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: *19-107518A10*

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Report due by *07/29/2022*, covering the MCE's network from *04/01/2022 – 06/30/2022*, FY22 Q4

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2022 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, or 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 (September 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 2021-22 Q2	January 2022	December 31, 2021
FY 2021-22 Q3	April 2022	March 31, 2022
FY 2021-22 Q4	July 2022	June 30, 2022
FY 2021-22 Q1	October 2021	September 30, 2021

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0622* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0622* 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.

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., June 30, 2022, for the quarterly report due to the Department on July 29, 2022).
- 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., June 30, 2022, for the quarterly report due to the Department on July 29, 2022).
  - 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	190,566	N/A	194,237	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	889	N/A	937	N/A
Primary care practitioners accepting new members	783	88%	842	90%
Primary care practitioners offering after-hours appointments	459	52%	490	52%
New primary care practitioners contracted during the quarter	23	3%	42	4%
Primary care practitioners that closed or left the MCE's network during the quarter	18	2%	66	7%

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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. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** **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 primary care medical providers (PCMPs) located in Gilpin County. • <u>OB/GYN Providers and Family Planning Services</u> CCHA identifies practices and providers that offer family planning services at the time of contracting and annually thereafter. Among the CCHA network, family planning services are offered by both primary care and OB/GYN providers. Though the number of OB/GYN providers contracted as PCMPs has decreased over time due to operations that are more aligned with specialty care than primary care medical home services, OB/GYN specialists continue to work with CCHA to ensure members continue to have access to women's health and family planning services. CCHA's care coordination and member support teams work directly with members to help coordinate access to care, including family planning needs identified by the member. CCHA accomplishes this in collaboration with members by assessing member needs and preferences, discussing family planning services as appropriate, and referring members to women's health specialty providers for necessary covered services if not provided by the member's designated primary care provider. Additionally, CCHA promotes women's health services on the CCHA website, which includes comprehensive benefit information and how to contact CCHA for additional guidance or help. • <u>COVID-19 response</u>: In response to public health orders due to the COVID-19 outbreak that began in March 2020, CCHA and the provider network have continued to assess and update processes to maximize member access. 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 ○ Planning/administering COVID-19 vaccinations

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. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** **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
○ Currently, the most prominent issue that continues to disrupt provider operations and network maintenance are the workforce shortages/difficulty filling open positions. Though some providers have adjusted wages in hopes of hiring to full capacity, others have and/or are planning to consolidate care to operate out of fewer locations. 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. Since telehealth rules changed, claims data has consistently shown the highest utilization is for general office visits among established patients, with a majority of claims from federally qualified health centers (FQHCs) as the provider type, and roughly 25% from clinic practitioners. 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	190,566	N/A	194,237	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	4,294	N/A	4,617	N/A
Behavioral health practitioners accepting new members	3,881	98%	3,931	92%
Behavioral health practitioners offering after-hours appointments	3,094	78%	3,169	74%
New behavioral health practitioners contracted during the quarter	218	5.5%	184	4.3%

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners that closed or left the MCE's network during the quarter	27	0.7%	96	2.2%

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	8	17
Total SUD treatment facilities offering ASAM Level 3.3 services	1	1
Total SUD treatment facilities offering ASAM Level 3.5 services	6	23
Total SUD treatment facilities offering ASAM Level 3.7 services	2	12
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	10	18
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	6

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.

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

- Provider education

  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 contact information for provider experience and contract manager staff by region, which are also posted on the CCHA website.
  - A new Contact Us page, available from the CCHA website, which routes providers directly to their assigned Provider Experience Associate and helps CCHA track a 2-business day turnaround for response time.
  - Implementation of an online Provider Enrollment Application process. Training documents are available on the CCHA website and have been shared at CCHA Open Mic sessions.
  - 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, also available on the CCHA website.
  - Monthly Open Mic meetings are held for the behavioral health network, which provide a forum for educational opportunities and exchanging information.
  - Behavioral Health Listening sessions have been implemented to allow independent provider network providers to share feedback with CCHA leadership and identify opportunities for continued collaboration and education.
  - Increased provider communications with a supplemental publication that is specific to BH providers and is distributed monthly. CCHA also implemented BH-specific email alerts announcing behavioral health topics, including increased advertisement of monthly Open Mic sessions. These efforts have helped drive attendance and attention to educational information available to providers.
  - SUD-specific training:
    - BH Onboarding for SUD Benefit Expansion
    - ASAM Criteria in Health Care Management Training
    - Utilization Management SUD Training

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

- SUD provider network
  Initially, CCHA built the network based on HCPF's capacity assumptions, as included in its rate calculation. As real-world data has become available, CCHA has begun to expand network capacity beyond initial capacity assumptions. As of June 2022, CCHA has contracts with 28 of 35 (80%) of unique organizations and 55 out of 62 (89%) of unique locations offering SUD services across the State. CCHA is in contact with and continues to discuss participation from the remaining seven SUD organizations that are not yet contracted. Additionally, to further encourage provider participation, CCHA has remained in contact with providers who have indicated interest in the SUD benefit but have not yet enrolled. CCHA will deploy the use of single case agreements (SCAs) in addition to contracted providers to ensure there is appropriate member access as assessment and adjustment of the network unfolds. CCHA remains committed to working closely with our network of providers who render SUD services to provide education on processes, notification requirements, and to minimize paperwork associated with single case agreements where possible. 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.

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 has expanded access through telehealth services. However, a comparison of paid behavioral health claims from 2021 to 2022 indicates the following changes in the volume of paid claims for the current reporting period in 2022: 68% decrease in April, 70% decrease in May, and a 54% decrease in June. Though claims data for the reporting period is not yet final, the general trend in volume of paid claims continues to indicate utilization is decreasing. CCHA plans to continue tracking telehealth utilization through claims data to assess ongoing trends and inform network planning.

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 or deficiencies in MCE Networks related to access to care.

Table 4–Network Changes: Discussion

If the MCE experienced 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, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. **Note: If the MCE experienced 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 during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE

CCHA monitors and tracks changes in the network that could affect sufficiency of service delivery, availability, or provider capacity on an ongoing basis. CCHA notifies HCPF when network changes are significant and result in a deficiency within the network. CCHA also provides HCPF with notification of any issues related to quality of care, competence, and professional conduct and reports those issues and resolutions on a quarterly basis in the Quality of Care Concerns report. Below is a summary of network additions and terminations that occurred during the reporting period:
 	
Region 6 PCMP Network Additions
• Jefferson County
  ○ STRIDE CHC - Conifer
 	
Region 6 PCMP Network Terminations
The practice termination during this reporting period did not have a material impact to the network or result in a network deficiency. Members were notified and continue to have access to other PCMPs within the Region 6 network.
• Jefferson County
  ○ Practice closure due to provider retirement: Dr. Penelope Thron-Weber
 	
BH Network Additions
A total of 184 practitioners joined the network during the reporting period as follows:
• 166 new practitioners were added to existing provider groups statewide
  ○ Region 6: 21 new practitioners
  ○ Region 7: 32 new practitioners
  ○ Other counties outside of Regions 6 and 7: 113 new practitioners

If the MCE experienced 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, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. **Note: If the MCE experienced 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 during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE

• 18 solo practices joined the network statewide
  ○ Region 6: 6 new practices
  ○ Region 7: 3 new practices
  ○ Other counties outside of Regions 6 and 7: 9 new practices
 	
<u>BH Network Terminations</u>
The BH network terminations during the reporting period were due to typical churn and did not have a material impact to services, availability or provider capacity. CCHA reports all provider terminations to HCPF on a monthly basis.
 	
A total of 96 practitioners left the statewide network as follows:
• Region 6: 33 practitioners termed
  ○ 1 contract expired
  ○ 1 directory suppression – outreach/non-responsive
  ○ 19 moved out of area
  ○ 4 network management cancelled contract – contract non-compliance
  ○ 1 provider no longer with Tax ID
  ○ 1 left contracted group
  ○ 4 termed – created a new record
  ○ 2 opted out of network
• Region 7: 9 practitioners termed
  ○ 2 contracts expired
  ○ 1 moved out of area
  ○ 1 provider deceased
  ○ 1 provider no longer with Tax ID
  ○ 1 left contracted group
  ○ 1 retired/closed
  ○ 2 opted out of network
• Other counties outside of Regions 6 and 7: 54 practitioners termed
  ○ 1 contract expired
  ○ 1 directory suppression – outreach/non-responsive
  ○ 5 moved out of area
  ○ 21 network management cancelled contract – contract non-compliance
  ○ 12 providers no longer with Tax ID

If the MCE experienced 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, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. Note: If the MCE experienced 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 during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.
CHP+ MCO, Medicaid MCO, RAE
○ 1 retired or closed ○ 1 opted out of the network ○ 10 left contracted provider groups ○ 2 termed – created a new 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.

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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 ensure its network is sufficient so that services are provided to members on a timely basis.

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

CCHA has written policies and procedures that describe the member access standards, member rights and responsibilities, and the methodology used for assessing timeliness of access to physical health services, as outlined below.
 	
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 is 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 CFR § 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 looks for the next open appointment, starting with the schedule for the following day. 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 are typically separate 3NA measures for short visits (e.g., emergency follow up or acute care) and long visits (e.g., 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. As part of the Office Systems Review, this appointment availability data is also collected from non-coached practices (those with fewer than 300 members) on an annual basis and included in Quarter 3 reports.

Per the following table, the 3NA data CCHA collected from coached practices during the reporting period indicates timeliness standards were met.

Region 6: SFY 2021-2022 – Quarter 4				
Visit Type	Standard	Q4 Numerator	Q4 Denominator	Q4 Rate
Inpatient hospitalization follow-up	Within 7 days after discharge	83	90	92.2%
Non-urgent, symptomatic	Within 7 days of member request	84	90	93.3%
Urgent/Acute	Within 24 hours of member request	57	90	63.3%
Well-care physical examinations	Within 30 days of member request	89	90	98.9%

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

CCHA has written policies and procedures that describe the member access standards, member rights and responsibilities, and the methodology used for assessing timeliness of access to behavioral health services, as outlined below.
 	
<u>Policies and Procedures</u>
• 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 is 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 CFR § 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 2021 Appointment Access Survey was conducted July 1, 2021 – July 15, 2021. A total of 142 surveys were completed, and a summary of findings is in the following table.

Year Over Year Compliance Results			
Visit Type	Standard	Prescribers 2019/ 2020 / 2021	Non-Prescribers 2020/2021
Overall Compliance	-	66% / 82% / 71%	80% / 86% / 80%
Urgent Care	Within 48 hours of member request	55% / 83% / 70%	76% / 85% / 71%
Initial Visit Routine Care	Within 7 days of member request	37% / 55% / 36%	57% / 71% / 60%
Follow-up Routine Care	Within 30 days of member request	82% / 100% / 95%	98% / 100% / 98%
Non-Life-Threatening Emergent Care	Immediately	90% / 89% / 83%	84% / 86% / 89%

- Noted year over year improvements:
  - Overall compliance among behavioral health prescribers improved from 66% in 2019 to 80% in 2020.
  - Increase in compliance for Non-Life-Threatening Emergent Care for Non-prescribers increased by 3% for 2021 and was up from 5% from the 2019 of 84%.
- 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, in early October CCHA sent letters 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. Due to the low response rate to date of the corrective action plans, CCHA is developing an action plan to follow up with practitioners who have not yet responded.

CCHA made follow-up calls to all the providers that were non-complaint and CCHA had no record of the corrective action plans being returned. CCHA resent corrective action letters to 30% of the providers that said they did not receive the original letter. We are in process of receiving the action plans back and have received 38% of the action plans back. Also, during the calls, CCHA found several addresses that were incorrect and some providers that have termed from the network, so the plans were not returned.

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 in its contracted counties, including region-specific contracted counties for RAEs' behavioral health networks. 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 compliance with minimum time and distance requirements for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report compliance with minimum time and distance requirements 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 for each associated network category (PROVCAT code). If a practitioner provides primary care for adult and pediatric members at a specific location, count the practitioner once under the Adult Primary Care Practitioner PROVCAT code, once under the Pediatric Primary Care Practitioner PROVCAT code, and once under the Family Practitioner PROVCAT code. For example, a primary care nurse practitioner (NP) that serves adult and pediatric members can be categorized with the PV063, PV064, and PV065 PROVCAT codes. That practitioner will then be counted for the minimum network standards for pediatric primary care practitioner (NP) (PV064 and PV065); adult primary care practitioner (NP) (PV063 and PV064); and family practitioner (NP) (PV064).

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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 contracted urban counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted 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
• Gynecology, OB/GYN
  ○ 99% member access
• Family Practitioner
  ○ 99% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  o 98% member access
• SUD Treatment Facilities-ASAM 3.3
  ○ 0% member access
• SUD Treatment Facilities-ASAM 3.5
  ○ 98% member access
 	
Broomfield County
• SUD Treatment Facilities-ASAM 3.3
  ○ 0% member access
 	
Clear Creek County
• Adult Primary Care
  ○ 99% member access
• Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  ○ 0% member access
• General Psychiatrists and Other Psychiatric Prescribers
  ○ 75% member access
• Pediatric Psychiatrists and Other Psychiatric Prescribers
  ○ 72% member access
• General SUD Treatment Practitioner
  ○ 75% member access

- Pediatric SUD Treatment Practitioners
  - 72% member access
- SUD Treatment Facilities-ASAM 3.1
  - 72% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 68% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% member access
- SUD Treatment Facilities-ASAM 3.5
  - 92% member access
- SUD Treatment Facilities-ASAM 3.7
  - 92% member access
- SUD Treatment Facilities-ASAM 3.7 WM
  - 68% member access
- SUD Treatment Facilities
  - 99% member access

Gilpin County

- Adult Primary Care
  - 26% member access
- Pediatric Primary Care
  - 29% member access
- Gynecology, OB/GYN
  - 28% member access
- Family Practitioner
  - 27% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 25% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% member access
- SUD Treatment Facilities-ASAM 3.7
  - 99% member access

Jefferson County

- Adult Primary Care
  - 99% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 96% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 99% member access
- SUD Treatment Facilities-ASAM 3.3
  - 0% 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:

- In addition to CCHA's efforts to connect members with educational resources and access to vaccines, CCHA continues to identify and partner with network providers to expand member outreach and increase vaccination rates. The successes, challenges, and notable trends associated with these efforts are monitored closely and reported in the Monthly COVID-19 Vaccination Report deliverable to HCPF.
- CCHA continues to support initiatives through annual Community Incentive Program funding. For calendar year 2022, CCHA is funding ten community-based organizations' initiatives in Region 6. The CCHA Community Incentive Program provides funding support for initiatives that aim to increase member access and address gaps in services such as transportation, food assistance/pantry resources, access to behavioral health, rental/housing costs, and case management services.

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 contracted rural counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
MCE to provide narrative response here regarding these contract requirements.

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 contracted frontier counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
MCE to provide narrative response here regarding these contract requirements.

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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					
Benchmark Behavioral Health Systems, Inc	000000	Wood Cross, UT	BF142	Residential Treatment Facility (RTF)	[redacted]
Cornell Correction of California, LLC	000000	Fremont (Canon City, CO)	BF142	Residential Treatment Facility (RTF)	[redacted]
Valley Hope Association	9000187267	Arapahoe	BF085	Residential Treatment Facility (RTF) ASAM 3.5 Special Connections	[redacted]
ViaMar Health Inst of the PB LLC dba ViaMar Health Institutes of the Palm Beaches LLC	000000	West Palm Beach, FL	BF142	Residential Treatment Facility (RTF)	[redacted]
Youth Villages, Inc.	000000	Bartlett, TN	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.