



**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: *19-107518A7*

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Report Submitted on: *July 30, 2021*

Report due by *7/30/2021*, covering the MCE's network from *4/1/2021 – 6/30/2021*, FY21 Q4

*—Final Copy: June 2021 Release—*



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# 1. Instructions for Using the Network Adequacy Quarterly Report Template

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

## Definitions

- “MS Word template” refers to the *CO Network Adequacy\_Quarterly Report Word Template\_F1\_0621* document.
- “MS Word MCE Data Requirements” refers to the *CO Network Adequacy\_MCE\_DataRequirements\_F1\_0621* 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) <i>(Hospitals, Pharmacies, Imaging Services, Laboratories)</i>	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 <i>(RAEs’ network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)</i>	X		X
Ancillary Physical Health Services <i>(Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy)</i>	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., June 30, 2021, for the quarterly report due to the Department on July 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., June 30, 2021, for the quarterly report due to the Department on July 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
<i>Sample</i>	0	0.0%	0	0.0%
<b>CHP+ MCO, Medicaid MCO, RAE</b>				
Total members	173,765	N/A	178,038	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with “PV” or “PG”)	800	N/A	826	N/A
Primary care practitioners accepting new members	713	89.1%	723	87.5%
Primary care practitioners offering after-hours appointments	484	60.5%	533	64.5%
New primary care practitioners contracted during the quarter	21	2.6%	40	4.8%
Primary care practitioners that closed or left the MCE’s network during the quarter	22	2.8%	70	8.5%

**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:

- General lack of providers:  
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.
- OB/GYN Providers:  
Recruiting and maintaining OB/GYN providers as part of the PCMP network remains a challenge. Among OB/GYN practices/providers who decline contracting as a PCMP or voluntarily terminate their PCMP contract, a majority report the reason is due to operations that are more aligned with providing specialty care services than with the comprehensive preventive and sick care services provided by a primary care medical home. Although access to OB/GYN providers who are currently contracted as PCMP providers appears to be insufficient, actual member access to OB/GYN services is maintained through contracted PCMP providers who provide such services, as well as non-PCMP OB/GYN providers who remain open to serving Medicaid members as a specialty provider.
- COVID-19 response:  
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
  - 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**

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 consistently shows the highest utilization is for general office visits among established patients, with 53% of claims indicating federally qualified health center (FQHC) as the provider type, 46% indicating clinic practitioner, and 1% indicating non-physician practitioner or rural health clinic. 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
<i>Sample</i>	0	0.0%	0	0.0%
<b>CHP+ MCO, Medicaid MCO, RAE</b>				
Total members	173,765	N/A	178,038	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with “BV” or “BG”)	3,607	N/A	3,708	N/A
Behavioral health practitioners accepting new members	3,229	90%	3,510	97%
Behavioral health practitioners offering after-hours appointments	2,608	72%	2,897	78%
New behavioral health practitioners contracted during the quarter	242	7%	76	2.2%
Behavioral health practitioners that closed or left the MCE’s network during the quarter	46	1.3%	14	0.4%

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

Requirement	Previous Quarter	Current Quarter
	Number	Number
<i>Sample</i>	0	0
<b>RAE</b>		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	3	3
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	33	35 + flex
Total SUD treatment facilities offering ASAM Level 3.3 services	0*	0*
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	5	4
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	24 + 24 flex	40 + 24 flex
Total SUD treatment facilities offering ASAM Level 3.7 services	1	2
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	36	36
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	7	5
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	107	123
Total SUD treatment facilities offering ASAM Level 3.7 WM services	3	2
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	110	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.***



**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:

- Out-of-state providers  
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.
- 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 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.
  - Monthly Open Mic meetings are held for the behavioral health network, which provide a forum for educational opportunities and exchanging information.
  - SUD-specific training:
    - BH Onboarding for SUD Benefit Expansion
    - ASAM Criteria in Health Care Management Training
    - Utilization Management SUD Training
- 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 an example, CCHA conducted outreach to all 3.2WM providers who had been licensed for SUD services for interest and inclusion in the SUD network during this reporting period. This outreach has proven fruitful with additions to the network that we expect to be realized and reported in the next network adequacy reporting period. As previously reported, 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 receiving today – the majority of care continues to be rendered within CCHA’s network of SUD providers. CCHA will deploy the use of single case agreements in addition to

**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**

contracted providers to ensure there is appropriate member access as assessment and adjustment of the network unfolds. Most single case agreements (SCAs) have been issued in the 3.2WM and 3.7WM levels, as these services are typically more immediate in nature and not appropriate to refer. CCHA expects recent work in the 3.2WM space and conversations across with providers who perform services across the ASAM spectrum will reduce the number of SCAs needed due to providers joining the network for these services. CCHA remains committed to working closely with our network of 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. 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 initially extended an invite to all Special Connections designated providers to become in network at the beginning of the benefit expansion, as not all have been willing to accept the Special Connections rate at this time. Providers continue to express 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.

Effective June 1, 2021, following feedback received from contracted SUD providers regarding the 24-hour notification process for 3.2WM and 3.7 WM services, CCHA implemented the following changes to help reduce providers’ administrative burden:

- A 24-hour notification is no longer required when members admit into 3.2 WM and/or 3.7 WM levels of care. Claims for 3.2 WM and/or 3.7 WM can be submitted directly to CCHA without prior notification for all members admitting on/after June 1, 2021.
- CCHA will conduct medical necessity reviews for admissions for 3.2 WM and 3.7 WM that are more than four days in length.
- CCHA will conduct retrospective medical necessity reviews for 3.2 WM and 3.7 WM admissions more than four days in length.

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**

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. However, the volume of paid behavioral health claims began to decline during the reporting period as compared to the volume for the same timeframe in 2020. Though claims data for the reporting period is not yet final, the trend in volume of paid claims indicates utilization is steadily decreasing as follows: 1,334% in March 2021, 265% in April 2021, 22% in May, and 28% in June 2021. 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
<i>Sample</i>	0	0.0%	0	0.0%
<b>CHP+ MCO, Medicaid MCO</b>				
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

- Boulder County
  - CHPG Primary Care Lafayette
- Broomfield County
  - Senior Health First – Westminster
  - Centennial Valley Pediatrics – Broomfield
- Jefferson County
  - STRIDE CHC – Golden High School

#### Region 6 PCMP Network Terminations

- Boulder County
  - Site closure: Boulder Community Health – Wellness Program of BCH
- Jefferson County
  - Terminated for cause: Provider Federal Health Care, Inc.

#### BH Network Additions

A total of 76 practitioners joined the network during the reporting period as follows:

- 64 new practitioners were added to existing provider groups statewide
  - Region 6: 10 new practitioners
  - Region 7: 17 new practitioners
  - Other counties outside of Regions 6 and 7: 37 new practitioners
- 12 solo practices joined the network statewide
  - Region 6: 3 new practices
  - Region 7: 2 new practices
  - Other counties outside of Regions 6 and 7: 7 new practices

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**

BH Network Terminations

Note: CCHA reports all provider terminations to HCPF on a monthly basis.

- 14 practitioners left the statewide network as follows:
  - Region 6: 2 practitioners termed
    - 1 nonresponsive to re-credentialing
    - 1 left contracted provider group
  - Region 7: 2 practitioners termed
    - 1 nonresponsive to re-credentialing
    - 1 left contracted provider group
  - Other counties outside of Regions 6 and 7: 10 practitioners termed
    - 1 nonresponsive to re-credentialing
    - 1 opted to out of the network
    - 8 termed due to duplicate provider records

**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.

## 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**

<p><b>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?</b></p> <p><b>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?</b></p>
<p><b>CHP+ MCO</b></p>
<p><i>MCE to provide narrative response here regarding these contract requirements.</i></p>

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

<p><b>Did the MCE discontinue providing covered services to members within an entire county within the MCE’s service area?</b></p> <p><b>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?</b></p>
<p><b>CHP+ MCO</b></p>
<p><i>MCE to provide narrative response here regarding these contract requirements.</i></p>

**Table 8-CHP+ MCO Provider Network Changes: Discussion**

<p><b>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?</b></p> <p><b>If the MCE answered “yes”, did the MCE notify the Department, in writing, of the change?</b></p>
<p><b>CHP+ MCO</b></p>
<p><i>MCE to provide narrative response here regarding these contract requirements.</i></p>

## 4. Appointment Timeliness Standards

### 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.
<b>CHP+ MCO, Medicaid MCO, RAE</b>
<p><u>Policies and Procedures</u></p> <ul style="list-style-type: none"> <li>• All PCMP contracts require the following standards for member access:           <ul style="list-style-type: none"> <li>○ Inpatient follow-up appointment within 7 days after discharge.</li> <li>○ Non-urgent, symptomatic care visit within 7 days after the request.</li> <li>○ Urgent care appointment within 24 hours after the initial identification of need.</li> <li>○ Well-care visit within 1 month after the request, unless an appointment is required sooner to ensure the provision of screenings.</li> </ul> </li> <li>• CCHA Member Rights and Responsibilities Policy           <ul style="list-style-type: none"> <li>○ 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 <i>For Members</i> section of CCHA's website.</li> <li>○ 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).</li> </ul> </li> </ul> <p><u>Methodology for Assessing Timeliness:</u> 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.</p> <p>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</p>



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 typically separate 3NA measures for short visits (emergency follow up or acute care) and long visits (physical exams). Assessing the 3NA for unique appointment types provides information about timeliness and informs where improvements are necessary. Note: times reserved for same-day appointments are counted as emergency follow up or acute care visits when assessing 3NA access.
4. Assessment of each PCMP's 3NA is conducted on the same day of the week and at the same time of day if possible. CCHA analyzes and graphs the data, which provides a visual representation of the practice/provider access and areas of improvement.
5. The 3NA findings are used to help practices understand their demand and consider whether their provider resources are sufficient. If 3NA findings indicate timeliness standards are not being met, practice transformation coaches work with the practice to evaluate and optimize empanelment using Right-Size Panel and Demand analysis tools.

Current Status of Network Timeliness:

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 practices during the reporting period indicates timeliness standards were met. This data is collected from non-coached practices on an annual basis as part of the Office Systems Review and will be included in the SFY 2021-22 Q3 report.

SFY 2020-2021 – Quarter 4				
Visit Type	Standard	Q4 Numerator	Q4 Denominator	Q4 Rate
<b>Inpatient hospitalization follow up</b>	Within 7 days after discharge	89	97	91.75%
<b>Non-urgent, symptomatic</b>	Within 7 days of member request	92	97	94.85%
<b>Urgent/Acute</b>	Within 24 hours of member request	63	97	64.95%
<b>Well-care physical examinations</b>	Within 30 days of member request	93	97	95.88%

**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. The 2021 annual Appointment Access Survey will be conducted in the fall.

## 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 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).

**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
  - 98% member access
- Pediatric Primary Care
  - 99% member access
- Family Practitioner
  - 99% member access
- Gynecology, OB/GYN
  - 99% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 24% 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
  - 83% member access
- Family Practitioner
  - 85% member access
- Gynecology, OB/GYN
  - 86% member access

- Pediatric Primary Care
  - 86% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 6% member access
- General Psychiatrists and Other Psychiatric Prescribers
  - 77% member access
- Pediatric Psychiatrists and Other Psychiatric Prescribers
  - 70% 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

#### Gilpin County

- Adult Primary Care
  - 21% member access
- Family Practitioner
  - 23% member access
- Gynecology, OB/GYN
  - 24% member access
- Pediatric Primary Care
  - 25% member access
- Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals
  - 3% 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 Hospitals or Psychiatric Units in Acute Care Hospitals
  - 97% member access
- SUD Treatment Facilities-ASAM 3.1
  - 85% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 84% 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 Hospitals or Psychiatric Units in Acute Care Hospitals
  - 86% member access
- SUD Treatment Facilities-ASAM 3.1
  - 59% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 61% 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
  - 89% 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 access to the COVID-19 vaccine and vaccination rates among members:
  - During the reporting period, CCHA continued work to identify and partner with network providers and community organizations 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.
  - COVID-19 vaccination data from CIIS is now included in CCHA’s member rosters and available to the provider network. Member rosters are updated weekly to reflect any changes in members’ vaccination status to help inform targeted outreach and ongoing efforts to increase member vaccination rates.
- 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 second 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 242 Health First Colorado members, providing over \$21,000 in direct member services (vehicle repair, insurance, registration, bus passes).

**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 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
  - 88% member access
- Pediatric SUD Treatment Practitioner
  - 90% 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 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
  - 44% member access
- SUD Treatment Facilities
  - 22% member access
- SUD Treatment Facilities-ASAM 3.1
  - 22% member access
- SUD Treatment Facilities-ASAM 3.2 WM
  - 27% 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.

## 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
<i>Franklin Q. Smith</i>	0000000	<i>Denver</i>	<i>PV050</i>	<i>Adult Only Primary Care</i>	■
<i>Chrysalis Behavioral Health</i>	0000000	<i>Baca</i>	<i>BF085</i>	<i>SUD Treatment Facility, ASAM Levels 3.1 and 3.3</i>	■
<b>CHP+ MCO, Medicaid MCO, RAE</b>					
VitalCare	9000153764	Jefferson Westminister, CO	N/A Non-medical home care agency	Home & Community Based Services (HCBS)	■
Cornell Corrections of California, Inc.; Southern Peaks Regional Treatment Center	0000000	Fremont Canon City, CO	BF142	Residential Treatment Facility (RTF)	■
Parker Valley Hope Association	0000000	Douglas Parker, CO	BF142	Residential Treatment Facility (RTF) ASAM Level 3.5	■
Jefferson Hills Corporation	0000000	Jefferson Lakewood, CO	BF145	Residential Treatment Facility (RTF) ASAM Level 3.1	■

**Table A-2-Practitioners with SCAs: Discussion**

<p><b>Describe the MCE’s approach to expanding access to care for members with the use of SCAs.</b></p> <p><b>Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.</b></p>
<p><b>CHP+ MCO, Medicaid MCO, RAE</b></p>
<p>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.</p>

## 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.