



Network Adequacy Plan

Region 6

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Network Development

During the first year of implementation, CCHA's recruitment and contracting efforts were focused on primary and behavioral health care providers who were enrolled in the CO Medicaid program, in good standing with the Centers for Medicare and Medicaid Services (CMS), and interested in participating in the Accountable Care Collaborative (ACC) as a partner of the Regional Accountable Entity (RAE). When making outreach attempts, CCHA targeted public and private providers using the previous network of Primary Care Medical Providers (PCMPs), practices that were previously requested by members but not contracted to participate in the ACC, and practices that appeared on the non-contracted provider lists provided by the Department of Health Care Policy and Financing (HCPF). For behavioral health, CCHA focused initial outreach efforts 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. With seamless transition of care as the primary goal, all efforts were made to be inclusive of physical and behavioral health providers who were actively providing services to members.

Once outreach was successful, the contracting department worked to perform the necessary paperwork while provider relations focused on provider education and support around changes implemented with ACC Phase II. Information on attribution and other changes that came with ACC Phase II were discussed with providers during regional meetings and in smaller groups tailored to specific provider types such as Community Mental Health Centers (CMHC's) and Federally Qualified Health Centers (FQHCs).

In summary, CCHA focused a great deal of efforts on working with network providers and other RAEs to aid in transition and implementation of ACC Phase II, ensuring members would have continued access to both their physical and behavioral health providers.

Open Network

Beyond the work that CCHA did to onboard the provider network, CCHA believes that an open network is a necessary component of our long-term strategy to increase access to members. As such, CCHA continues targeted outreach to contract PCMPs within Region 6, and 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. To date, CCHA's behavioral health network provides access to all institutions for mental disease (IMDs) and is continuing efforts to contract all hospital systems, Community Mental Health Centers (CMHCs), and Federally Qualified Health Centers (FQHCs) statewide.

Contracting

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.

Onboarding

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, including orientation presentations, provider manuals, and a variety of other resources that help familiarize providers with CCHA's provider support model as well as the goals of the ACC program.

As part of the orientation process, CCHA makes an effort to facilitate individual meetings at provider offices to ensure the information is also aligned with each provider's goals and level of experience working with Medicaid members. More specifically, examples of information provided during orientation include CCHA newsletter topics/frequency, education and training materials available on the CCHA website, member support materials that can be ordered, and various tools available to help providers meet performance goals.

Provider Support

For new and existing practices, as described in CCHA Practice Support Plan, CCHA provides ongoing support to primary care practices through practice transformation initiatives, care coordination support, newsletters, member-specific materials, and provider-specific training and resources. CCHA also hosts semi-annual membership meetings for primary care providers, which include training opportunities. The next membership meeting is planned for November 2019.

Similarly, CCHA's provider relations team supports the behavioral health provider community through educational resources and materials, which are readily available on the CCHA website and distributed in provider newsletters. CCHA also hosts open mic sessions where behavioral health providers have an opportunity to convene with colleagues and CCHA staff to share questions/concerns and discuss resolutions for outstanding issues, such as contracting, billing, etc. Further, CCHA meets with key behavioral health facility partners and CMHCs for monthly Joint Operating Committee (JOC) meetings. These open mic sessions and JOC meetings remain an important aspect of building relationships with the provider network, identifying and mitigating trending issues, and hosting a forum for education and information. Finally, CCHA has welcomed a new behavioral health operations director who is dedicated to quality improvement. Quality improvement efforts are currently centered on claims auditing and identifying trending issues to inform providers' training needs. As we move into the next year, quality assurance activities will also be dedicated to continuous improvement of contracting, credentialing, and provider reimbursement workflows.

Network Monitoring and Maintenance

General Access Efforts

CCHA maintains and monitors the provider network in alignment with CCHA's *Provider Recruitment Standards and Measures for Appropriate Availability to Providers* policy and the CCHA Practice Support Plan. Through ongoing quantitative assessment and qualitative evaluation, CCHA is positioned to remain informed and responsive to gaps or barriers in the network that may be unique to a specific demographic or the geographic diversity of the region. Further, CCHA ensures that the contracted networks are capable of serving members across all ages, levels of ability, gender identities, and cultural identities. To aid in medical competence and offer members with the best experience possible, CCHA and network providers also 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 will collaborate with care providers to ensure language assistance services meet the needs of the member.

Addressing Gaps in Coverage

To recruit new primary care providers for areas where there are gaps in coverage, CCHA uses the monthly Enrollment Summary from the State to target outreach to non-contracted providers. This tool is also used to identify high-volume, non-contracted practices that have a potential to impact coverage gaps in a given area as well as recruit PCMPs that offer specialized care, such as OB/GYN women's health specialists who provide routine and preventative care services to members. Additionally, CCHA is working with HCPF to develop a provider recruitment letter, which will aid these ongoing efforts to add services to the network and engage new providers with the RAE and ACC. In areas where gaps in coverage exist because providers are generally lacking, CCHA continues to foster 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.

Regarding strategies to recruit and enhance the behavioral health network, CCHA aims to contract with all CMHCs, 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 Community Mental Health Centers, and 10 of 21 Federally Qualified Health Centers statewide. CCHA also continues to welcome independent providers and any provider with a single case agreement to join the network to help address gaps in coverage.

Although maintaining an open network will help address service gaps, CCHA understands it is only a component to assuring a full array of services is available to members. In an effort to continue closing gaps in network coverage, CCHA continues to pursue innovative opportunities to improve access. First, CCHA is contracted with IESO, which offers a digital platform that provides evidence-based cognitive behavioral therapy appropriate for members with low to moderate mental illness symptoms. CCHA is currently preparing a re-launch effort in Region 6, which is anticipated to kick off in August. Second, CCHA provides informational guidance to behavioral health providers to help expand services through telemedicine. During the first year, an estimated 2,100 members received telehealth services. CCHA processed telehealth claims for 90 behavioral health providers with 46 groups statewide. Of the claims submitted, 7% were submitted by providers in Region 6, 37% were from providers in Region 7, and the remainder was submitted by providers located outside of the Regions 6 and 7, as part of the statewide network. Finally, to facilitate the contracting process, CCHA has a provider email address that providers use to request to join the network and communicate with CCHA's provider relations team.

CCHA continues to monitor ongoing issues surrounding the lack of providers and availability of substance use services in rural counties. CCHA is exploring potential opportunities to recruit and engage providers who have not traditionally served Medicaid. More information will be reported if further evaluation identifies viable opportunities.

Contract Requirements

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 that PCMPs meet all of the criteria to qualify as a PCMP, 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.

CCHA further monitors the network's compliance with contractual requirements and NCQA access to care and quality of services standards using an array of tools, including:

- **Utilization of Services:** CCHA monitors member utilization, and works with providers on maintaining appropriate Medicaid panels and enrollment limits to ensure access to services and required member-to-provider ratios are met.
- **Geographic Location of Providers and Members:** 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.

- **Routine Appointment Waiting Times:** Member access to care is monitored and tracked through providers' timeliness of care, after-hours availability, and accessibility. Additionally, CCHA's practice support efforts help ensure providers can accommodate appointments for more urgent or acute care needs using the 3rd Next Available Appointment¹ methodology. In higher-volume practices, same-day and acute care is often provided by dedicated advance practice providers staffed within the practice.
- **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 recently 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. Additionally, CCHA will utilize the ECHO Survey to gauge member satisfaction with behavioral health services. Data received from HCPF will be reviewed with practices and used identify opportunities for improving patient satisfaction.
- **Provider Data Review:** 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.

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.

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.

Network Adequacy and Reporting Standards

Quarterly, or as requested by HCPF, CCHA shall submit 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.

Ultimately, 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 our maintenance and monitoring activities but also through our attention to provider support and partnership. 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. Once partnered with CCHA, PCMP practices and providers that participate in CCHA’s Provider Incentive and Value-Based Payment programs have the opportunity to receive quarterly payments for their engagement with members and CCHA.

Access for Members with Disabilities

CCHA continues to make strides with the efforts initiated over the past year to ensure access for members with physical and/or mental disabilities. Ongoing efforts include assessing the network’s accommodations, ensuring staff are appropriately trained, and collaborating with local experts to stay up to date on disability competent care.

More specifically, CCHA assessed existent accessibility among the network and discovered practices were underreporting on their access accommodations. As such, CCHA expanded the accessibility information collected on the provider contracting application forms for PCMP locations and behavioral health providers. CCHA also collects the level of access each behavioral health provider can provide to members with physical and/or mental disabilities. With support from the data, CCHA is working to update the online directory to include more detailed accessibility information. These efforts will also help ensure our care coordination and member support staff can connect members to accessible locations based on individual member needs.

As far as direct support, CCHA staff have received training from external partners on delivering disability competent care, which enhanced the support tools available to both members and providers. Practice transformation coaches also encourage practices to assess their practice for ADA compliance and can connect them with necessary resources and training on cultural competency. Further, CCHA has various resources available to providers on the CCHA website, including cultural competency training material and a Caring for Diverse Populations toolkit. CCHA’s Provider Newsletter frequently highlights educational and training information to ensure providers can readily access the most current resources available. CCHA will continue to expand its training options and inform providers accordingly as additional training becomes available. Lastly, care coordinators also support network providers in caring for members with special needs, specifically focusing on complex care coordination, transitions of care, maternity care, high ER use, Medicare-Medicaid enrollees, and general care coordination.

Collaboration is also a key component to ensuring access. CCHA continues to partner with local organizations to explore options to better engage providers and inform members. For example, CCHA is assisting the Center for People with Disabilities (CPWD) and The Independence Center in raising awareness of the new category for Parking Privilege placards: Remuneration – Exempt. This placard waives parking meter fees for persons with certain limitations. Information was distributed to the provider network in the most recent provider newsletter, which included links to a brochure, the parking privileges application, and an informational document created by The Independence Center.

Moving forward, CCHA plans to continue building upon previous collaborations among primary care providers, disability advocacy groups, and Long Term Services and Supports case management agencies to improve continuity of care for members.

Caseload Standards

CCHA's member enrollment determines the composition and capacity of our provider network, including PCMPs, specialists, hospitals, behavioral health providers, and ancillary providers. Provider access will be monitored using population growth, utilization, numbers and types of providers needed, number of providers serving Medicaid, number of providers accepting new Medicaid members, geographic location of members and providers, and accessibility. Specifically, CCHA plans to assess and monitor provider standards in a multitude of ways, such as:

- Geographical mapping and analysis to determine the physical location of each provider in relation to where members reside, which will help inform provider recruitment efforts.
- Assess ratios of members to providers by provider type to determine whether access to services is appropriate based on utilization of services.
- All providers within the travel distance requirements established in the RAE contract will be targeted for ongoing partnership and contracting.
- Determine capacity by multiplying the provider counts for each provider type by the applicable capacity ratio to determine network capacity. Compare the resultant capacity of the network adequacy model to enrollment numbers.
- Optimize continuity of services for members through collaboration and partnership with population centers and high-volume Medicaid providers, and develop more tailored outreach and contracting strategies in areas of sparse provider access to improve continuity in underserved areas.
- Evaluate the capacity and adequacy of the network using a combination of geographic adequacy and the capacity standards in geographical mapping software.
- Compare PCMP utilization and payment data using CCHA's differential payment methodology to identify providers who are over capacity per caseload standards and whose engagement efforts need reassessment.

With full assessment of the network, provider caseloads will be 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

In practice, CCHA monitors the network and provider caseload, at minimum, on a quarterly basis. Detailed information about network activities is reported to HCPF in the quarterly Network Report, upon discovery of a significant change in the network, and upon request from HCPF.

Mental Health Certifications

As indicated in Table 1, CCHA is contracted with both physicians and psychiatrists. Within Region 6, CCHA is contracted with our two CMHCs, Mental Health Partners and Jefferson Center for Mental Health, three psychiatric hospitals, and two short-term residential treatment centers which are 27-65 certified. CCHA has an open network in which all IMDs and all but one CMHC is contracted statewide.

Access for Special Populations

As part of the integrated care coordination model, CCHA works with members, network providers, and the multiple agencies comprising the systems of care to align strategies and prevent obstacles for members through service delivery in multiple community-based settings. Care coordinators help unify and bring resources together, addressing member needs across agencies and systems to reduce duplication, maximize resources, expand member support to integrated care and community resources, and help achieve the best outcomes.

CCHA employs a multi-disciplinary team of care coordinators who facilitate direct connections among members, providers, case management agencies, hospitals, community resources, schools, criminal justice centers, RAEs, and other health neighborhood stakeholders. With a broad network of care coordinators both in the RAE offices and co-located in provider, hospital, and community settings, CCHA and our partners will continue working to ensure members needs are met in alignment with the no wrong door approach to accessing care. Further, co-located care coordinators also support provider staff in the integration and resolution of member needs by identifying care gaps that can be addressed by the provider and helping with the development of member-centered treatment plans.

CCHA's care coordination model is designed to be responsive to both population-specific and member-identified needs, including the following special populations:

- Child welfare-involved members, including foster care:
 - CCHA is working with DHS CORE providers to negotiate rates on certain codes to better support these providers who work with the child-welfare population. Additionally, CCHA is educating core providers on requirements for prior authorization and billing to better streamline operations.

- CCHA is partnering with local DHS and community mental health centers in the region to increase engagement and behavioral health assessments among members involved in foster care.
- CCHA care coordinators attend various case staffing meetings led by DHS 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.
- CCHA identifies members involved in child welfare, and coordinates multi-disciplinary team meetings with families and providers to determine how the systems in place can best meet the ongoing needs of the family.
- **Maternity:**
 - CCHA co-locates clinical care coordinators in hospitals and works to engage members in person, at the point of care. CCHA is also informed of members who are pregnant through direct outreach, referrals, and daily notifications. Once a member is identified for the maternity program, CCHA will engage the member to complete an assessment, develop a care plan, and coordinate supports and services as appropriate.
 - CCHA has collaborated with Healthy Communities to create MOU's, onboarding processes, and shared workflows, which will ensure appropriate referrals to CCHA's Maternity Care Coordination program.
 - CCHA has met with regional representatives of Nurse Family Partnership in order to discuss workflows to ensure timely behavioral health referrals for mothers identified at risk for depression.
- **Justice-involved members:**
 - CCHA uses a number of strategies to identify and support members who are transitioning out of the criminal justice system, including:
 - Monitoring member lists from the Department of Corrections (DOC), which identifies members who are preparing for release;
 - Collaborating with community corrections and parole offices to participate in in-reach events;
 - Co-locating at community corrections facilities, re-entry events, and parole facilities; and
 - Providing direct coordination of member's physical, behavioral, and social needs in partnership with case managers and parole officers.
 - CCHA's care coordinators provide wrap-around support for justice-involved members, including DOC prison systems, parolees, statutorily discharged but not on parole, on probation, involved in pre-trial and diversion programs, or living in community corrections and halfway/transitional housing programs.
 - CCHA also attempts to engage Department of Justice case managers, probation staff, and parole officers on the member's care team. Through jail in-reach, CCHA educates members upon entry to the system, develops a plan of care, introduces members to network providers with whom they will continue care post discharge, and identifies other service needs as appropriate, such as behavioral health.
- **Members identified for the Client Over Utilization Program (COUP):**
 - As identified by the quarterly list provided by HCPF, CCHA engages members who meet the criteria for COUP and informs them of the health and community services available to them. CCHA is currently working on a plan to operationalize the program with input from the provider network.

- Medicare-Medicaid:
 - Medicare-Medicaid enrollees are identified by member rosters. CCHA coordinates in-home assessment to determine quality of setting, address risks related to falls and safety, and develop care plans for coordinating care.
 - CCHA works to develop relationships with other service providers, such as SEP agencies and other agencies providing longer-term services and supports, to coordinate care and case management services as determined by member needs.
 - CCHA is working with behavioral health providers to ensure efficiency in billing practices for members with dual coverage.

CCHA also employs behavioral health provider relations staff who work directly with the provider community to identify any issues and barriers related to access. This team will also work with IESO to offer alternative care options to members in special populations.

Finally, CCHA continues to refine the Health Neighborhood and Community Engagement strategy to meet the goals of the ACC and further partnership with provider and community stakeholders at the local and regional levels. The program aims to enhance efforts to reduce duplication, align strategic priorities, and leverage existing community alliances and resources. The program is guided by goals to improve integrated care:

- Streamline referral processes, needs and risk assessments;
- Expand access to care through telemedicine;
- Share data;
- Promote crisis services;
- Coordinate with hospitals;
- Facilitate transitions of care; and
- Reduce total cost while delivering quality care.

These efforts improve capabilities to meet member needs and are effectively facilitated through continued collaboration and partnership, including but not limited to the following stakeholders:

- Neighboring RAEs;
- Long-term services and supports providers, Single Entry Points, and Community Center Boards;
- Local county departments of human services;
- Local public health agencies (LPHA);
- Healthy Communities;
- Specialists;
- Network Providers, including PCMPs and behavioral health providers;
- Federally Qualified Health Centers;
- Corrections system;
- Community Mental Health Centers;
- Substance use providers / Managed Services Organizations;
- Area Agency on Aging;
- Aging and disability resources for Colorado;
- Non-emergent medical transportation; and
- Hospitals.

An example of this highly collaborative and multi-disciplinary approach is demonstrated in CCHA's work to ensure a high quality of care is accessible to children and families involved with child welfare. CCHA employs a pediatric care coordination team that coordinates with the family, providers, and community agencies on care planning. Care planning meetings help define roles and responsibilities, ensuring services are not duplicative and focus on the family's goals and strengths. In addition to collaboration with network providers, CCHA works with the following community agencies that provide services to children, youth, and their families in Region 6:

- Residential Child Care Facilities (Savio House, Mt. St. Vincent, Tennyson Center)
- Day treatment centers (Savio House, Mt. St. Vincent, Children's Hospital Neuropsychiatric Special Care Program, Tennyson Center)
- Private mental health therapists as well as Applied Behavioral Analysis (ABA), occupational, speech and physical therapists
- Agencies such as Behavioral Services of the Rockies, Hand Prints, Solace, Epic, Professional Pediatric Home Care, PASCO (Personal Assistance Services of Colorado)
- Programs including Nurse Family Partnership, Children with Special Health Care Needs, WIC
- DHS Child Protection Unit, and HCPF to ensure optimal use of community services in the least restrictive environment

CCHA, government and community agencies, families, and the multi-disciplinary team all work closely to ensure optimal use of community services. Through Creative Solution Meetings, Family Engagement Meetings, High Fidelity Wrap-around Meetings, Action Meetings, etc., the care team collectively helps ensure this special population can access the medical, psychosocial aspects of care in the least restrictive environment possible.

Table 1: Number of Network Providers by Provider Type and Areas of Expertise

	Boulder County			Broomfield County			Clear Creek County			Gilpin County			Jefferson County			Other County		
	Total	# Open to New Members	# Offering Weekend & After-Hours Appts.	Total	# Open to New Members	# Offering Weekend & After-Hours Appts.*	Total	# Open to New Members	# Offering Weekend & After-Hours Appts.	Total	# Open to New Members	# Offering Weekend & After-Hours Appts.	Total	# Open to New Members	# Offering Weekend & After-Hours Appts.	Total	# Open to New Members	# Offering Weekend & After-Hours Appts.
Adult Primary Care	199	184	18 sites	32	29	1 site	15	14	0 sites	0	0	0 sites	282	245	30 sites	N/A	N/A	N/A
Pediatric Primary Care	197	182	18 sites	32	29	1 site	15	14	0 sites	0	0	0 sites	318	281	31 sites	N/A	N/A	N/A
OB/GYN	19	15	15 sites	1	1	0 sites	0	0	0 sites	0	0	0 sites	12	5	0 sites	N/A	N/A	N/A
Family Planning	45	42	12 sites	4	4	0 sites	3	3	0 sites	0	0	0 sites	70	58	19 sites	N/A	N/A	N/A
Total PH Providers	Boulder County: 220 of 567 Unique PH Providers			Broomfield County: 33 of 567 Unique PH Providers			Clear Creek County: 15 of 567 Unique PH Providers			Gilpin County: 0 of 567 Unique PH Providers			Jefferson County: 334 of 567 Unique PH Providers			N/A		
Adult Mental Health	319	319	79	22	22	16	1	1	1	1	1	0	565	565	152	2,139	2,129	637
Pediatric Mental Health	318	318	78	22	22	16	1	1	1	1	1	0	452	452	151	2,135	2,124	633
Substance Use Disorder	4	4	1	0	0	0	0	0	0	0	0	0	9	9	3	28	28	12
Psychiatrist	15	15	0	0	0	0	0	0	0	0	0	0	31	31	1	128	126	11
Child Psychiatrist	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	13	13	1
Psychiatric Prescriber	18	18	0	0	0	0	0	0	0	0	0	0	48	48	4	225	222	25
Acute Care Hospitals	1	1	1	0	0	0	0	0	0	0	0	0	1	1	1	12	12	7
Other	10	10	4	2	2	1	0	0	0	0	0	0	22	22	2	157	141	11
Total BH Providers	Boulder County: 349 of 3,216 Unique BH Providers			Broomfield County: 24 of 3,216 Unique BH Providers			Clear Creek County: 1 of 3,216 Unique BH Providers			Gilpin County: 1 of 3,216 Unique BH Providers			Jefferson County: 628 of 3,216 Unique BH Providers			Other County: 2,383 of 3,216 Unique BH Providers		

Table 1 Notes:

- The data only includes providers that have an executed contract with CCHA. These numbers will be updated in Network Report quarterly.
- The physical health provider network data includes only rendering providers that qualify as primary care practitioners affiliated with a contracted primary care location in Region 6.
- Totals for each provider type are not necessarily unique. For example, a single rendering provider is included in both the adult and pediatric provider totals if services are open to both demographics and will be counted twice if rendering services in multiple counties.
- Primary care provider information is inclusive of required information for contracting and voluntary information not required for contracting. As such, the following information is likely underreported and/or not fully representative of the provider network:
 - Provider secondary and tertiary specialty types, particularly for Family Planning and OB/GYN specialists. Further, providers typically only report on specialty types for which they are enrolled as a Colorado Medicaid provider.
 - The number of individual providers accepting new Medicaid members, as this is primarily managed at the practice level.

Table 2: Cultural Competency Training by County and Provider Type

		% of Total Providers with Cultural Competency Training by County				
		Boulder County	Broomfield County	Clear Creek County	Gilpin County	Jefferson County
Provider Type	Adult Primary Care	75.4%	15.6%	100%	0%	40.8%
	Pediatric Primary Care	73.1%	15.6%	100%	0%	44.7%
	OB/GYN	68.4%	0%	0%	0%	26.7%
	Family Planning	91.1%	50%	100%	0%	58.3%
	Total PH Providers	74.5% or 164 of 220 Boulder County Providers Trained in Cultural Competency	15.2% or 5 of 33 Broomfield County Providers Trained in Cultural Competency	100% or 15 of 15 Clear Creek County Providers Trained in Cultural Competency	0% or 0 of 0 Gilpin County Providers Trained in Cultural Competency	44.6% or 149 of 334 Jefferson County Providers Trained in Cultural Competency
	Adult Mental Health	3.6%	0%	100%	0%	8.0%
	Pediatric Mental Health	3.6%	0%	100%	0%	8.0%
	Substance Use Disorder	0%	0%	0%	0%	60.0%
	Psychiatrist	0%	0%	0%	0%	60.0%
	Child Psychiatrist	0%	0%	0%	0%	0%
	Psychiatric Prescriber	6.3%	0%	0%	0%	0%
	Acute Care Hospitals	15.4%	0%	0%	0%	0%
	Total BH Providers	3.7% or 12 of 349 Boulder County Providers Trained in Cultural Competency	0% or 0 of 24 Broomfield County Providers Trained in Cultural Competency	100% or 1 of 1 Clear Creek County Providers Trained in Cultural Competency	0% or 0 of 1 Gilpin County Providers Trained in Cultural Competency	11.2% or 70 of 628 Jefferson County Providers Trained in Cultural Competency

Table 2 Notes:

- CCHA continues to refine processes to validate and streamline provider contracting data. As a result, cultural competency information is underreported across provider types, particularly for OB/GYN and Behavioral Health providers. Additionally, it is important to note that cultural competency may appear notably low due to multiple factors, including the following:
 - PCMP information reported in the plan includes both required and voluntary provider details. As such, voluntary details such as providers' secondary and tertiary specialty types, particularly family planning and OB/GYN specialists, are expectedly low and likely underreported.
 - Providers with OB/GYN and family planning specialties is significantly lower than other providers types, so the proportion of those provider specialties with cultural competency training is not directly comparable to the proportion of general practitioners with cultural competency training.
- Though CCHA experienced some issues with reporting on cultural competency training, it remains a high priority to resolve said data issues and ensure the network is trained in culturally competent care. Following are steps CCHA is taking to ensure the physical and behavioral health networks are trained on cultural competency:
 - Through the incentive program, CCHA encourages providers to attend the semi-annual provider meetings, and attendance is tracked for the educational portion of the incentive program.
 - CCHA plans to continue hosting provider training, including cultural competency training, during primary care and behavioral health provider meetings.

Figure 1: Breakdown of Languages Spoken by Physical Health Providers in Each County

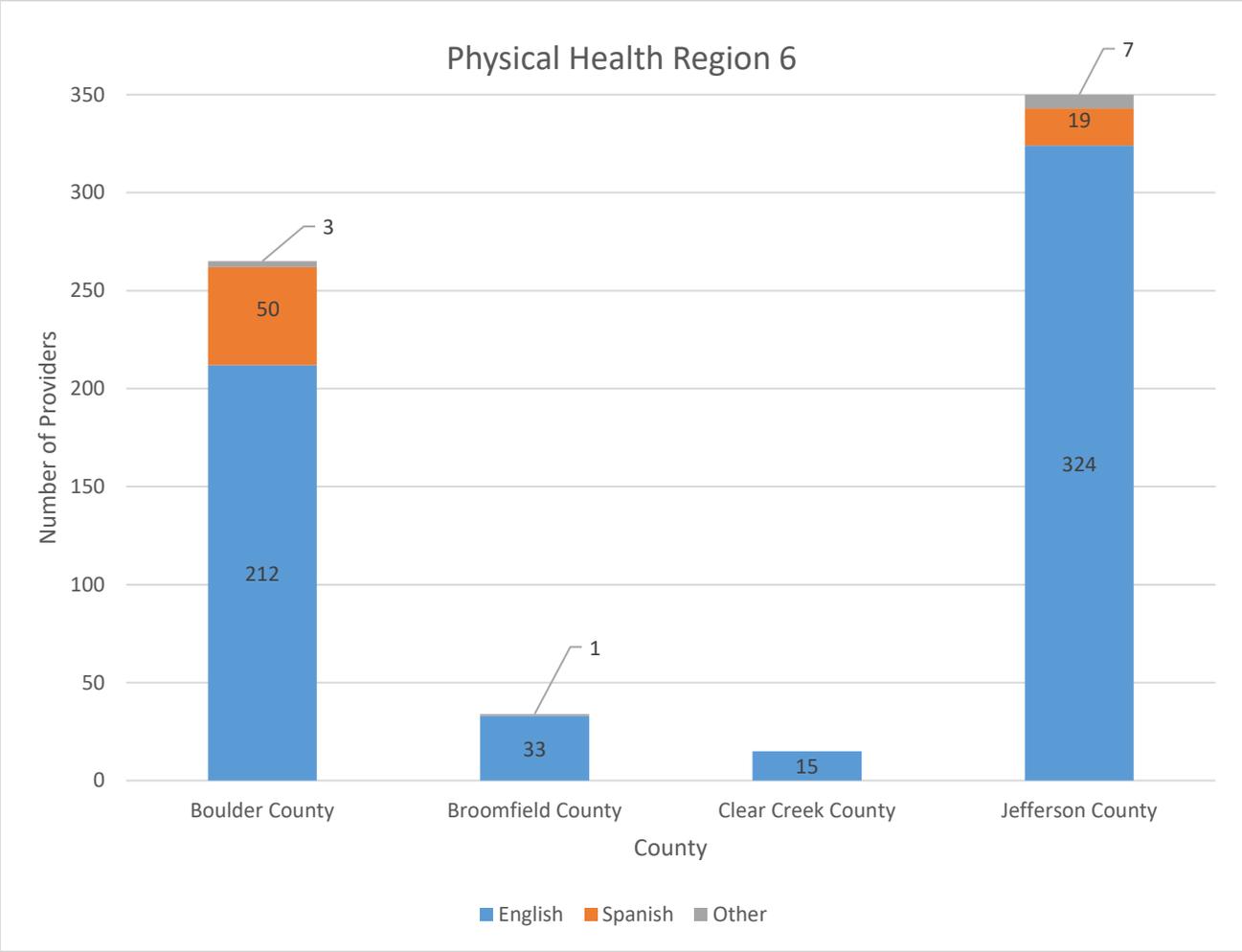


Figure 2: Breakdown of Languages Spoken by Behavioral Health Providers in Each County

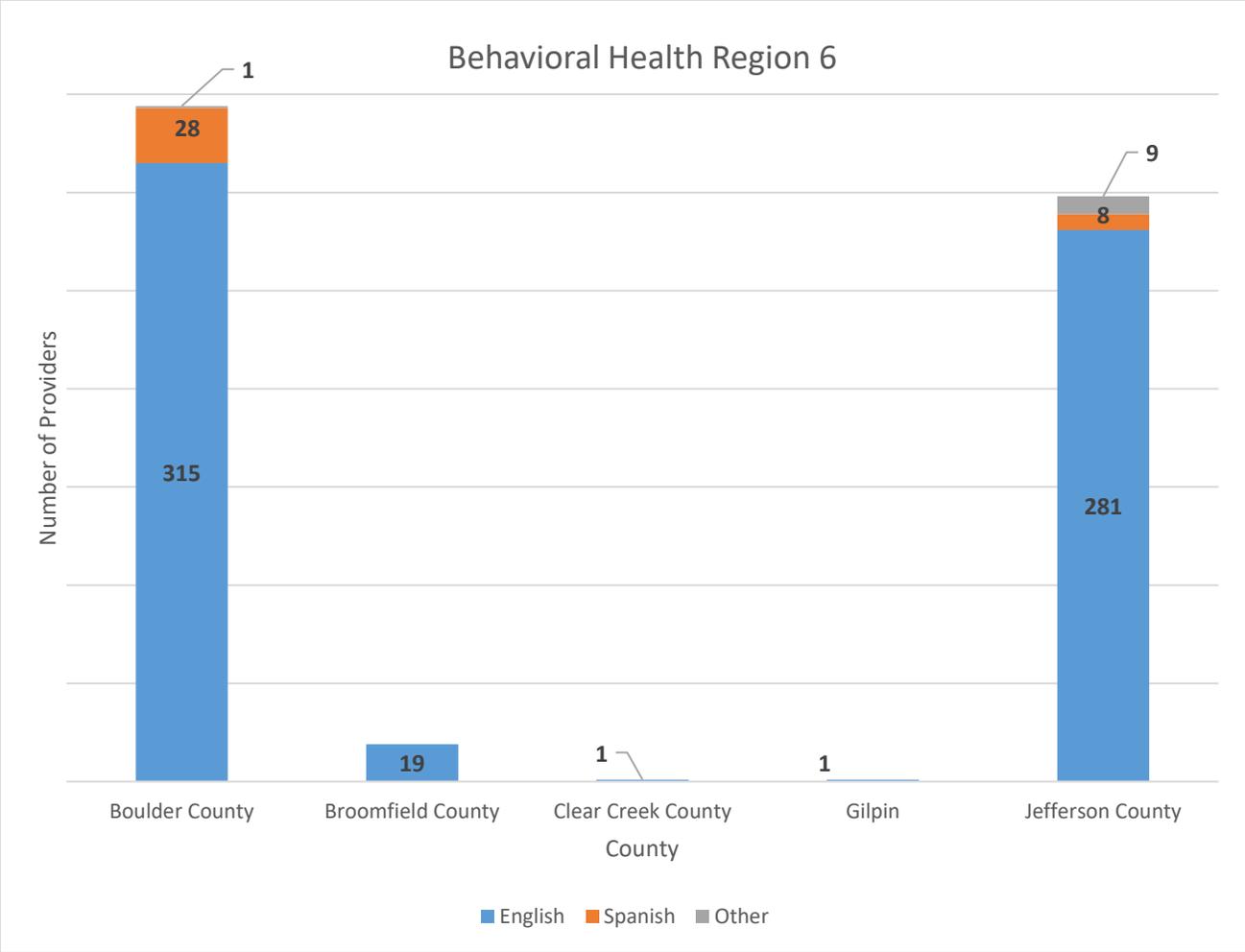
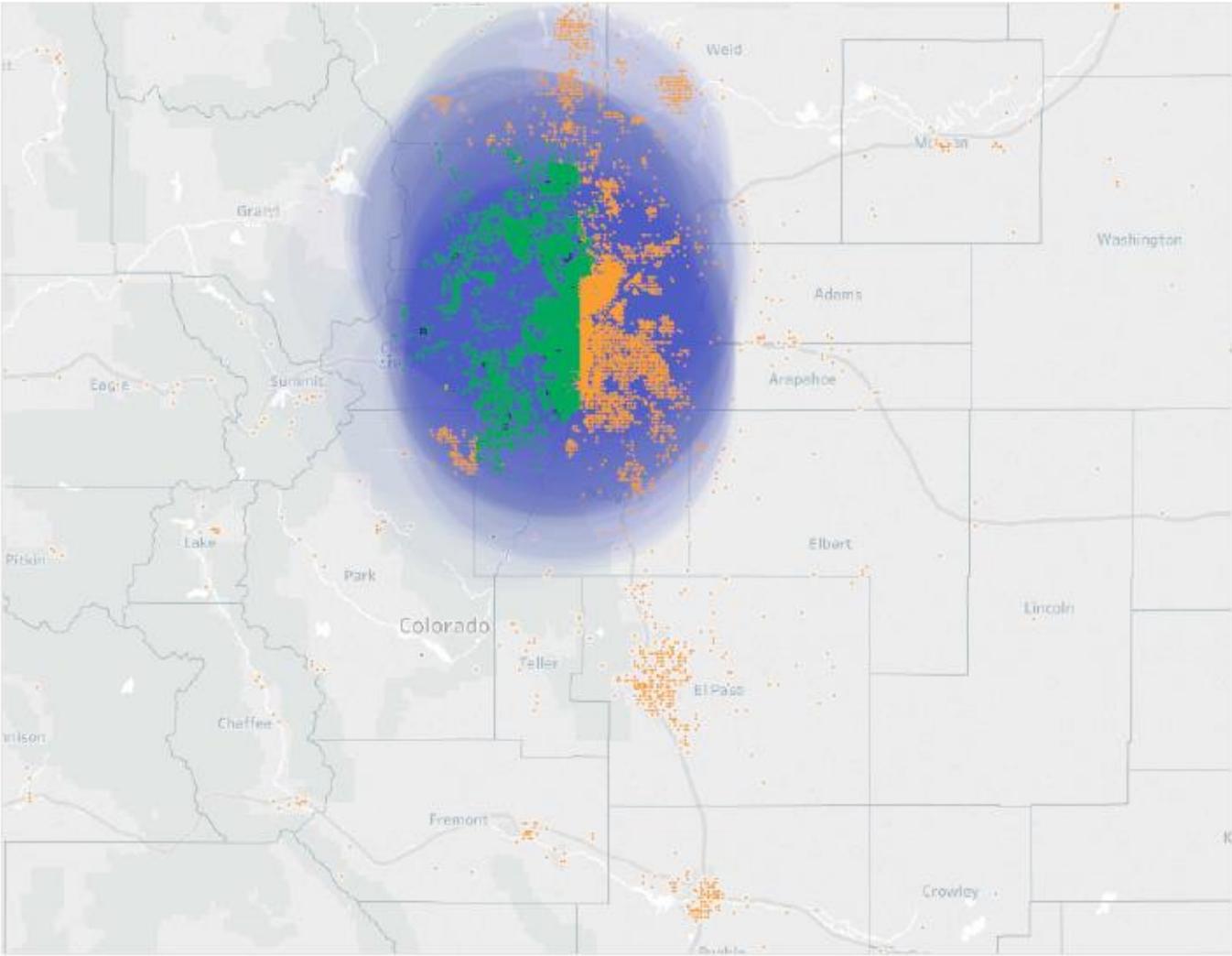


Figure 1 and Figure 2 Notes:

- Provider language is voluntary information collected at the time of contracting. Numbers are not fully representative of providers’ spoken languages.

Network Adequacy Map – Physical Health

- RAE
Multiple values
- Visualizations:
Multiple values
- Type (legend)
 - Member (In Area)
 - Member (Out of Area)
 - PCMP



Network Adequacy Map – Behavioral Health

- RAE
Multiple values
- Visualizations:
Multiple values
- Type (legend)
 - BH
 - Member (In Area)
 - Member (Out of Area)

