COLORADO COMMUNITY HEALTH ALLIANCE

Network Adequacy Plan

Region 7

July 30, 2021

Table of Contents

Network Development

As a Regional Accountable Entity (RAE), Colorado Community Health Alliance (CCHA) continually works to expand and enhance robust networks of physical and behavioral health providers to ensure members have reasonable choice in providers and access to necessary care, as envisioned by the Department of Health Care Policy and Financing (HCPF) through the Accountable Care Collaborative (ACC) Phase II. With a comprehensive network of behavioral health clinicians and primary care providers – comprised of adult and pediatric primary care providers, OB/GYNs, adult and pediatric mental health providers, substance use disorder providers, psychiatrists, psychiatric prescribers, and family planning providers – CCHA's recruitment and contracting efforts are currently focused on growing the network and addressing gaps through targeted outreach to providers enrolled in the CO Medicaid program, in good standing with the Centers for Medicare and Medicaid Services (CMS), and interested in participating in the ACC as a partner of the Regional Accountable Entity (RAE). As outlined in the Annual Recruitment Strategy, CCHA has a goal of contracting a minimum of four new PCMPs within the next year in Region 7. CCHA takes a "come as you are" approach with regard to contracting with providers in good standing, which allows practices of all sizes to participate in the ACC program to the degree in which they are comfortable.

CCHA continues to seek providers using methods that have long proved reliable for outreach and recruitment. When making outreach attempts, CCHA considers both public and private providers who appear on the non-contracted provider lists provided by the Department of Health Care Policy and Financing (HCPF), those who are requested by members, and those located in rural areas of Region 7. For behavioral health, CCHA remains open to all contracting requests from behavioral health providers statewide to assure member access to inpatient, outpatient, and all other covered mental health and substance use services. Outreach efforts are focused on local and regional provider listings to recruit and contract providers, including the network of Anthem providers in Colorado, and providers offering services under the expanded substance use disorder benefit. When conducting outreach and recruitment of new providers across both physical and behavioral health networks, CCHA considers the unique and culturally diverse membership in Region 7 to prioritize efforts to contract with providers who represent racial and ethnic communities, members who are deaf and hard of hearing, members with disabilities, and other culturally diverse communities.

Once outreach is successful, the contracting department works to perform the necessary paperwork while provider relations staff focuses on provider education and support to ensure providers are informed of CCHA resources and familiar with the structure and goals of the ACC.

Contracting and Compliance

As a standard policy, CCHA does not employ or contract with providers excluded from participation in Federal health care programs under section 1128 or section 1128A of the Social Security Act. CCHA will only enter into written contracts with primary care providers that meet the following criteria to qualify as a PCMP:

- Enrolled as a Colorado Medicaid provider.
- Licensed and able to practice in the State of Colorado.
- Practitioner holds an MD, DO, or NP provider license.
- Practitioner is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.

All primary care provider contracts are renewed annually to ensure agreements remain current with the ACC program and any new initiatives available to the network. The current contract requires PCMPs to meet all of the criteria to qualify as a PCMP, as indicated in Section 9.2.1 of the RAE contract, serve as a medical home for their members, comply with State and Federal regulations, and collaborate with the RAE to meet quality standards and member needs. Behavioral health providers are required to meet all credentialing criteria to participate in a Medicaid program, comply with State and Federal regulations, and collaborate with the RAE to meet quality standards and member needs. Prior to entering into an agreement, CCHA requires that both providers and practices complete an application form, which collects attestation for these criteria. Requirements of the CCHA network for both physical and behavioral health providers are detailed in provider contracts and in the primary care and behavioral health provider manuals posted to the CCHA website.

Provider Onboarding

CCHA aims to maintain a network that offers members ample choice and continuity of care across services. CCHA strives to accomplish this not only through contractual compliance activities but also through our attention to provider support and partnership. Orientations are offered upon request and to all newly contracted physical and behavioral health providers. CCHA's provider orientations are tailored for primary care and behavioral health providers and include presentations, provider manuals, and a variety of other resources that help familiarize providers with CCHA's provider support model, the vast array of services available to members, as well as the goals of the ACC program.

Network Maintenance

For SFY 2021-22, CCHA will continue ongoing network maintenance operations, as outlined in further detail below. Additionally, maintenance activities also include engaging the network to ensure providers are informed on current priorities of the RAE and ACC, member enrollment trends, and how they can help enhance access and quality in member care. Some of examples of these activities include:

- Provider revalidation: CCHA is working with providers to ensure they are in compliance with the Colorado NPI Law and prepared for revalidating enrollment as a Health First Colorado provider. In alignment with HCPF guidance and to further support providers and the revalidation process, CCHA will not deny or suspend provider claims if revalidation has not been completed by the posted revalidation due date. This process will remain intact until further notice or guidance from HCPF is received.
- Influx of member enrollment: Due to the COVID-19 pandemic, CCHA has been and will continue monitoring practice capacity to accommodate increases in member enrollment. As a result of these efforts, several practices increased their Medicaid panels, and CCHA worked with HCPF to facilitate re-assignment of newly enrolled members from practices that were over capacity and unable to expand Medicaid panels.
- Telehealth services: With the expansion of telehealth services, opportunities to increase access have also expanded. Claims data currently shows highest utilization is for general office visits among established patients, with 59% of claims from federally qualified health centers (FQHCs). Though the volume of telehealth services has decreased over time as practices return to normal business hours and in-person access has increased, CCHA plans to continue tracking utilization trends to help inform access improvement goals. Additionally, CCHA is planning to leverage the CCHA Member Advisory Committee to assess member experience with use of telehealth services to help inform potential strategies for increasing utilization in SFY 2021-22.
- Implementation of SUD benefit: CCHA proceeded with implementation of the inpatient and residential components of the SUD benefit, effective January 1, 2021, by building a highly

aligned, narrow network of high-performing SUD providers initially. Capacity has since expanded with contracts extended to all 3.2 WM providers in the State, as well as additional ASAM 3.5 and 3.7 WM levels of care. Single case agreements are deployed where necessary when care cannot be rendered within the contracted network. CCHA will continue to focus on assessing utilization of services, network adequacy, and additional opportunities for contracting.

- Prescription Benefit Tool: With HCPF's recent implementation of a prescription benefit module, CCHA has assessed the volume of the network that has an EHR compatible with the prescription benefit tool and will encourage its use, as well as share the informational and educational resources available.
- eConsult Platform: With anticipation of a statewide eConsult platform in January 2022, CCHA is prepared to support HCPF on successful implementation and promote utilization among the network by sharing information, resources, and training opportunities as they become available.

Provider Information and Network Directory

CCHA collects information about practice attributes upon contracting/credentialing for both physical and behavioral health providers, and annually for physical health providers during the Office Systems Review (OSR) when practice information is reviewed and updated. After initial contracting, the annual OSR is one mechanism by which CCHA remains current on practice details such as additional specialties; capacity to accept new members; culturally and linguistically appropriate services (CLAS) expertise and/or training; after hours and weekend appointment availability; and accessibility equipment or features such as proximity to mass transit, high-low exam table, listening loops, low-vision aids, various wheelchair accommodations, etc. Provider information for both the physical and behavioral health networks is also updated through CCHA surveys and upon notification of changes from providers, which also include practice attributes as well as practice additions, terminations, and changes to practitioner service locations. Providers are of the understanding that on-site visits may be used to verify information reported.

Provider demographics and high-level attributes are available in the network directory on CCHA's website at CCHAcares.com/for-members/find-a-provider. The provider directory allows members to filter their search by languages spoken, and whether the provider has accommodations for people with disabilities, is accepting new members, has completed cultural competency training, and offers telehealth services. As part of continuous improvement efforts, CCHA leveraged input from the CCHA Member Advisory Committee (MAC) to help inform improvements and updates to the directory such as the addition of a telehealth filter, displaying more robust accommodations in search results, and revising provider and practice type specialties to be more intuitive for members using the tool. The MAC also aided in development of a search tips guide, which is now available directly from the provider directory webpage. Directory information is updated at least monthly and with any network changes to ensure accurate and timely information is made available to members.

Practice Support and Incentives

As described in CCHA's Practice Support Plan, CCHA promotes network development and provides ongoing support to practices through practice transformation initiatives, care coordination support, newsletters, member support materials, provider education and training and resources. All providers have access to CCHA resources such as cultural competency training material and a Caring for Diverse Populations toolkit, which are made available on the CCHA website and announced in the CCHA Provider Newsletter. CCHA's Provider Newsletter also highlights educational and training information and, as part of the Health First Colorado Provider Academy, includes a monthly feature on other provider trainings and resources related to member care – an Infant Safe Sleep Partner Toolkit developed by the Colorado

Department of Human Services and heart healthy eating resources available through the American Heart Association, for example, were provided in the July 2021 newsletter.

Physical health providers qualified to participate in CCHA's Provider Incentive Program also have the opportunity to receive quarterly payments for meeting program performance goals, which are updated as needed to maintain alignment with population health priorities and the goals of the ACC. Additionally, as detailed in the CCHA Administrative Payments report for SFY 2021-2022, CCHA has transitioned to a new tiered payment methodology that is also better aligned with population health priorities. Payments are dependent on the member's utilization and complexity, and practices with enhanced services that address complex and chronic conditions receive advanced level rates for their assigned members.

Similarly, CCHA's provider relations team supports the behavioral health provider community through educational resources and materials, open mic sessions, and meetings with key behavioral health facility partners and Community Mental Health Centers (CMHCs). Open mic sessions remain an important aspect of connecting with the provider community, identifying and mitigating trending issues, and hosting a forum for education and information.

Recently, as part of the Provider Experience model, CCHA added new functionality to the behavioral health provider enrollment tool hosted on the Availity Portal to further automate and improve the online enrollment experience. Professional providers can now submit and track provider enrollment applications online using Availity's Digital Enrollment Dashboard. This functionality aims to streamline the application process and timeline for new behavioral health providers. CCHA is closely monitoring success of this new feature by tracking status, progress, and end-to-end processing timelines of contracting requests to evaluate workflow improvements and decrease overall processing timelines. on process improvement through claims audits and issue monitoring, particularly around contracting, credentialing, and provider reimbursement workflows. For direct provider support, CCHA hosted webinars to inform providers of telehealth changes and updated the CCHA website with a dedicated to COVID-19 landing page where resources specific to telehealth billing, claims, and HIPAA guidance are posted and updated as needed. Further, CCHA supports providers by alerting them to new information about resources and financial support opportunities available through other agencies such as the Colorado Medical Society, the Small Business Administration, and Federal and State COVID-19 Financial Support programs.

Finally, CCHA hosts town hall meetings to share information and updates with physical and behavioral health providers. Town hall meetings are designed to cover a variety of topics pertinent across networks, including: Business and Operations Information; Provider Education and Resources; Provider Engagement Opportunities; Care Coordination and Member Support; Health First Colorado Member Benefits Highlights; and Member Education Resources. Town hall meetings for SFY 2021-22 are planned for fall 2021 and spring 2022, and CCHA is currently assessing opportunities for in-person engagement.

Corrective Action

The CCHA provider relations team identifies and escalates provider issues and barriers, and Medicaid program officers review ongoing issues with CCHA leadership to determine the appropriate mechanism for corrective action on a case-by-case basis. If an issue warrants a Corrective Action Plan (CAP), CCHA's protocol is to develop a CAP with the provider and escalate to HCPF as appropriate. As part of this standard process, a report with recommended actions is submitted to HCPF, in writing, within five business days of discovering significant provider issues, deficiencies, or needs for corrective action.

Monitoring Access to Care

CCHA monitors the network's compliance with contractual requirements and NCQA access to care and quality of services standards using an array of mechanisms and tools, including assessing caseload standards, geographic location of providers to members, and appointment timeliness, as outlined in detail below. In addition, CCHA uses the following mechanisms to identify potential access issues through member and stakeholder feedback:

- Member Services Data: CCHA uses this data to identify potential compliance issues. For example, if we receive repeated calls regarding inaccessibility, the provider relations staff and/or a designated practice transformation coach works with the provider to support with issue resolution.
- Stakeholder Feedback: CCHA actively participates in alliances, committees, and advisory groups where additional network needs are discussed and assessed for trending issues that help improve processes and provider/member services.
- Quality of Care and Access Concerns: Quality and access issues are investigated as part of the provider support model and through practice transformation activities. Outcomes are reviewed through key performance indicators, quality reviews, and annual quality of care audits. Additionally, CCHA convened a Quality Management Committee (QMC) for behavioral health cases. The QMC will leverage the expertise of local providers to drive decisions on care standards and remain informed on trends in behavioral health and integrated care.
- Grievance and Appeals Data: CCHA reviews this data on a quarterly basis to identify and address any notable trends among providers and/or services.
- Member Satisfaction Surveys: CCHA will support HCPF's administration of the Consumer Assessment of Health Care Providers and Systems (CAHPS®) in querying members on key questions, including access to care.

Caseload Standards and Utilization of Services

CCHA's member enrollment determines the composition and capacity of our provider network, including PCMPs, specialists, hospitals, behavioral health providers, and ancillary providers. As detailed in the *CCHA Network Adequacy and Access Standards operating policy,* CCHA monitors member utilization and caseload standards to confirm member-to-provider ratio and network adequacy and reporting standards are met. Provider caseload is monitored, at minimum, on a quarterly basis during quarterly network adequacy assessment. With full assessment of the network, provider caseloads are monitored using the following member-to-provider ratios:

- Adult primary care providers: one per 1,800 adult members
- Adult mental health providers: one per 1,800 adult members
- Advanced practice primary care providers: one per 1,200 adult members
- Pediatric primary care: one per 1,800 child members
- Pediatric mental health providers: one per 1,800 child members
- Substance use disorder providers: one per 1,800 members

Additionally, CCHA analyzes out-of-network authorizations, service coordination needs, member cultural competency and language needs, provider capabilities, and provider claims data. CCHA's provider data review processes are currently underway and will be used to not only identify opportunities for provider training but also assess coverage.

Geographic Location of Providers to Members

CCHA works to establish a provider network that offers members a choice of at least two (2) appropriate providers within their zip code or within the maximum distance for their county classification, as identified below:

- Adult and pediatric primary care providers and OB/GYN providers:
    - Urban counties: 30 miles or minutes
    - Rural counties: 45 miles or minutes
    - Frontier counties: 60 miles or minutes
- Acute care hospitals:
    - Urban counties: 20 miles or minutes
    - Rural counties: 30 miles or minutes
    - Frontier counties: 60 miles or minutes
- Adult and pediatric behavioral health providers, including mental health providers, psychiatrists and psychiatric prescribers, and substance use disorder providers:
    - Urban counties: 30 miles or minutes
    - Rural counties: 60 miles or minutes
    - Frontier counties: 90 miles or minutes

CCHA evaluates geographic location of providers and members to identify network gaps and assess member choice. CCHA's industry-standard tools enable evaluation of network adequacy through use of geographic proximity between members and network providers, member access summaries, and accessibility reports.

Appointment Timeliness

To meet the needs of CCHA's membership, CCHA contracts with a provider network with the goal of ensuring timely access to care and services, taking into account the urgency of the need for services, including:

- Urgent care within 24 hours from the initial identification of need
- Outpatient follow-up appointments within 7 days after discharge from hospitalization
- Well-care visit within 1 month after member request
- Non-urgent, symptomatic care visit, including behavioral health (BH) services, within 7 days after member request
- Emergency BH care:
    - By phone within 15 minutes of the initial contact
    - In-person within 1 hour of contact in urban and suburban areas
    - In-person within 2 hours of contact in rural and frontier areas
    - Members may not be placed on waiting lists for initial routine BH services

CCHA's practice support efforts help ensure providers can accommodate appointments for more urgent or acute care needs using the 3rd Next Available Appointment[1] methodology. In higher-volume practices,

[1] Third Next Available Appointment is the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. Reference: Institute for Healthcare Improvement. CCHA also has an internal policy on use of this methodology.

same-day and acute care is often provided by dedicated advance practice providers staffed within the practice. Additionally, CCHA monitors access to BH services through the annual Appointment Access Survey. The survey is conducted each year in the fall and covers the following categories: Urgent Care, Initial Visit - Routine Care, Follow-up - Routine Care, and Non-Life - Threatening Emergency Care. Any access issues discovered during the annual survey are remediated through corrective action.

Network Adequacy and Reporting Standards

Network adequacy assessments help identify trends and opportunities for network improvement. CCHA assesses network adequacy on a quarterly basis, or as requested by HCPF, and submits analyses that include, at minimum, the following:

- PCMPs and behavioral health providers accepting new Medicaid members
- PCMPs and behavioral health providers offering after-hours appointment availability to Medicaid members
- Performance meeting time and distance standards
- Number of behavioral health provider single-case agreements used
- New PCMPs and behavioral health providers contracted during the quarter
- PCMPs and behavioral health providers that left the network during the quarter
- Additional information, such as member access to ASAM levels of care, as requested by HCPF

General Access Efforts

CCHA maintains and monitors the provider network in alignment with CCHA's *Provider Network Adequacy and Access Standards* policy and the CCHA Practice Support Plan. Through ongoing quantitative assessment and qualitative evaluation, CCHA is positioned to remain informed on gaps or barriers and respond accordingly to ensure contracted networks and ancillary partners are capable of meeting members' diverse needs and serving members across all ages, levels of ability, gender identities, and cultural identities. Further, to aid in medical competence and offer members with the best experience possible, CCHA and network providers facilitate language assistance services, including interpretation and American Sign Language services, at all points of access in the health neighborhood. Services can be coordinated through our member services department or the network provider directly, and the care coordination team collaborates with care providers to ensure language assistance services meet the needs of the member.

Another component of access to care includes CCHA's partnerships with the health neighborhood and community, which are essential to access and achieving the goals of the ACC. By aligning shared goals with provider and community stakeholders at the local and regional levels, we can effectively enhance member access and reduce duplication, and total cost of care.

Access for Special Populations

CCHA approaches access for all members, including members with disabilities and special populations, by collaborating with members, network providers, and the multitude of stakeholders comprising the health neighborhood. Care coordinators help unify and bring resources together, addressing member needs across agencies and systems to reduce duplication, maximize resources, expand member support through integrated care and community resources, and help achieve the best outcomes. Physical and behavioral health network managers and practice transformation coaches work directly with providers on access and availability to ensure the network is equipped to serve members and meet their unique needs.

For special populations defined by population health priorities and risk stratification methodologies, CCHA ensures access through various initiatives and targeted care coordination, as described in CCHA's Population Management Strategic Plan. Below is a summary of efforts to ensure access for high-risk members and priority populations such as those involved with the justice system and who are at high risk during pregnancy, due to chronic conditions or poorly managed conditions:

- CCHA employs a multidisciplinary care coordination team that coordinates with the family, providers, and community agencies on appropriate interventions and care planning. Care planning meetings help define roles and responsibilities, ensuring services are not duplicative and focus on the family's goals and strengths.
- CCHA has established co-location agreements, data sharing agreements, and referral processes with specialist providers, local departments of human services, single entry point and community centered boards, community corrections facilities, parole facilities, and hospitals. These formal relationships promote member engagement in person and at the point of care.
- CCHA care coordinators attend various case staffing meetings led by the Department of Human Services and HCPF to address the needs of children involved in the child welfare system. Such meetings include Creative Solution Meetings, Family Engagement Meetings, High Fidelity Wrap-around Meetings, Action Meetings, etc.

For special populations whose access is dependent on network capabilities or specialized services, CCHA ensures access by monitoring the network and working directly with service providers on options to meet member needs. Examples include the following efforts to ensure access for special populations including but not limited to members with disabilities, members seeking family planning services, members with chronic conditions, members identified as complex, and those who experience barriers due to limits in choice or proximity of providers and/or lack of transportation:

- Network participation: For SFY 2021-22, certain practices were invited to participate in the network at an advanced rate level with indication of enhanced services that aid population management and goals to improve health outcomes for complex members and members with chronic conditions such as diabetes, pregnancy, and asthma.
- Network monitoring: CCHA updated contracting applications to collect information about accessibility features and equipment, family planning services, and telehealth services. As previously mentioned, CCHA remains current on practice information during the annual OSR when these details are reviewed and updated.
- Practice support and resources: CCHA develops and connects providers with educational resources such as disability competent care training, telehealth information and guidance, practice transformation coaching, and value-based incentives for targeted engagement of special populations. Additionally, CCHA will identify ways to work with HCPF regarding the proposed spending plan for implementing and operationalizing the American Rescue Plan Act of 2021 this fall. Specifically, CCHA looks forward to aligning efforts that aim to strengthen and expand the behavioral health safety net by promoting disability and clinical competency training for providers to enhance the network's ability to better serve people with disabilities and individuals living with mental health and substance use disorder.
- Practice transformation coaching, and value-based incentives for targeted engagement of special populations.
- Data sharing: CCHA shares member-level data with providers that identifies priorities to help focus access and engagement efforts on special populations. Likewise, practice accessibility and provider details are shared with members through direct contact and via the Provider Directory on the CCHA website.

- Technology: CCHA promotes use of solutions that broaden member and provider engagement. For example, provider education and direct support to providers for increased use of telehealth.

Addressing Gaps in Coverage

CCHA approaches gaps in coverage in a number of ways, dependent on the source of the issue, which ranges from provider availability to circumstantial issues such as reporting limitations and the COVID-19 pandemic. Below are various strategies CCHA uses to address gaps in the network.

Collaboration and Partnership

In areas where gaps in coverage exist because providers are generally lacking, CCHA fosters collaborative relationships with local organizations and providers. Through formal and informal relationships with community partners, CCHA has better understanding of the community's unique needs, can leverage existing efforts to reduce gaps, and can prioritize efforts to improve member access to an appropriate range of services based on stakeholder feedback. CCHA's community partnerships team leads the regional Provider Improvement Advisory Committee (PIAC) and is dedicated to building and maintaining strong relationships within the community where feedback is obtained from a variety of representatives including county departments, non-profit organizations, and local service providers. Collaboration with such community organizations continues to play a key role in understanding gaps in coverage and identifying opportunities for resource development, provider recruitment, and reducing gaps in access and/or care.

Care Coordination

CCHA also leverages 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.

Targeted Provider Outreach and Recruitment

In areas where gaps in coverage could be remediated by recruiting non-contracted providers, CCHA considers stakeholder feedback, member requests, care coordination, and direct provider inquiries to target outreach and recruitment of providers not yet contracted with CCHA. In addition, CCHA uses the monthly Enrollment Summary from HCPF to target outreach to non-contracted providers, prioritizing PCMPs with a high-volume of membership that are non-contracted and have a potential to impact coverage gaps and/or offer specialized care, such as women's health services. Similarly, as outlined in the Annual Behavioral Health Provider Recruitment and Network Development Strategy, CCHA's provider solutions team utilizes available tools inform network improvement opportunities, including but not limited to volume of out-of-network authorizations or single case agreement requests, non-contracted and enrolled provider lists provided by HCPF, and utilization management. Out of network providers that are identified as having a material number of single case agreements or out of network authorization requests, are prioritized along with behavioral health providers requested by members.

Efforts to Reduce Gaps in Coverage

CCHA continues to monitor network gaps and coverage issues that, most notably, impact the adequacy of in-network access to OB/GYN providers and substance use services. 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 who voluntarily terminate their PCMP contract, a majority report the reason is due to operations that are more aligned with specialty care than with the requirements of a primary care medical home. Although access to OB/GYN providers who are currently contracted as PCMP providers appears to be inadequate, actual member access to OB/GYN services is maintained through contracted PCMP providers who provide women's health services, as well as non-PCMP OB/GYN providers who remain open to serving members as a specialty provider.

CMS updates to telehealth requirements expanded use of telehealth for both physical and behavioral health providers. Although utilization has steadily decreased as providers began increasing in-person visits and returning to normal business hours, CCHA is optimistic that the telehealth expansion will further reduce gaps over the long term. SUD services, for example, were included in the telehealth expansion, so telehealth remains a promising option to help with improving access to those services.

As detailed in CCHA's Behavioral Expansion Plan, below are examples of CCHA's efforts to expand the behavioral health network and reduce gaps in substance use disorder (SUD) and other behavioral health services where gaps have been identified.

- Collaboration with other RAEs to identify prospective contracts with behavioral health specialists located in other regions such as animal-assisted/equine therapy in Region 1, and residential treatment for children in Region 4.
- Exploring partnerships, pending consideration of provider capabilities and capacity, that could help increase access to eating disorder services via telehealth and/or in-person services.
- Managing intensive SUD services by maintaining a bed tracker and working with UM and care coordination teams to step members down from inpatient to lower levels of care as appropriate.
- Increasing high intensity behavioral health services by:
    - Continuing to work with Recovery Unlimited and Peak View in Region 7 to provide SUD intensive outpatient (IOP) services, and
    - Partnering with the local CMHCs as they develop and increase capacity for 3.5 and 3.7 ASAM levels of care and SUD IOP services, pending improvement in workforce shortages, and
    - Contracting discussions are in process with the Universal Health Services (UHS) facilities for Regions 6 and 7 to increase access to 3.7 WM services pending agreement on rates.

Finally, CCHA aims to contract with all CMHCs, Federally Qualified Health Centers (FQHCs), and hospital systems to provide extensive member choice and facility access to behavioral health services. To date, CCHA's behavioral health network provides access to all IMDs, 15 hospital systems, 16 of 17 CMHCs, and 10 of 21 FQHCs statewide. CCHA also continues to welcome independent providers and any provider with a single case agreement to join the network.

Data Limitations

CCHA also assesses circumstantial issues that present as network adequacy issues to determine actions necessary for resolution. One example of reporting limitations among PCMPs is due to gaps in provider data. Practitioners are contracted as affiliates of PCMP sites, and the scope of information collected

upon contracting includes contractually required information as well as voluntary details such as providers' secondary and tertiary specialty types, specific disability accommodations/equipment, cultural competencies, etc. As such, CCHA has updated contracting applications and OSR forms to help collect as many practice details as possible. These efforts have significantly increased the level of detail available about provider specialties and practice attributes; however, such discretionary details continue to be underreported, resulting in apparent insufficiencies in network specialties and expertise.

Similarly, within the behavioral health network, cultural competency training status is likely underreported, as it is voluntarily reported and updated by providers. CCHA recognizes the importance of identifying providers who have completed cultural competency training, however, and is implementing a process to obtain provider information after an online training has been completed. To support this process, CCHA is working to revise the Cultural Competency course evaluation, which will prompt providers to report details that can be used for tracking and updating their training status.

Mental Health Certifications

CCHA is contracted with Diversus CMHC, four psychiatric hospitals, and one Acute Treatment Unit (ATU) which are 27-65 certified. CCHA has an open behavioral health network in which all CMHCs across the state have been invited to join. CCHA will work with OBH to identify any new network providers able to accept mental health certifications in order to ensure and monitor adequacy.

Network Adequacy Analysis

Software

Physical Health Provider Analysis: Maptitude 2020, Build 4765, 64-bit
Behavioral Health Provider Analysis: Quest Analytics Suite™, Version 2019.4, Build 127, 64-bit

Time and Distance Methodology

When mapping members to their respective counties with analytics software, some addresses/zip codes map to a county that differs from the county indicated in the membership file. As such, the membership in each county does not precisely align with the member roster.

For the physical health network, time and distance calculations are provided for the Region 7 counties in which CCHA is designated to contract primary care providers. A total of 13,734 members were excluded from the time and distance portion of the report because their county of residence is not within a Region 7 county.

Appendix

Table 1: Cultural Competency by County

PROVIDER TYPE	El PASO COUNTY	PARK COUNTY	TELLER COUNTY	OTHER COUNTIES[2]
Total PH Providers Trained in Cultural Competency	209 of 535 Providers	0 of 2 Providers	9 of 31 Providers	N/A
Total BH Providers Trained in Cultural Competency	26 of 794 Providers	1 of 94 Providers	3 of 124 Providers	22 of 4,683 Providers

Table 2a: Number of Physical Health Providers by Provider Type

PROVIDER TYPE	EL PASO COUNTY			PARK COUNTY			TELLER COUNTY		
	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS
Adult Primary Care	423	362	164	2	2	0	30	14	7
Pediatric Primary Care	470	391	175	2	2	0	30	14	7
OB/GYN	59	41	40	0	0	0	0	0	0
Family Planning	259	231	132	2	2	0	7	7	6
Total Unique Providers	**535**			**2**			**31**		

[2] Other counties: includes all counties outside of Region 7.

Table 2b: Number of Behavioral Health Providers by Provider Type[3]

PROVIDER TYPE[4]	EL PASO COUNTY			PARK COUNTY			TELLER COUNTY			OTHER COUNTIES[5]		
	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS
General Behavioral Health	653	646	528	76	75	71	106	104	95	3,649	3,557	3,105
Pediatric Behavioral Health	6	6	6	0	0	0	0	0	0	8	8	8
General Psychiatrists and other Psychiatric Prescribers	106	92	106	10	10	9	12	12	11	604	573	604
Pediatric Psychiatrists and other Psychiatric Prescribers	29	29	27	3	3	3	3	3	3	33	32	25
General SUD Treatment Practitioner	17	17	13	5	5	5	3	3	3	174	172	138
Pediatric SUD Treatment Practitioner	1	1	1	0	0	0	0	0	0	2	2	1
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	3	3	3	0	0	0	0	0	0	9	9	9
Psychiatric Residential Treatment Facilities	3	3	3	0	0	0	0	0	0	6	6	6
SUD Treatment Facilities	11	11	11	0	0	0	0	0	0	70	70	70

[3] Practitioner counts derived from Provider Categories, NPI, Age Group served, and County.

[4] Pediatric provider types include providers with a pediatric specialty and providers who serve pediatric members only.

[5] Other counties: includes all counties outside of Region 7.

Table 2b: Number of Behavioral Health Providers by Provider Type[6], continued

PROVIDER TYPE[7]	EL PASO COUNTY			PARK COUNTY			TELLER COUNTY			OTHER COUNTIES[8]		
	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS
SUD Treatment Facilities-ASAM 3.1	0	0	0	0	0	0	0	0	0	6	6	6
SUD Treatment Facilities-ASAM 3.2 WM	1	1	1	0	0	0	0	0	0	4	4	4
SUD Treatment Facilities-ASAM 3.3	0	0	0	0	0	0	0	0	0	0	0	0
SUD Treatment Facilities-ASAM 3.5	0	0	0	0	0	0	0	0	0	4	4	4
SUD Treatment Facilities-ASAM 3.7	0	0	0	0	0	0	0	0	0	2	2	2
SUD Treatment Facilities-ASAM 3.7 WM	1	1	1	0	0	0	0	0	0	1	1	1
Total Unique BH Providers	**831**			**94**			**124**			**4,572**		

[6] Practitioner counts derived from Provider Categories, NPI, Age Group served, and County.

[7] Pediatric provider types include providers with a pediatric specialty and providers who serve pediatric members only.

[8] Other counties: includes all counties outside of Region 7.

Table 3: Network Adequacy Analysis

ACCESS STANDARD	PROVIDER TYPE	TOTAL MEMBERS[9]	PROVIDERS IN ACCESS RANGE[10]	PERCENT W/ACCESS	PERCENT W/OUT ACCESS
PCMP Network					
Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 45 miles/45 minutes Frontier - 2 Providers within 60 miles/60 minutes	Adult Primary Care Providers	109,057	382	99.0%	1.0%
	Pediatric Primary Care Providers	81,293	403	100.0%	0.0%
	OB/GYN Providers	75,327	69	98.0%	1.0%
Behavioral Health Practitioner Network					
Urban - 2 Providers within 30 miles/30 minutes Rural - 2 Providers within 60 miles/60 minutes Frontier - 2 Providers within 90 miles/90 minutes	General Behavioral Health	114,009	12,137	100%	0%
	Pediatric Behavioral Health	84,963	3,104	100%	0%
	General Psychiatrists and other Psychiatric Prescribers	114,009	822	100%	0%
	Pediatric Psychiatrists and other Psychiatric Prescribers	84,963	1,036	100%	0%
	General SUD Treatment Practitioner	114,009	262	99%	1%
	Pediatric SUD Treatment Practitioner	84,963	265	99%	1%

[9] Specific to the PCMP analysis, total membership excludes 13,734 members who were not included in the time and distance analysis as they reside outside of CCHA's geographic region.
[10] Providers may render services in more than one location. As such, access measures reflect each location in which practitioners render services.

Table 3: Network Adequacy Analysis, continued

ACCESS STANDARD	PROVIDER TYPE	TOTAL MEMBERS	PROVIDERS IN ACCESS RANGE[11]	PERCENT W/ ACCESS	PERCENT W/OUT ACCESS
Behavioral Health Hospitals & Treatment Facilities					
Urban - 1 Facility within 20 miles/20 minutes Rural – 1 Facility within 30 miles/30 minutes Frontier - 1 Facility within 60 miles/60 minutes	Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	198,972	12	94%	6%
Urban - 1 Facility within 30 miles/30 minutes Rural - 1 Facility within 60 miles/60 minutes Frontier - 1 Facility within 90 miles/90 minutes	SUD Treatment Facilities	198,972	81	98%	2%
	SUD Treatment Facilities-ASAM 3.1	198,972	6	8%	92%
	SUD Treatment Facilities-ASAM 3.2 WM	198,972	5	95%	5%
	SUD Treatment Facilities-ASAM 3.3	198,972	0	0%	100%
	SUD Treatment Facilities-ASAM 3.5	198,972	4	9%	91%
	SUD Treatment Facilities-ASAM 3.7	198,972	2	4%	96%
	SUD Treatment Facilities-ASAM 3.7 WM	198,972	2	95%	5%

[11] Providers may render services in more than one location. As such, access measures reflect each location in which practitioners render services.

Figure 1: Breakdown of Other (non-English) Languages Spoken by Physical Health Providers in Each County

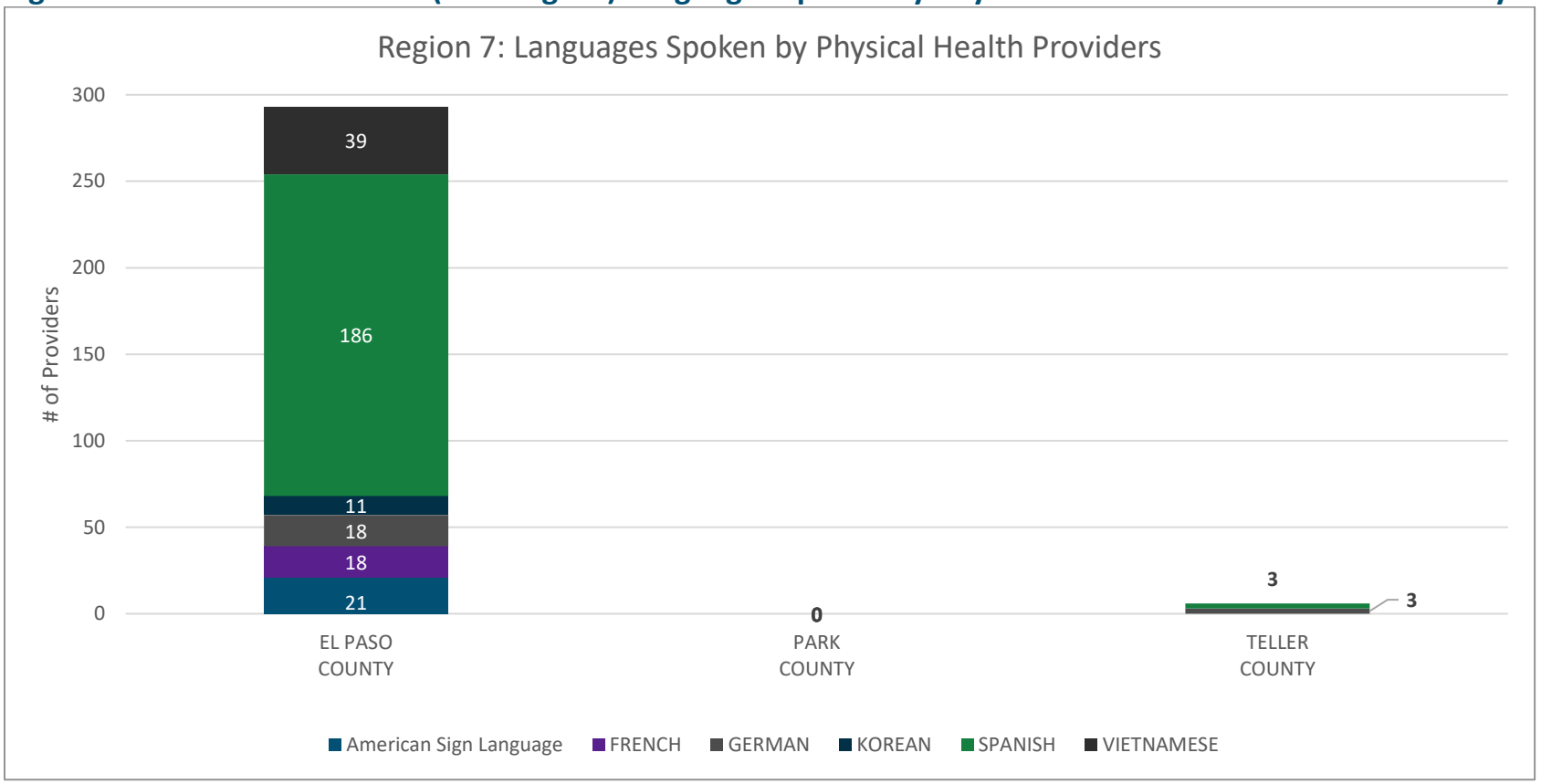

Figure 2: Breakdown of Other (non-English) Languages Spoken by Behavioral Health Providers in Each County

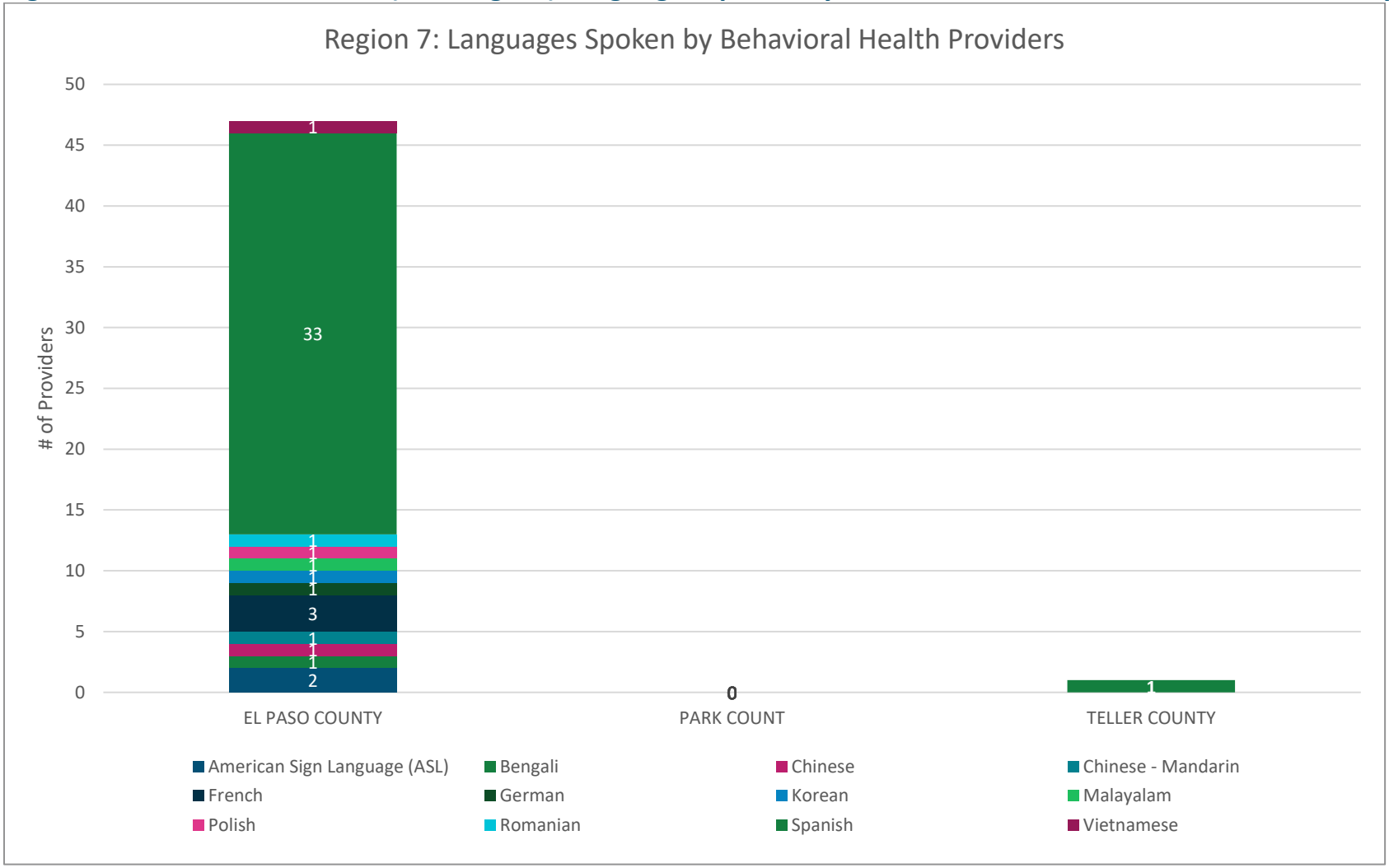

Figure 1 and Figure 2 Notes: Provider languages spoken is voluntary information collected at the time of contracting. Numbers are not fully representative of providers' spoken languages.