COLORADO
Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: *Colorado Community Health Alliance*

Line of Business: *RAE*

Contract Number: *19-107518A6*

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Report Submitted on: *4/30/2021*

Report due by 4*/30/2021*, covering the MCE's network from 1/1/2021 – 3/31/2021, FY Q3

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Contents

COLORADO
Department of Health Care Policy & Financing

1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the March 2021 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (March 2021 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	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2020-21 Q3	April 2021	March 31, 2021
FY 2020-21 Q4	July 2021	June 30, 2021
FY 2021-22 Q1	October 2021	September 30, 2021
FY 2021-22 Q2	January 2022	December 31, 2021

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0321* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0321* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service, excluding single case agreement (SCA) practitioners.
- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. The MCE should update the highlighted, italicized data fields on the cover page of this template to reflect their contact information, contract information, and report dates associated with the current report submission.

This report template contains a comprehensive list of NA requirements for the CHP+ MCO, Medicaid MCO, and RAE lines of business. Each table in this MS Word document contains a header row which confirms the applicable line(s) of business for each response. The table below shows expected network categories by MCE type. The accompanying MS Excel spreadsheets contain tabs in which network data can be imported (e.g., member counts, ratio results, time/distance calculation results).

Network Category	CHP+ MCO	Medicaid MCO	RAE
Facilities (Entities) (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X	
Prenatal Care and Women's Health Services	X	X	X
Primary Care Providers (PCPs)	X	X	X
Physical Health Specialists	X	X	
Behavioral Health Specialists *(RAEs' network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)*	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.

2. Network Adequacy

Establishing and Maintaining the MCE Network

Supporting contract reference: The MCE shall maintain a network that is sufficient in numbers and types of practitioners/practice sites to assure that all covered services to members will be accessible without unreasonable delay. The MCE shall demonstrate that it has the capacity to serve the expected enrollment in that service area.

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 30, 2021).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 30, 2021).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

Define unique practice sites by de-duplicating records by location, such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.

Table 1A-Establishing and Maintaining the MCE Network: Primary Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	166,029	N/A	173,765	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	795	N/A	800	N/A
Primary care practitioners accepting new members	708	89.1%	713	89.1%
Primary care practitioners offering after-hours appointments	476	59.9%	484	60.5%
New primary care practitioners contracted during the quarter	17	2.1%	21	2.6%
Primary care practitioners that closed or left the MCE's network during the quarter	13	1.6%	22	2.8%

COLORADO
Department of Health Care Policy & Financing

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, the primary barriers affecting the network were as follows: • <u>General lack of providers</u>: The Region 6 network is sufficient in terms of provider choice options available to members; however, in rural areas of Clear Creek and Gilpin counties, there are ongoing challenges due to the general deficiency in the number of providers in those areas. For example, members are able to access a provider within the time and distance standards in neighboring counties of Region 6, though there are no PCMPs located in Gilpin County. • <u>Attribution significantly exceeding enrollment limits</u>: While the provider network continues to adapt operations to ensure member access during the public health emergency, attribution that significantly exceeds currently established enrollment limits is becoming a network maintenance issue. Among practices that have received attribution in excess of 100-650+ members each month – representing excess volumes of 23%-208% above enrollment limits – are those that are unable to sustain high-volume membership. Though providers understand enrollment limits are not exact, they have expressed concern with continued participation in the network if they are unable to anticipate the relative volume of their membership based on enrollment limits. CCHA is working with these practices and HCPF on various options to help limit and decrease attribution as much as possible. • <u>COVID-19 response</u>: In response to public health orders due to the COVID-19 outbreak, CCHA and the provider network began implementing alternative processes in March 2020 that continued through the reporting period. Though practices have been taking steps to return to normal business hours and operations that ensure access to routine services such as immunizations and well visits, alternate operations remain in place among the broad network. Below is a summary of operations that continue to cause some disruption to network maintenance: ○ Site closures/consolidated care at certain locations ○ Reduced access for non-urgent routine care visits ○ Group visits canceled ○ Staff furloughs ○ Planning/administering COVID-19 vaccinations ▪ As an additional note, the alternative operations in the bullets above have significant implications for providers, as they are functioning with higher demand and fewer resources. Planning and administering COVID vaccinations increases those existent challenges. As such, it should be noted providers have expressed there is very little capacity among the network to participate in new initiatives or respond to additional requests during this public health emergency.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
▪ Additionally, financial strain is being exacerbated for PCMPs providing the vaccine, as provider staff are diverted from higher revenue-producing procedures to administer vaccinations. Increased use of telehealth: CMS updates to telehealth requirements have effectively expanded use of telehealth to help reduce barriers to access. During the reporting period, the physical health network maintained access to services through telehealth, with claims data showing the highest utilization for general office visits among established patients. Though the volume of telehealth services has decreased over time, correlated with practices returning to normal business hours and increases in in-person access, CCHA will continue tracking telehealth utilization trends. Given Colorado's adoption of updated telehealth rules, CCHA is hopeful providers' use of telehealth will remain a useful resource for engaging members who have historically faced challenges with access.

Table 2A-Establishing and Maintaining the MCE Network: Behavioral Health Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	166,029	N/A	173,765	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	6,474	N/A	3,607*	N/A
Behavioral health practitioners accepting new members	5,622	94%	3,229	90%
Behavioral health practitioners offering after-hours appointments	4,464	74%	2,608	72%
New behavioral health practitioners contracted during the quarter	110	1.6%	242	7%
Behavioral health practitioners that closed or left the MCE's network during the quarter	11	0.2%	46	1.3%

Note: CCHA's methodology for obtaining provider counts was updated with the new crosswalk and provider categories. Practitioner numbers for this quarter and future quarters reflect total number of unique NPIs.

Table 2B-Establishing and Maintaining the MCE Network: Substance Use Disorder (SUD) Treatment Facilities

Requirement	Previous Quarter	Current Quarter
	Number	Number
Sample	*0*	*0*
RAE		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	N/A	33
Total SUD treatment facilities offering ASAM Level 3.3 services	N/A	0*
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total SUD treatment facilities offering ASAM Level 3.5 services	N/A	5
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	N/A	24 + 24 flex
Total SUD treatment facilities offering ASAM Level 3.7 services	N/A	1
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	N/A	36
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	N/A	7
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	N/A	107
Total SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	110

Note: There are only a few beds in the state, and the RAE contract currently excludes rates for these services. However, CCHA will initiate single case agreements covering these services as needed.

COLORADO
Department of Health Care Policy & Financing

Table 2C-Establishing and Maintaining the MCE Network: Behavioral Health Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, the primary barriers affecting the network were as follows: • <u>Out-of-state providers</u> CCHA uses out-of-state providers when a member requires treatment at a residential treatment facility. These providers are included in Table A-1-Practitioners with SCAs: Data. • <u>Provider education</u> As CCHA has worked to improve the contracting timeline, needs for provider education on claims and billing processes increased. Following an influx of newly contracted clinicians, CCHA focused on increasing provider education and informational resources. Some examples include: ○ A dedicated COVID-19 landing page on the CCHA website that includes comprehensive telehealth expansion billing, claim, and HIPAA guidance. ○ Provider-facing contact list with contact information and a variety of topics, including contract managers by region. ○ Behavioral Health Provider Claim Questions/Issue Resolution Process Flow – document to outline the resources available and process flow of when to best engage the resources to expedite questions, and issue resolution. • <u>SUD provider network</u> CCHA remains concerned that the capacity assumptions used by the Department in its SUD benefit model are understated and that, as a whole, the benefit is underfunded. For example, one assumption provided to RAEs was Medicaid would occupy 30% of non-IMD bed capacity and 40% of IMD bed capacity in the State. Funding was allocated to the RAEs based on this bed capacity assumption. CCHA received a file from HCPF on 02/26 stating there are 2,561 total beds in the State, however the rate model assumed 1,873 beds. CCHA is proceeding by building a highly aligned, narrow network of high-performing SUD providers initially, and capacity will be expanded as a clearer picture of how the benefit is functioning over the coming months comes into focus. CCHA worked with the MSOs to understand the provider landscape and contract in a manner that provides access to our membership across all ASAM levels. CCHA also carefully reviewed the member transition lists that were provided leading up to January 1. The vast majority of members that were in care prior to the benefit expansion were receiving care from within CCHA's contracted network of providers. This follows true to authorization requests that we are

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
receiving today – the vast majority of care is being rendered within CCHA's network of SUD providers. Single case agreements are deployed where necessary when care cannot be rendered within our contracted network. Most single case agreements are issued in the 3.2WM and 3.7WM levels, as these services are typically more immediate in nature and not appropriate to refer. CCHA is working closely with our of network providers who render services at these levels to provide education on processes, notification requirements, and to minimize paperwork associated with single case agreements where possible. CCHA will deploy the use of single case agreements in addition to contracted providers to ensure there is appropriate member access as our assessment and adjustment of the network unfolds. Initially, we built our network based off the Department's capacity assumptions as included in its rate calculation. As real-world data became available we began to expand our network capacity beyond the Department's initial assumptions. Gaps in the continuum of SUD services exist in various regions of the state. These gaps have been longstanding and were reflected in the Office of Behavioral Health's Needs Analysis: Current Status, Strategic Positioning, and Future Planning report of April 2015. We will continue to work with community providers to expand the array of available SUD services across the care continuum to ensure member access to medically appropriate levels of service. CCHA has extended an invite to all Special Connections designated providers to become in network, not all have been willing to accept the Special Connections rate at this time. Providers have expressed dissatisfaction in the SUD reimbursement. The providers who are contracted with CCHA have expressed appreciation for the opportunity to serve a concentration of CCHA members, as this allows both parties to operate within rate setting parameters. Increased use of telehealth: CMS updates to telehealth requirements have effectively expanded use of telehealth to help reduce barriers to access. A vast majority of the behavioral health network have expanded access through telehealth services, as noted by the 3,651% increase in claims volume for January 2021 through March 2021, as compared to the volume for the same timeframe in 2020. CCHA plans to continue tracking telehealth utilization through claims data to assess ongoing trends and inform network planning. Given Colorado's adoption of updated telehealth rules, CCHA is hopeful providers' use of telehealth will increase and show better engagement among members who have historically faced challenges with access.

Table 3A-Establishing and Maintaining the MCE Network: Specialty Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO				
Total members		N/A		N/A
Total specialty care practitioners (i.e., PROVCAT codes beginning with "SV" or "SG")		N/A		N/A
Specialty care practitioners accepting new members				
Specialty care practitioners offering after-hours appointments				
New specialty care practitioners contracted during the quarter				
Specialty care practitioners that closed or left the MCE's network during the quarter				

Table 3B-Establishing and Maintaining the MCE Network: Specialty Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of specialty care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO
MCE to provide narrative response here regarding these contract requirements.

3. Network Changes and Deficiencies

Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes in MCE Networks related to quality of care, competence, or professional conduct.

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE

CCHA monitors and tracks trends that may affect quality of care, competence, and professional conduct on an ongoing basis. This information and resolution are reported to HCPF on a quarterly basis in the Quality of Care report, and CCHA notifies the Department within 10 days if issues result in changes in the network. Below is a summary of network additions and terminations that occurred during the reporting period:
 	
Region 6 PCMP Network Additions
• Jefferson County
  ○ Federal Health Care, Inc.
 	
Region 6 PCMP Network Terminations
Note: CHPG has opted to disaffiliate all women's-only clinics due to focus on women's health services. Although this results in fewer OB/GYN sites contracted as PCMPs and providing primary care services, the clinics will continue to accept referrals from CCHA and see Medicaid members for specialty care.
• Boulder County
  ○ CHPG Women's Health Louisville: services focused on women's health/no longer aligned with PCMP contract
• Jefferson County
  ○ SCL Health Medical Group Littleton: relocation outside of Region 6
  ○ CHPG Church Ranch Women's Health: services focused on women's health/no longer aligned with PCMP contract
  ○ CHPG Women's Specialty Health Church Ranch: services focused on women's health/no longer aligned with PCMP contract
 	
BH Network Additions
• 231 new practitioners were added to existing provider groups statewide as follows:
  ○ Region 6: 12 new practitioners
  ○ Region 7: 26 new practitioners
  ○ Other counties outside of Regions 6 and 7: 193 new practitioners

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

• 11 solo practices joined the network statewide as follows:
  ○ Region 6: 4 new practices
  ○ Region 7: 4 new practices
  ○ Other counties outside of Regions 6 and 7: 3 new practices
 	
<u>BH Network Terminations</u>
Note: CCHA reports all provider terminations to HCPF on a monthly basis.
• 46 practitioners left the statewide network as follows:
  ○ Region 6: 6 practitioners termed
  ▪ 2 left contracted provider groups
  ▪ 4 termed due to duplicate provider records
  ○ Region 7: 24 practitioners termed
  ▪ 24 left contracted provider groups
  ○ Other counties outside of Regions 6 and 7: 16 practitioners termed
  ▪ 15 left contracted provider groups
  ▪ 1 termed due to duplicate provider record

Table 5-CHP+ MCO Network Volume Changes and Notification: Discussion

If the MCE experienced at least a five percent (5%) increase or decrease in its network in a thirty (30) calendar day period, describe the change and answer the following questions: **Did the MCE notify the Department, in writing, within ten (10) business days of the change?** **Was the change due to a practitioner/practice site/entity's request to withdraw; was the change due to the MCE's activities to obtain or retain NCQA accreditation?** **Was the change due to a practitioner/practice site/entity's failure to receive credentialing or re-credentialing from the MCE?**
CHP+ MCO
MCE to provide narrative response here regarding these contract requirements.

COLORADO
Department of Health Care Policy & Financing

Inadequate Network Policies

Supporting contract reference: If the MCE fails to maintain an adequate network that provides Members with access to PCPs within a county in the MCE's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible Members by providing the MCE a thirty (30) calendar day written notice.

Table 6-CHP+ MCO Inadequate Access to PCPs: Discussion

Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area? **If the MCE answered "yes", did the Department designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members?**
CHP+ MCO
MCE to provide narrative response here regarding these contract requirements.

Table 7-CHP+ MCO Discontinue Services to an Entire County: Discussion

Did the MCE discontinue providing covered services to members within an entire county within the MCE's service area? **If the MCE answered "yes", did the MCE provide no less than sixty (60) calendar days prior written notice to the Department of the MCE's intent to discontinue such services?**
CHP+ MCO
MCE to provide narrative response here regarding these contract requirements.

Table 8-CHP+ MCO Provider Network Changes: Discussion

Did the MCE experience an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network? **If the MCE answered "yes", did the MCE notify the Department, in writing, of the change?**
CHP+ MCO
MCE to provide narrative response here regarding these contract requirements.

Appointment Timeliness Standards

Supporting contract reference: The MCE shall provide coverage of emergency and non-urgent medical services. The MCE shall have written policies and procedures describing how members can receive coverage of emergency services or urgently needed services while temporarily absent from the MCE's service area.

Table 9-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE

Policies and Procedures
• All PCMP contracts require the following standards for member access:
  ○ Inpatient follow-up appointment within 7 days after discharge.
  ○ Non-urgent, symptomatic care visit within 7 days after the request.
  ○ Urgent care appointment within 24 hours after the initial identification of need.
  ○ Well-care visit within 1 month after the request, unless an appointment is required sooner to ensure the provision of screenings.
• CCHA Member Rights and Responsibilities Policy
  ○ CCHA adopts Federal and State of Colorado laws and regulations that pertain to the rights of members and ensure that its staff and network providers take those rights into account when furnishing services to members. Members are entitled to the right to have health care services provided in accordance with the requirement for timely access and medically necessary care. CCHA does not adversely regard a member who exercises their rights, as stated below. CCHA communicates member rights and responsibilities to members per contract guidelines via the *For Members* section of CCHA's website.
  ○ Providers are notified via the Provider Manual, which are available and distributed according to the contract requirements, and via provider newsletters. CCHA staff receive educational information on member rights and responsibilities during new hire orientation. CCHA shall comply with any other applicable Federal and State laws including 42 CFR § 438.100 and 42 C.F.R. § 438.400 (b).
 	
Methodology for Assessing Timeliness:
The CCHA practice transformation coaches and network managers work with PCMPs to collect third next available appointment (3NA) 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 (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.

<u>Current Status of Network Timeliness:</u>

CCHA conducts appointment availability assessment and improvement efforts with coached practices on a quarterly basis, and appointment availability is assessed with non-coached practices (those with fewer than 300 members) annually as part of the Office Systems Review.

Per the following table, the 3NA data CCHA collected from coached and non-coached practices in Q3 indicates timeliness standards were met.

Region 6: SFY 2020-2021 – Quarter 3*				
Visit Type	Standard	Q3 Numerator	Q3 Denominator	Q3 Rate
Inpatient hospitalization follow up	Within 7 days after discharge	109	119	91.60%
Non-urgent, symptomatic	Within 7 days of member request	114	119	95.80%
Urgent/Acute	Within 24 hours of member request	81	119	68.07%
Well-care physical examinations	Within 30 days of member request	118	119	99.16%

*Note: Visit Type for 3NA analysis was updated this quarter to align with timeliness standards in the RAE contract.

Table 10-Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Policies and Procedures • CCHA Member Rights and Responsibilities Policy ○ CCHA adopts Federal and State of Colorado laws and regulations that pertain to the rights of members and ensure that its staff and network providers take those rights into account when furnishing services to members. Members are entitled to the right to have health care services provided in accordance with the requirement for timely access and medically necessary care. CCHA does not adversely regard a member who exercises their rights, as stated below. CCHA communicates member rights and responsibilities to members per contract guidelines via the *For Members* section of CCHA's website. ○ Providers are notified via the Provider Manual, which are available and distributed according to the contract requirements, and via the provider newsletters. CCHA staff receive educational information on member rights and responsibilities during new hire orientation. CCHA shall comply with any other applicable Federal and State laws including 42 CFR § 438.100 and 42 C.F.R. § 438.400 (b). • Behavioral health provider access requirements: ○ Emergency behavioral health care by phone within fifteen (15) minutes after initial contact, including TTY accessibility; in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours after contact in rural and frontier areas. ○ Non-urgent, symptomatic behavioral health services – within seven (7) days after a member's request.

- Administrative intake appointments or group intake processes shall not be considered as a treatment appointment for non-urgent, symptomatic care.
- Members shall not be placed on waiting lists for initial routine service requests.

CCHA monitors the behavioral health services through the annual Appointment Access Survey, which covers the following categories: Urgent Care, Initial Visit - Routine Care, Follow-up - Routine Care, and Non-Life Threatening Emergency Care. The 2020 Appointment Access Survey was conducted between October 6, 2020 and October 12, 2020. A total of 157 surveys were completed, and below is a summary of findings.

- Noted year over year improvements:
  - Overall compliance among behavioral health prescribers improved from 66% in 2019 to 82% in 2020.
  - Increase in compliance for all appointment types. Most notably, Urgent Care showed a 28% increase in compliance between 2019 and 2020.
- Appointment timeliness standards met for the following:
  - Follow-up - Routine Care standards met by prescribing and non-prescribing practitioners
- Appointment timeliness standards not met for the following:
  - Urgent Care standards not met by non-prescribing and prescribing practitioners
  - Initial Visit - Routine Care standards not met by non-prescribing and prescribing practitioners
  - Non-Life Threatening Emergency Care standards not met by non-prescribing practitioners
  - Non-Life Threatening Emergency care standards not met by prescribing or non-prescribing practitioners

Any provider who does not meet the contracted access to care standards is placed under corrective action to remediate the access issue. As such, letters were sent to practitioners indicating which appointment type was non-compliant with the access requirements. Enclosed with the letter, an Appointment Availability Survey Response form was provided for the practitioners to indicate the corrective actions taken to meet the standards.

CCHA conducted the follow-up survey between October 7, 2020 and October 12, 2020 to confirm practitioners' compliance with the standards. Among all re-surveyed providers, 80% of appointments demonstrated improvement and met access standards.

- Appointment timeliness standards met following corrective action:
  - Follow-up - Routine Care standards met by prescribing and non-prescribing practitioners
  - Urgent Care standard met by non-prescribing practitioners

In February 2021, CCHA sent letters to non-compliant practitioners with an Appointment Availability Survey Response form to be completed and sent back to CCHA indicating corrective action plans. CCHA is currently still receiving corrective action plans from those practitioners.

5. 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 practitioners/practice sites/entities in the MCE's Region.

Enter time and distance compliance results (e.g., "Met" or "Not Met") in the MS Excel template. Use Tables 11, 12, and 13 for additional relevant information regarding the MCE's compliance with time and distance requirements. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care. For physical health time and distance requirements, MCEs are only required to report data for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report results for all members regardless of county residence.

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).
- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

There are two levels of primary care practitioners: primary practitioners that can bill as individuals (e.g., MDs, DOs, NPs, and CNS') and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

A practitioner/practice site/entity should only be counted one time in the MCE's data submission; if a practitioner provides primary care for the Adult-Only or Pediatric network categories (and is not an Obstetrician/Gynecologist), the MCE should count the primary care practitioner one time under the Family Practitioner network category.

COLORADO
Department of Health Care Policy & Financing

Table 11–Urban Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE

Time and Distance Results
Below is a summary of time and distance standards in which time and/or distance was not 100% per the results in the MS Excel workbook.
 	
Boulder County
• Adult Primary Care
  ○ 99% member access
• Family Practitioner
  ○ 99% member access
• Gynecology, OB/GYN
  ○ 99% member access
• Psychiatric Residential Treatment Facilities
  ○ 25% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 19% member access
• SUD Treatment Facilities-ASAM 3.3
  ○ 0% member access
• SUD Treatment Facilities-ASAM 3.5
  ○ 98% member access
• SUD Treatment Facilities-ASAM 3.7
  ○ 86% member access
• SUD Treatment Facilities-ASAM 3.7 WM
  ○ 86% member access
 	
Broomfield County
• SUD Treatment Facilities-ASAM 3.3
  ○ 0% member access
 	
Clear Creek County
• Adult Primary Care
  ○ 87% member access
• Family Practitioner
  ○ 90% member access
• Gynecology, OB/GYN
  ○ 90% member access
• Pediatric Primary Care

- 95% member access
- Psychiatric Residential Treatment Facilities
  - 0% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 5% member access
- General Psychiatrists and Other Psychiatric Prescribers
  - 77% member access
- Pediatric Psychiatrists and Other Psychiatric Prescribers
  - 70% member access
- Pediatric Behavioral Health Providers
  - 98% member access
- General SUD Treatment Practitioner
  - 77% member access
- Pediatric SUD Treatment Practitioners
  - 70% member access
- SUD Treatment Facilities-ASAM 3.1
  - 46% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 8% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% member access
- SUD Treatment Facilities-ASAM 3.5
  - 49% member access
- SUD Treatment Facilities-ASAM 3.7
  - 68% member access
- SUD Treatment Facilities-ASAM 3.7 WM
  - 68% member access
- SUD Treatment Facilities
  - 97% member access

<u>Gilpin County</u>

- Adult Primary Care
  - 87% member access
- Family Practitioner
  - 86% member access
- Gynecology, OB/GYN
  - 85% member access
- Pediatric Primary Care
  - 83% member access
- Psychiatric Residential Treatment Facilities
  - 0% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 1.4% member access
- SUD Treatment Facilities-ASAM 3.2 WM

- 99% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% member access
- SUD Treatment Facilities-ASAM 3.7
  - 99% member access
- SUD Treatment Facilities-ASAM 3.7 WM
  - 99% member access

Jefferson County

- Adult Primary Care
  - 99% member access
- Family Practitioner
  - 99% member access
- Psychiatric Residential Treatment Facilities
  - 94% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 96% member access
- SUD Treatment Facilities-ASAM 3.1
  - 85% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 85% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% member access
- SUD Treatment Facilities-ASAM 3.5
  - 98% member access

Other urban counties outside of Region 6

- Psychiatric Residential Treatment Facilities
  - 86% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 84% member access
- General SUD Treatment Practitioner
  - 99% member access
- Pediatric SUD Treatment Practitioner
  - 99% member access
- SUD Treatment Facilities-ASAM 3.1
  - 60% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 60% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% member access
- SUD Treatment Facilities-ASAM 3.5
  - 94% member access
- SUD Treatment Facilities-ASAM 3.7

- 91% member access
- SUD Treatment Facilities-ASAM 3.7 WM
  - 91% member access

Addressing Access to Care

CCHA utilizes community partnership and care coordination to reduce barriers to accessing care. CCHA developed a training guide designed to help member-facing staff identify complaints that may stem from limited access to care. Access-related issues are triaged to provider solutions and network management staff for assessment and any further action that may be necessary. CCHA's care coordination and member support teams also work directly with members to develop care plans that help address barriers, including but not limited to any challenges related to proximity of providers. When travel time and/or distance is a barrier, CCHA works with the member and local providers to help coordinate transportation or other types of intermediate interventions such as telehealth.

Additionally, CCHA's community partnerships team is focused on developing strong relationships with county departments, non-profit organizations, and local service providers. In areas where time and distance requirements are not met, CCHA collaborates with these community entities on identifying additional resources and opportunities for reducing access barriers and/or recruiting providers.

Below is a summary of such efforts aimed to increase access in areas where time and distance standards are not being met:

- Efforts to increase COVID-19 vaccination support, provider resources, and member access:
  - CCHA is working to partner with network providers serving as vaccination sites to further member outreach and access to vaccines, aided by use of incentive funding. As described in CCHA's COVID-19 Vaccination Response Plan, these efforts are aimed to increase access and promote equity among minority populations, particularly members of color and those who are homebound.
  - Under circumstances when justice-involved members have received an initial dose of the COVID vaccine but are released from corrections prior to receiving the second dose, CCHA is also collaborating with provider vaccination sites within the region that have agreed to administer the second dose.
- Through CCHA's 2021 Community Incentive Program, funding was provided for the following initiatives to help increase access for members:
  - Evergreen Christian Outreach (EChO) was awarded funding for a 2nd year, and continues their mission to increase member access to wrap-around services in the rural areas of Jefferson County. Specifically, EChO provides food pantry items, job assistance, rent assistance, transportation services, and a variety of client/case management services such as intensive case management addressing various needs such as rental/housing costs, dental work, miscellaneous medical equipment, etc. During this reporting period, EChO served 260 Health First Colorado members, providing over $21,000 in direct member services (vehicle repair, insurance, registration, bus passes). Finally, EChO hired a new Jobs Center Manager, who will scale up job services in the following months to offer additional assistance with resume writing, developing interview skills, managing unemployment, etc.

Table 12–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE

Time and Distance Results
Below is a summary of time and distance standards in which time and/or distance was not 100% per the results in the MS Excel workbook.
 	
Other rural counties outside of Region 6
• Psychiatric Residential Treatment Facilities
  ○ 0% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 0% member access
• General Psychiatrists and Other Psychiatric Prescribers
  ○ 97% member access
• Pediatric Psychiatrists and Other Psychiatric Prescribers
  ○ 97% member access
• Pediatric Behavioral Health Providers
  ○ 96% member access
• General SUD Treatment Practitioner
  ○ 89% member access
• Pediatric SUD Treatment Practitioner
  ○ 91% member access
• SUD Treatment Facilities
  ○ 12% member access
• SUD Treatment Facilities-ASAM 3.1
  ○ 0% member access
• SUD Treatment Facilities-ASAM 3.2 WM
  ○ 1% member access
• SUD Treatment Facilities-ASAM 3.3
  ○ 0% member access
• SUD Treatment Facilities-ASAM 3.5
  ○ 0% member access
• SUD Treatment Facilities-ASAM 3.7
  ○ 0% member access
• SUD Treatment Facilities-ASAM 3.7 WM
  ○ 0% member access

Addressing Access to Care

In addition to ongoing provider recruitment and outreach, CCHA's approach to understanding and reducing access barriers also relies on the care coordination efforts. CCHA developed a training guide designed to help member-facing staff identify complaints that may stem from limited access to care. Access-related issues are triaged to provider solutions and network management staff for assessment and any further action that may be necessary. CCHA's care coordination and member support teams also work directly with members to develop care plans that help address barriers, including but not limited to any challenges related to proximity of providers. When travel time and/or distance is a barrier, CCHA works with the member and local providers to help coordinate transportation or other types of intermediate interventions such as telehealth.

Table 13–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE

Time and Distance Results
Below is a summary of time and distance standards in which time and/or distance was not 100% per the results in the MS Excel workbook.
 	
Frontier counties outside of Region 6
• Psychiatric Residential Treatment Facilities
  ○ 0% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 0% member access
• General Psychiatrists and Other Psychiatric Prescribers
  ○ 12% member access
• Pediatric Psychiatrists and Other Psychiatric Prescribers
  ○ 9% member access
• General Behavioral Health Providers
  ○ 88% member access
• Pediatric Behavioral Health Providers
  ○ 73% member access
• General SUD Treatment Practitioners
  ○ 50% member access
• Pediatric SUD Treatment Practitioners
  ○ 90% member access
• SUD Treatment Facilities
  ○ 22% member access
• SUD Treatment Facilities-ASAM 3.1
  ○ 22% member access

- SUD Treatment Facilities-ASAM 3.2 WM
    - 49% member access
- SUD Treatment Facilities-ASAM 3.3
    - 0% member access
- SUD Treatment Facilities-ASAM 3.5
    - 0% member access
- SUD Treatment Facilities-ASAM 3.7
    - 0% member access
- SUD Treatment Facilities-ASAM 3.7 WM
    - 0% member access

Addressing Access to Care

In addition to ongoing provider recruitment and outreach, CCHA's approach to understanding and reducing access barriers also relies on the care coordination efforts. CCHA developed a training guide designed to help member-facing staff identify complaints that may stem from limited access to care. Access-related issues are triaged to provider solutions and network management staff for assessment and any further action that may be necessary. CCHA's care coordination and member support teams also work directly with members to develop care plans that help address barriers, including but not limited to any challenges related to proximity of providers. When travel time and/or distance is a barrier, CCHA works with the member and local providers to help coordinate transportation or other types of intermediate interventions such as telehealth.

COLORADO
Department of Health Care Policy & Financing

Appendix A. Single Case Agreements (SCAs)

Individual practitioners with single case agreements (SCAs) are not counted as part of the MCE's health care network and should be excluded from tabulations in the body of this MS Word report and the associated MS Excel report(s). However, the Department acknowledges the role of SCAs in mitigating potential network deficiencies and requests that the MCE use Tables A-1 and A-2 below to list individual practitioners or SUD treatment facilities with SCAs and describe the MCE's use of SCAs.

Table A-1-Practitioners and SUD Treatment Facilities with SCAs: Data

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	[redacted]
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	[redacted]
CHP+ MCO, Medicaid MCO, RAE					
VitalCare	9000153764	Jefferson Westminster, CO	N/A Non-medical home care agency	Home & Community Based Services (HCBS)	[redacted]
Cornell Corrections of California, Inc.; Southern Peaks Regional Treatment Center	0000000	Fremont Canon City, CO	BF142	Residential Treatment Facility (RTF)	[redacted]
HMIH Cedar Crest, LLC	0000000	Belton, TX	BF142	Residential Treatment Facility (RTF)	[redacted]
Center for Change	0000000	Orem, UT	BF142	Residential Treatment Facility (RTF)	[redacted]
Cinnamon Hills Youth Crisis Center	0000000	St George, UT	BF142	Residential Treatment Facility (RTF)	[redacted]
Rolling Hills Hospital, LLC	0000000	Ada, OK	BF142	Residential Treatment Facility (RTF)	[redacted]
Spring Brook Behavioral Health System	000000	Travelers Rest, SC	BF142	Residential Treatment Facility (RTF)	[redacted]

Table A-2-Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. **Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.**
CHP+ MCO, Medicaid MCO, RAE
With the exception of the expanded SUD benefit, CCHA has an open behavioral health network that allows all practitioners who are Medicaid approved, meet CCHA credentialing criteria, and accept a contract to serve CCHA members. CCHA Provider Solutions utilizes all available tools for provider recruitment, including but not limited to out of network authorization and single case agreement requests. Out of network providers that are identified as having a material number of single case agreements or requests for out of network authorization are prioritized for recruitment into the network.

Appendix B. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.

Instructions for Appendices

To add an image:

- Go to "Insert" and click on "Pictures".
- Select jpg file and click "Insert".

To add an additional Appendix:

- Go to "Layout" and click on "Breaks".
- Select "Next Page" and a new page will be created.
- Go to "Home" and select "HSAG Heading 6".
- Type "Appendix C." and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

Optional MCE Content

Free text

Appendix C. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.