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Department of Health Care Policy & Financing

FY 2020–2021 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: *7/31/2020*

Report due by *07/31/2020*, covering the MCE's network from 04/01/2020 – 06/30/2020, FY Q4

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2020 release of 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 CO Network Adequacy Crosswalk Definitions (June 2020 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 (FY) Quarter (Q) Reported	Months Included in the Report
FY 2019-20 Q4	April, May, June
FY 2020-21 Q1	July, August, September
FY 2020-21 Q2	October, November, December
FY 2020-21 Q3	January, February, March

Definitions

- "MS Word template" refers to the *CO2020-21_Network Adequacy_Quarterly Report Word Template_F1_0620* document.
- "MS Word MCE Data Requirements" refers to the *CO2020-21_Network Adequacy_MCE_DataRequirements_F1_0620* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO2020-21_Network Adequacy_Quarterly Report Excel Template_<MCE Type>_Geoaccess Compliance* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- 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. The MCE should update the highlighted, italicized data fields on the cover page of this template to reflect their contact information, contract information, and report dates associated with the current report submission.

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 spreadsheets contain 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) (*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 (*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.

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., June 30, 2020, for the quarterly report due to the Department on July 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., June 30, 2020, for the quarterly report due to the Department on July 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 Data

Requirement	Previous Quarter		Current Quarter*	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	132,928	N/A	145,858	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	798	N/A	775	N/A
Primary care practitioners accepting new members	732	91.7%	750	96.8%
Primary care practitioners offering after-hours appointments	490	61.4%	473	61.0%
New primary care practitioners contracted during the quarter	6	1.0%	10	1.3%
Primary care practitioners that closed or left the MCE's network during the quarter	25	4.2%	4	0.5%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, the primary barriers affecting the network were as follows: • General lack of providers: 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 located in Gilpin County. • COVID-19 response: In response to public health orders due to the COVID-19 outbreak, CCHA and the Provider Network began implementing alternative processes in March 2020 that continued through the Q4 reporting period. With the network focused on making various operational adjustments, there has been some reluctance to pursue new initiatives that could further strain resources, particularly among independent and smaller practices. Below is a summary of updates reported by providers in Region 6 that caused some disruption to network maintenance: ○ Reduced hours ○ Dental limited to emergency services ○ Site closures/consolidated care at certain locations ○ Limited access for non-urgent routine care visits ○ Group visits canceled ○ Staff furloughs Increased use of telehealth: Although the COVID-19 emergency exacerbated challenges to care delivery, CMS updates to telehealth requirements have effectively expanded use of telehealth to help reduce barriers to access. At the beginning of the reporting period, a vast majority of the physical health network had expanded access through telehealth services, with claims data showing the highest utilization for general office visits among established patients and psychotherapy visits. CCHA plans to continue tracking telehealth utilization through claims data to assess trends and inform network planning.

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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	132,928	N/A	145,858	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	4,639	N/A	5,571	N/A
Behavioral health practitioners accepting new members	4,383	94%	4,764	86%
Behavioral health practitioners offering after-hours appointments	2,508	54%	4,059	73%
New behavioral health practitioners contracted during the quarter	117	0.25%	184	0.33%
Behavioral health practitioners that closed or left the MCE's network during the quarter	34	0.07%	15	0.03%

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. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, the primary barriers affecting the network were as follows: • <u>Behavioral health provider reimbursement changes</u>: 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: ○ Solo clinician: Catherine Mathon | Boulder, CO | Effective end date: 6/11/2020 ○ Solo clinician: Lindsey Phillips | Ft. Collins, CO | Effective end date: 5/1/2020 ○ Solo clinician: Danielle M Patterson | Colorado Springs, CO | Effective end date: 06/25/20 ○ Solo clinician: Lauren M Ferguson | Conifer, CO | Effective end date: 05/28/20 ○ Solo clinician: Ezekiel A Odonkor | Fort Collins, CO | Effective end date: 05/16/20

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. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe.

If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.

CHP+ MCO, Medicaid MCO, RAE

- Out-of-State Providers:
  CCHA uses out-of-state providers when a member requires treatment at a residential treatment facility. These providers are included in Table A-1-Practitioners with SCAs: Data.

- Provider education:
  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. Some examples include:
  - A dedicated COVID-19 landing page on CCHAcares.com that includes comprehensive telehealth expansion billing, claim, and HIPAA guidance.
  - Provider-facing contact list with contracting information and a variety of contacts, including contract managers by region.

Increased use of telehealth:
Although the COVID-19 emergency exacerbated challenges to care delivery, CMS updates to telehealth requirements have effectively expanded use of telehealth to help reduce barriers to access. At the beginning of the reporting period, a vast majority of the behavioral health network had expanded access through telehealth services. This was noted through claims activity, which indicated increases in use of telehealth by nearly 2800% in March 2020 and 5619% in April 2020. CCHA plans to continue tracking telehealth utilization through claims data to assess ongoing trends and inform network planning.

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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 (i.e., PROVCAT codes beginning with "SV" or "SG")		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. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO
N/A

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 4-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. **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. This information and resolution are reported to HCPF on a quarterly basis in the Quality of Care report, and CCHA notifies the Department within 10 days if issues result in changes in the network. Below is a summary of network additions and terminations that occurred during Q4:
 	
Region 6 PCMP Network Additions
• No new PCMPs contracted during the reporting period.
 	
Region 6 PCMP Network Terminations
• Jefferson County.
  ○ Vernon M. Smith, Jr. MD.
  ▪ Terminated without cause for inappropriate billing practices.
  ▪ CCHA notified the Department of the termination on 6/2/2020 and within ten days of the change.
  ▪ With fewer than 50 CCHA members attributed to Dr. Smith, CCHA anticipates no impact to network access resulting from this termination. Members attributed to Dr. Smith received a letter from CCHA notifying them of the change, and to call CCHA for support finding another provider.
 	
BH Network Additions:
• 153 new practitioners were added to existing provider groups statewide as follows:
  ○ Region 6: 8 new practitioners
  ○ Region 7: 21 new practitioners
  ○ Other counties outside of Regions 6 and 7: 124 new practitioners
• 31 solo practices joined the network statewide as follows:
  ○ Region 6: 12 new practices
  ○ Region 7: 5 new practices
  ○ Other counties outside of Regions 6 and 7: 14 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. 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
Note: CCHA reports all provider terminations to HCPF on a monthly basis. During the reporting period, three practitioners left the network due to reimbursement. See Table 2B for a summary of all practitioners who left the network due to reimbursement.
• 14 practitioners left contracted provider groups statewide as follows:
  ○ Region 6: 3 practitioners termed
  ○ Region 7: 5 practitioners termed
  ○ Other counties outside of Regions 6 and 7: 6 practitioners termed
• 1 practitioner in Region 7 was sanctioned and terminated from the network

Table 5-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: Did the MCE notify the Department, in writing, within ten (10) business days of the change? 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? 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

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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 6-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? **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 7-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? **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 8-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? **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 9-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:
• All PCMP contracts require the following standards for member access:
  ○ Urgent care appointment within 24 hours after the initial identification of need.
  ○ Inpatient follow-up appointment within 7 days after discharge.
  ○ Non-urgent, symptomatic care visit within 7 days after the request.
  ○ Well-care visit within 1 month after the request, unless an appointment is required sooner to ensure the provision of screenings.
• CCHA Member Rights and Responsibilities Policy
  ○ 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.
  ○ 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).
 	
Methodology for Assessing Timeliness:
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.
 	
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:
CCHA conducts appointment availability assessment and improvement efforts with coached practices on a quarterly basis, and appointment availability is assessed with non-coached practices (those with fewer than 300 members) annually as part of the Office Systems Review.

The CCHA Provider Incentive Program is used to help drive quality improvement activities, including access and availability of appointments for members. During Q4 SFY 2019-2020, 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.

Per the following table, the 3NA data CCHA collected from coached practices in Q4 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 4				
Visit Type	Standard	Q4 Numerator	Q4 Denominator	Q4 Rate
Urgent/Acute	Within 24 hours of member request	68	85	80%
Inpatient hospitalization follow up	Within 7 days after discharge	83	85	98%
Non-urgent, symptomatic	Within 7 days of member request	84	85	99%
Emergency visit follow up	Within 7 days of ED visit	84	85	99%
Well-care physical examinations	Within 30 days of member request	85	85	100%

Table 10-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:
• CCHA Member Rights and Responsibilities Policy
  ○ 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.
  ○ 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).
• Behavioral health provider access requirements:
  ○ 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. The follow-up survey will be part of the next annual Appointment Access Survey, which is planned for Fall 2020 and dependent on the status of COVID-19 and public health guidance at that time.

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 time and distance compliance results (e.g., "Met" or "Not Met") in the MS Excel template. Use Tables 11, 12, and 13 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. For physical health time and distance requirements, MCEs are only required to report data for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report results for all members regardless of county residence.

- 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, NPs, and CNS') 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 MCE's data submission; if a practitioner provides Adult and Pediatric Primary Care (and is not an OB/Gyn), the MCE should count the practitioner one time under the Family Practitioner network category.

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Table 11–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. **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:
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.
Boulder County
• Adult Primary Care
  ○ 99% member access
• Pediatric Primary Care
  ○ 99% member access
• Gynecology, OB/GYN
  ○ 99% member access
• Family Practitioner
  ○ 99% member access
• Psychiatric Residential Treatment Facilities
  ○ 56% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 24% member access
• Pediatric Mental Health Providers
  ○ 28% member access
• Pediatric Psychiatrists and Other Psychiatric Prescribers
  ○ 99% member access
Broomfield County
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 99% member access
Clear Creek County
• Adult Primary Care
  ○ 64% member access
• Pediatric Primary Care
  ○ 73% member access
• Gynecology, OB/GYN
  ○ 67% member access
• Family Practitioner
  ○ 68% member access
• Psychiatric Residential Treatment Facilities
  ○ 0% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 5% member access

- Adult Psychiatrists and Other Psychiatric Prescribers
    - 77% member access
- Pediatric Psychiatrists and Other Psychiatric Prescribers
    - 67% member access
- Pediatric Mental Health Providers
    - 55% member access
- Adult Substance Use Disorder Providers
    - 77% member access
- Pediatric Substance Use Disorder Providers
    - 69% member access

Gilpin County

- Adult Primary Care
    - 89% member access
- Pediatric Primary Care
    - 84% member access
- Gynecology, OB/GYN
    - 87% member access
- Family Practitioner
    - 87% member access
- Psychiatric Residential Treatment Facilities
    - 12% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
    - 3% member access
- Pediatric Mental Health Providers
    - 39% member access

Jefferson County

- Adult Primary Care
    - 98% member access
- Psychiatric Residential Treatment Facilities
    - 97% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
    - 96% member access
- Pediatric Mental Health Providers
    - 99% member access

Other urban counties outside of Region 6:

- Psychiatric Residential Treatment Facilities
    - 87% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
    - 86% member access
- Pediatric Psychiatrists and Other Psychiatric Prescribers
    - 98% member access
- Pediatric Mental Health Providers
    - 93% member access
- Adult Substance Use Disorder Providers

- 99% member access
- Pediatric Substance Use Disorder Providers
  - 99% member access

Addressing Access to Care:
CCHA utilizes community partnership and care coordination to reduce barriers to accessing care. 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 telehealth.

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 and have a behavioral health diagnosis.
- With CCHA Community Incentive Program funding assistance, Evergreen Christian Outreach (EChO) is increasing member access to wrap-around services. During the reporting period, EChO's services were focused on preparing food kits to homeless members. Pre-packaged food kits included basic food pantry items, coolers, and small car-cooking appliances to help with food security and social distancing during the pandemic.
- Although the COVID-19 emergency exacerbated many challenges to care delivery, the following activities helped identify and alleviate some of the resultant access barriers:
  - CCHA surveyed all PCMPs to assess the scope of operational changes and to gain better understanding of their needs for informational/financial/resource support. Network managers and practice transformation coaches followed up with practices accordingly.
  - CCHA worked with the network and care coordination teams to conduct COVID-specific outreach to high-risk/high-cost members, including those releasing from the Department of Corrections, to ensure timely access to care.
  - CCHA distributed a total of $1,595,986.22 COVID Support Funds to independent and safety net providers in Region 6. Funds were provided to help practices return to pre-COVID operations and toward care of members with complex needs and those identified as high risk by HCPF.

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Table 12–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. **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
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.
 	
Other rural counties outside of Region 6:
• Psychiatric Residential Treatment Facilities
  ○ 0% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 0% member access
• Adult Psychiatrists and Other Psychiatric Prescribers
  ○ 98% member access
• Pediatric Psychiatrists and Other Psychiatric Prescribers
  ○ 4% member access
• Adult Mental Health Providers
  ○ 98% member access
• Pediatric Mental Health Providers
  ○ 0% member access
• Adult Substance Use Disorder Providers
  ○ 90% member access
• Pediatric Substance Use Disorder Providers
  ○ 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 telehealth.

Table 13–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. **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
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.
 	
Frontier counties outside of Region 6:
• Psychiatric Residential Treatment Facilities
  ○ 0% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 0% member access
• Adult Psychiatrists and Other Psychiatric Prescribers
  ○ 30% member access
• Pediatric Psychiatrists and Other Psychiatric Prescribers
  ○ 0% member access
• Adult Mental Health Providers
  ○ 89% member access
• Pediatric Mental Health Providers
  ○ 0% member access
• Adult Substance Use Disorder Providers
  ○ 37% member access
• Pediatric Substance Use Disorder Providers
  ○ 46% 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 telehealth.

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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-1 and A-2 below to list individual practitioners with SCAs and describe the MCE's use for SCAs.

Table A-1-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				
Millcreek of Arkansas	0000000	Fordyce, AR	BF142	Psychiatric Residential Treatment Facility
Cinnamon Hills Youth Crisis Center	0000000	Saint George, UT	BF142	Psychiatric Residential Treatment Facility
Youth Villages	0000000	Memphis, TN	BF142	Psychiatric Residential Treatment Facility
Center for Change	0000000	Orem, UT	BF142	Psychiatric Residential Treatment Facility
Cornell Corrections of California, Inc, dba Southern Peaks Residential Treatment Center	0000000	Fremont (Canon City, CO)	BF142	Psychiatric Residential Treatment Facility
Texas Neuro Rehab	0000000	Austin, TX	BF142	Psychiatric Residential Treatment Facility
HMIH Cedar Crest, LLC dba Cedar Crest Hospital & RTC	0000000	Belton, TX	BF142	Psychiatric Residential Treatment Facility

Table A-2-Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. 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 Behavioral Health Provider Data:

- CCHA continues to work on correcting issues that caused some of the Medicaid IDs for behavioral health providers to be excluded from the 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.