborative. We are assessing the level of behavioral health integration of our currently contracted providers and will deploy practice transformation resources as needed to move these practices along the integrated care continuum. Additionally, Colorado Access has a dedicated staff member who will be assessing whether or not any additional providers need to be targeted in order to identify and address any gaps in service prevision within our two RAE regions.

Our provider assessment is a tool that is being targeted to COA's entire PCP network to assess practice's ability to meet all contractual requirements, including integrated behavioral and physical health care, and to help us provide targeted practice transformation assistance as needed to those interested practices. These assessments are distributed to providers in waves, beginning in October 2018 and continuing through February 2019. Once all assessments are completed, COA will be conducting a broader analysis to determine best mechanisms to provide guidance and/or training in many areas, including integrated care.

Through our AccessCare Services (ACS) group, Colorado Access will continue to work to deploy telehealth services in a variety of settings, further augmenting the adequacy of our network. With an initial focus on integrating behavioral health support into primary care settings, the ACS model utilizes an integrated approach to combine specialty mental health services with physical health and primary care. It provides licensed behavioral health clinicians, substance abuse counselors, and psychiatric providers with the ability to screen, diagnose, provide brief intervention, and recommend psychotropic medication regimens all while collaborating with the primary care physician through a virtual platform. As a distinct group within the COA corporate structure, ACS is not bound by regional borders, and staff are open to foster potential relationships with providers throughout the state—an important aspect of network adequacy under the RAE attribution methodology. ACS and COA will track referrals and consults within the program to help guide practice transformation and integration efforts.

Denver Health Medicaid Choice

As the regional organization for Denver County, Colorado Access partners closely with Denver Health Medicaid Choice (DHMC), a limited managed care plan operated by Denver Health. DHMC manages physical health benefits for up to 90,000 Health First Colorado members who reside in Denver County, which is approximately 40 percent of Colorado Access' membership in Denver County. Colorado Access is responsible for ensuring DHMC maintains and monitors a network of appropriate providers for its Health First Colorado members. Colorado Access also partners with Denver Health through contracting with its primary care clinics to provide care and care coordination services for Health First Colorado members who are not enrolled in the DHMC managed care plan. Colorado Access maintains and monitors the behavioral health provider network for all Health First Colorado members in Denver County.

Colorado Access and Denver Health staff meet at least twice a month to review and discuss requirements of the regional organization contract and identify any needed improvements to operational workflows, including coordinating member care between the DHMC plan and Colorado Access provider networks.

DHMC currently maintains an adequate provider network (see Appendix II – DHMC Network Adequacy Plan). Colorado Access' provider engagement, care management, customer service and leadership teams regularly communicate with respective staff at Denver Health on multiple activities. Denver Health and DHMC staff actively participate in provider forums and trainings hosted by Colorado Access to receive updates regarding the Accountable Care Collaborative Program. Colorado Access' provider engagement and customer service teams help providers and members understand the DHMC plan. The care management team assists with identifying and escalating member needs to DHMC, including need for authorization of care outside of DHMC's network. As the

second phase of the Accountable Care Collaborative progresses and performance data become available, Colorado Access will engage DHMC in its activities to influence key performance indicators and behavioral health incentive measures.

Contract Citation 9.5.1.2.

How [will the Contractor] ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities?

With implementation of the Professional Provider Agreement[4], Colorado Access has a tool to survey each of our primary care and behavioral health providers for their readiness to render services to Medicaid enrollees with physical and mental disabilities. Compliance with the Americans with Disabilities Act (ADA) is a section noted, specifically, in the PPA and every COA provider will be required to complete it. Information gathered via the PPA is loaded into our credentialing system, sorted, and reported upon, on a regular basis. These reports will be used to focus outreach and training by our Practice Transformation and Provider Relations teams and to analyze where gaps may exist.

In addition, COA will work openly and extensively with our community partners, Community Engagement, and Member Engagement teams to identify opportunities for increasing access to care for members with a disability and to better understand the barriers that exist for those members when accessing care.

COA's participation in the Medicare-Medicaid Demonstration (MMP) provided learnings for making reasonable accommodations for physically or mentally disabled members. Since dually-eligible individuals first became qualified for membership in the ACC, Colorado Access has worked to better coordinate resources for Medicaid-Medicare members and to better support providers who service their needs.

Lessons learned from the MMP program have highlighted, for us, the need to more wholly integrate LTSS services into RAE programming, and COA is committed to furthering that integration within our RAE work. Since MMP is no longer an active program, dually-eligible members are now included in our general care management outreach and support protocols, which helps assimilate their needs among our care management teams—while still highlighting higher-risk members for additional support.

COA has built upon MMP provider surveys and outreach to identify areas for inclusion in general provider trainings and forums, and has incorporated ADA training and links to ADA resources in our provider relations efforts. In addition, our MMP experience helped identify providers who may accept Medicare but not Medicaid, and that has informed provider relations

[4] Please see Appendix 1

outreach, with regard to expanding our network. Though this has met with mixed results, COA will continue to focus on building as inclusive a network as possible.

Contract Citation 9.5.1.3. – 9.5.1.7.

Below are tables that outline our current number of providers, with a focus on provider expertise, across our regions:

Number of network providers by provider type

Provider Type	Denver
Adult Primary Care	354
Pediatric Primary Care	836
Ob/Gyn	57
Adult Mental Health	782
Pediatric Mental Health	792
Substance Use Disorder	37
Psychiatric Prescribers	478
Family Plannig	1574
Psychiatrists	335
Child Psychiatrists	32
Total	**2,858**

Geographic location of providers in relationship to where Medicaid members live
Physical Health: distance to providers

	Total Members	Total Providers	# of members w/in access	% of members w/in access	# of members outside access	% of members outside access
All Region Providers	123,797	854	121,502	98.1	2,295	1.9

Physical Health: time to providers

	Total Members	Total Providers	# of members w/in access	% of members w/in access	# of members outside access	% of members outside access
All Region Providers	123,797	854	121,671	98.3	2,126	1.7

Behavioral Health: distance to providers

	Total Members	Total Providers	# of members w/in access	% of members w/in access	# of members outside access	% of members outside access
All Region Providers	200,438	831	197,282	98.5	3,156	1.5

Behavioral Health: time to providers

	Total Members	Total Providers	# of members w/in access	% of members w/in access	# of members outside access	% of members outside access
All Region Providers	200,438	831	198,304	98.9	2,134	1.1

Cultural and language expertise of providers

Denver	
Amharic	2
Arabic	1
Bosnian	1
German	32
Spanish	689
Faroese	42
France	22
Hebrew	1
Hindi	5
Igbo	1
Korean	4
Lithuanian	2
Marathi	1
Portuguese	17
Russian	31
Tamil	1
Urdu	2
Vietnamese	44
Yoruba	1
Chinese	86

Number of Physical Health network providers accepting new Medicaid members by provider type

	Denver
Adult Primary Care	134
Pediatric Primary Care	242

Number of Physical Health providers offering weekend and afterhours appointment availability to Medicaid members

Denver
199

Number of Behavioral Health network providers accepting new Medicaid members by provider type

	Denver
Adult Mental Health	317
Pediatric Mental Health	7

Number of Behavioral Health Providers offering weekend and afterhours appointment availability to Medicaid members

Denver
82

Percent of PCMPs accepting new Medicaid members

	Denver
Adult Primary Care	17.70%
Pediatric Primary Care	28.33%

Percent of behavioral health providers accepting new Medicaid members

	Denver
Adult Mental Health	55.32%

Pediatric Mental Health	1.30%

Percent of PCMPs offering afterhours appointments

Denver
23.3%

Percent of behavioral health providers offering afterhours appointments

Denver
15.2%

Contract Citation 9.5.1.8. – 9.5.1.9.

Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the Department to ensure standards are being met and maintained across the Contractor's provider network.

Caseload for behavioral health providers.

Colorado Access does not directly monitor the specific caseload of individual behavioral health clinicians in our network. However, we will require all community mental health centers and all organizationally credentialed providers to have caseload policies and procedures. These must practice internal monitoring to ensure caseloads are reasonable and appropriately tiered based on the acuity of members on their caseload. This information will be reviewed during provider credentialing and re-credentialing.

Our behavioral health/SUD provider network includes nearly 7,000 contracted providers. We contract with individual practitioners, including LCSWs and LPCs, psychiatrists, psychologists, etc. We also contract with multiple types of facilities, including community mental health centers, integrated care clinics, hospitals, group practices, ATUs, and residential facilities. Due to this heterogeneity within our behavioral health network, it is not feasible to establish standardized case load ratios. In many cases, providers and facilities are required to meet specific caseload standards as defined by licensure.

Colorado Access addresses member health acuity and severity across our network via care management. Our care management department uses several data points to create a four-quadrant

stratification model for identifying members with both physical health and behavioral health severity, which guides care management outreach.

Regarding network adequacy and quality of care issues, we have standardized processes to identify and address these issues, and lack of a standard case load definition does not present a barrier to these processes.

Contract Citation 9.5.1.10.

> ***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.***

All of COA's contracted community mental health centers are licensed to accept mental health certifications. Because of complex and nuanced reasons, ensuring that our regions have adequate capacity to meet the need is not a reflection of the total number of facilities able to accept mental health certifications, rather, a reflection of the intricacies involved in transitioning care among facilities for members who are impacted by CRS 27-65-102. Our experience has shown that barriers typically involve licensed facilities refusing to accept a certification from the discharging inpatient hospital, for a particular member. To mitigate these issues and meet the needs of our members, COA's Utilization Management and Care Management teams will continue their processes of coordinating between facilities and outpatient providers to address barriers to member discharge, including issues related to the transfer of involuntary treatment and medication certification. This includes developing individualized care plans, seeking out and connecting with disparate "27-65" licensed providers, and helping to arrange for transitions of care for our members.

Contract Citation 9.5.1.11.

> ***A description of how the Contractor's network of providers and other Community resources meet the needs of the Member population in the Contractor's region, specifically including a description of how members in special populations are able to access care.***

Colorado Access is committed to ensuring that each of our members has an understanding of and access to providers and resources that will help them become healthy and remain healthy. This requires the unified efforts of numerous medical and non-medical partners aimed at defining mutually reinforcing agendas and supporting mutually reinforcing actions.

As a primarily urban/suburban region, network adequacy issues stem less from physical proximity to providers than from system fragmentation, unilateral efforts to mitigate structural impediments, adequate access to timely care (both specialty and primary care), and the need for focused efforts towards ensuring that members with chronic conditions—or those utilizing services inappropriately—have access to the proper care they need, when they need it. Throughout SFY 2018-19, COA worked to lay the foundation for addressing these access issues, and will utilize

these partnerships and systems in SFY 2019-20 to assess and respond to network access needs. These efforts reflect COA's belief that network adequacy is not simply a function of the number of providers in a region, but rather a function of the timely accessibility of those providers to the members who need their services.

System Fragmentation and Unilateral Efforts to Mitigate Structural Impediments

Colorado Access will continue to utilize its Governance Council (GC) platform to develop shared responses to systemic issues that impact access. For SFY 2019-20, much of the focus will shift toward populations identified via the Potentially Avoidable Conditions (PAC) model and those high-cost members whom the Department has categorized as "impactable." COA will facilitate the coordination of the multiple providers represented on the Governance Council to ensure a shared focus on access to timely, proper care for these members and that varying perspectives on these populations are incorporated into the mobilization of adequate network resources aimed at connecting them to appropriate physical, behavioral, and long-term care.

Adequate Access to Timely Care

During SFY 2018-19, COA implemented several foundational platforms to assess the adequacy of the provider network. These platforms do not act, simply, to evaluate provider numbers and ratios, but to define network adequacy in terms of timely accessibility to preventive and appropriate specialty care. COA will utilize these platforms during SFY 2019-20 to consistently gauge the sufficiency of the region's network and help guide responses to access issues. Some examples include:

- An extensive PCMP survey, conducted during SFY 2018-19, aimed at identifying areas for support and improvement within the PCMP network (120 surveys were distributed with an 86% return rate). The survey has helped to identify challenges faced by disparate providers in meeting and enhancing their accessibility to COA members and adequacy of their roles as PCMPs. Throughout SFY 2019-20, COA will utilize results of the survey to channel practice support and align practice efforts toward systemic improvement in PCMP accessibility.
- A Business Intelligence model that analyzes regional attribution and identifies areas for concern and improvement. For SFY 2019-20, COA will utilize this model to consistently evaluate the provider network and attribution patterns, and identify providers who may not be operating with the ideal Medicaid panel size. If it is determined that a provider's panel size or attribution pattern does not reflect adequate accessibility, COA will engage and work to mitigate barriers to access.
- A behavioral health (BH) inpatient incentive payment plan that enhances partnership among COA and the BH inpatient hospitals within its network, while focusing on increasing access to and utilization of follow-up services within seven days of discharge. COA will execute the plan with each of its BH inpatient hospitals during the summer and fall of 2019. The plan will tie directly to network adequacy by driving collaboration across various levels of BH care, increasing timely access to important follow-up services for COA members.
- A geo-mapping project aimed at understanding where members in Elbert County access their services. Past network adequacy reports have indicated the dearth of Medicaid providers in Elbert County; yet, Elbert's proximity to the Denver area

belies traditional rural adequacy concerns. The geo-mapping will help clarify access patterns for members who live in Elbert County, while underscoring the type and breadth of supports COA can offer within that county to help ensure adequate access to services.

Focused Efforts on Identified Populations

COA has an extensive network of behavioral health and primary care providers, which includes large health care systems, inpatient hospitals, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), independent physical and behavioral health providers, and providers who focus on particular populations, such as refugees and homeless members. In order to help ensure that this extensive network adequately meets the needs of certain populations, COA will focus, in SFY 2019-20, on identifying and connecting disparate resources in the dispensation of care to members who require additional supports to access and benefit from health care services. COA will:

- Utilize the lock-in function of the Client Overutilization Program (COUP) to ensure adequate access to an appropriate point-of-care for members who a seeking care via the emergency room or misusing pharmacy benefits.
- Articulate and execute on a county engagement strategy that:
    - Identifies barriers to supports and care for foster children and tailors county-specific remedies to those barriers;
    - Focuses discussion and effort on connecting children, who are in danger of becoming fostered, to appropriate behavioral health care;
    - Explores methods for quickly connecting COA care management staff to members who are recently released from county jails;
    - Further enhances COA's involvement in the Collaborative Management Programs (CMPs) adopted by several regional counties.
- Work with the Governance Council Health Strategy Committee to develop strategies that engender cross-system and integrative approaches to ensuring adequate access to appropriate care for members identified with potentially avoidable or "impactable" conditions and utilization patterns.
- Continue to highlight support for providers and agencies who specialize in servicing refugee populations.
- Continue to actively participate in Creative Solutions meetings with the Department and Individualized Service and Support Team (ISST) meetings with the various regional CMPs to help ensure that member situations are understood, helping to adequately connect them with the care they need.

Evaluate internal Utilization Management practices to confirm that policies and procedures lead to the most adequate level of care for members, for the appropriate amount of time, leading to greater efficiencies—thus, greater adequacy—across the system.