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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: *19-107520A3*

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Report due by 1/31/2020, covering the MCE's network from 10/1/2019 – 12/31/2019, SFY Q2

—Final Copy—

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Contents

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Department of Health Care Policy & Financing

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_1219* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_1219* 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" 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.

- An "entity" refers to a hospital, pharmacy, imaging services, and laboratories.

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 (*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 providers 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., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
- To count practitioners/practices/entities ("providers"):
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 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 practices or entities 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: Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	169,237	N/A	165,214	N/A
Total practitioners	482	N/A	483	N/A
Practitioners accepting new members	409	84.7%	410	84.9%
Practitioners (or practices) offering after-hours appointments	33	34.7%	33	35.1%
New practitioners contracted during the quarter	9	1.9%	5	1.0%
Practitioners that closed or left the MCE's network during the quarter	0	0.0%	3	0.6%
Total behavioral health practitioners	2,327	N/A	2,218	N/A

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners accepting new members	2,243	96%	2,032	97%
Behavioral health practitioners (or practices) offering after-hours appointments	571	26%	1,430	64%
RAE				
Total PCMP practice sites	94	N/A	94	N/A
PCMP practice sites accepting new members	33	34.7%	79	84.0%
PCMP practice sites offering after-hours appointments	80	84.2%	33	35.1%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of providers 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: • Behavioral health provider reimbursement changes: 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. Two practitioners opted out of the behavioral health network due to the change in rates. • Behavioral health contracting timeline: 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. As part of these efforts, CCHA also increased provider education and informational resources around processes. • General lack of providers: The Region 7 Provider Network is highly diverse in terms of network adequacy and access to care. All members residing in Region 7 have a choice of two or more providers; however, there are ongoing challenges due to the general lack of health care providers in Park and Teller counties.

COLORADO
Department of Health Care Policy & Financing

Categories Included in Network

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

- To count practitioners/practices/entities ("providers") for Table 2A:
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 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 practices or entities 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.
  - Do not include Federally Qualified Health Centers (FQHCs) when counting Essential Community Providers (ECPs).
  - Use the following hierarchy for determining unique providers, with the narrowest definition first (e.g., if a School Based Health Center [SBHC] is also an FQHC or Rural Health Clinic [RHC], report it under the SBHC row in Table 2A):
    - Indian Health Care Providers (i.e., a healthcare program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization)
    - SBHC
    - FQHC
    - RHC
    - Substance Use Disorder Clinics (*interChange* Provider Type 64)
    - Hospitals
    - Community Mental Health Centers (CMHC)
    - Essential Community Providers
      - ECPs include all other private providers that cannot be qualified as a FQHC or SBHC; i.e., Providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of the patient population. To be designated as an "ECP", the provider must demonstrate that it meets the requirements defined in Section 25.5-5-404(2) C.R.S.
    - Other-Primary Care Providers
    - Other-Behavioral Health Providers

– The providers capable of billing both Medicare and Medicaid category may duplicate providers counted in the categories described above.

Table 2A-Categories in Network: Data

Requirement	Total In-Network
Sample	*0*
CHP+ MCO, Medicaid MCO, RAE	
Indian Health Care Providers	0
School Based Health Centers (SBHC)	2
Federally Qualified Health Centers (FQHC)	86
Rural Health Clinics (RHC; not applicable to Medicaid MCO)	86
Substance Use Disorder Clinics	59
Hospitals	11
Community Mental Health Centers (CMHC)	57
Essential Community Providers (ECP; not applicable to Medicaid MCO)	1
Other-Primary Care Providers	0
Other-Behavioral Health Providers	15
CHP+ MCO, Medicaid MCO	
Pharmacies	0
CHP+ MCO, Medicaid MCO, RAE	
Providers capable of billing both Medicare and Medicaid	755

Table 2B-Categories in Network: Discussion

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with providers 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 behavioral providers 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. 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.

COLORADO
Department of Health Care Policy & Financing

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 3-Access for Special Populations: Discussion

Describe the methods used by the MCE to count providers 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 70 practices; 90% of behavioral health practices statewide and 73 practices in the Region 7 network have reported enhanced physical access and/or accessible equipment as of the end of the reporting period. 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 Office Systems Review with practice transformation coaches and/or 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. 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. In addition to monitoring provider access, CCHA assesses all members for transportation needs to help facilitate members' access to the network. Transportation is arranged directly through Non-Emergent Medical

Describe the methods used by the MCE to count providers 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.
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 102 member cases, and provided 213 transportation resources. To support a culturally competent network, CCHA and network providers facilitate language assistance services, including interpretation and American Sign Language 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. The CCHA Quality team attends daily rounds with the CCHA clinical team to ensure that we are proactively identifying any quality of care concerns. We track and trend all potential concerns and prepare individual reports for facilities that meet our minimum "trend" threshold (per our policy). CCHA uses the reports as an opportunity to understand facility policy and procedures and to address any concerns we are seeing as an oversight body. We also participate in clinical quality reviews at some facilities. We believe this has opened up the discussions surrounding best practices and collaboration between entities. We also utilize our Quality Management Committee (QMC) on a quarterly basis to review challenging quality of care cases and use it as a platform to share best practices across the regions. Finally, 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 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
No changes were submitted to the State or noted during the reporting period. CCHA will continue to monitor and track any trend that may affect quality of care, competence, and professional conduct. Though there were no changes related to quality of care, the following is a summary of provider additions and terminations that occurred during the reporting period: • To correct an administrative record, UCHealth disaffiliated their Woodland Park clinic and re-affiliated the clinic using the appropriate site ID. CCHA notified all members assigned to the Woodland Park clinic to ensure they were informed on their options to continue care at the clinic or choose a different provider. BH Provider Terminations: • Left the network due to rate change: 2 • Left the network due to unspecified reason: 5

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 provider'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 provider's failure to receive credentialing or re-credentialing from the MCE?**
CHP+ MCO
N/A

COLORADO
Department of Health Care Policy & Financing

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 provider.

- Retroactively enrolled or providers with a pending contract status are not available to offer services and should be excluded from this discussion.

Table 6-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 provider? **2. Did the MCE have a health care provider that was no longer identified as a participating provider in the *interChange*?** **If the MCE answered "yes" to Requirement 2 above, did the MCE terminate its health care provider contracts for provision of services to members with contracted providers?**
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 7-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 8-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 9-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 10-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 the request.
  ○ 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 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).
 	
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:

The CCHA Provider Incentive Program is used to help drive quality improvement activities, including access and availability of appointments for members. During Q1 and Q2 SFY2019-2020, PCMPs 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. Beginning in Q3, CCHA will expand this work and begin collecting 3NA data from non-coached practices and assessing hospital follow-up appointments.

The 3NA data CCHA collected from coached practices in the following tables indicates there was a slight dip in well-care visit availability from Q1 to Q2 of SFY 2019-2020. Though this is relatively common during cold and flu season, CCHA will monitor in upcoming quarters to confirm the rates rise again, as anticipated, to meet member demand. Efforts to collect data for hospital follow-up appointments and from non-coached practices are slated to begin in Q3 as CCHA continues to work with the network on improving appointment availability.

Region 7: SFY 2019-2020 – Quarter 1				
Visit Type	Standard	Q1 Numerator	Q1 Denominator	Q1 Rate
Urgent/Acute	Within 24 hours of member request	44	63	70%
Inpatient hospitalization follow up	Within 7 days after discharge	Starting data collection in SFY19-20 Q3		
Non-urgent, symptomatic	Within 7 days of member request	51	63	81%
Well care physical examinations	Within 30 days of member request	57	63	90%
Region 7: SFY 2019-2020 – Quarter 2				
Visit Type	Standard	Q2 Numerator	Q2 Denominator	Q2 Rate
Urgent/Acute	Within 24 hours of member request	48	62	77.4%
Inpatient hospitalization follow up	Within 7 days after discharge	Starting data collection in SFY19-20 Q3		
Non-urgent, symptomatic	Within 7 days of member request	55	62	88.7%
Well care physical examinations	Within 30 days of member request	53	62	85.6%

Table 11-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. Any provider who does not meet the contracted access to care standards is placed under corrective action to remediate the access issue. Results from the 2019 survey are currently being evaluated and will be reported in Q3.

4. Time and Distance Standards

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 providers 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 tables below. ***A provider should only be counted one time in the tables below; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under Family Practitioner.***

COLORADO
Department of Health Care Policy & Financing

Table 12-Software Package Used for Time and Distance Calculations

List and describe the software package(s) and/or processes that your MCE uses to calculate provider counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed. **If your MCE does not use driving distances when calculating time and distance results, describe the method used.**
CHP+ MCO, Medicaid MCO, RAE
Software: • Tableau • QGIS – installed in Q2 for use beginning in Q3 • GeoNetworks 2018, Version 2 for behavioral health providers As CCHA continues to streamline the data warehouse for physical and behavioral health data, the comprehensive provider datasets are maintained in separate systems. As such, time and distance results are provided for the behavioral health network only for this reporting period. Time and Distance Methodology – Physical Health Network: Though PCMP time and distance calculations are unavailable for Q2, CCHA reviewed distance in Tableau by mapping members and the radial distance around PCMPs, per the standards. Any fallout indicates an area of deficiency, which is then further assessed to understand the deficiency, i.e. whether the area is lacking providers or the provider is not contracted with CCHA. By this methodology, all members in the network have access to a PCMP within time and distance standards. Although this method of assessment is effective in determining areas of focus for achieving network adequacy, there is opportunity for improvement and it excludes capabilities to calculate time and distance according to specifications. However, CCHA recently procured QGIS software and looks forward to reporting on this measure in the Q3 report. Time and Distance Methodology – Behavioral Health Network: When mapping the members to the counties using the GeoNetworks program, some zip codes do not map to the same county indicated in the member roster. For example, 1,164 member reside in Park County per the member roster, but GeoNetworks assigned 1,081 member addresses to Park County. As such, CCHA deferred to GeoNetworks county assignment for assessing time and distance. Though the membership in each county is not aligned with the member roster, all members on the roster are included and accounted in the time and distance results.

COLORADO
Department of Health Care Policy & Financing

Table 13–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
Discussion – 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. El Paso County • Psychiatric Residential Treatment Facilities: o Time standard: 99% member access o Distance standard: 99% member • Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals o Time standard: 98% member access o Distance standard: 97% member • Adult Substance Use Disorder Provider o Time standard: 99% member access o Distance standard: 99% member • Pediatric Substance Use Disorder Provider o Time standard: 100% member access o Distance standard: 99% member Park County • Psychiatric Residential Treatment Facilities: o Time standard: 73% member access o Distance standard: 59% member • Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals o Time standard: 8% member access o Distance standard: 0% member • Pediatric Substance Use Disorder Provider o Time standard: 93% member access o Distance standard: 70% member Teller County • Psychiatric Residential Treatment Facilities: o Time standard: 94% member access o Distance standard: 91% member • Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals o Time standard: 7.5% member access o Distance standard: 0% member • Adult Substance Use Disorder Provider

- Time standard: 100% member access
- Distance standard: 98% member

- Pediatric Substance Use Disorder Provider
  - Time standard: 99% member access
  - Distance standard: 94% member

Addressing Access to Care:

CCHA continues to prioritize access by partnering with the local county departments, non-profit organizations, and providers in nearby counties to ensure the members are able to access covered services without unreasonable delay. Examples of efforts to increase access in Teller County include:

- CCHA's partnership with Aspen Mine Center (AMC). AMC will continue providing care coordination services in Teller County during the 2020 calendar year. Further, CCHA provisioned and trained AMC care coordination staff on use of CCHA's care management system, Essette, to help improve and streamline care coordination services.
- Awarding Ute Pass Regional Health Service District outreach funds through the CCHA Community Incentive Program, which provides a co-responder model to members, will help improve access to behavioral health services in Teller County.

Table 14–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

Similar to CCHA's urban counties, members residing in Park County have access to providers in neighboring Region 7 counties within the time and distance standards. However, CCHA remains alert to the ongoing lack of provider options within the county and partners with local county departments, non-profit organizations, and providers in nearby counties to ensure the members are able to access covered services without unreasonable delay. Examples of efforts to increase access through partnerships include:
• Continued discussions to contract the HealthONE clinic in Fairplay.
  ○ CCHA provided HealthONE with contracting documents.
  ○ As of December 2019, the clinic's site and provider Medicaid IDs were pending.
• CCHA's partnership with Rocky Mountain Rural Health (RMRH). RMRH will continue providing care coordination services in Teller County during the 2020 calendar year. Further, CCHA provisioned and trained RMRH care coordination staff on use of CCHA's care management system, Essette, to help improve and streamline care coordination services.

Table 15–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
N/A – No frontier counties in Region 7.

Network Directory

Supporting contract reference: For each of the following provider types covered under this contract the MCE must make the following information on the MCE's network providers available to the enrollee in paper form upon request and electronic form:

- Provider'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 providers will accept new enrollees,
- The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training,
- Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

Table 16-Network Directory: Discussion

Please list the MCE's website URL. **Is the MCE provider network information updated at least monthly?** **Did the MCE make the network providers' information available to the enrollee in paper form upon request and electronic form?**
CHP+ MCO, Medicaid MCO, RAE
CCHA Website URL: www.CCHAcares.com 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.

Appendix A. 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 is working on correcting issues that caused some of the Medicaid IDs for behavioral health providers to be excluded from the report. The issue will be resolved in the next report.

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.