2020 - 2021

COLORADO COMMUNITY HEALTH ALLIANCE

Network Adequacy Plan

Region 7

Table of Contents

Network Development

During the first two years of implementation, CCHA's focus was on building a robust network of physical and behavioral health providers, ensuring members would have continued access to care through implementation of the Accountable Care Collaborative (ACC) Phase II. With a comprehensive network of behavioral health clinicians and primary care providers – comprised of adult and pediatric primary care providers, OB/GYNs, adult and pediatric mental health providers, substance use disorder providers, psychiatrists, psychiatric prescribers, and family planning providers – CCHA's recruitment and contracting efforts began to shift more toward addressing gaps in the network through targeted outreach to providers enrolled in the CO Medicaid program, in good standing with the Centers for Medicare and Medicaid Services (CMS), and interested in participating in the ACC as a partner of the Regional Accountable Entity (RAE). As outlined in the Annual Recruitment Strategy, CCHA has a goal of contracting a minimum of four new PCMPs annually in each region. CCHA takes a "come as you are" approach with regard to contracting with providers in good standing, which allows practices of all sizes to participate in the ACC program to the degree in which they are comfortable.

Though the primary focus of network development has shifted, CCHA continues to seek providers using methods that have proved reliable for outreach and recruitment. When making outreach attempts, CCHA considers both public and private providers who appear on the non-contracted provider lists provided by the Department of Health Care Policy and Financing (HCPF), those who are requested by members, and those located in rural areas of Region 7. For behavioral health, CCHA remains open to all contracting requests from behavioral health providers statewide to assure member access to inpatient, outpatient, and all other covered mental health and substance use services. Outreach efforts are focused on local and regional provider listings to recruit and contract providers, including Behavioral Health Organizations (BHO) directories, the network of Anthem providers in Colorado, and the Colorado Department of Human Services' (DHS) CORE Services Program providers.

Once outreach is successful, the contracting department works to perform the necessary paperwork while provider relations focuses on provider education and support to ensure providers are informed with CCHA resources and familiar with the construct and goals of the ACC.

Contracting and Compliance

As a standard policy, CCHA does not employ or contract with providers excluded from participation in Federal health care programs under section 1128 or section 1128A of the Social Security Act. CCHA will only enter into written contracts with primary care providers that meet the following criteria to qualify as a PCMP:

- Enrolled as a Colorado Medicaid provider.
- Licensed and able to practice in the State of Colorado.
- Practitioner holds an MD, DO, or NP provider license.
- Practitioner is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.

All primary care provider contracts are renewed annually to ensure agreements remain current with the ACC program and any new initiatives available to the network. The current contract requires PCMPs to meet all of the criteria to qualify as a PCMP, as indicated in Section 9.2.1 of the RAE contract, serve as a medical home for their members, comply with State and Federal regulations, and collaborate with the RAE to meet quality standards and member needs. Behavioral health providers are required to meet all credentialing criteria to participate in a Medicaid program, comply with State and Federal regulations, and collaborate with the RAE to meet quality standards and member needs. Prior to entering into an agreement, CCHA requires that both providers and practices complete an application form, which collects attestation for these criteria. Requirements of the CCHA network for both physical and behavioral health providers are detailed in provider contracts and in the primary care and behavioral health provider manuals posted to the CCHA website.

Provider Onboarding

CCHA aims to maintain a network that offers members ample choice and continuity of care across services. CCHA strives to accomplish this not only through contractual compliance activities but also through our attention to provider support and partnership. Orientations are offered upon request and to all newly contracted physical and behavioral health providers. CCHA's provider orientations are tailored for primary care and behavioral health providers and include presentations, provider manuals, and a variety of other resources that help familiarize providers with CCHA's provider support model, the vast array of services available to members, as well as the goals of the ACC program.

Network Maintenance

For SFY 2021, CCHA will continue ongoing network maintenance operations, as outlined in further detail below. Additionally, maintenance activities also include engaging the network to ensure providers are informed on current priorities of the RAE and ACC, member enrollment trends, and how they can help enhance access and quality in member care. Some of examples of these activities include:

- Provider revalidation: CCHA is currently working with providers to ensure they are in compliance with the Colorado NPI Law and prepared for revalidating enrollment as a Health First Colorado provider.
- Influx of member enrollment: Due to the COVID-19 pandemic, CCHA has been and will continue monitoring practice capacity to accommodate increases in member enrollment. As a result of these efforts, several practices have increased their Medicaid panels to help prevent access issues.
- Telehealth services: With the expansion of telehealth services, including SUD, opportunities to increase access have also expanded. CCHA is tracking telehealth utilization through claims data to assess trends, leverage these services to improve access, and inform network planning.
- Implementation of SUD benefit: CCHA is collaborating with HCPF to prepare for implementation of the inpatient and residential components of the SUD benefit, anticipated to go live January 1, 2021. CCHA is also continuing efforts to develop the network and contract additional SUD providers, having contracted 9 new SUD providers last quarter.

Provider Information and Network Directory

CCHA collects information about practice attributes upon contracting/credentialing for both physical and behavioral health providers, and annually for physical health providers during the Office Systems Review (OSR) when practice information is reviewed and updated. After initial contracting, the annual OSR is one mechanism by which CCHA remains current on practice details such as additional specialties; capacity to accept new members; culturally and linguistically appropriate services (CLAS) expertise and/or training; after hours and weekend appointment availability; and accessibility equipment or features such as proximity to mass transit, high-low exam table, listening loops, low-vision aids, various wheelchair accommodations, etc. Provider information for both the physical and behavioral health networks is also updated through CCHA surveys and upon notification of changes from providers, which also include practice attributes as well as practice additions, terminations, and changes to practitioner service locations. Providers are of the understanding that on-site visits may be used to verify information reported.

Provider demographics and high-level attributes are available in the network directory on CCHA's website at CCHAcares.com/for-members/find-a-provider. The provider directory allows members to filter their search by languages spoken, and whether the provider has accommodations for people with disabilities, is accepting new members, has completed cultural competency training, and offers telehealth services. Directory information is updated at least monthly and with any network changes to ensure accurate and timely information is made available to members.

Practice Support and Incentives

As described in CCHA's Practice Support Plan, CCHA promotes network development and provides ongoing support to practices through practice transformation initiatives, care coordination support, newsletters, member support materials, provider education and training and resources. Network Providers partnered with CCHA and qualified to participate in CCHA's Provider Incentive and Value-Based Payment programs also have the opportunity to receive quarterly payments for engagement with members and CCHA, as well as the aid of various tools to help providers meet performance goals. Providers have additional access to resources, which are made available on the CCHA website, including cultural competency training material and a Caring for Diverse Populations toolkit. CCHA's Provider Newsletter also highlights educational and training information and, as part of the Health First Colorado Provider Academy, includes a monthly feature on other provider trainings and resources related to member care. Finally, as detailed in the CCHA Administrative Payments report for SFY 2020-2021, CCHA will begin working with providers on transitioning its tiered payment methodology this year. The new payment methodology will offer enhanced payment for providers who have attributed complex members and advanced infrastructure that promotes population health priorities and the goals of the ACC.

Similarly, CCHA's provider relations team supports the behavioral health provider community through educational resources and materials, open mic sessions, and Joint Operating Committee (JOC) meetings with key behavioral health facility partners and Community Mental Health Centers (CMHCs). Open mic sessions and JOC meetings remain an important aspect of connecting with the provider community, identifying and mitigating trending issues, and hosting a forum for education and information.

Within the last year, CCHA welcomed a new behavioral health operations director who has focused efforts on process improvement through claims audits and issue monitoring, particularly around contracting, credentialing, and provider reimbursement workflows. With that, CCHA developed additional training and informational resources for the provider community such as a provider-facing contact list with contracting information and a variety of contacts, including contract managers by region. More recently, these process improvement efforts aided in CCHA's responsiveness to the COVID-19 emergency, which enabled CCHA to quickly update systems and implement resources to support providers and telehealth expansion. Operationally, CCHA's claim systems were updated immediately and provider claim submissions have been carefully monitored, assuring no errant claim denials for telehealth have occurred. For direct provider support, CCHA hosted webinars to inform providers of telehealth changes and updated the CCHA website with a dedicated to COVID-19 landing page where resources specific to telehealth billing, claims, and HIPAA guidance are posted and updated as needed. Further, CCHA supports providers by alerting them to new information about resources and financial support opportunities available through other agencies such as the Colorado Medical Society, the Small Business Administration, and Federal and State COVID-19 Financial Support programs.

Finally, for physical and behavioral health providers, CCHA hosts semi-annual town hall meetings. Recently, CCHA piloted an integrated virtual town hall meeting for physical and behavioral health providers across Region 6 and Region 7. The integrated virtual town hall meetings were designed to cover a variety of topics pertinent across networks, including: Business and Operations Information; Provider Education and Resources; Provider Engagement Opportunities; Care Coordination and Member Support; Health First Colorado Member Benefits Highlights; and Member Education Resources. Given the successful launch of the virtual town hall meetings, CCHA plans to continue using this format and will assess alternating virtual and in-person town hall meetings following the next virtual meeting planned for November 2020.

Corrective Action

The CCHA provider relations team identifies and escalates provider issues and barriers, and Medicaid program officers review ongoing issues with CCHA leadership to determine the appropriate mechanism for corrective action on a case-by-case basis. If an issue warrants a Corrective Action Plan (CAP), CCHA's protocol is to develop a CAP with the provider and escalate to HCPF as appropriate. As part of this standard process, a report with recommended actions is submitted to HCPF, in writing, within five business days of discovering significant provider issues, deficiencies, or needs for corrective action.

Monitoring Access to Care

CCHA monitors the network's compliance with contractual requirements and NCQA access to care and quality of services standards using an array of mechanisms and tools, including assessing caseload standards, geographic location of providers to members, and appointment timeliness, as outlined in detail below. In addition, CCHA uses the following mechanisms to identify potential access issues through member and stakeholder feedback:

- Member Services Data: CCHA uses this data to identify potential compliance issues. For example, if we receive repeated calls regarding inaccessibility, the provider relations staff and/or a designated practice transformation coach works with the provider to support with issue resolution.

- Stakeholder Feedback: CCHA actively participates in alliances, committees, and advisory groups where additional network needs are discussed and assessed for trending issues that help improve processes and provider/member services.
- Quality of Care and Access Concerns: Quality and access issues are investigated as part of the provider support model and through practice transformation activities. Outcomes are reviewed through key performance indicators, quality reviews, and annual quality of care audits. Additionally, CCHA convened a Quality Management Committee (QMC) for behavioral health cases. The QMC will leverage the expertise of local providers to drive decisions on care standards and remain informed on trends in behavioral health and integrated care.
- Grievance and Appeals Data: CCHA reviews this data on a quarterly basis to identify and address any notable trends among providers and/or services.
- Member Satisfaction Surveys: CCHA will support HCPF's administration of the Consumer Assessment of Health Care Providers and Systems (CAHPS®) in querying members on key questions, including access to care. ECHO will not be administered this fiscal year due to state budget constraints, but CCHA looks forward to collaborating with HCPF and OBH in future years to administer this survey.

Caseload Standards and Utilization of Services

CCHA's member enrollment determines the composition and capacity of our provider network, including PCMPs, specialists, hospitals, behavioral health providers, and ancillary providers. As detailed in the *CCHA Network Adequacy and Access Standards operating policy,* CCHA monitors member utilization and caseload standards to confirm member-to-provider ratio and network adequacy and reporting standards are met. Provider caseload is monitored, at minimum, on a quarterly basis during quarterly network adequacy assessment. With full assessment of the network, provider caseloads are monitored using the following member-to-provider ratios:

- Adult primary care providers: one per 1,800 adult members
- Adult mental health providers: one per 1,800 adult members
- Advanced practice primary care providers: one per 1,200 adult members
- Pediatric primary care: one per 1,800 child members
- Pediatric mental health providers: one per 1,800 child members
- Substance use disorder providers: one per 1,800 members

Additionally, CCHA analyzes out-of-network authorizations, service coordination needs, member cultural competency and language needs, provider capabilities, and provider claims data. CCHA's provider data review processes are currently underway and will be used to not only identify opportunities for provider training but also assess coverage.

Geographic Location of Providers to Members

CCHA works to establish a provider network that offers members a choice of at least two (2) appropriate providers within their zip code or within the maximum distance for their county classification, as identified below:

- Adult and pediatric primary care providers and OB/GYN providers:
  - Urban counties: 30 miles or minutes
  - Rural counties: 45 miles or minutes
  - Frontier counties: 60 miles or minutes
- Acute care hospitals:
  - Urban counties: 20 miles or minutes
  - Rural counties: 30 miles or minutes
  - Frontier counties: 60 miles or minutes
- Adult and pediatric providers: mental health, psychiatrists and psychiatric prescribers, and substance use disorder:
  - Urban counties: 30 miles or minutes
  - Rural counties: 60 miles or minutes
  - Frontier counties: 90 miles or minutes

CCHA evaluates geographic location of providers and members to identify network gaps and assess member choice. CCHA's industry-standard tools enable evaluation of network adequacy through use of the following: geographic overview maps, provider and member location maps, member access summaries, and accessibility reports.

Appointment Timeliness

To meet the needs of CCHA's membership, CCHA contracts with a provider network with the goal of ensuring timely access to care and services, taking into account the urgency of the need for services, including:

- Emergency BH care:
  - By phone within 15 minutes of the initial contact
  - In-person within 1 hour of contact in urban and suburban areas
  - In-person within 2 hours of contact in rural and frontier areas
- Urgent care within 24 hours from the initial identification of need
- Non-urgent symptomatic care visit within 7 days after member request
- Well-care visit within 1 month after member request
- Outpatient follow-up appointments within 7 days after discharge from hospitalization
- Members may not be placed on waiting lists for initial routine BH services

CCHA's practice support efforts help ensure providers can accommodate appointments for more urgent or acute care needs using the 3rd Next Available Appointment[1] methodology. In higher-volume practices, same-day and acute care is often provided by dedicated advance practice providers staffed within the practice. Additionally, behavioral health appointment availability is measured through provider surveys.

Network Adequacy and Reporting Standards

Network adequacy assessments help identify trends and opportunities for network improvement. CCHA assesses network adequacy on a quarterly basis, or as requested by HCPF, and submits analyses that include, at minimum:

- PCMPs and behavioral health providers accepting new Medicaid members;
- PCMPs and behavioral health providers offering after-hours appointment availability to Medicaid members;
- Performance meeting time and distance standards;
- Number of behavioral health provider single-case agreements used;
- New PCMPs and behavioral health providers contracted during the quarter;
- PCMPs and behavioral health providers that left the network during the quarter; and
- Additional information, as requested by HCPF.

General Access Efforts

CCHA maintains and monitors the provider network in alignment with CCHA's *Provider Network Adequacy and Access Standards* policy and the CCHA Practice Support Plan. Through ongoing quantitative assessment and qualitative evaluation, CCHA is positioned to remain informed on gaps or barriers and respond accordingly to ensure contracted networks and ancillary partners are capable of meeting members' diverse needs and serving members across all ages, levels of ability, gender identities, and cultural identities. Further, to aid in medical competence and offer members with the best experience possible, CCHA and network providers facilitate language assistance services, including interpretation and American Sign Language services, at all points of access in the health neighborhood. Services can be coordinated through our member services department or the network provider directly, and the care coordination team collaborates with care providers to ensure language assistance services meet the needs of the member.

Another component of access to care includes CCHA's partnerships with the health neighborhood and community, which are essential to access and achieving the goals of the ACC. By aligning shared goals with provider and community stakeholders at the local and regional levels, we can effectively enhance member access and reduce duplication, and total cost of care.

[1] Third Next Available Appointment is the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. Reference: Institute for Healthcare Improvement. CCHA also has an internal policy on use of this methodology.

Access for Special Populations

CCHA approaches access for all members, including members with disabilities and special populations, by collaborating with members, network providers, and the multitude of stakeholders comprising the health neighborhood. Care coordinators help unify and bring resources together, addressing member needs across agencies and systems to reduce duplication, maximize resources, expand member support through integrated care and community resources, and help achieve the best outcomes. Physical and behavioral health network managers and practice transformation coaches work directly with providers on access and availability to ensure the network is equipped to serve members and meet their unique needs.

For special populations defined by population health priorities and risk stratification methodologies, CCHA ensures access through various initiatives and targeted care coordination, as described in CCHA's Population Health and Health Neighborhood plans and reports. Below is a summary of efforts to ensure access for high risk members and priority populations such as those involved with the justice system and who are at high risk during pregnancy or due to diabetes and other conditions:

- CCHA employs a multidisciplinary care coordination team that coordinates with the family, providers, and community agencies on appropriate interventions and care planning. Care planning meetings help define roles and responsibilities, ensuring services are not duplicative and focus on the family's goals and strengths.
- CCHA has established co-location agreements, data sharing agreements, and referral processes with specialist providers, local departments of human services, single entry point and community centered boards, community corrections facilities, parole facilities, and hospitals. These formal relationships promote member engagement in person and at the point of care.
- CCHA care coordinators attend various case staffing meetings led by the Department of Human Services and HCPF to address the needs of children involved in the child welfare system. Such meetings include Creative Solution Meetings, Family Engagement Meetings, High Fidelity Wrap-around Meetings, Action Meetings, etc.

For special populations whose access is dependent on network capabilities or specialized services, CCHA ensures access by monitoring the network and working directly with service providers on options to meet member needs. Examples include the following efforts to ensure access for special populations including but not limited to members with disabilities, members seeking family planning services, members referred for COUP lock-in, and those who experience barriers due to limits in choice or proximity of providers and/or lack of transportation:

- Network monitoring: CCHA updated contracting applications to collect information about accessibility features and equipment, family planning services, telehealth services, interest in information or participation in the network as a COUP provider. As previously mentioned, CCHA remains current on practice information during the annual OSR when these details are reviewed and updated.
- Practice support and resources: CCHA develops and connects providers with educational resources such as disability competent care training, telehealth information and guidance, practice transformation coaching, and value-based incentives for targeted engagement of special populations.

- Data sharing: CCHA shares member-level data with providers that identifies priorities to help focus access and engagement efforts on special populations. Likewise, practice accessibility and provider details are shared with members through direct contact and via the Provider Directory on the CCHA website.
- Technology: CCHA promotes use of solutions that broaden member and provider engagement. For example, provider education and direct support to providers for increased use of telehealth.

Addressing Gaps in Coverage

CCHA approaches gaps in coverage in a number of ways, dependent on the source of the issue, which range from provider availability to circumstantial issues such as reporting limitations and the COVID-19 pandemic. In areas where gaps in coverage exist because providers are generally lacking, CCHA fosters collaborative relationships with local organizations and providers. Through formal and informal relationships with community partners, CCHA has better understanding of the community's unique needs, can leverage existing efforts to reduce gaps, and can prioritize efforts to improve member access to an appropriate range of services.

In areas where gaps in coverage could be remediated by recruiting non-contracted providers, CCHA uses the monthly Enrollment Summary from HCPF to target outreach to non-contracted providers. The Enrollment Summary is also used to identify high-volume, non-contracted practices that have a potential to impact coverage gaps as well as recruit PCMPs that offer specialized care, such as women's health specialists who provide routine and preventative care services to members. As outlined in the Annual Behavioral Health Provider Recruitment and Network Development Strategy, CCHA's provider solutions team utilizes available tools, including but not limited to, out of network authorization or single case agreement requests, non-contracted and enrolled provider lists provided by HCPF, stakeholder feedback, member requests received by member support services, care coordination, and/or utilization management, and direct provider inquiries. Out of network providers that are identified as having a material number of single case agreements or out of network authorization requests, will be prioritized along with behavioral health providers requested by members.

Regarding efforts to address gaps in coverage for behavioral health, CCHA aims to contract with all CMHCs, Federally Qualified Health Centers (FQHCs), and hospital systems to provide extensive member choice and facility access. To date, CCHA's behavioral health network provides access to all IMDs, 15 hospital systems, 16 of 17 CMHCs, and 10 of 21 FQHCs statewide. CCHA also continues to welcome independent providers and any provider with a single case agreement to join the network.

With that, CCHA continues to monitor ongoing issues surrounding the lack of providers and availability of substance use services in rural counties and continues to pursue innovating opportunities to ensure access. The COVID-19 emergency presented challenges to care delivery, which exacerbated existing coverage gaps. However, CMS updates to telehealth requirements expanded use of telehealth for both physical and behavioral health providers, and CCHA is optimistic that this expansion will further reduce gaps in coverage over the long term. SUD services, for example, are included in the telehealth expansion, which provides an opportunity for increased access that was not previously available. Additionally, CCHA noted month-over-month increases in use of telehealth by nearly 2,800% in March 2020 and 5,619% in April 2020. CCHA plans to continue tracking telehealth utilization through claims data to understand trends and inform a strategy for leveraging telehealth services to improve members' access to care.

Data Limitations

CCHA also assesses circumstantial issues that present as network adequacy issues to determine actions necessary for resolution. One example of reporting limitations is due to gaps in provider data. When reporting providers who can be categorized in multiple categories, such as OB/GYN specialists who also serve as a general primary care practitioners, RAEs must assign the provider to a single category for reporting. 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 skews the results of network adequacy analyses and negatively affects member-to-provider ratios and time and distance calculations. Further, practitioners are contracted as affiliates of PCMP sites, and the scope of information collected upon contracting includes contractually required information as well as voluntary details such as providers' secondary and tertiary specialty types, specific disability accommodations/equipment, cultural competencies, etc. With that, CCHA has updated contracting applications and OSR forms to help collect as many practice details as possible. These efforts have significantly increased the level of detail available about provider specialties and practice attributes; however, such discretionary details continue to be underreported, resulting in apparent insufficiencies in network specialties and expertise.

Mental Health Certifications

As indicated in Table 2b, CCHA is contracted with both physicians and psychiatrists. Within Region 7, CCHA is contracted with AspenPointe CMHC, four psychiatric hospitals, and one Acute Treatment Unit (ATU) which is 27-65 certified. CCHA has an open network in which all IMDs and all but one CMHC is contracted statewide.

Network Adequacy Analysis

Software

Physical Health Provider Analysis: QGIS, Version 3.10 and Maptitude 2020, Build 4720, 64-bit
Behavioral Health Provider Analysis: Quest Analytics Suite, Version 2019.4, Build 127, 64-bit

Time and Distance Methodology

When mapping members to their respective counties with analytics software, some addresses/zip codes map to a county that differs from the county indicated in the membership file. As such, the membership in each county does not precisely align with the member roster.

For the physical health network, time and distance calculations are provided for the Region 7 counties in which CCHA is designated to contract primary care providers. A total of 9,778 members were excluded from the time and distance portion of the report because their county of residence is not within a Region 7 county.

Appendix

Table 1: Cultural Competency by County

PROVIDER TYPE	EL PASO COUNTY	PARK COUNTY	TELLER COUNTY
Total PH Providers Trained in Cultural Competency	**239 of 476 Providers**	**0 of 2 Providers**	**7 of 12 Providers**
Total BH Providers Trained in Cultural Competency	**46 of 1,136**	**0 of 25**	**2 of 52**

Table 2a: Number of Physical Health Providers by Provider Type

PROVIDER TYPE	EL PASO COUNTY			PARK COUNTY			TELLER COUNTY		
	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS
Adult Primary Care	367	337	163	2	2	0	11	9	4
Pediatric Primary Care	397	342	155	2	2	0	11	9	4
OB/GYN	9	6	6	0	0	0	0	0	0
Family Planning	221	211	136	2	2	0	5	5	5
Total Unique Providers	**476**			**2**			**12**		

Table 2b: Number of Behavioral Health Providers by Provider Type

PROVIDER TYPE	EL PASO COUNTY			PARK COUNTY			TELLER COUNTY			OTHER COUNTY		
	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MBRS	# OFFERING WEEKEND & AFTER-HOURS
Adult Mental Health Providers	985	919	682	17	13	10	49	47	35	3490	2849	2520
Pediatric Mental Health Providers	1	1	0	0	0	0	0	0	0	19	17	14
Adult Psychiatrist /Psychiatric Prescribers	66	62	52	2	2	2	2	2	2	390	316	329
Pediatric Psychiatrist /Psychiatric Prescribers	47	46	29	0	0	0	1	1	0	109	105	102
Adult SUD Providers	18	17	7	3	3	3	0	0	0	174	172	99
Pediatric SUD Providers	19	18	8	3	3	3	0	0	0	176	174	100
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	3	2	3	0	0	0	0	0	0	9	9	9
Psychiatric Residential Treatment Facilities	2	2	3	0	0	0	0	0	0	12	12	12
Total Number of Unique BH Providers	**1136**			**25**			**52**			**4358**		

Table 3: Network Adequacy Analysis

PROVIDER TYPE	TOTAL MBRS	TOTAL PROVIDERS W/IN ACCESS RANGE	ACCESS STANDARD	PERCENT W/ ACCESS	PERCENT W/O ACCESS
Adult Primary Care Providers	90,995	413	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 45 miles/45 minutes Frontier - 2 Providers within 60 miles/60 minutes	98%	2%
Pediatric Primary Care Providers	72,510	435	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 45 miles/45 minutes Frontier - 2 Providers within 60 miles/60 minutes	99%	1%
RAE OBGYN Providers	63,596	79	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 45 miles/45 minutes Frontier - 2 Providers within 60 miles/60 minutes	99%	1%
Adult Mental Health Providers	100,339	4,757	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	100%	0%
Pediatric Mental Health Providers	78,163	22	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	2%.	98%
Adult Psychiatrist / Psychiatric Prescribers	100,339	499	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	99%	1%
Pediatric Psychiatrist / Psychiatric Prescribers	78,163	165	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	98%	2%
Adult SUD Providers	100,339	205	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	98%	2%
Pediatric SUD Providers	78,163	208	Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	99%	1%
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	178,502	28	Urban - 2 Providers within 20 miles or 20 minutes Rural - 2 Providers within 30 miles or 30 minutes Frontier - 2 Providers within 60 miles or 60 minutes	91%	9%
Psychiatric Residential Treatment Facilities	178,502	17	Urban - 2 Providers within 20 miles or 20 minutes Rural - 2 Providers within 30 miles or 30 minutes Frontier - 2 Providers within 60 miles or 60 minutes	87%	13%

Figure 1: Breakdown of Other (non-English) Languages Spoken by Physical Health Providers in Each County

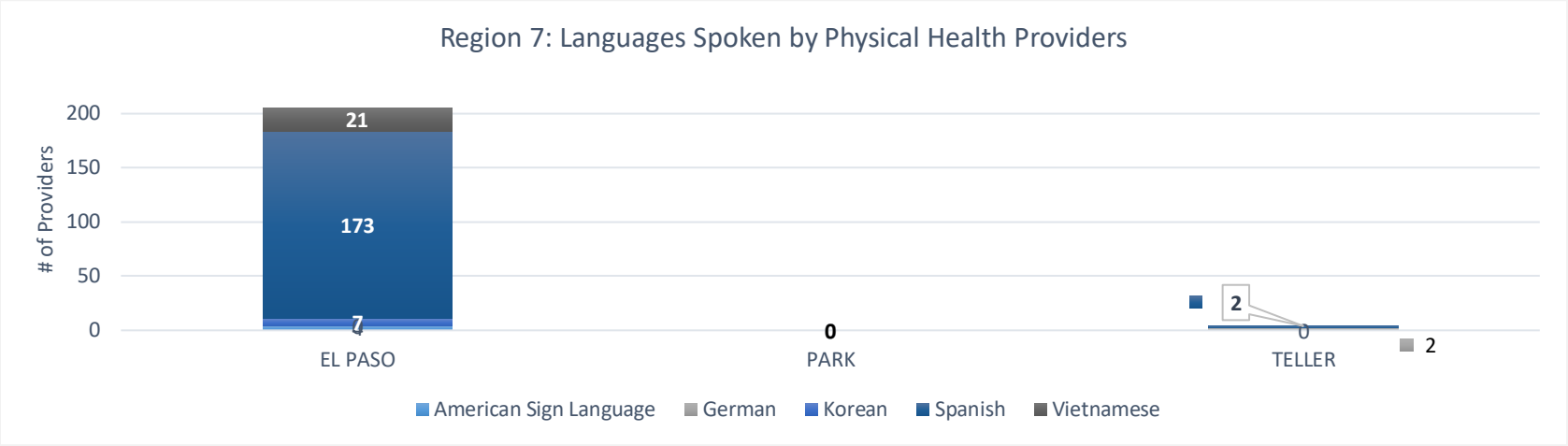

Figure 2: Breakdown of Other (non-English) Languages Spoken by Behavioral Health Providers in Each County

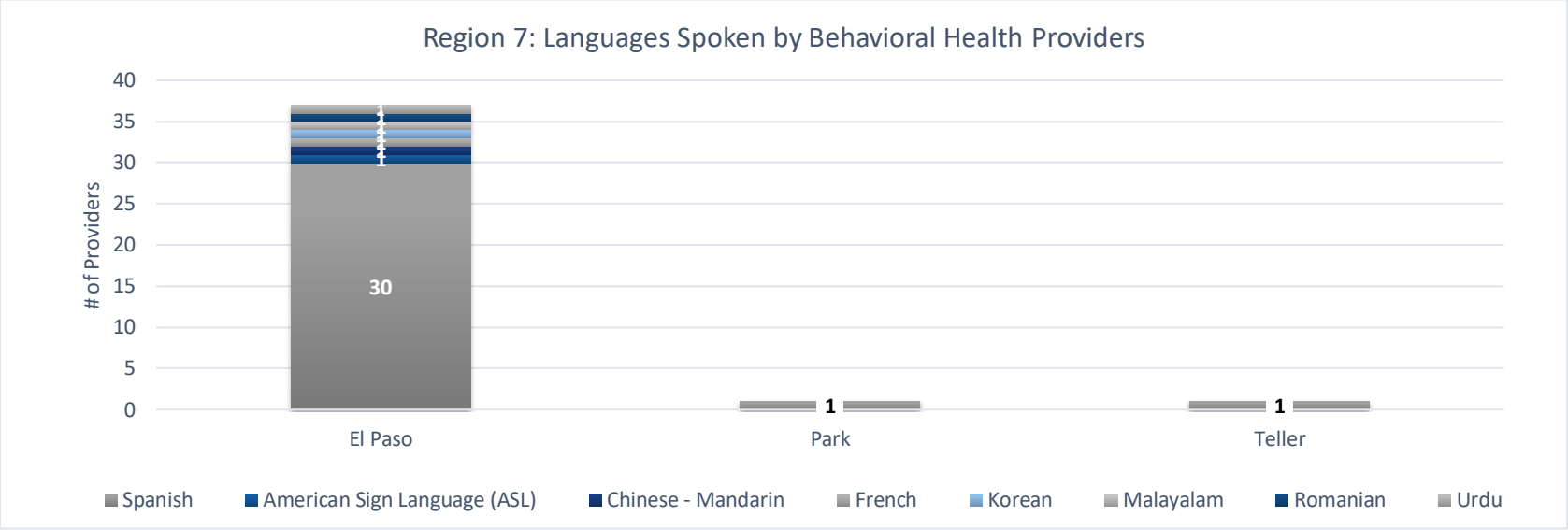

Figure 1 and Figure 2 Notes: Provider languages spoken is voluntary information collected at the time of contracting. Numbers are not fully representative of providers' spoken languages.