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Department of Health Care Policy & Financing

# FY 2019–2020 Network Adequacy Quarterly Report Template

Managed Care Entity: *Colorado Community Health Alliance*

Line of Business: *RAE*

Contract Number: *19-107518A3*

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Report Submitted on: *May 7, 2020*

Report due by 5/7/2020, covering the MCE's network from 1/1/2020 – 3/31/2020, FY Q3

*—Final Copy—*

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# Contents

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# 1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the fiscal year (FY) 2019-20 Network Adequacy Crosswalk Definitions (December 4, 2019 version).

The practitioners, practice sites, and entities included in the quarterly NA report will include ordering, referring, and servicing contractors that provide care through a Colorado Medicaid or CHP+ MCE. To ensure consistent data collection across MCEs, each MCE must use this HCPF-approved report template (MS Word and MS Excel templates) to present the MCE's quarterly NA report and data for the corresponding practitioners, practice sites, and entities. Report due dates will align with those outlined in the MCE's contract, unless otherwise stated.

| Fiscal Year Quarter Reported | Months Included in the Report |
|---|---|
| FY 2019-20 Q2 | October, November, December |
| FY 2019-20 Q3 | January, February, March |
| FY 2019-20 Q4 | April, May, June |
| FY 2020-21 Q1 | July, August, September |

## Definitions

- "MS Excel template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Excel Template_F1_0320* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_0320* document.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.
- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service, excluding single case agreement (SCA) practitioners.

- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

## Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business.

This report template contains a comprehensive list of NA requirements for the CHP+ MCO, Medicaid MCO, and RAE lines of business. Each table in this MS Word document contains a header row which confirms the applicable line(s) of business for each response. The table below shows expected network categories by MCE type. The accompanying MS Excel spreadsheet contains tabs in which network data can be imported (e.g., member counts, ratio results, time/distance calculation results).

| Network Category | CHP+ MCO | Medicaid MCO | RAE |
|---|---|---|---|
| Facilities (Entities)<br>(*Hospitals, Pharmacies, Imaging Services, Laboratories*) | X | X | |
| Prenatal Care and Women's Health Services | X | X | X |
| Primary Care Providers (PCPs) | X | X | X |
| Physical Health Specialists | X | X | |
| Behavioral Health Specialists | X | | X |
| Ancillary Physical Health Services<br>(*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*) | X | X | |

## Questions

- Contact the MCE's Department contract manager or specialist for data submission instructions and assistance with questions or access to HCPF's FTP site.

# 2. Network Adequacy

## Establishing and Maintaining the MCE Network

Supporting contract reference: The MCE shall maintain a network that is sufficient in numbers and types of practitioners/practice sites to assure that all covered services to members will be accessible without unreasonable delay. The MCE shall demonstrate that it has the capacity to serve the expected enrollment in that service area.

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2020, for the quarterly report due to the Department on April 30, 2020).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2020, for the quarterly report due to the Department on April 30, 2020).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

**Define unique practice sites by de-duplicating records by location, such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.**

**Table 1A-Establishing and Maintaining the MCE Network: Primary Care/PCMP Data**

| Requirement | Previous Quarter | | Current Quarter | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| *Sample* | *0* | *0.0%* | *0* | *0.0%* |
| **CHP+ MCO, Medicaid MCO, RAE** | | | | |
| Total members | 135,451 | N/A | 132,928 | N/A |
| Total primary care practitioners/PCMP practice sites | 590 | N/A | 798 | N/A |
| Primary care practitioners/PCMP practice sites accepting new members | 522 | 88.5% | 732 | 91.7% |
| Primary care practitioners/PCMP practice sites offering after-hours appointments | 279 | 47.2% | 490 | 61.4% |
| New primary care practitioners/PCMP practice sites contracted during the quarter | 27 | 4.6% | 6 | 1.0% |
| Primary care practitioners/PCMP practice sites that closed or left the MCE's network during the quarter | 9 | 1.5% | 25 | 4.2% |

**Table 1B-Establishing and Maintaining the MCE Network: Primary Care/PCMP Discussion**

| **Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners/PCMP practice sites to assure that all covered services will be accessible to members without unreasonable delay.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| During the reporting period, the primary barriers affecting the network were as follows:<br>• General lack of providers:<br>The Region 6 network is sufficient in terms of provider choice options available to members; however, in rural areas of Clear Creek and Gilpin counties, there are ongoing challenges due to the general deficiency in the number of providers in those areas. For example, members are able to access a provider within the time and distance standards in neighboring Region 6 counties, though there are no PCMPs and just one behavioral health provider in located in Gilpin County.<br>• COVID-19 response:<br>In response to public health orders due to the COVID-19 outbreak, CCHA and the provider network began implementing alternative processes in March 2020. Below is a summary of updates reported by providers in Region 6, which are anticipated to temporarily cause some disruption to network maintenance:<br>○ Reduced hours<br>○ Site closures/consolidating care at certain locations<br>○ Implementing telemedicine<br>○ Rescheduling non-urgent routine care visits<br>○ Staff furloughs |

**Table 2A-Establishing and Maintaining the MCE Network: Behavioral Health Data**

| **Requirement** | **Previous Quarter** | | **Current Quarter** | |
|---|---|---|---|---|
| | **Number** | **Percent** | **Number** | **Percent** |
| *Sample* | *0* | *0.0%* | *0* | *0.0%* |
| **CHP+ MCO, Medicaid MCO, RAE** | | | | |
| Total members | 135,451 | N/A | 132,928 | N/A |
| Total behavioral health practitioners | 2,273 | N/A | 4,639* | N/A |
| Behavioral health practitioners accepting new members | 2,096 | 92.0% | 4,383 | 94% |
| Behavioral health practitioners offering after-hours appointments | 1,401 | 61.0% | 2,508 | 54% |

*The large increase in behavioral health providers reported this quarter is largely due to a change in reporting methodology to include the statewide network, rather than regionally, as previously reported.

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**Table 2B-Establishing and Maintaining the MCE Network: Behavioral Health Discussion**

| **Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| During the reporting period, the primary barriers affecting the network were as follows:<br>• Behavioral health provider reimbursement changes:<br>Effective January 1, 2020, CCHA updated the reimbursement rates of the behavioral health network to better align with managed care payment methodologies. The new rate model compensates clinicians based on license levels; physician level clinicians with MD or DO credentials receive 100% of the fee schedule, and master level clinicians receive 80% of the physician rate. Below is a summary of practitioners who have opted out of the behavioral health network due to the rate change since it was announced at the end of the first quarter:<br>○ Solo clinician: Catherine Mathon \| Boulder, CO \| Effective end date: 6/11/2020<br>○ Solo clinician: Lindsey Phillips \| Ft. Collins, CO \| Effective end date: 5/1/2020<br>• Behavioral health contracting timeline:<br>CCHA was experiencing significant delays in the contracting timeline, which affected development of the behavioral health network. However, CCHA has worked diligently over the past 18 months to streamline the contracting and credentialing process to decrease the turnaround time.<br>• Provider education:<br>As CCHA has worked to improve the contracting timeline, needs for provider education on claims and billing processes increased. A relatively high volume of newly contracted clinicians were not previously enrolled with Medicaid or working within the Medicaid environment. As a result, CCHA significantly increased provider education and informational resources. |

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**Table 3A-Establishing and Maintaining the MCE Network: Specialty Care Data**

| Requirement | Previous Quarter | | Current Quarter | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| *Sample* | *0* | *0.0%* | *0* | *0.0%* |
| **CHP+ MCO, Medicaid MCO** | | | | |
| Total members | | N/A | | N/A |
| Total specialty care practitioners | | N/A | | N/A |
| Specialty care practitioners accepting new members | | | | |
| Specialty care practitioners offering after-hours appointments | | | | |
| New specialty care practitioners contracted during the quarter | | | | |
| Specialty care practitioners that closed or left the MCE's network during the quarter | | | | |

**Table 3B-Establishing and Maintaining the MCE Network: Specialty Care Discussion**

| **Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of specialty care practitioners to assure that all covered services will be accessible to members without unreasonable delay.** |
|---|
| **CHP+ MCO, Medicaid MCO** |
| *N/A* |

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## Categories Included in Network

Supporting contract reference: The MCE shall ensure that its contracted networks are capable of serving all members, including contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

**Table 4A-Categories in Network: Discussion**

| **Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| CCHA has a "come as you are" philosophy and is willing to recruit and contract with any provider who is in good standing with CMS, enrolled in the CO Medicaid program and expresses interest in participating in the ACC. Through this approach to contracting, members have options in their selection of a primary care and/or behavioral provider based on their unique healthcare needs. The network is represented by behavioral health clinicians and adult, pediatric, family, and OB/GYN primary care providers who help provide appropriate and timely access to care. When making outreach attempts, CCHA targets PCMPs and behavioral health providers using the non-contracted and enrolled provider lists provided by HCPF. CCHA also attempts to contract practices that have been requested by members. This allows us to have as diverse a network of providers as possible.<br><br>Specific to the increasing use of telemedicine accompanying COVID-19 response efforts, CCHA noted an increase in challenges related to communication accessibility such as translation services and communication aids. CCHA is monitoring these barriers and the care coordination team is working with members and their providers to reduce communication-related challenges members may experience while utilizing services via telehealth.<br><br>Otherwise, barriers affecting CCHA's ability to serve all members are largely attributed to limits in the number of existent provider types such as psychiatric prescribers. Other barriers, which primarily affect the PCMP network, are due to gaps in provider data. Providers are contracted as affiliates of PCMP sites, and the scope of information collected upon contracting includes contractually required information as well as voluntary details. Voluntary details such as providers' secondary and tertiary specialty types are likely underreported, which result in apparent insufficiencies in network specialties and expertise, e.g. OB/GYN specialists, specific disability accommodations/equipment, cultural competencies, etc. Additionally, when reporting providers who can be categorized as both a general primary care practitioner and an OB/GYN specialist, RAEs must assign the provider to one category or the other. CCHA's methodology for this circumstance is to assign the provider's category as a general primary care practitioner unless he or she is associated with a women's-only practice. As such, OB/GYN specialists in the network are underreported, which negatively affects member-to-provider ratios and time and distance calculations. |

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## Access for Special Populations

Supporting contract reference: The MCE shall have the ability to meet the needs of members in special populations. When establishing and maintaining its networks, MCEs shall take the following into consideration: members access to transportation and whether the location provides physical access and accessible equipment for members with disabilities. The MCE shall have the ability to meet the needs of members with limited English proficiency.

**Table 5-Access for Special Populations: Discussion**

| **Describe the methods used by the MCE to count practitioners/practice sites/entities as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| CCHA recently modified the primary care contracting applications. In alignment with behavioral health contracting applications, the primary care applications now collect comprehensive details about the level of accessibility and accommodations available to meet the needs of the diverse member network, including additional specialties and accessible features such as proximity to mass transit, high-low exam table, listening loops, low-vision aids, various wheelchair accommodations, etc. To bridge any gaps in provider data after the contracting applications were updated, existing providers were asked to complete a supplemental information form to collect the additional information. To date, CCHA has received the supplemental information form from 94 practices. Moving forward, CCHA's practice transformation coaches will capture the supplemental information annually during the Office Systems Review (OSR). The OSR is conducted to review practice updates and includes information about enhanced accessibility and ADA accommodations the practice implemented during the prior year. Currently, 90% of behavioral health practices statewide and 54% of primary care practices in the Region 6 network have reported enhanced physical access and/or accessible equipment as of the end of the reporting period.<br><br>In determining the number of network providers that have physical access and/or accessible equipment, CCHA counts a provider as having physical access and/or accessible equipment if they have indicated one or more accessible attributes on the contracting applications or supplemental information form. This information and high-level attributes of each practice are indicated in the provider directory on the CCHA website. To ensure access information remains updated, practice information is reviewed and updated at least annually through an OSR with practice transformation coaches and/or through CCHA surveys that allow providers to report on culturally and linguistically appropriate services (CLAS) training status and provisions such as interpreter services. Providers are of the understanding that on-site visits may be used to verify such reported information. |

| **Describe the methods used by the MCE to count practitioners/practice sites/entities as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| CCHA also promotes ongoing network development through provider resources and training. Providers can access resources, such as the Caring for Diverse Populations Toolkit and other provider competency resources, on the CCHA website. Further, as part of the Health First Colorado Provider Academy, CCHA distributes information about other provider trainings and resources related to member care, such as the Partners for Children's Mental Health learning series on Trauma Informed Practices in Primary Care. Health First Colorado Provider Academy information is featured monthly in the CCHA Provider Newsletter. During the reporting period, CCHA conducted two virtual Town Hall webinars, which were attended by 112 physical and behavioral health providers across Regions 6 and Region 7. Webinar covered the following topics:<br>• Business and Operations Information<br>• Provider Educations & Resources<br>• Provider Engagement Opportunities<br>• Care Coordination & Member Support<br>• Health First Colorado Member Benefits Highlights<br>• Member Education Resources<br><br>In addition to monitoring provider access, CCHA assesses all members for transportation needs to help facilitate members' access to the network. Transportation is arranged through the State Non-Emergent Medical Transportation (NEMT) vendors and, on rare occasion, through Lyft or Uber to help ensure members have access to care. During the reporting period, CCHA coordinated transportation for 72 member cases, and provided 238 transportation resources.<br><br>To support a culturally competent network, CCHA and network providers facilitate language assistance services, including interpretation and American Sign Language (ASL) services, at all points of member access. Services can be coordinated through our member services department or the provider network directly, and the care coordination team collaborates with care providers to ensure language assistance services meet the needs of the member. During the reporting period, 7 ASL service requests and 24 language translation service requests were coordinated in Region 6.<br><br>The CCHA quality team attends daily rounds with the CCHA clinical team to proactively identify any quality of care concerns. The teams track and trend all potential concerns and prepare individual reports for facilities that meet the minimum trend threshold (per CCHA policy). CCHA uses the reports as an opportunity to understand facility policy and procedures and to address the noted quality of care concerns. Additionally, CCHA staff participate in clinical quality reviews at some facilities, which has enabled open discussions surrounding best practices and collaboration between entities. On a quarterly basis, the Quality Management Committee (QMC) convenes to review challenging quality of care cases and share best practices across the regions. As reported in the Region 6 Quality of Care Summary Report, 11 QOC referrals were reviewed during |

| **Describe the methods used by the MCE to count practitioners/practice sites/entities as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| the reporting period. Of the 11 QOC cases reviewed, five cases had a quality issue substantiated and six did not have a quality issue substantiated.<br><br>CCHA monitors network access through member and stakeholder feedback, noting any trends in access. If any member, whether or not in special populations, indicates that a network provider is unable or unwilling to accommodate his/her needs, CCHA works with the member to establish care with another provider and ensures the member is informed of their general rights and option to file a grievance. |

# 3. Network Changes and Deficiencies

## Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes in MCE Networks related to quality of care, competence, or professional conduct.

**Table 6-Network Changes: Discussion**

| **If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change.**<br>**Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| CCHA monitors and tracks trends that may affect quality of care, competence, and professional conduct on an ongoing basis. Though none of the network changes during the reporting period were related to quality of care, competence, or professional conduct, below is a summary of network additions and terminations that occurred during Q3:<br>PCMP Network Additions<br>• Boulder County<br>  ○ SCL Medical Group Superior<br>• Jefferson County<br>  ○ UCHealth Primary Care Arvada West<br>  ○ Potomac Square Family Medicine Westminster<br><br>PCMP Network Terminations<br>• Broomfield County<br>  ○ Relocated to Region 2: Boulder Community Health – Internal Medicine Associates of Buffalo Ridge<br><br>BH Network Additions:<br>• 99 new practitioners were added to existing provider groups statewide as follows:<br>  ○ Region 6: 12 new practitioners<br>  ○ Region 7: 34 new practitioners<br>  ○ Other counties outside of Regions 6 and 7: 53 new practitioners<br>• 18 solo practices joined the network statewide as follows:<br>  ○ Region 6: six new practices<br>  ○ Region 7: six new practices<br>  ○ Other counties outside of Regions 6 and 7: six new practices |

| If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change.<br>Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency. |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| BH Network Terminations<br>*Note: none of the practitioner terminations indicated below were related to CCHA's rate changes.*<br>• 34 practitioners left contracted provider groups statewide as follows:<br>  ○ Region 6: 5 practitioners termed<br>  ○ Region 7: 8 practitioners termed<br>  ○ Other counties outside of Regions 6 and 7: 21 practitioners termed |

**Table 7-CHP+ MCO Network Volume Changes and Notification: Discussion**

| If the MCE experienced at least a five percent (5%) increase or decrease in its network in a thirty (30) calendar day period, describe the change and answer the following questions:<br>Did the MCE notify the Department, in writing, within ten (10) business days of the change?<br>Was the change due to a practitioner/practice site/entity's request to withdraw; was the change due to the MCE's activities to obtain or retain NCQA accreditation?<br>Was the change due to a practitioner/practice site/entity's failure to receive credentialing or re-credentialing from the MCE? |
|---|
| **CHP+ MCO** |
| *N/A* |

## *interChange* Policies

Supporting contract reference: The MCE shall employ measures to help ensure that the MCE and all of their contracted, ordering or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating practitioner/practice site/entity.

- Retroactively enrolled or practitioners/practice sites/entities with a pending contract status are not available to offer services and should be excluded from this discussion.

**Table 8-CHP+ MCO *interChange* Policies: Discussion**

| **1. Does the MCE employ measures to help ensure all contracted, ordering, or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating practitioner/practice site/entity?**<br>**2. Did the MCE have a health care practitioner/practice site/entity that was no longer identified as a participating practitioner/practice site/entity in the *interChange*?**<br>**If the MCE answered "yes" to Requirement 2 above, did the MCE terminate its health care practitioner/practice site/entity contracts for provision of services to members with contracted practitioner/practice site/entity?** |
|---|
| **CHP+ MCO** |
| *N/A* |

## Inadequate Network Policies

Supporting contract reference: If the MCE fails to maintain an adequate network that provides Members with access to PCPs within a county in the MCE's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible Members by providing the MCE a thirty (30) calendar day written notice.

**Table 9-CHP+ MCO Inadequate Access to PCPs: Discussion**

| **Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area?**<br>**If the MCE answered "yes", did the Department designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members?** |
|---|
| **CHP+ MCO** |
| *N/A* |

**Table 10-CHP+ MCO Discontinue Services to an Entire County: Discussion**

| **Did the MCE discontinue providing covered services to members within an entire county within the MCE's service area?**<br>**If the MCE answered "yes", did the MCE provide no less than sixty (60) calendar days prior written notice to the Department of the MCE's intent to discontinue such services?** |
|---|
| **CHP+ MCO** |
| *N/A* |

**Table 11-CHP+ MCO Provider Network Changes: Discussion**

| **Did the MCE experience an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network?**<br>**If the MCE answered "yes", did the MCE notify the Department, in writing, of the change?** |
|---|
| **CHP+ MCO** |
| *N/A* |

## Appointment Timeliness Standards

Supporting contract reference: The MCE shall provide coverage of emergency and non-urgent medical services. The MCE shall have written policies and procedures describing how members can receive coverage of emergency services or urgently needed services while temporarily absent from the MCE's service area.

**Table 12-Physical Health Appointment Timeliness Standards**

| **Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| Policies and Procedures:<br>• All PCMP contracts require the following standards for member access:<br>  ○ Urgent care appointment within 24 hours after the initial identification of need.<br>  ○ Inpatient follow-up appointment within 7 days after discharge.<br>  ○ Non-urgent, symptomatic care visit within 7 days after the request.<br>  ○ Well-care visit within 1 month after the request, unless an appointment is required sooner to ensure the provision of screenings.<br>• CCHA Member Rights and Responsibilities Policy<br>  ○ CCHA adopts Federal and State of Colorado laws and regulations that pertain to the rights of members and ensure that its staff and network providers take those rights into account when furnishing services to members. Members are entitled to the right to have health care services provided in accordance with the requirement for timely access and medically necessary care. CCHA does not adversely regard a member who exercises their rights, as stated below. CCHA communicates member rights and responsibilities to members per contract guidelines via the *For Members* section of CCHA's website.<br>  ○ Providers are notified via the Provider Manual, which are available and distributed according to the contract requirements, and via provider newsletters. CCHA staff receive educational information on member rights and responsibilities during new hire orientation. CCHA shall comply with any other applicable Federal and State laws including 42 CFR § 438.100 and 42 C.F.R. § 438.400 (b).<br><br>Methodology for Assessing Timeliness:<br>The CCHA practice transformation coaches and network managers work with PCMPs to collect third next available data, which is used to assess the network and ensure it meets timeliness requirements for urgent care, non-symptomatic care, and well-care physical examinations.<br><br>Third next available appointment is a national measure used to assess access to care. It examines the third available appointment instead of the next available appointment to account for cancelations and other events |

that result in unexpected appointment availability, thereby providing a more accurate representation of true appointment availability. Using the third next available appointment eliminates chance occurrences from the measure of availability. To collect this data, CCHA uses the following process:

1. CCHA staff meets with both the PCMP's office manager and a scheduler.
2. The scheduler opens the appointment book and, starting with the schedule for the following day, looks for the next open appointment. There must be an open slot in the schedule. If there are no open appointments, the subsequent day's schedule is reviewed for an open appointment. This process is continued until the third next available appointment (3NA) is identified. The 3NA value is the number of working days from tomorrow to reach the third available appointment. For example, if 3NA is tomorrow, the value is 0.
3. If the schedule reserves times based on appointment type, e.g. physical exams or certain procedures, 3NA is assessed for each unique appointment type. For example, there typically separate 3NA measures for short visits (emergency follow up or acute care) and long visits (physical exams). Assessing the 3NA for unique appointment types provides information about timeliness and informs where improvements are necessary. Note: times reserved for same-day appointments are counted as emergency follow up or acute care visits when assessing 3NA access.
4. Assessment of each PCMP's 3NA is conducted on the same day of the week and at the same time of day if possible. CCHA analyzes and graphs the data, which provides a visual representation of the practice/provider access and areas of improvement.
5. The 3NA findings are used to help practices understand their demand and consider whether their provider resources are sufficient. If 3NA findings indicate timeliness standards are not being met, practice transformation coaches work with the practice to evaluate and optimize empanelment using Right-Size Panel and Demand analysis tools.

Current Status of Network Timeliness:

The CCHA Provider Incentive Program is used to help drive quality improvement activities, including access and availability of appointments for members. During Q1 through Q3 SFY2019-2020, PCMPs that qualified to participate in the incentive program earned up to 5% of their incentive payment by meeting 3NA timeliness criteria for annual physical well visits within 30 days and emergency department follow-up within 48 hours.

CCHA focused appointment availability assessment and improvement efforts on coached practices during Q1 and Q2. In Q3, CCHA expanded assessment efforts and began collecting 3NA data from non-coached practices (those with fewer than 300 members). This data will continue to be collected from non-coached practices on an annual basis as part of the Office Systems Review.

Per the following table, the 3NA data CCHA collected from non-coached practices indicates timeliness standards were met. This data will continue to be collected from non-coached practices on an annual basis as part of the Office Systems Review.

| Region 6: SFY 2019-2020 – Quarter 3 | | | | |
|---|---|---|---|---|
| Visit Type | Standard | Q3 Numerator | Q3 Denominator | Q3 Rate |
| **Urgent/Acute** | Within 24 hours of member request | 92 | 124 | 74.2% |
| **Inpatient hospitalization follow up** | Within 7 days after discharge | 111 | 124 | 89.5% |
| **Non-urgent, symptomatic** | Within 7 days of member request | 100 | 124 | 80.6% |
| **Emergency visit follow up** | Within 7 days of ED visit | 100 | 124 | 80.6% |
| **Well-care physical examinations** | Within 30 days of member request | 112 | 124 | 90.3% |

**Table 13-Behavioral Health Appointment Timeliness Standards**

| **Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.** |
|---|
| **CHP+ MCO, RAE** |
| Policies and Procedures:<br>• CCHA Member Rights and Responsibilities Policy<br>○ CCHA adopts Federal and State of Colorado laws and regulations that pertain to the rights of members and ensure that its staff and network providers take those rights into account when furnishing services to members. Members are entitled to the right to have health care services provided in accordance with the requirement for timely access and medically necessary care. CCHA does not adversely regard a member who exercises their rights, as stated below. CCHA communicates member rights and responsibilities to members per contract guidelines via the *For Members* section of CCHA's website.<br>○ Providers are notified via the Provider Manual, which are available and distributed according to the contract requirements, and via the provider newsletters. CCHA staff receive educational information on member rights and responsibilities during new hire orientation. CCHA shall comply with any other applicable Federal and State laws including 42 CFR § 438.100 and 42 C.F.R. § 438.400 (b).<br>• Behavioral health provider access requirements:<br>○ Emergency behavioral health care by phone within fifteen (15) minutes after initial contact, including TTY accessibility; in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours after contact in rural and frontier areas. |

- Non-urgent, symptomatic behavioral health services – within seven (7) days after a member's request.
- Administrative intake appointments or group intake processes shall not be considered as a treatment appointment for non-urgent, symptomatic care.
- Members shall not be placed on waiting lists for initial routine service requests.

CCHA monitors the behavioral health services through the annual Appointment Access Survey, which covers the following categories: Urgent Care, Initial Visit - Routine Care, Follow-up - Routine Care, and Non-Life Threatening Emergency Care. The last survey was conducted with 81 providers between November 20 and December 4, 2019; below is a summary of the survey results.

- Appointment timeliness standards met for the following:
  - Follow-up - Routine Care standards met by non-prescribing practitioners surveyed
  - Non-Life Threatening Emergency care standards met by prescribing practitioners surveyed

- Appointment timeliness standards not met for the following:
  - Urgent Care standards not met by non-prescribing and prescribing practitioners
  - Initial Visit - Routine Care standards not met by non-prescribing and prescribing practitioners
  - Follow-up - Routine Care standards not met by prescribing practitioners
  - Non-Life Threatening Emergency Care standards not met by non-prescribing practitioners surveyed

Any provider who does not meet the contracted access to care standards is placed under corrective action to remediate the access issue. As such, letters were sent to practitioners indicating which appointment type was non-compliant with the access requirements. Enclosed with the letter, an Appointment Availability Survey Response form was provided for the practitioners to indicate the corrective actions taken to meet the standards. CCHA will conduct a follow-up survey to confirm practitioners' compliance with the standards following correction actions.

Lessons learned from the 2019 survey:

The 2019 Appointment Access Survey captured information based on individual practitioners' responses to his/her appointment timeliness only. Since the survey did not capture information about the practitioner's employment status as a solo, group, or mental health center provider, the results of the survey may not fully represent actual appointment timeliness. The second annual Appointment Access Survey will be conducted in late fall of 2020 and will be updated to capture the practitioner status as a solo, group, or mental health center provider. As with group settings and mental health centers, access standards could otherwise be met by other practitioners if the individual responding to the survey is unavailable.

## Health Care Network Time and Distance Standards

Supporting contract reference: The MCE shall ensure that its network has a sufficient number of practitioners, practice sites, and entities who generate billable services within their zip code or within the maximum distance for their county classification. The MCE must use GeoAccess or a comparable service to measure the travel time and driving distance between where members live and the physical location of the practitioners/practice sites/entities in the MCE's Region.

Enter detailed time and distance results in the MS Excel template. Use Tables 13, 14, and 15 for additional relevant information regarding the MCE's compliance with time and distance requirements. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care.

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).
- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

There are two levels of primary care practitioners: primary practitioners that can bill as individuals (e.g., MDs, DOs, and NPs) and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

**A practitioner/practice site/entity should only be counted one time in the MS Excel template tabs; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under the Family Practitioner category.**

**Table 14-Software Package Used for Time and Distance Calculations**

| List and describe the software package(s) and/or processes that your MCE uses to calculate practitioner/practice site/entity counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed.<br>If your MCE does not use driving distances when calculating time and distance results, describe the method used. |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| As CCHA continues to streamline the data warehouse for physical and behavioral health data, the comprehensive provider datasets are maintained in separate systems with distinct software for assessing time and distance for the provider networks. |

Software:

- QGIS, Version 3.10, for physical health providers
- Quest Analytics Suite, Version 2019.4, Build 127, 64.bit for behavioral health providers

Time and Distance Methodology – Physical Health Network:

Time and distance calculations for the physical health network are provided for the Region 6 counties in which CCHA is designated to contract primary care providers. A total of 31,463 members were excluded from the time and distance portion of the report because their county of residence is not within a Region 6 county. Additionally, CCHA defers to the county associated with the member's address when calculating time and distance standards, though some zip codes do not map to the same county indicated in the member roster. As such, the *PH Time-Distance* tabs reflect different totals for the number of enrolled members residing in each county than those indicated the *Members by County* and *PH Ratios* tabs.

Time and Distance Methodology – Behavioral Health Network:

When mapping members to their respective counties using the Quest Analytics program, some addresses/zip codes map to a different county than the member information provided through the HCPF Roster Report. For example, the March 2020 roster report shows 4,531 members in Broomfield County, yet the Quest Analytics program assigns 4,296 members based on their address. As such, the membership in each county does not precisely align with the member roster.

**Table 15–Urban Health Care Network Time and Distance Standards: Discussion**

| **Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template.**<br>**List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| Time and Distance Results:<br>Below is a summary of time and distance standards in which time and/or distance was not 100% per the results in the MS Excel workbook.<br>Boulder County<br>• Adult Primary Care<br>  ○ Time standard: 93% member access<br>  ○ Distance standard: 96% member access<br>• Pediatric Primary Care:<br>  ○ Time standard: 93% member access<br>  ○ Distance standard: 96% member access |

- Gynecology, OB/GYN
  - Time standard: 93% member access
  - Distance standard: 96% member access
- Family Practitioner
  - Time standard: 93% member access
  - Distance standard: 96% member access
- Psychiatric Residential Treatment Facilities:
  - Time standard: 17% member access
  - Distance standard: 81% member
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - Time standard: 13% member access
  - Distance standard: 24% member access

Broomfield County

- Adult Primary Care
  - Time standard: 97% member access
  - Distance standard: 98% member access
- Pediatric Primary Care:
  - Time standard: 96% member access
  - Distance standard: 98% member access
- Gynecology, OB/GYN
  - Time standard: 96% member access
  - Distance standard: 98% member access
- Family Practitioner
  - Time standard: 97% member access
  - Distance standard: 98% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - Time standard: 98% member access
  - Distance standard: 99% member access

Clear Creek County

- Adult Primary Care
  - Time standard: 71% member access
  - Distance standard: 81% member access
- Pediatric Primary Care:
  - Time standard: 71% member access
  - Distance standard: 37% member access
- Gynecology, OB/GYN
  - Time standard: 71% member access
  - Distance standard: 37% member access
- Family Practitioner
  - Time standard: 71% member access
  - Distance standard: 81% member access

- Psychiatric Residential Treatment Facilities:
  - Time standard: 6% member access
  - Distance standard: 49% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - Time standard: 3% member access
  - Distance standard: 3% member access
- Adult Psychiatrists and other psychiatric prescribers
  - Time standard: 65% member access
  - Distance standard: 70% member access
- Pediatric Psychiatrists and other psychiatric prescribers
  - Time standard: 34% member access
  - Distance standard: 70% member access
- Pediatric Mental Health
  - Time standard: 21% member access
  - Distance standard: 65% member access
- Adult Substance Use Disorder
  - Time standard: 58% member access
  - Distance standard: 97% member access
- Pediatric Substance Use Disorder
  - Time standard: 58% member access
  - Distance standard: 97% member access

<u>Gilpin County</u>

- Adult Primary Care
  - Time standard: 48% member access
  - Distance standard: 68% member access
- Pediatric Primary Care:
  - Time standard: 24% member access
  - Distance standard: 32% member access
- Gynecology, OB/GYN
  - Time standard: 27% member access
  - Distance standard: 32% member access
- Family Practitioner
  - Time standard: 50% member access
  - Distance standard: 68% member access
- Pediatric Mental Health
  - Time standard: 94% member access
  - Distance standard: 100% member access
  -

<u>Jefferson County</u>

- Adult Primary Care
  - Time standard: 93% member access
  - Distance standard: 96% member access

- Pediatric Primary Care:
  - Time standard: 93% member access
  - Distance standard: 96% member access
- Gynecology, OB/GYN
  - Time standard: 92% member access
  - Distance standard: 96% member access
- Family Practitioner
  - Time standard: 93% member access
  - Distance standard: 96% member access
- Psychiatric Residential Treatment Facilities:
  - Time standard: 96% member access
  - Distance standard: 99% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - Time standard: 63% member access
  - Distance standard: 95% member access

Other urban counties outside of Region 6:

- Psychiatric Residential Treatment Facilities:
  - Time standard: 85% member access
  - Distance standard: 95% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - Time standard: 49% member access
  - Distance standard: 87% member access

Addressing Access to Care:

In addition to ongoing provider recruitment and outreach, CCHA's approach to understanding and reducing access barriers also relies on the care coordination and community partnerships teams' efforts.

CCHA developed a training guide designed to help member-facing staff identify complaints that may stem from limited access to care. Access-related issues are triaged to provider solutions and network management staff for assessment and any further action that may be necessary. CCHA's care coordination and member support teams also work directly with members to develop care plans that help address barriers, including but not limited to any challenges related to proximity of providers. When travel time and/or distance is a barrier, CCHA works with the member and local providers to help coordinate transportation or other types of intermediate interventions such as telemedicine.

Additionally, CCHA's community partnerships team is focused on developing strong relationships with county departments, non-profit organizations, and local service providers. In areas where time and distance requirements are not met, CCHA collaborates with these community entities on identifying additional resources and opportunities for reducing access barriers and/or recruiting providers.

Below is a summary of such efforts aimed to increase access in areas where time and distance standards are not being met:

- CCHA is working with Front Range Partners to provide access to a psychiatric prescriber through telepsychiatry and to coordinate wrap around services for high risk/high cost members who have been discharged from an inpatient facility who have a behavioral health diagnosis.
- CCHA awarded Community Incentive Program funding to Evergreen Christian Outreach (EChO) to help with members' access to wrap-around services. During the reporting period, EChO assisted 115 members with access to IntelliRide services as well as expenses related to personal transportation including vehicle repair, insurance premiums, license renewal, tires, gas cards, and RTD bus passes. This assistance is critical to member access and success, as reliable transportation contributes to increased employment stability as well improved access to primary, specialty, and behavioral health care.
- Region 6: The COVID-19 emergency exacerbated many challenges to care delivery. However, in response to the emergency, CMS updated telemedicine requirements. The updates effectively expanded member access to care via telemedicine, and the vast majority of physical and behavioral health providers implemented telemedicine processes by the end of the reporting period. Following are examples of activities aimed to help with telemedicine implementation and the scope of its use:
    - CCHA conducted Telemedicine Webinars on March 24 and March 26 for both physical and behavioral health providers to help inform CMS' guidance updates.
    - CCHA continues working with The Independence Center and published an article they wrote to help raise awareness of communication challenges members may face during this time. The article was distributed in the CCHA's Provider Newsletter in April 2020.

**Table 16–Rural Health Care Network Time and Distance Standards: Discussion**

| **Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template.**<br>**List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| Time and Distance Results<br>Below is a summary of time and distance standards in which time and/or distance was not 100% per the results in the MS Excel workbook.<br>Other counties outside of Region 6:<br>• Psychiatric Residential Treatment Facilities<br>  ○ Time standard: 0% member access<br>  ○ Distance standard: 0% member access<br>• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals<br>  ○ Time standard: 0% member access<br>  ○ Distance standard: 0% member access |

- Adult Psychiatrists and other psychiatric prescribers
    - Time standard: 97% member access
    - Distance standard: 98% member access
- Pediatric Psychiatrists and other psychiatric prescribers
    - Time standard: 96% member access
    - Distance standard: 97% member access
- Adult Mental Health
    - Time standard: 99% member access
    - Distance standard: 99% member access
- Pediatric Mental Health
    - Time standard: 91% member access
    - Distance standard: 92% member access
- Adult Substance Use Disorder
    - Time standard: 90% member access
    - Distance standard: 92% member access
- Pediatric Substance Use Disorder
    - Time standard: 90% member access
    - Distance standard: 92% member access

Addressing Access to Care:

In addition to ongoing provider recruitment and outreach, CCHA's approach to understanding and reducing access barriers also relies on the care coordination efforts. CCHA developed a training guide designed to help member-facing staff identify complaints that may stem from limited access to care. Access-related issues are triaged to provider solutions and network management staff for assessment and any further action that may be necessary. CCHA's care coordination and member support teams also work directly with members to develop care plans that help address barriers, including but not limited to any challenges related to proximity of providers. When travel time and/or distance is a barrier, CCHA works with the member and local providers to help coordinate transportation or other types of intermediate interventions such as telemedicine.

**Table 17–Frontier Health Care Network Time and Distance Standards: Discussion**

| **Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template.**<br>**List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| Time and Distance Results<br>Below is a summary of time and distance standards in which time and/or distance was not 100% per the results in the MS Excel workbook.<br>Other counties outside of Region 6:<br>• Psychiatric Residential Treatment Facilities<br>○ Time standard: 0% member access<br>○ Distance standard: 0% member access<br>• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals<br>○ Time standard: 0% member access<br>○ Distance standard: 0% member access<br>• Adult Psychiatrists and other psychiatric prescribers<br>○ Time standard: 59% member access<br>○ Distance standard: 63% member access<br>• Pediatric Psychiatrists and other psychiatric prescribers<br>○ Time standard: 49% member access<br>○ Distance standard: 55% member access<br>• Adult Mental Health<br>○ Time standard: 91% member access<br>○ Distance standard: 92% member access<br>• Pediatric Mental Health<br>○ Time standard: 49% member access<br>○ Distance standard: 55% member access<br>• Adult Substance Use Disorder<br>○ Time standard: 55% member access<br>○ Distance standard: 56% member access<br>• Pediatric Substance Use Disorder<br>○ Time standard: 55% member access<br>○ Distance standard: 56% member access<br><br>Addressing Access to Care:<br>In addition to ongoing provider recruitment and outreach, CCHA's approach to understanding and reducing access barriers also relies on the care coordination efforts. CCHA developed a training guide designed to help member-facing staff identify complaints that may stem from limited access to care. Access-related issues are triaged to provider solutions and network management staff for assessment and any further action that may |

be necessary. CCHA's care coordination and member support teams also work directly with members to develop care plans that help address barriers, including but not limited to any challenges related to proximity of providers. When travel time and/or distance is a barrier, CCHA works with the member and local providers to help coordinate transportation or other types of intermediate interventions such as telemedicine.

## Network Directory

Supporting contract reference: For each of the following practitioner/practice site/entity types covered under this contract the MCE must make the following information on the MCE's network practitioners/practice sites/entities available to the enrollee in paper form upon request and electronic form:

- Practitioner/practice site/entity's name as an individual or entity, as well as any group affiliations,
- Business street address,
- Telephone number,
- Electronic mail address,
- Website URLs, as appropriate,
- Specialties, as appropriate,
- Whether network practitioners/practice sites/entities will accept new enrollees,
- The cultural and linguistic capabilities of network practitioners/practice sites/entities, including languages (including ASL) offered by the practitioner/practice site/entity or a skilled medical interpreter at the practitioner's office, practice site, or entity location, and whether the practitioner/practice site/entity has completed cultural competence training,
- Whether network practitioner's offices, practice sites, or entity locations have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

**Table 18-Network Directory: Discussion**

| **Please list the MCE's website URL.**<br>**Is the MCE practitioner/practice site/entity network information updated at least monthly?**<br>**Did the MCE make the network practitioners'/practice sites'/entities' information available to the enrollee in paper form upon request and electronic form?** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| CCHA Website URL: www.CCHAcares.com<br><br>Network information is updated at least monthly and upon notification of changes from providers. Network updates are processed and reflected in the network directory on the CCHA website monthly. Network changes include PCMP and practitioner additions and terminations, as well as any changes to practitioner service locations. |

The network directory is available to members from the CCHA website. Additionally, CCHA provides information in paper form upon member request. CCHA also provides network information that is specific to member preference, which may include but is not limited to a choice of providers who can accommodate specific cultural, linguistic, and/or accessibility requirements.

COLORADO
Department of Health Care Policy & Financing

# Appendix A. Single Case Agreements (SCAs)

Individual practitioners with single case agreements (SCAs) are not counted as part of the MCE's health care network and should be excluded from tabulations in the body of this MS Word report and the associated MS Excel report(s). However, the Department acknowledges the role of SCAs in mitigating potential network deficiencies and requests that the MCE use Tables A-A and A-B below to list individual practitioners with SCAs and describe the MCE's use for SCAs.

**Table A-A-Practitioners with SCAs: Data**

| Individual SCA Practitioner | Medicaid ID | County Name | HCPF Network Category Code(s) | HCPF Network Category Description |
|---|---|---|---|---|
| *Franklin Q. Smith* | *0000000* | *Denver* | *PV050* | *Adult Primary Care* |
| **CHP+ MCO, Medicaid MCO, RAE** | | | | |
| The Center for Change | 0000000 | Orem, UT | BF142 | Psychiatric Residential Treatment Facility |
| Benchmark Behavioral Health System | 0000000 | Woods Cross, UT | BF142 | Psychiatric Residential Treatment Facility |
| Cornell Corrections of California, Inc., DBA Southern Peak Regional Treatment Center | 0000000 | Canon City, CO | BF142 | Psychiatric Residential Treatment Facility |
| Cedar Crest, LLC, dba Cedar Crest Hospital & RTC | 0000000 | Belton, TX | BF142 | Psychiatric Residential Treatment Facility |
| Lakemary Center | 0000000 | Paola, KS | BF142 | Psychiatric Residential Treatment Facility |
| Griffith Centers for Children | 0000000 | (El Paso) Colorado Springs, CO | BF142 | Psychiatric Residential Treatment Facility |

**Table A-B-Practitioners with SCAs: Discussion**

| **Describe the MCE's approach to expanding access to care for members with the use of SCAs.**<br>**Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| CCHA has an open behavioral health network that allows all practitioners who are Medicaid approved, meet CCHA credentialing criteria, and accept a contract to serve CCHA members. CCHA Provider Solutions utilizes all available tools for provider recruitment, including but not limited to out of network authorization and single case agreement requests. Out of network providers that are identified as having a material number of single case agreements or requests for out of network authorization are prioritized for recruitment into the network. |

# Appendix B. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.

## Instructions for Appendices

To add an image:

- Go to "Insert" and click on "Pictures".
- Select jpg file and click "Insert".

To add an additional Appendix:

- Go to "Layout" and click on "Breaks".
- Select "Next Page" and a new page will be created.
- Go to "Home" and select "HSAG Heading 6".
- Type "Appendix C." and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

## Optional MCE Content

Missing Medicaid IDs in Physical and Behavioral Health Provider Data:

- Medicaid IDs missing in the Individual PH Practitioners tab are associated with a single provider group. The issue preventing their Medicaid IDs from being included in the report is expected to be resolved for the Q4 report.
- CCHA also continues to work on correcting issues that caused some of the Medicaid IDs for behavioral health providers to be excluded from the report. This issue is anticipated to be resolved in the next report.

# Appendix C. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.