Colorado Access

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Introduction

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

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

Contract Citation 9.8.1.1.

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

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

RCCO (Primary Care) Provider Network

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

Building on this foundation, COA will use various resources to further target potential additions and grow our network of providers. COA has a dedicated provider contracting

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

team that responds to inquiries and requests to participate in our network on a daily basis. These requests consistently arise from:

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

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

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

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

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

Behavioral Health Provider Network

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

[2] Please see Appendix 1

procedures remain the same as when operating as the BHO. Future amendments will apply to all contracts, whether executed prior to or after July 1, 2018.

As such, our network of behavioral health providers continues uninterrupted and is the footing for our RAE efforts to ensure adequate access to behavioral health services for our members. This existing network includes contracted relationships with every Community Mental Health Center in the state, hospital systems, behavioral health providers who are integrated with PCMPs, and independent behavioral health providers, statewide. Colorado Access has completed contracting with Behavioral Health providers, but we are always evaluating our network to expand member access to services.

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

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

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

Our PPA asks providers if they are able to "effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities." We interpret "cognitive disabilities" to mean mental disabilities. If the Department has different guidance, please let us know, and we will incorporate that into our PPA.

Under the RAE contract, Colorado Access will be responsible for administering the behavioral health program for the region previously administered by Behavioral Healthcare Incorporated (BHI). As part of our plan to ensure network adequacy under the RAE, COA has outreached former BHI providers who were not previously a part of our network. Currently, COA has finalized contracts with 56 out of 59 of these "non-PAR" providers.

[3] Please see Appendix 1

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

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

Integrated Care and Telehealth

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

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

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

Contract Citation 9.8.1.2.

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

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

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

Contract Citation 9.8.1.3. – 9.8.1.7.

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

[4] Please see Appendix 1

Number of network providers by provider type

	Adams	Arapahoe	Douglas	Elbert	RAE 3 Total	Other
Adult Primary Care	468	295	135	3	**901**	**810**
Pediatric Primary Care	247	151	104	0	**502**	**98**
Ob/Gyn	38	61	33	0	**132**	**119**
Adult Mental Health	597	765	85	17	**1,464**	**2,249**
Pediatric Mental Health	42	3	0	0	**45**	**15**
Substance use disorder	8	12	5	0	**25**	**30**
Psychiatrist	76	59	13	0	**148**	**140**
Child Psychiatrist	31	3	0	0	**34**	**15**
Psychiatric Prescribers	106	58	12	0	**176**	**146**
Family Planning	0	0	0	0	**0**	**0**
Total	**1,613**	**1,407**	**387**	**20**	**3,427**	**3,622**

Geographic location of providers in relationship to where Medicaid members live

Physical Health: distance to providers

County	Total number of Members	Total number of Providers	Members w/in desired access to 2 providers	%	Avg. distance to provider 1 (miles)	Avg. distance to provider 2 (miles)
Adams	119,069	4,752	119,069	100	0.9	1.0
Arapahoe	124,760	2,048	124,760	100	0.9	1.0
Douglas	20,149	914	20,149	100	1.7	1.7
Elbert	2,517	23	2,511	99.8	7.7	7.7

Physical Health: time to providers

County	Total number of Members	Total number of Providers	Members w/in desired access to 2 providers	%	Avg. time to provider 1 (min)	Avg. time to provider 2 (min)
Adams	119,069	4,752	119,069	100	1.7	1.8
Arapahoe	124,760	2,048	124,736	100	1.9	1.9
Douglas	20,149	914	20,149	100	2.3	2.3
Elbert	2,517	23	2,458	97.7	7.9	7.9

Behavioral Health: distance to providers

County	Total number of Members	Total number of Providers	Members w/in desired access to 2 providers	%	Avg. distance to provider 1 (miles)	Avg. distance to provider 2 (miles)
Adams	119,069	1,918	119,069	100	1.1	1.1
Arapahoe	124,760	2,279	124,760	100	0.9	0.9
Douglas	20,149	295	20,149	100	1.6	1.6
Elbert	2,517	46	2,517	100	6.2	6.2

Behavioral Health: time to providers

County	Total number of Members	Total number of Providers	Members w/in desired access to 2 providers	%	Avg. time to provider 1 (min)	Avg. time to provider 2 (min)
Adams	119,069	1,918	119,069	100	1.9	1.9
Arapahoe	124,760	2,279	124,736	100	1.8	1.8
Douglas	20,149	295	20,149	100	2.1	2.1
Elbert	2,517	46	2,506	99.6	6.7	6.7

Cultural and language expertise of providers

	Adams	Arapahoe	Douglas	Elbert
Abkhaz		12		
Afar			1	
Afrikaans		4		
Amharic		34		
Arabic	12	59		
Bosnian		4		
Chinese	8	18	8	
Czech		1	12	
Dutch				
Faroese				
Farsi	8	6	6	
French	56	66	27	
German	15	13	21	
Greek		19		
Hebrew	19	1		
Hindi		61		

Igbo	21			
Italian		2	3	
Japanese				
Korean		29		
Lithuanian				
Malay	12			
Mandarin	1	26	26	
Persian	13			
Polish		10	5	
Portuguese		8	8	2
Romanian		6		
Russian	12	33	12	
Sign language	51	15		
Spanish	340	518	269	
Tagalog		1		
Thai		14		
Translation Services Available by Request	8	38	28	5
Urdu		10		
Vietnamese			1	

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

	Adams	**Arapahoe**	**Douglas**	**Elbert**
Adult Primary Care	321	184	102	2
Pediatric Primary Care	177	110	90	0
Total locations	**498**	**294**	**192**	**2**

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

Adams	**Arapahoe**	**Douglas**	**Elbert**
123	58	31	0

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

	Adams	Arapahoe	Douglas	Elbert
Adult Mental Health	214	222	37	2
Pediatric Mental Health	34	1	0	0
Total locations	**248**	**223**	**37**	**2**

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

Adams	Arapahoe	Douglas	Elbert
58	55	6	0

Contract Citation 9.8.3.1-9.8.3.4

Percent of PCMPs accepting new Medicaid members

	Adams	Arapahoe	Douglas	Elbert
Adult Primary Care	69%	62%	76%	67%
Pediatric Primary Care	72%	73%	87%	0%
Total locations	**70%**	**66%**	**80%**	**67%**

Percent of behavioral health providers accepting new Medicaid members

	Adams	Arapahoe	Douglas	Elbert
Adult Mental Health	36%	29%	44%	12%
Pediatric Mental Health	81%	33%	0%	0%
Total locations	**39%**	**29%**	**44%**	**12%**

Percent of PCMPs offering afterhours appointments

Adams	Arapahoe	Douglas	Elbert
17%	13%	13%	0%

Percent of behavioral health providers offering afterhours appointments

Adams	Arapahoe	Douglas	Elbert
7%	6%	5%	0%

Contract Citation 9.8.1.8. – 9.8.1.9.

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

Caseload for behavioral health providers.

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

Contract Citation 9.8.1.10.

Number of behavioral health providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region.

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

Contract Citation 9.8.1.11.

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

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

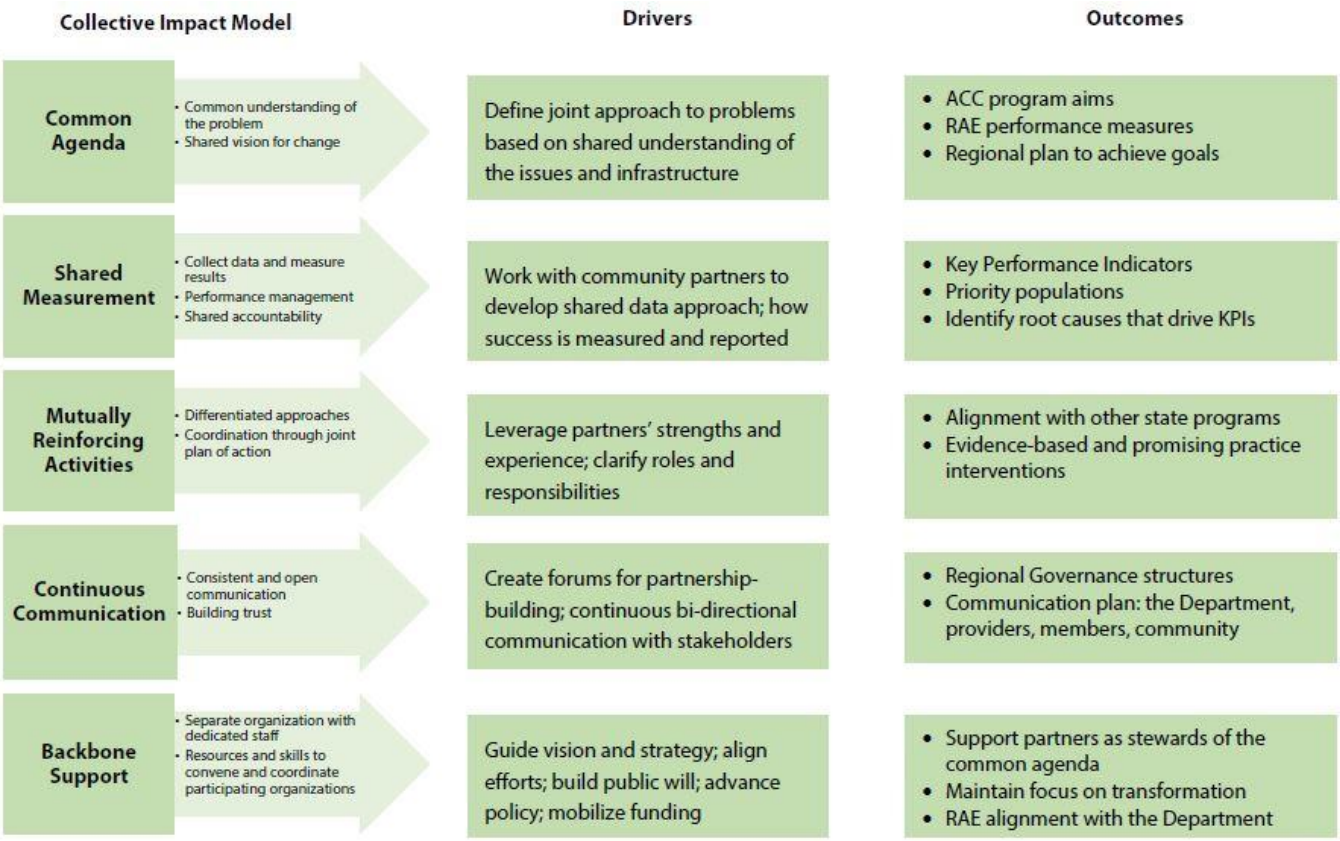
As a primarily urban/suburban region, network adequacy issues stem less from physical proximity to providers than from system fragmentation and unilateral efforts to mitigate structural impediments. In short, there are many resources within our regions whose focus is on meeting various needs of underserved and vulnerable populations, but these resources often operate independently from each other—inhibiting efficiency and effectiveness across the spectrum. Therefore, COA champions a transformative process that leverages community resources and collective wisdom across all sectors that interface with our members. Through this process we are able to better understand the barriers to sustainable healthfulness faced by our members as well as the structural obstacles that impact those who serve them. In general terms, we describe these processes as **Health Transformation Framework** and **COA Health Neighborhood**.

Health Transformation Framework

The Colorado Access Health Transformation Framework is built upon the Collective Impact Model and its five conditions for success which, working synergistically, produce alignment and lead to powerful results. They are:

1. **A common agenda:** The partners committed to the Collective Impact Model (organizations, agencies and other stakeholders) have a common understanding of the problems, a collective approach to solving them, and a shared vision for change.
2. **Shared measurement systems:** The partnership has a collective focus on performance management and shared accountability. To bring consistency and clarity to these efforts, participants define and implement shared methods for collecting data and measuring results.
3. **Mutually reinforcing activities:** Through a coordinated, joint plan of action, each participating organization or other stakeholder conducts a specific and differentiated set of activities that support and align with the actions of others.
4. **Continuous communication:** Partners have a forum for consistent and open communication, with a focus on building the mutual trust necessary to succeed.
5. **Backbone organization:** The partnership is led by one organization—the chief support system—that has the staff, resources, and skills to convene, handle logistics, and coordinate the various efforts of the collective.

The graphic below outlines the Collective Impact Model and how it will drive COA strategies and outcomes:



Under the Collective Impact model, partner agencies work to define common goals and measurement systems in order to better engage across large-scale initiatives—and to keep all partners engaged until goals are achieved. As the Backbone Agency, COA has convened a Governing Council for R3 (as well as R5), that includes our most prominent providers. Together, we work to prioritize coordinated actions and mutual incremental goals aimed at driving KPI performance. The ultimate "shared measurement systems" are Department defined KPIs. However, by bringing our most influential providers together into a single council, and tasking that council to help define viable, coordinated approaches to meeting the KPIs, KPI performance becomes a shared endeavor for all involved parties, as opposed to a summary of unilateral provider actions within a common region.

COA's Health Transformation Framework includes partnering with disparate entities whose missions focus on meeting the needs of specialty populations. By engaging across these various systems and leading the identification of mutual agendas, we will help foster consistent, meaningful, and thorough access to the care and resources necessary to enhance

the health of our most vulnerable members. These interactions will be reported on via our quarterly Network Adequacy Reports.

COA Health Neighborhood Model

For Members already engaged with or needing to become engaged with the healthcare system, COA employs a Health Neighborhood model that utilizes technology, care coordination, collaboration, specialty care compacts, analysis, and community/member engagement to enhance meaningful access to—and utilization of—care for our members. The eight key functions of the COA health neighborhood model are:

1. Share clinical information, supported by appropriate Health Information Technology (HIT) systems. Creating mechanisms for sharing clinical data across the health neighborhood to ensure efficient and effective flow of appropriate member information to facilitate consultations, referrals, and care transitions.
2. Ensure appropriate and timely consultations and referrals. Implementing a series of mutually-reinforcing activities that improve the efficiency and effectiveness of specialty resources by ensuring that specialists see the right patient at the right time and in the right setting.
3. Expand the neighborhood. Partnering with regional stakeholders to assure that all relevant providers, especially medical specialists, are identified, engaged and participating in the health neighborhood.
4. Provide ongoing care coordination and ensure successful transitions of care. Implementing comprehensive care coordination services to improve coordination across the neighborhood, especially during transitions between providers; reducing members' barriers in accessing the system and complying with treatment plans; and honoring a member's preferences and wellness goals.
5. Guide determination of responsibility in co-management situations. Improving coordination and collaboration between PCMP and behavioral health providers and specialists, through care compacts, protocols and business processes that clearly define respective roles regarding pre-consultation exchange, formal consultations, co-management, and transfer of care.
6. Develop individualized care plans for complex members. Developing individualized care plans for high-risk, complex members that identify their health care needs, honor and incorporate their preferences, and include interventions to connect them with the services and supports they require to achieve whole-person health.
7. Collect and analyze social determinant of health data consistently across the neighborhood. Collaborating with neighborhood partners to universally screen for social factors that influence member health. Use data to identify appropriate referrals to community-based resources. Aggregate and analyze data to inform regional population health and care coordination activities.
8. Build and strengthen community resource linkages. Developing a centralized resource directory and improving referrals and warm handoffs between clinical providers and community and social service agencies.

The COA Health Neighborhood model acknowledges that communities are unique, dynamic, and constantly adapting to local needs and opportunities. Within each of the eight key functions of the model, our approach is not one-size-fits-all. Instead, we will build on the local resources, infrastructures, relationships, and processes that we have developed with our partners to lead the region toward a more efficient, organized, and effective system—with improved, meaningful access to care and resources. This includes consistent connection to the ideas and policies of a wide range of partners coupled with the expertise to realistically guide discussions and goals toward real-world actions and outcomes. As with the Health Transformation Framework, we will report on Health Neighborhood interactions in more detail in the quarterly Network Adequacy Report, but examples of current partnerships include:

- Community Mental Health Centers & Federally Qualified Health Centers;
- Major commercial providers and hospital systems;
- Regional Governance Councils for Region 3 and Region 5;
- Each active Interagency Oversight Group within our regions;
- School districts in various counties in our regions;
- Healthy Communities;
- County Departments of Human Services and Local Public Health Agencies;
- County jails and State correctional facilities;
- Various partners and stakeholders engaged with our Single Entry Point and CHP+ functions;
- State of Colorado agencies and committees (PIAC and its advisory committees).

When combined with our efforts to enhance and grow our primary care and behavioral health networks, an active and engaged care management structure, in-depth provider support and training, practice transformation and integration efforts, and constructive Member engagement, our Health Transformation and Health Neighborhood models will ensure that our members have access to the care and resources they need, along with the backing of organizations mutually focused on improving opportunities for sustained healthfulness.