COLORADO
Department of Health Care Policy & Financing

Annual Network Management Strategic Plan

Instructions and Narrative Report

RAE Name	Colorado Community Health Alliance (CCHA)
RAE Region #	6
Reporting Period	SFY23-24, 07/01/2023-06/30/2024
Date Submitted	September 15, 2023
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Purpose: Regional Accountable Entities (RAEs) are responsible for managing and improving the health of their respective members. As part of that responsibility, RAEs are required: to develop, support and engage their provider networks and the broader health neighborhoods in these efforts; and to reward them financially respective to their efforts to improve member health outcomes and to increase value in their respective regions. This plan outlines each RAE's strategic approaches to accomplish these tasks and to meet the goals of ACC Phase II during the upcoming contract year.

Instructions: Please provide a narrative that outlines your strategic approach to leverage your regional resources to maximize the care delivery system and community to reduce costs and improve member health outcomes and the experience of care of members. Address how your strategic approach has or has not evolved since the previous year's submission with evidence to support these changes. The narrative must describe the RAE's planned strategies, including process and outcome goals, relative to: PCMP and behavioral health provider network development; practice support, transformation, and communication; health neighborhood and community engagement; and administrative payments and incentives.

1) **PCMP and behavioral health provider network** – Please describe your region's plan to develop your PCMP and behavioral health provider networks. Please be sure to address that which is required in the Network Adequacy Plan Deliverable Guidance.
2) **Practice support and transformation** - Please describe the types of information and administrative, data & technology support (including plans to promote the use of telehealth solutions and the Dept's eConsult platform [once adopted], trainings, and practice transformation, to advance the Whole-Person Framework and to implement the Population Management Strategy, that your region plans to provide network providers.
3) **Communication** – Please describe your region's plan to maintain necessary, both proactive and responsive, communication with network providers and other health neighborhood partners (and other oversight entities) as dictated by section 3.9.2

contract, as well as promoting communication among network providers. Please be sure to address communication with behavioral health providers, including rate changes and internal processes for responding to provider questions and complaints. *(Specific member-level grievances are captured in the Grievances and Appeals deliverable*).

4) **Health neighborhood and community** - Please describe your region's plan to engage, support (including financial), leverage, and advance the health neighborhood and community to ensure members timely and appropriate access to necessary services. Please be sure to address your plans to establish relationships and improve processes, communication, and collaboration with the health neighborhood and community including coordinating with crisis services, MSOs, etc. Also address your plans to increase appropriate and efficient utilization of specialty care.
5) **Administrative payments and incentives** - Please describe your region's plan to distribute administrative payments and incentive payments. Be sure to provide descriptions of your arrangements for PMPM Administrative Payments, Key Performance Indicator (KPI) and/or Performance Pool incentive payments to contracted PCMPs and Health Neighborhood entities. These arrangements should involve varying payment models and payment amounts for varying types of service. Please include your approach to pay and monitor performance of entities that provide care management for members with complex care needs. *(Include any larger documents or policies as attachments.)*

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Strategic Plan Narrative

1. PCMP and Behavioral Health Provider Network Development

Network Development

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). With a comprehensive network of primary care providers and behavioral health providers statewide – comprised of adult and pediatric primary care medical providers (PCMPs), adult and pediatric mental health providers, substance use disorder (SUD) providers, psychiatrists, psychiatric prescribers, and family planning providers – CCHA's recruitment and contracting efforts are focused on growing the network and addressing gaps through targeted outreach to providers who are enrolled in Health First Colorado (Colorado's 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 two new PCMPs within the next year in Region 6, with a focus on access in rural areas. CCHA maintains its "come as you are" approach with regard to contracting with providers in good standing, which promotes member access and 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 HCPF, those who are requested by members, and those located in rural areas of Region 6. 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 Elevance providers in Colorado and those offering substance use disorder services. 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 6 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 in which health disparities exist.

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 (medical doctor), DO (doctor of osteopathy), or NP (nurse practitioner) 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 the 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. For behavioral health provider applications, and in alignment with timeliness requirements, CCHA responds to inquiries within two business days and completes the contracting and credentialing process or denies network admission within 90 days of submission for 90% of applications received. 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. As detailed in the practice support section, physical health provider orientations are offered upon request and to all newly contracted physical, and behavioral health provider orientations are offered regularly throughout the year.
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 SFY23-24, 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 National Provider Identifier (NPI) Law and prepared for revalidating enrollment as a Health First Colorado provider. CCHA will continue including revalidation information in CCHA provider newsletters to help providers prepare and understand what to expect, including: how to verify their revalidation due date, when to anticipate notifications to begin the revalidation process, and where to find additional resources. Pending further details from HCPF, CCHA is also planning to conduct targeted provider outreach and will provide as much support as possible to ensure timely completion of revalidation.
- Provider satisfaction: In SFY22-23, CCHA distributed a provider satisfaction survey to gain insight on CCHA's areas of opportunity from a provider perspective. CCHA will use the results of the survey to address gaps in provider satisfaction, as determined by a follow-up survey that will be distributed at the end of the current fiscal year.
- Changes in member enrollment: CCHA is closely monitoring changes related to the Continuous Enrollment Unwind. Pertinent to maintaining network adequacy, CCHA's objective is to maintain members' continuity of care and access to services to the greatest extent possible. CCHA is monitoring increases/decreases in member enrollment across the network and adjusting provider support as needed. In addition to developing provider resources to help retain membership by promoting benefit renewal, CCHA is also prepared to address any significant changes in attribution, including impacts to provider payments and capacity to serve members.
- Telehealth services: With the expansion of telehealth services, opportunities to increase access have also continued to expand. Claims for 2023 is for general office visits among established patients. Though the volume of such telehealth services has decreased as in-person appointments increased throughout the public health emergency, telehealth continues to be valuable tool for aiding in strategies to improve access to other types of services. For SFY23-24, CCHA will continue to assess access and utilization of telehealth services, including feedback on member experience, to help inform pursuit of new initiatives and updates to existing strategies.
- BH benefit expansion: CCHA is preparing to add Autism Spectrum Disorder (ASD) as a covered diagnosis for psychological testing and psychotherapy services under the capitated behavioral health benefit, effective January 1, 2024. CCHA will continue to collaborate with HCPF on this implementation and monitor continuity of care for this population.
- Diversity, Equity, and Inclusion: In partnership with the community and our providers, CCHA seeks opportunities to understand, embrace and celebrate the diversity of the regions we serve with goals to further address barriers and to promote equal access and quality care that will help members reach their highest potential. 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. Additionally, CCHA is targeting provider recruitment and access in rural areas in alignment with CCHA's health equity plan.

- eConsult Platform: CCHA will promote practice adoption and use of the HCPF's chosen e-Consult platform, encouraging PCMP use of the eConsult platform and how it can help fill gaps in services where specialist shortages exist for Health First Colorado members. CCHA anticipates e-Consultations will support practices and members with improved access to specialty care and condition management services, as well as aid in reduced costs associated with ancillary Medicaid costs associated with face-to-face consultations.
- SUD Benefit Access: CCHA continues to focus on contracting opportunities to ensure the network sufficiently meets member needs. Since the start of the SUD benefit expansion, CCHA has increased SUD access as detailed below and deploys single case agreements where necessary when services cannot be rendered within the contracted network.
    - American Society of Addiction Medicine (ASAM) 3.1: 19-facility increase (633%)
    - ASAM 3.3: 2-facility increase (1900%)
    - ASAM 3.5: 26-facility increase (520%)
    - ASAM 3.7: 15-facility increase (1500%)
    - ASAM 3.2 Withdrawal Management (WM): 11-facility increase (157%)
    - ASAM 3.7WM: 6-facility increase (200%)

Provider Information and Network Directory

CCHA collects information about practice attributes upon contracting/credentialing for both physical (PH) and behavioral health (BH) 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, practitioner race/ethnicity, 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.

CCHA understands the importance of having current provider information to help maintain an accurate provider directory, ensuring providers are accessible to members. Provider information for both the physical and behavioral health networks is updated through CCHA surveys and upon notification of changes from providers, including practice attributes, additions, terminations, and changes to practitioner service locations. Providers are of the understanding that on-site visits may be used to verify information reported. Additionally, CCHA developed a new webpage that includes clear directions on how a provider can update their information with CCHA and the HCPF InterChange. The webpage also provides directions on how members can report any incorrect information they discover on the provider portal.

Provider demographics and high-level attributes are available in the network directory on CCHA's website at CCHAcares.com/findadoc. 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. CCHA had MAC members test the directory firsthand in both Regions 6 and 7 and provide suggestions for improvement. Based on member findings, CCHA implemented a telehealth filter, modified displays for more robust accommodations in search results, and revised provider and practice type specialties to be more intuitive for members using the tool. The MAC also aided in the development of a search tips guide, which is available directly from the provider directory. Directory information is updated monthly to include any network changes and ensure accurate and timely information is available to members.

Corrective Action

The CCHA provider relations team identifies and escalates provider issues and barriers, and Medicaid program officers along with Compliance 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 National Committee for Quality Assurance (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 repeated calls regarding inaccessibility are received, the provider relations staff and/or a designated practice transformation coach (PTC) 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 convenes 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. In addition, CCHA implemented care coordination and post-call member surveys to assess experience at the closure of a case/interaction with the member.
- Appointment Access Surveys and Third Next Available Monitoring: CCHA monitors appointment timeliness across the provider network to monitor accessibility.
- Network Changes and Deficiencies Monitoring: CCHA monitors the provider network for changes or deficiencies that could affect service delivery, availability or capacity within the provider network.

Caseload Standards and Utilization of Services

CCHA's member enrollment determines the composition and capacity of our provider network, including PCMPs, behavioral health providers, specialists, hospitals, 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 ongoing and 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:
  - 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, unless an appointment is required sooner to ensure the provision of screening per HCPF's accepted periodicity schedule
- 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, 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 summer 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 plans.

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

Additionally, CCHA monitors the network for both anticipated and unexpected changes in the network. For network changes that result in a material change or deficiency that has the potential to affect service delivery, availability, or capacity of the network, CCHA notifies HCPF within five business days of the change, including the following details:

- A description of how the change affects service delivery,
- The availability or capacity of covered services,
- CCHA's plan to minimize disruption to member care and service delivery, and
- CCHA's plan to remediate the deficiency.

[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.

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, outlined below. 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 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 and community. 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 PTCs 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 members 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 (DHS), Single Entry Points (SEPs) and Community Centered Boards (CCBs), 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 SFY23-24, 6 additional practices were invited to participate in the Region 6 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 provider race and ethnicity, in addition to accessibility features and equipment, family planning services, and telehealth services details CCHA began collecting last year. 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 working with HCPF regarding the proposed spending plan for implementing and operationalizing the American Rescue Plan Act. Specifically, CCHA looks forward to aligning efforts that aim to strengthen and expand the behavioral health safety net system by distributing funding and offering practice support to help increase access to high-intensity outpatient behavioral health services that better meet the needs of people with disabilities and individuals living with mental health and substance use disorder.
- 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.

Community: Collaboration, Partnership, and Incentives

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 a 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 Program 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. Additionally, as also noted in the Practice Support section, the CCHA Community Incentive Program (CIP) is established to support distribution of earned incentive dollars to stakeholders whose mission aligns with the goals of the ACC for initiatives that supplement Medicaid-covered services and contribute to meeting whole-person needs. Awardee focus areas vary by each organization but generally address social determinants of health, benefit and benefit transition assistance, and pregnancy/postpartum support.

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 in rural areas and those 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 to 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 obstetrics and gynecology (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 there are few OB/GYN providers currently contracted as PCMPs, 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 specialty providers who remain open to serving members.

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 and other behavioral health services where gaps have been identified.

- BH network investments:
    - Effective January 1, 2022, CCHA implemented rate increases for the independent provider network, which amounted to increases of between 9% - 16% for commonly used psychotherapy codes.
    - Effective December 1, 2022, CCHA implemented an additional rate increase for the independent provider network. Certain highly utilized codes increased by a total of 20% as a result of both rate increases.
    - A number of providers have been enrolled/re-enrolled in CCHA's BH Quality Incentive Program and the new BH Facility Incentive Program for calendar year (CY) 2023. Both programs afford quality bonus payments based on performance against quality measures.

- Contracting efforts: CCHA contracted with Cedar Springs and Centennial Peaks, both high-volume 3.7WM providers. Additionally, effective July 2022, contracts were executed with Valley Hope (Special Connections) and Southern Peaks (psychiatric residential treatment facility). CCHA continues to add SUD providers to the network across all ASAM levels. More recently, Johnstown Heights was added to the network effective January 2023.
- Increasing high intensity behavioral health services: As is detailed in the Practice Support section, CCHA issued a Request for Proposal (RFP) and will be administering one-time funding to contracted behavioral health providers through the American Rescue Plan Act (ARPA) to develop and expand programming for high-intensity outpatient behavioral health services. Additionally, here are some of CCHA's ongoing efforts toward increased services:
    - Initiating work with Paragon BH, Consultants for Children, Mountain Vista Psychology and Savio to expand respite, home-based services, High Fidelity wraparound, neurofeedback, and multisystemic therapy (MST) for youth and families.
    - Expanding SUD intensive outpatient program (IOP) and medication-assisted treatment (MAT) services with Recovery Unlimited and rural access to intensive services with Conifer Counseling.

Finally, CCHA aims to contract with all community mental health centers (CMHCs), Federally Qualified Health Centers (FQHCs), and hospital systems to provide extensive member choice and facilitate access to behavioral health services. To date, CCHA's behavioral health network provides access to private institutes for mental disease (IMDs), hospital systems, CMHCs, and 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 revised the Cultural Competency course evaluation, which prompts providers to report details that can be used for tracking and updating their training status.

Mental Health Certifications

CCHA is contracted with both CMHCs in Region 6, Mental Health Partners and Jefferson Center for Mental Health, and 16 of 17 CMHCs statewide. The CMHC network is comprised of 2,281 unique practitioners who provide services for members on 27-65 certifications. With expansion of the SUD benefit, CCHA partnered with Signal Managed Service Organization (MSO) to ensure participating SUD facilities are able to transition from Substance Use Emergency Commitment (EC) to Substance Use Involuntary Commitment (IC) when applicable. CCHA is committed to ongoing work with the Behavioral Health Administration (BHA) and network facilities that currently accept EC or IC to ensure members on mental health and substance use certifications receive the care they need.

Network Adequacy Analysis

Software

Physical Health Provider Analysis: Maptitude 2021, Build 4930, 64-bit
Behavioral Health Provider Analysis: Quest Analytics Suite™, Version 2022.4, Build 1222, 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 6 counties in which CCHA is designated to contract primary care providers. A total of 55,236 members were excluded from the time and distance portion of the report because their county of residence is not within a Region 6 county.

SFY22-23 Goals Outcomes

CCHA is committed to quality in the services we provide to the community and has tracked the following metrics to evaluate efforts and identify opportunities for improvement. We are pleased to present the following updates we achieved in SFY22-23.

- Process Measures:
    - Develop an evaluation for PCMP+ practices who are offering diabetes program services
        - Goal: CCHA will evaluate PCMP+ practices to assess best practices and evidence-based programming for diabetes care.
        - Update: CCHA conducted an evaluation of the PCMP+ program to assess practice performance under the tiered payment model. While designing our evaluation and considering available data measures of success, we decided to modify this goal and focus on overall Key Performance Indicator (KPI) performance for all

PCMP+ practices. The evaluation assessed practices for their performance related to KPIs and found that PCMP+ practices had a higher verified membership and performed better on the dental and Emergency Department Per Thousand Per Year (ED PKPY) KPI measures.

- Create Public Health Emergency (PHE) Unwind Resource Center on website and notify providers of the resource ongoing via the provider newsletter
  - Goal: CCHA will support providers through the PHE Unwind by promoting regular and consistent information among the network, maintaining above average open rates for the industry, as defined by Constant Contact to be 28.5%.
  - Update: CCHA exceeded its goal by sharing frequent updates with providers on PHE Unwind topics through:
    - Eleven provider newsletters, with an average distribution of 4,152 individuals, and an average open rate of 37.6% for these issues.
    - Eight BH provider bulletins, with an average distribution of 4,154 individuals, and an average open rate of 40.7%
    - Four specialty provider newsletters, with an average distribution of 154 specialty providers, with an average open rate of 39%.
    - Two special announcements, with an average distribution of 4,170 and an average open rate of 42%.
- Collaborate with HCPF on the distribution of funding tied to Senate Bill (SB) 19-222, including passing dollars through to support the provider workforce and program expansion, and reporting on financial and programmatic outcomes
  - Goal: CCHA will expand network capacity for high-intensity outpatient services for SUD, and increase access to community-based, transitional step-down care.
  - Update: In support of SB19-222 and the goal to expand the behavioral health safety net system in Colorado, CCHA is collaborating with HCPF to expand access to community-based behavioral health services. CCHA issued a Request for Proposal (RFP) in quarter three (Q3) and is administering one-time funding to contracted behavioral health providers through the American Rescue Plan Act (ARPA) to develop and expand programming for high-intensity outpatient behavioral health services. Nine behavioral health providers were selected to receive a total of $2 million in the first round of distribution of High Intensity Outpatient Program funding.

- Outcome Measures:
  - Maintain an adequate network that offers members their choice of 2 PCMPs
    - Goal: CCHA will expand the network by two (2) PCMPs in each region.

        - Update: CCHA exceeded this goal by expanding our PCMP network by six PCMPs in SFY22-23.
    - Expand BH respite care availability
        - Goal: CCHA will increase the number of BH respite providers actively serving members to two (2) active programs by 6/30/23.
        - Update: CCHA was unable to achieve this goal of expanding to two respite providers in each region by the end of SFY23; however, CCHA was able to leverage one-time American Rescue Plan Act (ARPA) Safety Net Expansion dollars through our High Intensity Outpatient Treatment Capacity Expansion project to fund Paragon BH Connections to expand their in-home services and respite.
    - Support delivery of a standardized member experience and place of service access to condition management and care coordination services among CCHA's PCMP network
        - Goal: 90% of PCMPs that are eligible to contract at a higher payment level pursue application and opt to engage with CCHA at that enhanced level.
        - Update: 79% of eligible practices opted to engage in PCMP+ contracting for the SFY24 contract year. In addition to the 40 previously contracted PCMP+ practices that opted to continue at this level, we successfully recruited six additional practices to pursue this enhanced contract level.

SFY23-24 Goals

CCHA is committed to quality in the services we provide to the community and will track the following metrics to evaluate efforts and identify opportunities for improvement.

- Process Measures:
    - Maintain the PHE Unwind Resource Center on CCHA's website and notify providers of the resource ongoing via the provider newsletter
        - Goal: CCHA will support providers through the PHE Unwind by promoting regular and consistent information among the network, maintaining above average open rates for the industry, as defined by Constant Contact.
    - Collaborate with HCPF on the distribution of funding tied to SB19-222, including passing dollars through to support the provider workforce and program expansion, and reporting on financial and programmatic outcomes
        - Goal: CCHA will expand network capacity for high-intensity outpatient services by distributing $3.7 million in funding provider projects and manage reporting of service expansion to CCHA members.
- Outcome Measures:
    - Maintain an adequate network that offers members their choice of 2 PCMPs
        - Goal: CCHA will expand the network by two (2) PCMPs in each region.
        - Goal: Improve year-over-year provider satisfaction survey results.

- Expand BH respite care availability
  - Goal: CCHA will increase the number of BH respite providers actively serving members to two (2) active programs by 6/30/24.
- Support delivery of a standardized member experience and place of service access to condition management and care coordination services among CCHA's PCMP network
  - Goal: 90% of PCMPs that are eligible to contract at a higher payment level pursue application and opt to engage with CCHA at that enhanced level.

COLORADO
Department of Health Care Policy & Financing

PCMP and Behavioral Health Provider Network Appendix

Table 1: Cultural Competency by County

Provider Type	Boulder County	Broomfield County	Clear Creek County	Gilpin County	Jefferson County	Other Counties[2]
Total PH Providers Trained in Cultural Competency	143 of 336 Providers	6 of 51 Providers	2 of 2 Providers	2 of 2 Providers	127 of 423 Providers	N/A
Total BH Providers Trained in Cultural Competency	5 of 413 Providers	0 of 57 Providers	1 of 3 Providers	0 of 1 Providers	7 of 695 Providers	32 of 5,650 Providers

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

Provider Type	Boulder County			Broomfield County			Clear Creek County			Gilpin County			Jefferson 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	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# OFFERING WEEKEND & AFTER-HOURS
Adult Primary Care	321	302	179	34	25	10	2	2	2	2	2	0	319	277	194
Pediatric Primary Care	212	193	135	45	41	10	2	2	2	0	0	0	346	319	191
Family Planning	166	166	96	2	2	0	0	0	0	2	2	0	68	64	30
Total Unique Providers	**336**			**51**			**2**			**2**			**423**		

[2] Other counties: includes all counties outside of Region 6.

Table 2b: Number of Behavioral Health Providers by Provider Type[5]

Provider Type[3]	Boulder County			Broomfield County			Clear Creek County			Gilpin County			Jefferson County			Other Counties[4]		
	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS
General Behavioral Health	374	368	144	52	52	34	2	2	1	1	1	1	607	559	301	4,601	4,362	3,329
Pediatric Behavioral Health	374	368	145	52	52	34	2	2	1	1	1	1	613	565	304	4,586	4,362	3,329
General Psychiatrists and other Psychiatric Prescribers	33	34	12	3	3	0	1	1	0	0	0	0	61	50	28	819	782	612
Pediatric Psychiatrists and other Psychiatric Prescribers	35	34	12	3	3	0	1	1	0	0	0	0	64	53	28	822	784	608
General SUD Treatment Practitioner	5	3	3	2	2	1	0	0	0	0	0	0	16	15	8	159	141	114
Pediatric SUD Treatment Practitioner	5	3	3	2	2	1	0	0	0	0	0	0	17	16	8	159	141	114
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	2	2	0	0	0	0	0	0	0	0	0	0	1	1	0	12	12	5

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

[4] Other counties: includes all counties outside of Region 6.

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

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

Provider Type	Boulder County			Broomfield County			Clear Creek County			Gilpin County			Jefferson County			Other Counties[7]		
	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS	TOTAL	# OPEN TO NEW MEMBERS	# w/WEEKEND & AFTER-HOURS
Psychiatric Residential Treatment Facilities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUD Treatment Facilities	10	10	7	1	1	1	1	1	0	0	0	0	31	31	17	211	205	115
SUD Treatment Facilities-ASAM 3.1	2	2	2	0	0	0	0	0	0	0	0	0	2	2	2	18	17	13
SUD Treatment Facilities-ASAM 3.2 WM	1	1	1	0	0	0	0	0	0	0	0	0	1	1	1	16	16	10
SUD Treatment Facilities-ASAM 3.3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1
SUD Treatment Facilities-ASAM 3.5	0	0	0	0	0	0	0	0	0	0	0	0	3	3	2	28	26	16
SUD Treatment Facilities-ASAM 3.7	1	1	0	0	0	0	0	0	0	0	0	0	2	2	0	13	13	7
SUD Treatment Facilities-ASAM 3.7 WM	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	8	7	3
Total Number of Unique BH Providers	**413**			**57**			**3**			**1**			**695**			**5,650**		

[6] Practitioner counts derived from Provider Categories, NPI, Age Group served, and County.
[7] Other counties: includes all counties outside of Region 6.

Table 3: Network Adequacy Analysis

ACCESS STANDARD	PROVIDER TYPE	TOTAL MEMBERS	PROVIDERS IN ACCESS RANGE[8]	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	90,367	656	100.0%	0%
	Pediatric Primary Care Providers	48,063	579	99.98%	0.02%
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	120,925	24,051	100.0%	0%
	Pediatric Behavioral Health	72,990	12,285	100.0%	0%
	General Psychiatrists and other Psychiatric Prescribers	120,925	1,148	100.0%	0%
	Pediatric Psychiatrists and other Psychiatric Prescribers	72,990	1,348	100.0%	0%
	General SUD Treatment Practitioner	120,925	605	100.0%	0%
	Pediatric SUD Treatment Practitioner	72,990	606	100.0%	0%

[8] 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[9]	PERCENT W/ ACCESS	PERCENT W/OUT ACCESS
Behavioral Health Hospitals & Treatment Facilities					
Urban - 2 Providers within 20 miles/20 minutes Rural - 2 Providers within 30 miles/30 minutes Frontier - 2 Providers within 60 miles/60 minutes	Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	193,915	15	90.0%	10.0%
	SUD Treatment Facilities	193,915	203	99.0%	1.0%
	SUD Treatment Facilities-ASAM 3.1	193,915	22	98.0%	2.0%
	SUD Treatment Facilities-ASAM 3.2 WM	193,915	18	99.0%	1.0%
	SUD Treatment Facilities-ASAM 3.3	193,915	2	1.0%	99.0%
	SUD Treatment Facilities-ASAM 3.5	193,915	31	98.0%	2.0%
	SUD Treatment Facilities-ASAM 3.7	193,915	16	98.0%	2.0%
	SUD Treatment Facilities-ASAM 3.7 WM	193,915	9	97.0%	3.0%

[9] 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

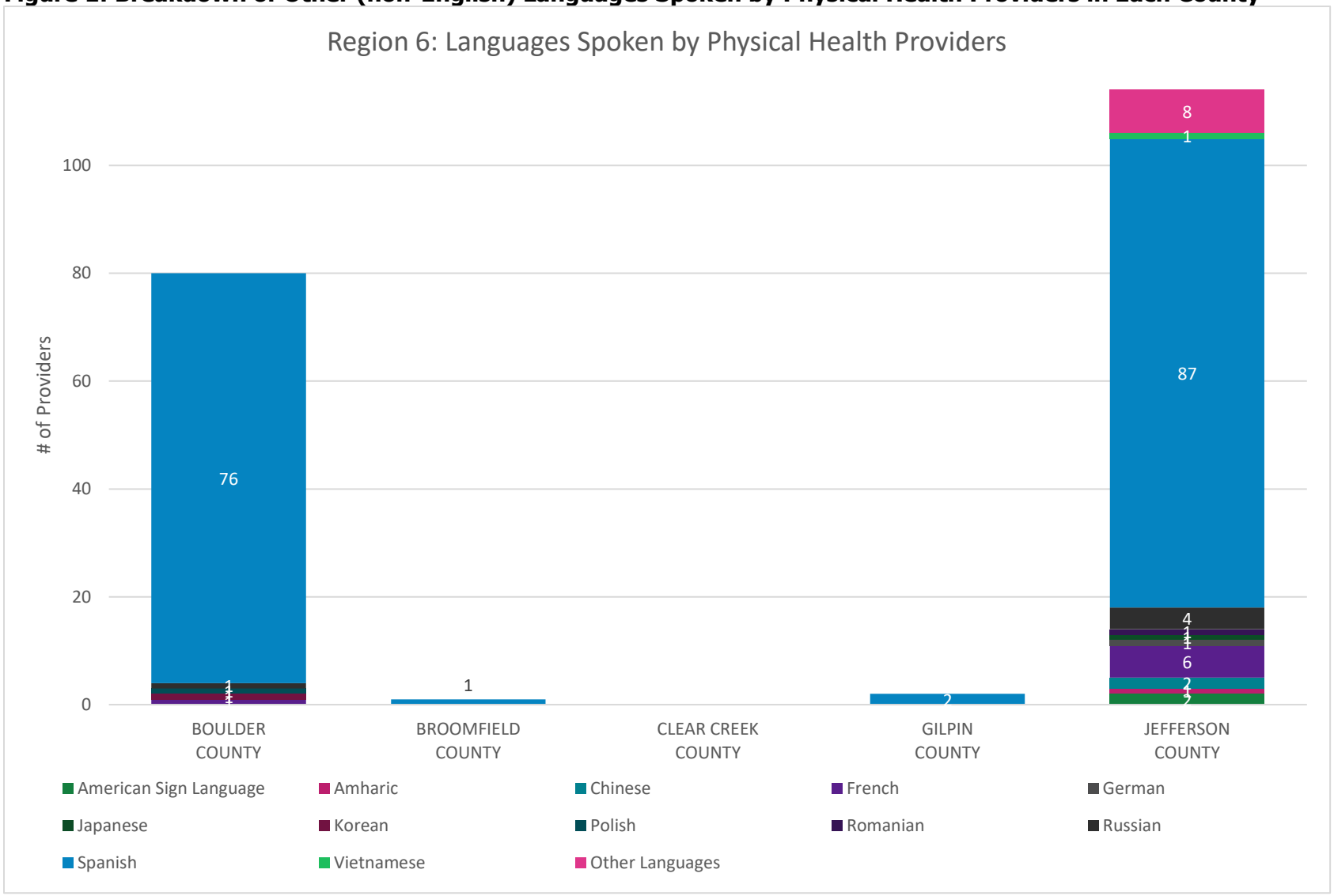

Figure 2: Breakdown of Other (non-English) Languages Spoken by Behavioral Health Providers in Each County

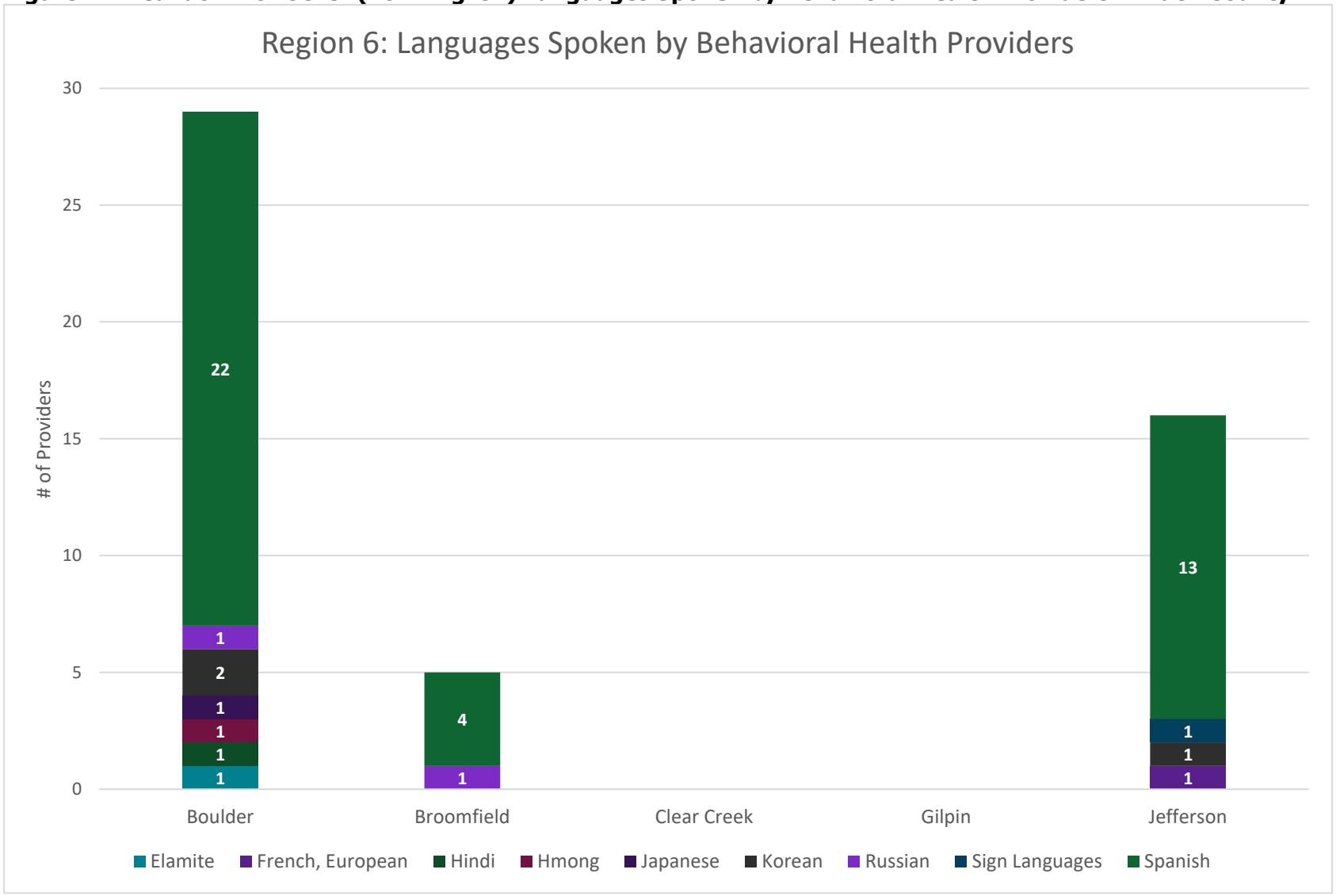

Figure 1 and Figure 2 Notes: Provider languages spoken is voluntary information collected at the time of contracting. Numbers are not fully representative of providers' spoken languages.

2. Practice Support & Transformation

CCHA's provider support plan utilizes a multidisciplinary team dedicated to assisting primary care and behavioral health (BH) providers in navigating Health First Colorado and achieving the goals of the Accountable Care Collaborative (ACC). CCHA works with providers to achieve these goals by educating providers about Health First Colorado benefits, providing data, sharing best practices, and aligning quality improvement activities and evidence-based programs. More specifically, and as detailed in the following sections, CCHA works with Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), the independent Provider Network (IPN), and Primary Care Medical Provider (PCMP) practices on all aspects of the quadruple aim through various initiatives that seek to improve health outcomes, targeted practice transformation coaching/support, and array of informational tools and administrative support. Though a standardized approach to practice collaboration and support, CCHA is able to remain flexible and adapt to individual practice needs, as well as broad-scale circumstances that impact member, practice, and/or health care priorities such as the COVID-19 pandemic and the Continuous Enrollment Unwind.

Practice Support Teams

CCHA practice support teams continue to offer various levels of direct support to achieve practice-driven goals and the goals of the ACC. CCHA's practice support teams are comprised of the following:

- Network managers/provider experience staff work with practices on contracting and a wide range of provider topics such as revalidation, policy changes, attribution, billing/claims issues, etc. The network team generally advocates for providers, helps educate providers on CCHA's practice services, Health First Colorado benefits, CCHA systems, and communicates critical information between HCPF and the provider network.
- Practice transformation coaches (PTCs) support practices with quality improvement tools and activities, data, establishing quality improvement teams, and ACC initiatives such as understanding and meeting the Key Performance Indicators (KPIs), the Behavioral Health Incentive Program (BHIP), and the Alternative Payment Methodology (APM) measures.
- Care coordinators provide member and practice support through CCHA's comprehensive and integrated care coordination model, which helps ensure access to whole-person care and member needs are addressed in a timely manner. CCHA has an established process for providers to refer members to CCHA for care coordination services, and the care coordination team also proactively and directly supports practices and provider services as follows:
    - Facilitate scheduling member appointments for preventive and specialist care with both physical and behavioral health providers
    - Co-locate staff in practice and hospital settings to coordinate services at the point of care and when members are engaged in care
    - Provide timely communication to PCMPs on care plans, community resource involvement, and patient/family goals

- Community liaisons establish relationships and collaborate with community partners to promote health, meet regularly with organizations that provide medical and non-medical community-based resources, and provide updates to the provider community on which resources are available.

Standard Support Services:
Practice support teams work together to engage providers in CCHA's foundational support services, which include Informational Tools/Administrative Support, Practice Transformation, and Value-Based Payments. Through these tenets of support, CCHA is able demonstrate continuity of practice services and evolve goals to ensure focus areas meet the needs of the region and priorities set forth by HCPF and the ACC.

Practice Transformation
Practice transformation is provided to PCMP practices with 300 or more CCHA members and offered to other PCMP and behavioral health practices upon request. CCHA practice transformation coaches work with practices and help streamline quality improvement efforts through the following activities:

- Monthly quality improvement meetings, including standardized meeting tools such as agendas and reports, which promote consistency and accountability.
- Development of practice-specific interventions based on unique performance capabilities and practice operations.
- Member data to help inform where gaps and opportunities for improvement exist.
- Technical and operational assistance needed to improve referral and condition management workflows as applicable and needed.
- Review of quality improvement scorecard and Healthcare Effectiveness Data and Information Set (HEDIS) metrics, development of improvement projects for the High Intensity Outpatient program, and claims/documentation compliance support for behavioral health practices.
- Data and reports needed for risk stratification, targeted outreach/intervention for various goals such as KPI improvement, gaps in care, inappropriate emergency department utilization, etc.
- Administration of Incentive Programs, which further promote practice engagement with KPI performance and value-based care, offering incentive payments to both PH and BH providers that qualify for participation and meet the goals of the program.

Informational and Administrative Support (Provider Training)
Providers receive ongoing education monthly, quarterly, and annually on topics identified through various channels (i.e., changes to covered benefits, HCPF policy updates, provider requests, etc.). CCHA uses a multi-modal approach to sharing information to increase reach and engage providers through their preferred method(s). As such, provider resources, education, and training are delivered in various formats and announced/delivered through the CCHA website, CCHA Provider

Portal, in-person, virtually via live or recorded webinar, during provider orientations, stakeholder forums, and via both print and electronic communications such as provider manuals, newsletters, and both clinical and non-clinical educational materials.

- Provider Portals & Resource Tools
  - CCHA Website: As further detailed in the Communications section, the CCHA website, CCHAcares.com, is a translatable, Americans with Disabilities Act (ADA) compliant tool with a broad range of information for providers regarding CCHA, Health First Colorado, the ACC, and engagement with CCHA. The website is also the source of many provider resources such as community resources, provider trainings, patient educational materials, provider-specific manuals and guides, regional advisory meetings/minutes, and more.
  - CCHA Provider Portal: The provider portal is the mechanism by which CCHA securely shares PCMP performance summaries, payment details, and member reports. CCHA reached its goal to increase providers' active use of the portal in SFY2022-23; of the 136 practices with access to the portal, 87 engaged at least once between January and June of 2023, demonstrating 63.9% of practices in Region 6 are actively using the portal. CCHA plans to continue expanding the availability of information, resources, and materials available to practices, including health equity data which is a goal for SFY2023-24.
  - Availity: CCHA's designated Electronic Data Interchange (EDI) Gateway: Allows BH providers to verify member eligibility and benefits, submit authorization requests, share supporting documentation, verify claims status and payment information efficiently, conveniently and securely.
  - Secured File Transfer Protocol (SFTP): CCHA established an SFTP site to quickly and securely distribute health data, notifying attributed behavioral health care coordinators/providers of relevant information regarding member clinical care and service level utilization.
  - FindHelp (formerly Aunt Bertha): CCHA offers a social determinant of health (SDOH) resource search engine that is available to providers through CCHA's Find Help Community Resource Link at CCHAcares.com/findhelp. Providers can assess SDOH needs, search for resources and submit referrals for community-based organizations through the CCHA FindHelp site.

- Provider Training & Education
  - Provider Orientation
    - New physical health (PH) providers receive a formal orientation by a network manager, either in-person or virtually dependent on practice preference, within thirty (30) calendar days of their contract effective date or as the practice schedule allows. The provider orientation includes a review of the provider manual, CCHA policies and procedures, and an overview of support provided by CCHA. Provider

orientations/informational sessions are also available to existing network practices, as periodically communicated via newsletters and in provider postings on the CCHA website.
    - CCHA offers monthly a monthly provider orientation, which is targeted toward new behavioral health (BH) providers but open to all BH providers who would like an overview of CCHA. This orientation includes additional elements specific to capitated BH, such as utilization management and the claims submission process.
- Other Provider Training
    - BH Provider Education Series: CCHA plans to continue offering the following engagement and training opportunities for BH providers on an ongoing basis in SFY23-24, including:
        - BH Provider Education Series: focuses on a specific topic each month (including Availity tools and overview, coding manual changes, documentation standards, and BH provider manual review), and CCHA staff provide up-to-date information on current initiatives, changing policies/programs and other topics as requested.
        - Open Mic Sessions: offer BH providers a monthly forum to engage CCHA staff, exchange information, and receive updates and reminders. These forums have provided stakeholders an opportunity to ask questions and share feedback with the CCHA team.
        - BH Provider Bulletin: monthly communication resource that provides behavioral health-specific information in a concise, bulleted format to the BH provider network. More information is detailed in the Communication section of this report.
- Provider Manuals
    - CCHA publishes Behavioral and Physical Health Provider manuals which outline the requirements with which network providers must comply. Manuals are updated at least annually and are available on the CCHA website and via email, fax, or standard United States Mail upon request. CCHA distributes provider memos or bulletins, which may serve to amend or update the information in the provider manual between editions.
- Materials
    - CCHA continues developing practice support and member materials to help navigate Health First Colorado benefits and educate members about their health. Practice materials can be ordered for free from the website and include a CCHA Quick Reference Guide, depression screening guides and tools, BH referral guides, and KPI reference guides. Member materials include the Map to Medicaid brochures, care coordination brochures, prevention topics, BH guides/referral information, general disease education materials, and more.

SFY 2023-24 Focus Areas for Practice Support

CCHA recognizes that its provider network plays an integral part in achieving these goals of the quadruple aim, CCHA's practice support and community partnership efforts have an integral role in overall the Population Management Program, which is built upon understanding the populations served, aligning interventions to meet members' needs, and forming strong provider and community partnerships.

With that, CCHA plans to continue working with practices through the foundational practice support mechanisms described in the previous section, and strategically adapts goals to improve upon performance and respond to local and prevalent needs. Following are areas of opportunity for the upcoming fiscal year, including how CCHA plans to support the network through practice transformation, improvement and development of supplemental support data, incentives, informational/educational resources, and connection to care coordination and community services.

Population Health and Condition Management

The Department of Health Care Policy & Financing (HCPF) Population Management Framework informs CCHA practice support work, as it guides the statewide goals for Population Management that will help achieve HCPF and state goals for improving health outcomes and reducing unnecessary costs through targeted care management services and interventions that address conditions most prevalent among Health First Colorado (Colorado's Medicaid Program) members. Through the population management framework, CCHA is also able to support practices based on the local needs and priorities.

CCHA works with practices to identify existing programs related to chronic conditions, maternity care, and complex high-need members. In addition to value-based payments, practice transformation, support tools, and direct assistance with various initiatives outlined below, following are examples demonstrating how CCHA aligns practice support work with the population framework to achieve regional goals.

- Data sharing: CCHA shares member-level data with practices to help prioritize member outreach, engagement, and care management/coordination efforts. Practices and other organizations contracted to provide care coordination services are provided hospital admit, discharge, and transfer (ADT) reports and member rosters. ADT reports are used to inform follow-up outreach after a hospitalization. Member rosters include the following indicators and details that are used to inform various initiatives related to member care and quality improvement activities: Complex indicator (based on CCHA-approved definition), number of emergency department (ED) visits within a 12-month period, corrections/foster care involvement, certain diagnoses (e.g., asthma, diabetes, chronic obstructive pulmonary disease (COPD), hypertension, pregnancy), COVID-19 vaccine status/dose details, mental health center engagement, case management agency engagement, and continuous enrollment details (e.g., renewal date, eligibility begin/end dates, and stop reason descriptions).

- Administrative Payments and Program Support: CCHA is continuing with the current tiered payment model for distributing administrative payments to PCMPs. This payment strategy helps promote enhanced condition management services at the point of care and is responsive to member complexity and member engagement in benefit services.
- Program Support: CCHA PTCs support practices with both performance improvement and condition management services by providing member-level data, developing workflows, guiding quality improvement efforts, using standardized tools to track progress, and supporting connection to community resources.
- Care coordination: CCHA care coordination services complement practice support efforts with established workflows that allow practices to refer members who need additional care coordination and care management support.

For the SFY23-24, population health efforts will further focus on data improvements, creating efficiencies through partnership and shared goals. Here are some of the examples demonstrating how CCHA is working to accomplish that:

- Diversity, Equity, and Inclusion (DEI) Plan alignment and integration: CCHA committed to incorporating DEI into all internal and external operations including practice support. Here are some examples of the work CCHA is doing to integrate DEI into existing efforts:
    - CCHA is adding demographic filters to all member-level reports to aid in analysis and identify trends among disparate populations and inform efforts to improve equality and outcomes for our most vulnerable members. Data enhancements will help inform goals and efforts to improve health equality, KPI performance, and health outcomes.
    - Community partnerships: CCHA is continuing to work with community partners whose efforts complement provider services, KPI goals, and have a focus on DEI. For example, CCHA is providing funding for Elephant Circle to support doula training and support throughout pregnancy for Black and African American members who are pregnant.
    - Informational materials: CCHA is currently working with community partners to develop materials that align with the regional DEI plan. The hope with this effort is to create semi-customizable materials that can be co-branded and tailored to meet the needs of trusted community stakeholders and the members with whom they engage.
- Access Improvement:
    - CCHA is working to identify providers to help improve KPIs and increase access through mobile services, for example, particularly in rural areas and Black, Indigenous, and People of Color (BIPOC) communities where data indicates access to medical services is limited and/or health disparities exist. Providers also have the option to indicate their race, ethnicity, and special skills/services, which can help with members identify and select a PCMP who can meet their needs and with whom they may be better able to relate.
    - Telehealth: The expansion of telehealth services during the public health emergency (PHE) is ongoing and has demonstrated an effective supplemental option for increasing access and availability to services. Following the PHE unwind, CCHA has and will continue the expanded definition of telemedicine for many BH services including BH specialty providers for consultation, assessment, and treatment. PTCs will also continue supporting practices to set up

workflows around telehealth and e-consults to help improve timeliness and access, especially for specialty care and to help reduce member barriers such as lack of transportation or childcare.
    - Mobile Crisis Response (MCR) Benefit: Effective July 1, 2023, certain crisis intervention services are now covered by HCPF and the RAEs through the MCR benefit. CCHA is working with the Administrative Service Organizations (ASOs) currently administering this benefit to support the transition and will collaborate with both the Behavioral Health Administration and HCPF on technical assistance over the coming year.
- Enhanced Data Solutions:
    - Clarify implementation: CCHA has been exploring options to review quality outcomes among our behavioral health providers in order to drive updated quality measures and provider incentive programs. Clarify Health has been contracted to review outcomes at the member level and compare these among similar providers to promote quality care in our network. Clarify Health is currently ingesting data and initial reviews will begin Q2 SFY 23-24.
    - CCHA has transitioned provider reports to PowerBI, which allows for more customized views that can be tailored to focus different practice and population priorities.
- Continuous Enrollment Unwind:
    - Continuous Enrollment Unwind support activities remain an ongoing priority. Practice resources and guides are posted to the CCHA website, distributed in provider newsletters, and communicated through PTCs. These resources enable providers with valuable details that can be used to discuss continuity of care at the point of care when the member is engaged.
    - CCHA is also hosting Continuous Enrollment (CE) question and answer (Q&A) sessions, which is a support forum for providers and community partners to ask questions, receive general updates, and collaborate around the outreach and enrollment process. The Q&A sessions also help highlight issues and trends that may require higher level intervention or assistance from HCPF. CCHA will continue updating practice and member support as needed for the duration of the Continuous Enrollment Unwind period and will be responsive to practice needs as member volume fluctuates.
- Practice Transformation Coaches (PTC): Though practice support is provided in collaboration among all practice support team staff, PTCs have a critical role in helping practices seamlessly assimilate goals from different initiatives and programs into clinic workflows, as well as connecting practice staff to care coordination and other practice support services that help ensure whole-person care for members.

Value-Based Payments

PCMP Tiered Payment Model

CCHA's tiered PCMP payment model aligns with HCPF's Population Management Framework and encourages delivery of enhanced condition management services at the point of care, which helps address conditions most prevalent among Health First Colorado members, as identified by the state. For SFY23-24, CCHA will maintain this three-tiered payment model which compensates practices based on enhanced asthma/diabetes/maternity care management program services, as well as members' complexity and utilization of benefits.

Primary Care Medical Provider Incentive Program:

CCHA is committed to investing all KPI incentive dollars earned back into the community. Seventy-five percent (75%) of funds go back to PCMPs through the Provider Incentive Program; the remaining 25% of funds are directed to community partners or providers through the Community Incentive Program to fund innovative projects that address high-priority community and member needs.

For CCHA to distribute incentive dollars to PCMPs, CCHA as a region must first accomplish the Tier 1 or Tier 2 KPI goals. PCMPs with attribution of 300 members or more, and PCMPs located in rural areas are eligible for CCHA PCMP Incentive Program participation. CCHA's incentive criteria is reviewed and updated annually at the beginning of each calendar year and as needed to help drive practice performance and engagement in ACC initiatives. Currently, PCMP Incentive Program performance goals are focused on the following categories:

- Practice Transformation (10%)
- Key Performance Indicators (90%)

Though CCHA struggled to achieve most KPIs in SFY22-23, the performance goals were updated in January 2023 to narrow the scope of the incentive, including the new oral evaluation KPI, and promote active engagement between practices and their practice transformation coach. Overall, for SFY22-23, CCHA distributed $5,279,270.08 in incentives to 92 PCMP practices in Region 6.

CCHA plans to implement the following strategies to improve KPI Performance and support practice goals:

- Goal Alignment: CCHA is aligning KPI efforts with populations identified in DEI data and plans. As such, CCHA is also approaching providers and community partners to aid in targeted improvement efforts, particularly those that are located in rural areas and/or are engaged with members who identify as BIPOC and where health disparities exist.
- PCMP Incentive Program: CCHA will evaluate the criteria and performance goals for the 2024 PCMP Incentive Program, as this pay for performance strategy has demonstrated effectiveness with improvement efforts and practice engagement. In

addition to any updates in KPI measures, performance goals for the incentive program that are currently being considered for inclusion include:
    - Alignment with CMS core metrics
    - Medication adherence measures aimed at reducing complications, costs, and improving chronic condition management
- Support Materials: CCHA updates provider support materials and information to help ensure providers are informed on measure updates, such as depression screening and follow up, and timely prenatal and postpartum care, which will be reinforced through practice transformation.
- Prevention: CCHA's long-term practice efforts are largely grounded in prevention and aiming to meet KPI goals. CCHA works to increase well visits, prenatal visits, oral care, and vaccination rates through practice transformation with the PCMP network, developing practice-specific goals using member data to close gaps in services and/or care. Examples of targeted prevention efforts include:
    - Healthy Rewards: CCHA is launching a Healthy Rewards program in late 2023, which will reward members for healthy behaviors that align with KPIs and BH Incentives such as prenatal care, well care visits, and hospital/ED follow-up visits. These incentives will be used in conjunction with practice transformation and improvements efforts with the goal of engaging members in their own care through the trusted relationship with their PCMP or BH providers.
    - Vaccination trends: Ongoing efforts to increase vaccination rates, including but not limited to COVID-19 vaccines, among members of the BIPOC, pediatric, and high-risk member populations.
    - Appointment access: PTCs continue working with providers to assess appointment availability. Identifying volume and trends around missed appointments helps inform improvement strategies, such as updates to outreach, that better address member needs.
    - CCHA continues to work closely with HCPF to address data disparities related to the prenatal and well visit KPIs, including how billing practices can be improved to ensure members are appropriately counted toward KPIs. CCHA looks forward to an expeditious resolution, as provider communication and training will be planned accordingly if coding issues result in perceived gaps in care.
    - Reduce ED Utilization: CCHA revised its ED outreach strategy to focus on connecting with members who have 12 or more ED visits within six months. After promising results from piloting this approach in Region 7, CCHA expanded the outreach strategy to Region 6 and has engaged Accountable Care Network (ACN) providers to do the same with their assigned members. CCHA will continue this effort and monitor utilization rates to determine whether the efforts had an impact on regional performance rates.

Community Incentive Program (CIP):

The overall goal of the Community Incentive Program is to fund services that are not billable Health First Colorado benefits but help equip members with the tools and skills needed to be self-sufficient and successfully manage their health. The CIP application and selection process is managed annually by the Regional PIAC's voting membership to promote local needs and priorities, while also supporting projects that align with priorities of the ACC program, KPIs, and/or other important initiatives. For example, in 2023, CCHA will invest over $2.9 million in 21 projects in Region 6 and 19 projects in Region 7, including the following Region 6 awardees:

- Americas for Conservation + the Arts (AFC+A): Their project focuses on ensuring equity and access for underserved populations affected by the PHE unwind.
- Center for Valued Living: A first-time applicant and awardee to the CIP, the Center for Valued Living aims to expand access to behavioral health care to populations in critical need.

The 2024 CIP will help fund practice and community stakeholder projects serving vulnerable populations, as selected by the voting members from CCHA's regional PIAC. More specifically, 2024 CIP funding will support projects focused on health equity, physical and behavioral health integration, child/family supports and services addressing social determinants of health, and continuous coverage unwind efforts.

Behavioral Health Incentive Programs

CCHA partners with providers on initiatives designed to improve outcomes on pre-established regional performance targets, such as increasing rates of depression screenings in primary care settings, as well as facilitating timely access to behavioral health follow-up services after a positive depression screen, discharge from psychiatric inpatient placement, and/or from entering the foster care system. Incentive payments are offered to reward high-performing providers for their contributions in meeting or exceeding benchmarks on measures. Following are the BH incentive programs:

Behavioral Health Quality Incentive Program (BHQIP)

CCHA implemented the BHQIP, which provides incentives to eligible BH network providers for supporting members' BH needs with quality care and services. Centered around improving clinical quality indicators, health outcomes, and a focus on prevention and appropriate follow-up, the BHQIP goals are to create efficiencies, reduce inappropriate utilization, address social determinants of health (SDOH), and increase the value of services. Providers participating in the program who meet the quality, service, and utilization goals established in BHQIP are eligible to receive incentive payments annually.

For CY2022, 32 providers were enrolled in the BHQIP and received regular support from Behavioral Health Practice Transformation Coaches to monitor and improve performance. For CY2023, 45 providers are enrolled in the BHQIP and receiving regular support from Behavioral Health Practice Transformation Coaches to monitor and improve performance. CCHA plans to continue these support efforts and aims to increase coaching sessions with BH providers by 10%. Additionally,

CCHA exceeded last year's goal of enrolling 40 providers in the BH incentive program, so another focus for the upcoming year will be on efforts to improve scorecard performance among engaged practices.

Behavioral Health Facility Incentive Program (BHFIP):
In CY2023, CCHA implemented the new Behavioral Health Facility Incentive Program, with participation from five hospitals with value-based quality metrics focused on reducing readmission rates and increasing outpatient follow-up. Facilities participating in the program who meet the quality, service, and utilization goals established in BHFIP are eligible to receive incentive payments annually and are receiving regular support from Behavioral Health Practice Transformation Coaches to monitor and improve performance.

High Intensity Outpatient Services Program:
In support of SB19-222 and the goal to expand the behavioral health safety net system in Colorado, CCHA is collaborating with HCPF to expand access to community-based behavioral health services. CCHA issued a Request for Proposal (RFP) and will be administering one-time funding to contracted behavioral health providers through the American Rescue Plan Act (ARPA) to develop and expand programming for high-intensity outpatient behavioral health services.

- Key priority areas of service expansion include behavioral health respite, multi-systemic therapy, wraparound services, psychosocial rehabilitation, comprehensive community support services, assertive community treatment and intensive evidenced-based models in clinical specialties, i.e., biofeedback, Trauma Systems Therapy (TST), Functional Family Therapy (FFT).
- Nine behavioral health providers were selected to receive a total of $2 million in the first round of distribution of High Intensity Outpatient Program funding.

HCPF Collaborations

- Alternative Payment Methodology (APM): CCHA assists practices with participation in HCPF initiatives through practice transformation coaches (PTCs), newsletter information, and by facilitating completion of any state requirements as follows:
    - APM 1: PTCs assist providers with measure selection, structural measure validation, data sharing, understanding changes to provider rates, and performance improvement activities. PTCs also inform PCMPs about opportunities about information gathering sessions and encourage participation.
    - APM 2: PTCs share information about APM 2 opportunities with PCMPS, help complete provider interest forms, and assist HCPF with sharing data and scheduling informational meetings.
    - Prescriber Tool APM: PTCs have been educating PCMPs about the upcoming Prescriber Tool APM, helping to develop workflows, and support with electronic health record (EHR) changes necessary to utilize the prescriber tool. PTCs are

also working with practices to opt out of Prescriber Tool APM if appropriate due to significant barriers or provider request.

- HCPF E-Consult Platform: CCHA will promote practice adoption and use of the state's chosen e-Consult platform through direct practice support from network managers and PTCs, newsletter information, and any support resources that become available as go-live approaches. CCHA is further considering how to encourage PCMP use of the eConsult platform, particularly to help fill the gap where specialist shortages exist for Health First Colorado members. CCHA anticipates e-Consultations will support practices and members with improved access to specialty care and condition management services, particularly in rural areas, as well as help reduce ancillary Medicaid costs associated with face-to-face specialty consultations, duplicative visits/testing, transportation, and childcare. As such, there is consideration to incorporate use of the e-Consult platform into the PCMP Incentive Program. The incentive program is evaluated for updates annually, and addition of e-Consult utilization will be determined later this year as CCHA assesses regional priorities and practice response to implementation of the platform.

Additional information regarding each initiative is provided throughout the report. CCHA continues using lessons learned and assessing practice support strategies. We build upon progress year over year to support the medical home model as the focal point of care to increase preventative care, improve member outcomes, and reduce costs. PTCs are committed to sharing best practices so that successes can be scaled up across the region and reports are continuously improved to meet the changing needs of the RAE and providers.

SFY22-23 Goals Outcomes

CCHA is committed to quality in the services we provide to the community and has tracked the following metrics to evaluate efforts and identify opportunities for improvement. We are pleased to present the following updates we achieved in SFY22-23.

- Process Measures:
  - Number of practices who participate in at least ten (10) quality meetings annually
    - Goal: At least 50% of practices eligible for the PCMP Incentive Program will participate in at least ten (10) quality meetings annually.
    - Update: Throughout SFY22-23, 50.81% of eligible PCMP practices across both regions participated in at least 10 quality meetings.
  - Continue to collaborate with HCPF to increase engagement and utilization of the Prescriber Tool Real Time Benefit Inquiry (RTBI) Module
    - Goal: 75% of providers who have completed the Prescriber Tool attestation in phase 1 of the project will actively engage and pursue additional phases of the Prescriber Tool implementation.

        - Update: CCHA continues to promote the use of the Prescriber Tool and educate providers on the importance of this tool, however this goal is currently on hold with HCPF as there are no additional phases of the tool available to providers since the submission of last year's plan.
    - Number of BH practices that receive coaching by BH practice transformation coaches (PTCs)
        - Goal: CCHA will establish connections between BH PTCs and at least ten (10) BH practices in each region.
        - Update: CCHA exceeded this goal with our BH PTCs having engaged 65 behavioral health practices in Region 6 in coaching to resolve claims processing issues, improve quality metric performance and develop improvement projects for the High Intensity Outpatient Program.
    - Number of practices who participate in Behavioral Health Incentive programs
        - Goal: At least forty (40) practices eligible for BH provider incentive programs (BHQIP and Social Determinant of Health Provider Incentive Program (SDOHPIP)) will enroll for calendar year 2023.
        - Update: CCHA exceeded our goal of enrolling 40 providers in our BH incentive programs and has enrolled 45 providers in the BHQIP and five hospitals in the BHFIP for CY2023. The SDOHPIP was discontinued at the end of CY22.

- Outcome Measures:
    - Improve member health outcomes, increase access to appropriate services, and improve provider satisfaction.
        - Goal: CCHA will achieve the tier 1 goal in at least three (3) Key Performance Indicators, as defined by the SFY22-23 KPI Specification document.
        - Update: CCHA did not meet this goal in SFY22-23. We regularly met prenatal visits and started the year by meeting oral evaluations, but with the increasing quarterly goals, CCHA found it challenging to maintain meeting the goal even with slight improvements in performance.
    - Number of complex high-need members engaged in extended care coordination (ECC) who are connected to healthcare services (defined as at least one (1) visit to PCMP or specialist within the last year)
        - Goal: CCHA will establish a baseline during the first reporting period, then determine a goal.
        - Update: CCHA measured performance on this metric during SFY22-23 to determine a baseline. In Q1Q2, 93.47% of complex high-need members engaged in ECC were connected to healthcare services. In Q3Q4, performance is 93.39% at the time of submission of this report, which does not reflect full claims run out. Baselines will be set after full claims runout occurs.
    - Number/percent of members with a diagnosis of diabetes who have at least one well visit with their PCMP or specialist in the last twelve (12) months

        - Goal: 75% of members with a diagnosis of diabetes have at least one visit with their PCMP or specialist within the last twelve (12) months.
        - Update: In Q1Q2, 95.9% of members with diabetes had at least one well visit with a PCMP or specialist in the last 12 months. In Q3Q4, that number remained steady at 95.73%, which does not reflect full claims run out.
    - Number/percent of members with a diagnosis of diabetes who had at least one (1) hemoglobin A1c (HbA1c) done in the last twelve (12) months
        - Goal: 90% of members with a diagnosis of diabetes have at least one (1) HbA1c done in the last twelve (12) months.
        - Update: CCHA did not meet this goal in SFY22-23. In Q1Q2, 24.18% of members with diabetes had at least one HbA1c test completed within the last year. In Q3Q4, performance was 65.02% as of the time of this submission. The Q1Q2 data showed a very low rate of members getting their HbA1c within the last year; CCHA reviewed the methodology to calculate this metric and identified additional codes that were missing from the initial data set that should be included (per HEDIS measure specifications). As a result, the Q3Q4 rate increased significantly, and CCHA will continue to monitor performance.
    - Number of members who attend a behavioral health follow-up appointment within 7 days from discharge from an inpatient placement for a BH condition:
        - Goal: CCHA will achieve the improvement target as defined in the SFY22-23 BHIP Specification document.
        - Update: CCHA did not achieve the targets for follow-up within 7 days of an inpatient hospital discharge for a mental health condition in SFY23. In Region 6, a process improvement workgroup was established to review opportunities to determine process gaps and barriers, increase alignment between interventions and the incentive program calculation methodology, and reconcile claims to verify proper adjudication of services reported in project tracking.
    - Number of members who receive a depression screening during a well visit at primary care
        - Goal: CCHA will achieve the improvement target as defined in the SFY22-23 BHIP Specification document.
        - Update: CCHA successfully completed the SFY22 PIP to increase depression screening and follow-up after a positive depression screen. We held regular meetings with providers to promote utilization of G codes. Region 6 met the target for the gate measure in SFY21-22. We are reviewing proposed changes to the measure for SFY23-24 and will implement necessary changes.

SFY23-24 Goals

CCHA is committed to quality in the services we provide to the community and will track the following metrics to evaluate efforts and identify opportunities for improvement.

- Process Measures:
  - Number of practices who participate in at least ten (10) quality meetings annually
    - Goal: At least 50% of practices eligible for the PCMP Incentive Program will participate in at least ten (10) quality meetings annually.
  - Continue to collaborate with HCPF to increase adoption and engagement of the eConsult platform
    - Goal: Strategize use of incentives to encourage use of eConsult and set a baseline for the percent of providers who utilize this resource after implementation.
  - Number of providers receiving behavioral Health practice transformation coaching.
    - Goal: Increase number of BH providers receiving coaching by 10%.
  - Scorecard performance out of 100 points for providers who participate in Behavioral Health Incentive programs
    - Goal: Increase average score card performance in incentive programs by 5 points.

- Outcome Measures:
  - Improve member health outcomes, increase access to appropriate services, and improve provider satisfaction.
    - Goal: CCHA will achieve the tier 1 goal in at least three (3) Key Performance Indicators, as defined by the SFY22-23 KPI Specification document.
    - Goal: Achieve improvement benchmarks on three (3) Behavioral Health Incentive measures in SFY23-24.
  - Number/percent of members ages 12 and older who are screened for depression, and if positive, a follow-up plan is documented.
    - Goal: CCHA will achieve the improvement target as defined in the SFY23-24 KPI Specification document.
  - Number of members engaged in extended care coordination (ECC) who are connected to healthcare services (defined as at least one visit to PCMP or specialist within the last year)
    - Goal: 95% of members who are engaged in a CCHA condition management program will be connected to healthcare services.
  - Number/percent of members with a diagnosis of diabetes who had at least one (1) HbA1c done in the last twelve (12) months
    - Goal: 90% of members with a diagnosis of diabetes have at least one (1) HbA1c done in the last twelve (12) months.
  - Number of members who attend a behavioral health follow-up appointment within 7 days from discharge from an inpatient placement for a BH condition:
    - Goal: CCHA will achieve the improvement target as defined in the SFY23-24 BHIP Specification document.

- Number of members who receive a follow up visit within 30 days of a positive depression screening.
  - Goal: CCHA will achieve the improvement target as defined in the SFY23-24 BHIP Specification document.

3. Communication

Overall Approach:

CCHA tailors each communication strategy based on the nature of the messaging, target audience and timeframe for communication. This plan outlines our approach to communicating with network providers and the health neighborhood and community. We utilize a number of communication methods (also known as vehicles) to share information with our target audiences.

The following are high-level messaging topics we communicate:

- CCHA and HCPF contract, policy, rate, billing and operational updates and initiatives
- PCMP network maintenance, events and training opportunities, technical assistance, quality initiatives, and performance metrics
- Behavioral health provider network maintenance, billing, rates, prior authorization policies, events and training opportunities, technical assistance, quality initiatives and performance metrics
- Provider and health neighborhood and community incentive programs, including but not limited to the Community Incentive Program and the High Intensity Outpatient Services Program
- CCHA and Health First Colorado member benefits and copay changes
- Population health management strategies related to disease prevention, screening and management resources, including but not limited to diabetes, asthma, maternity and postpartum contraception, and depression
- Public health emergency updates including, but not limited to, COVID-19 topics such as awareness and prevention, telehealth and testing
- Disaster response communications, including "just in time" messaging that addresses the needs of members, providers and health neighborhood and community partners; messaging relies heavily on trusted sources such as county emergency response teams and state agencies

These topics have been chosen based on feedback from network providers, the health neighborhood and community and HCPF.

Development Process

CCHA utilizes the CCHA Communication Planning Template to prepare for and develop communications for target audiences. The template is a starting point and may vary depending on the scope of the messaging need. During development, CCHA consults and engages internal teams and external stakeholders regarding communication strategies (refer to the *CCHA Communication Planning*

Template). CCHA will continue to determine the appropriateness and utilize messaging already available from subject matter sources such as HCPF or other trusted sources. CCHA has found this to be critically important when communicating with the provider network, health neighborhood and community, and members during the public health emergency and disaster response and will continue to apply this approach in non-crisis situations.

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Department of Health Care Policy & Financing

Communication Methods

CCHA uses various communication methods to reach our network providers and health neighborhood and community partners and increase communication among the network. The following table summarizes current communication methods by topic, vehicle, audience and frequency. New methods and topics have been denoted.

Topic	Newsletter[1,2]	Specialist Newsletters[1,2]	Alerts[1,2]	Online & Printed Materials[1]	Social Media[1]	Direct Outreach (phone/e mail)[1,2]	Letters and/or Fax[1,2]	Webinar (live and/or recorded)[1,2]	Network Town Halls and/or In-person Meetings[1,2]	BH Provider Joint Operations Committee[1,2]	BH Provider Chat[1]	BH Provider Open Mic Call[1,2]	BH Provider Outpatient Inquiries Inbox[1]	BH Provider Bulletin[1,2]	BH Provider Education Series[1,2]
Frequency	Monthly	Quarterly	Ad-Hoc	Ad-Hoc	Ad-Hoc	Ad-Hoc	Ad-Hoc	Ad-Hoc	Ad-Hoc, Monthly, Quarterly, Bi-Annually	Monthly, Quarterly, Bi-Annually	Ad-Hoc	Monthly	Ad-Hoc	Monthly	Monthly
Behavioral health policy, billing and operations	X	X	X	X		X	X	X	X	X	X	X	X	X	X
Behavioral health quality	X	X	X	X		X	X	X	X	X		X	X	X	X
Disease prevention, screening and management resources	X	X	X	X	X			X	X					X	X
Operational updates	X	X	X	X		X	X	X	X	X	X	X	X	X	X
Policy updates	X	X	X	X		X	X	X	X	X	X	X	X	X	X
Rate changes	X	X	X	X		X	X	X	X	X	X	X	X	X	X
Member benefit updates	X	X	X	X	X	X	X	X	X	X		X		X	
CCHA contract updates	X	X	X	X		X	X	X	X	X		X		X	
Medicaid technical assistance	X	X	X	X		X	X	X	X	X		X		X	
Provider network networking			X	X					X						
Open Q&A						X		X	X	X	X	X	X		X
Program or resource updates					X	X	X	X	X	X		X	X	X	X
Public health emergency updates	X	X	X	X	X	X		X	X	X		X		X	
Regular business operations	X	X	X	X	X	X		X	X	X	X	X	X	X	
Training/continuing education	X	X	X	X	X	X		X	X	X		X		X	
Upcoming events	X	X	X		X			X		X		X		X	
Disaster response	X	X	X		X	X								X	

Frequency
Ad-Hoc = As needed based on the urgency and purpose of the message; or initiated by a network provider or Health Neighborhood member
Monthly = Occurs at regular monthly intervals
Quarterly = Occurs at regular quarterly intervals
Bi-Annually = Occurs bi-annually

Communication Strategy Rationale
[1] Strategy is used based on previous experience and best practices for communicating with target audience.
[2] Strategy is used based on input from target audience and/or demonstrated effectiveness through utilization and engagement data.

Audience

All = Network Providers, Health Neighborhood, Community Partners and Other Stakeholders
Network Providers = Contracted Primary Care Medical Providers and Behavioral Health Providers
BH Network Providers = Contracted Behavioral Health Providers

In addition to the aforementioned communication vehicles, behavioral health provider resources are published on CCHAcares.com/providertools, and regularly featured in the provider newsletter and behavioral health provider bulletin. These resources include a Behavioral Health Provider Contact List and Behavioral Health Provider Escalation Path which outline processes for responding to provider questions and complaints.

New Communication Solutions

- Behavioral Health Provider Bulletin – Based on feedback from BH independent provider network (IPN) workgroups and other stakeholder forums in 2022, CCHA began distributing a specific behavioral health provider bulletin strictly for behavioral health-related topics. In 2023, CCHA incorporated feedback from behavioral health providers to revamp the structure, making the bulletins shorter and easy to consume. CCHA has seen great engagement from these bulletins and plans to continue this communication vehicle; it is distributed to more than 4,000 providers and consistently achieves around a 40% open rate, which is above the industry standard of 35%.
- CCHA organizes a range of monthly behavioral health education opportunities, such as open mic sessions, provider orientations and a provider education series that features a new topic of interest each month.
- CCHA produces a quarterly specialist newsletter to share important reminders, updates and helpful resources with providers. These newsletters are distributed to approximately 180 specialty providers and achieve a 50% open rate, which is above the industry average of 35%.

Emerging Issues

Additionally, CCHA adapts its communication strategies based on emerging issues within the community. Examples include:

- End of the Public Health Emergency (PHE) – CCHA employs various channels to effectively communicate information about the end of the PHE. We utilize our provider newsletters, bulletins and specialist newsletters to disseminate relevant updates to providers. Additionally, we have produced dedicated newsletters and developed a webpage that serves as a centralized hub for the latest information. To ensure our members are reachable, we have created materials that guide them in updating their addresses. Furthermore, we leverage community resources to reach members. Fourteen Community Incentive Program recipients are using incentive funds to assist members through the PHE unwind. This includes our community partner, Julissa Soto, who actively engages with the Hispanic community where they feel comfortable and hosts a radio show to address questions and concerns. Moreover, we make HCPF resources and toolkits accessible in multiple locations on our website and regularly encourage providers to access these resources.
- COVID-19 – The need for COVID-specific alerts has decreased, but CCHA has templates and distribution lists in place to communicate quickly should the need arise again.
- Disaster Response – CCHA staff promptly responded to offer support, clear communication, and care coordination resources to members impacted following the shooting at Club Q in Colorado Springs in November 2022. Staff also outreached providers and community partners to identify needs CCHA could support. We made sure resources and support were readily available by creating a webpage dedicated to Club Q, adding a banner to our homepage, and sharing information, resources and updates via our provider newsletters and social media posts.
- Crisis Communication Plan – Following recent critical events such as the Club Q and Boulder shootings, and the Marshall and Middle Fork Fires, CCHA reflected on lessons learned during crisis communications and developed a Crisis Response Plan,

which serves as a framework for communication expectations to support our members and provider network during crisis situations, natural disasters, etc. This document will continue to guide our leadership in responding to these unforeseeable events in a thoughtful, coordinated, and intentional manner to best support our members, provider network, and broader community.

Contingency/Crisis Communication Methods

CCHA follows accelerated development and approval processes for urgent communications to target audiences, including but not limited to network providers, members, health neighborhood, community partners and other stakeholders. CCHA subject matter experts and Communications Department leadership lead the accelerated development process to reduce overall review, approval and launch time.

In a crisis, CCHA is mindful to leverage existing and consistent messaging from trusted sources like state and federal government and other subject matter experts. This approach has proven to be incredibly important during the COVID-19 public health emergency and continues to be important during the public health emergency unwind. CCHA remains committed to aligning messaging with state partners like HCPF and the Colorado Department of Public Health and Environment. We have and will continue to utilize this approach based on feedback from members, providers and the community that consistency is key for trust-building during this uncertain time.

CCHA has the following "just in time" communication vehicles:

- Automated outbound call campaigns
- Community events to raise awareness
- Dedicated pages or sections on CCHAcares.com (see CCHAcares.com/ClubQ)
- Direct 1-to-1 email outreach
- Email alerts via electronic newsletter (see Club Q Shooting Response and Resources alert and Planning for the End of Continuous Enrollment email)
- Local media
- Mailings
- Direct 1-to-1 phone calls
- Social media posts, including using Facebook boosting and ads
- Text messaging

Our local CCHA call centers act as a failsafe for each other during a crisis or disaster scenario. The Colorado Springs office would take over for the Denver office if needed and vice versa. Local information technology (IT) has procedures to quickly get critical functionality back online in case of failures or outages. The vast majority of office-based staff can maintain normal business operations and hours remotely as well. Additional details can be found in the *CCHA Business Continuity Plan*.

Evaluation Methods
The following are examples of current evaluation techniques we use depending on the vehicle, nature of the communication and frequency.

- Input and questions from county departments of human and social services and members of the state legislature through standing and ad-hoc meetings, reports and communications
- Input and questions from HCPF through standing and ad-hoc meetings, reports and communications
- Newsletter open and click rates, replies to newsletter messages and forwards
- Input and questions from health neighborhood and community partners through standing and ad-hoc meetings, reports and communications
- Monitoring of questions received by Provider Relations, PTCs, Member Support Services, inquiries through the online Contact Us form and call center metrics
- Input and questions from other RAEs through standing and ad-hoc meetings, reports and communications
- Meeting or webinar surveys, attendance and engagement
- Program Improvement Advisory Committee meetings and ad-hoc engagement
- Social media engagements, including shares, likes and replies
- Website analytics, click rates and time spent on page

If CCHA determines existing communication methods for providers are insufficient and/or require consideration of additional staffing or enhanced support, the discussion is initiated in CCHA's monthly Joint Operations Committee (JOC). During this forum, CCHA leadership identifies, reviews and considers emerging operational impact. Additionally, the JOC would consider realigning resources to meet the increased demand, including staff, contact hours and other operational changes.

SFY22-23 Goals Outcomes
CCHA is committed to quality in the services we provide to the community and has tracked the following metrics to evaluate efforts and identify opportunities for improvement. We are pleased to present the following updates we achieved in SFY22-23.

- Process measures:
  - Publish and distribute CCHA monthly newsletter
    - Goal: CCHA will publish at least ten (10) newsletters in SFY22-23.
    - Update: CCHA exceeded this goal by distributing 12 provider newsletter bulletins.
  - Publish and distribute frequent behavioral health provider bulletins
    - Goal: CCHA will publish at least ten (10) behavioral health provider bulletins in SFY22-23.

        - Update: CCHA exceeded this goal by distributing 12 BH provider bulletins in SFY22-23.
- Outcome measures:
    - Percent open rate for CCHA monthly newsletter
        - Goal: Monthly percent open rate will exceed the industry average as defined by Constant Contact.
        - Update: The industry average open rate is 34.84%, and CCHA's provider newsletter achieved on average a 38.5% open rate.
    - Percent open rate for behavioral health provider bulletin
        - Goal: Monthly percent open rate will exceed the industry average defined by Constant Contact.
        - Update: The industry average open rate is 34.84%, and CCHA's BH provider bulletin achieved on average a 40% open rate.
    - Number/percent of eligible PCMP practices with provider portal access who actively use the portal
        - Goal: 50% of practices with established access will engage with the portal at least once per six months.
        - Update: 60.7% of PCMP practices in Region 6 with portal access had logged in to access the portal in the first half of the SFY. 65.2% of practices had accessed the portal during the second half of the SFY.

SFY23-24 Goals

CCHA is committed to quality in the services we provide to the community and will track the following metrics to evaluate efforts and identify opportunities for improvement.

- Process measures:
    - Publish and distribute CCHA monthly newsletter
        - Goal: CCHA will publish at least ten (10) newsletters in SFY23-24.
    - Publish and distribute frequent behavioral health provider bulletins
        - Goal: CCHA will publish at least ten (10) behavioral health provider bulletins in SFY23-24.
- Outcome measures:
    - Percent open rate for CCHA monthly newsletter
        - Goal: Monthly percent open rate will exceed the industry average as defined by Constant Contact.
    - Percent open rate for behavioral health provider bulletin
        - Goal: Monthly percent open rate will exceed the industry average defined by Constant Contact.
    - Number/percent of eligible PCMP practices with provider portal access who actively use the portal
        - Goal: 50% of practices with established access will engage with the portal at least once per six months.

4. Health Neighborhood & Community Engagement

Overall Approach:

CCHA's vision is to have a connected and engaged health neighborhood and community that efficiently utilizes public resources and optimizes the health of its members. CCHA leverages data to identify regional health neighborhood and community entities where members are already engaged, including PCMPs, EDs, local health agencies, and community-based organizations, such as Benefits In Action. CCHA focuses on establishing and maintaining collaborative partnerships with multiple systems/partners spanning beyond the provider network, including hospitals, health departments, mental health centers, case management agencies, etc., with the goal of supporting each entity's unique needs. This support may include care coordination support, member engagement and navigation, Medicaid technical assistance, and funding opportunities including administrative payments and additional incentive/performance dollars. Through this work, CCHA endeavors to help meet the goals of the ACC, decrease costs, improve efficient use of specialty care, and ultimately ensure improved outcomes for members.

CCHA is fortunate to serve Regions 6 and 7, which has a robust health neighborhood and community. Due to the overwhelming opportunities for potential partnership, CCHA has developed a stratification method for deployment of resources. This stratification method evolved since the start of the RAE contract as it became obvious that CCHA had extensive options for involvement in the health neighborhood and community, rarely resulting in reportable outcomes. As such, CCHA developed an intentional approach to prioritize entities for engagement to best serve our members and region:

- Entities whose primary focus is to drive ACC goals and performance metrics
- Entities directly responsible for shared member care
- Entities driving innovative programming outside the realm of traditional Medicaid services
- Entities that are promoting health equity initiatives that impact our member populations
- Entities that may help fill gaps identified in local community health needs assessments

Based on this prioritization, and in an effort to create alignment, CCHA uses the following mechanisms to establish relationships, and improve processes, communication, and collaboration with the health neighborhood and community.

- Memoranda of understanding (MOUs) - CCHA formalizes relationships with partners through these agreements to clarify roles, identify case leads, specify data sharing agreements, enhance communication, and determine training opportunities.
- PIAC and Member Advisory Committee (MAC) - CCHA leverages these committees to formalize stakeholder engagement opportunities and ensure we hear community and member voices regarding CCHA operations and performance.
- Incentive programs - CCHA provides funding opportunities including the Community Incentive Program (CIP) through the PIAC, and SEP/CCB Incentive Program to help drive innovative programming and health equity initiatives in the community for entities that serve our members to effect change through activities not normally billable under traditional Medicaid benefits.

- Community collaboration meetings - CCHA participates in many meetings with stakeholders throughout the community, leveraging opportunities to establish, maintain and enhance relationships with other health neighborhood entities as well as educating about the RAE's role and services available to mutual members.
- Information sharing - CCHA shares resources via monthly newsletters, email blasts, and individual outreach with health neighborhood and community partners to ensure stakeholders are informed of key initiatives/updates and members receive consistent, aligned messaging regardless of where they receive it.
- Data Sharing - CCHA completes Memorandums of Understanding (MOUs) and/or Business Associates Agreements (BAA) with specific entities to be able to share member level data and leverage trusted partners to complete member outreach. Bi-directional data is also shared to track outcomes.
- Activities to reduce duplication and improve coordination across the health care system - CCHA works to establish co-locations and/or single points of contact, develop care coordination (CC) workflows and referral pathways, and host/participate in complex case reviews to engage with members who are working with partner organizations in the community.

Strategies related to the health neighborhood and community

- Promote opportunities for current partnerships (which may include formal MOUs to promote data sharing) with health neighborhood entities to further align with CCHA's health equity goals and our Population Management and Network Management Strategic Plans and support evidence-based programming.
- Identify and partner with community organizations that support equity, diversity, and inclusion initiatives focused on reducing identified health disparities that impact our members. CCHA will seek to provide financial resources and staff technical assistance to community organizations, particularly those serving special populations such as maternity members and members in rural areas.
- Identify opportunities to highlight Medicaid members' voices by including members in every aspect of the PIAC, to include agenda development, member representation at each meeting, and providing input through post-meeting feedback sessions quarterly.
- Develop and improve referral pathways through formalized workflows with partner agencies to increase efficiency of the health care system, reduce duplication and costs, and improve member experience and outcomes.
- Maintain relationships with new case management agencies (CMA) and other community organizations that serve members on waivers to ensure members are accessing preventative care including well checks and oral visits, and further prevent avoidable ED visits.
- Assess opportunities to increase direct engagement with foster/child welfare members and establish workflows with DHS agencies for this population to increase rates of well and dental visits. Continue to provide DHS agencies with ongoing

education on the role of the RAE and Medicaid benefits, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

- Partner with local school districts and other organizations serving youth and families to promote preventative care for pediatric populations, including well-visits, oral health exams, immunizations and behavioral health resources.
- Collaborate with organizations serving justice-involved members to ensure members receive appropriate behavioral health services and preventative care as shown through the Department of Corrections (DOC) and KPI metrics.
- Align PHE Continuous Enrollment Unwind coordination activities with HCPF and local county Departments of Human Services (DHS) to manage resources, ensure we remain up to date and educate our staff and partner agencies to support members.
- Continue to operationalize PHE Continuous Enrollment Unwind communication campaigns to promote standardized messaging on the enrollment process. The communication campaign includes stakeholder Q&A sessions for health neighborhood and community partners and ongoing member outreach campaigns to provide education and support in updating addresses and completing the renewal process.
- Collaborate with Individualized Services and Support Teams (ISSTs) through the Collaborative Management Programs (CMPs) in Broomfield, Boulder, and Jefferson counties to conduct community-wide staffings for youth and families for prevention or intervention efforts. CCHA also works with the CMPs to address system-level gaps.
- Strengthen complex and condition management programming and services through the SEP/CCB Incentive Program, by conducting monthly SEP/CCB case reviews, weekly ADT data exchanges, and quarterly trainings.
- Maintain bidirectional communication and collaboration with Signal, the Administrative Service Organization (ASO), and regional CMHCs to promote access to crisis services and a coordinated network.
- Advance cross sector collaboration with local housing providers, physical and behavioral health safety net providers and HCPF to ensure members experiencing homelessness have their needs addressed, services are provided in a timely manner, and to maximize efficiency of resources.
- Engage community champions and leaders to partner on local initiatives, offering flexibility to community organizations that allows them to test and implement new strategies for engaging the community, prioritizing health equity activities.
- Improve member access to care by working with local organizations to address gaps and barriers, including transportation and telemedicine technology, especially in rural areas.
- Partner with community organizations and health neighborhood entities to promote COVID-19 vaccine administration to increase vaccine rates for both general and targeted member populations.

Strategies for increasing appropriate utilization of specialty care

As a RAE, CCHA works to reframe and foster relationships between PCMPs and specialists by enhancing capacity and promoting quality improvement in the provider network, incentivizing condition management through established agreements, maintaining relationships and supporting partners to help fill gaps, and outreaching and engaging specialty providers willing to accept Medicaid members. In addition to facilitating the provision of wrap around services, care coordination and complex case reviews provide an

opportunity to assess a member's specialty care utilization and identify over/under utilization. CCHA includes the entire care team in these complex case reviews and when all providers are present, it increases communication and collaboration to find solutions to meet the member's needs and promote appropriate utilization.

CCHA Practice Transformation Coaches (PTCs) help providers create proper workflows and best practices for referrals to specialty care. PTCs encourage providers to include all test results with referrals to help decrease duplication of testing which also helps the specialist to review the case prior to scheduling to ensure the referral is appropriate. PTCs involve care coordinators in Quality Improvement (QI) meetings help to provide education and options for PCMPs as needed. Additionally, CCHA looks forward to the increased specialty care consultation opportunities with the upcoming statewide eConsult platform in SFY23-24 and will support HCPF implementation efforts.

Members in rural communities face additional challenges with access to specialty care. They may have long commutes to specialists and face transportation barriers. To improve access in rural areas, CCHA has partnered with local organizations to supply kiosks that members can use to facilitate a telehealth appointment. Four kiosks have been established and CCHA renewed the agreements with the partner agencies to continue to offer this service. Behavioral health services will be prioritized, and other visit-types such as well visits, specialists or wrap around services can be accommodated.

At the individual member level, CCHA's Member Support Services Team (MSS) conducts targeted condition management outreach to members to ensure they are connected to the appropriate specialist to manage chronic health conditions. When members are outreached, appropriate assessments are completed to determine gaps in care, including the need for care coordination, subsequent care plan development with the health team and applicable referrals to specialty care. CCHA trains its staff to help guide conversations with members to ensure the PCMP is encouraged as the focal point of care. Similarly, CCs educate members about the correct specialist to see and collaborate with providers regarding member needs to prevent unnecessary appointments with specialists. CCs educate members on the importance of the PCMP as their focal point of care, how to ask the right questions, and how and when to ask for a referral.

Strategies for coordinating with crisis services

Collaboration with Local Crisis System, Administrative Services Organizations (ASO), and Managed Service Organizations (MSOs):
CCHA collaborates with Signal, who serves as the MSO and ASO, for crisis services in the region. Signal has partnered with the CMHCs, Jefferson Center for Mental Health (JCMH) and Mental Health Partners (MHP) alongside other community partners for crisis services and follow-up care. Regular meetings between Signal, Front Range Health Partners (FRHP, an entity that represents JCMH and MHP), and CCHA discuss ways to best collaborate to ensure timely access to services following a crisis encounter. CCHA also meets with JCMH, MHP and FRHP regularly to discuss current program initiatives to improve coordination and communication. Signal

shares their crisis encounter data that they collect as part of their contracts. In partnering with JCMH and MHP, Signal has been able to better communicate and impact the rate of members receiving the necessary 7-day follow-up after a crisis event.

For members who are at risk for suicide, CCHA care coordination will outreach the Colorado Crisis Service Hotline for support and refer members to the closest walk-in center (JCMH and MHP) to assess needs; members can be further transferred to a Crisis Stabilization Unit, Acute Treatment Provider, or inpatient facility. CCHA offers education on Colorado Crisis Services to members through care coordination and via our website. Further, CCHA provides administrative payments on an annual basis to support the Crisis Line component of the Colorado Crisis System.

CCHA continues to meet with Signal and FRHP quarterly to discuss services under ASO Colorado Crisis Services, Child Youth Mental Health Treatment Act (CYMHTA), MSO (SUD), and other services. The CCHA Care Coordination leadership team also meets with Signal alongside JCMH and MHP on a regular basis to support ongoing collaboration and process improvements. Specifically, CCHA meets with Signal and FRHP monthly to discuss opportunities for data sharing across the ASO, RAE and CMHCs to support population-level tracking across the behavioral health system. Additionally, the leadership group assigns single points of contact (SPOC) for referrals, including a CCHA SPOC for Signal to outreach on mutual members under the ASO or MSO. MHP and JCMH also have a CCHA SPOC to help manage referrals being made to walk-in centers. CCHA, Signal and FRHP will continue to meet monthly to collaborate on supporting Colorado Crisis Services along with initiatives with Colorado Crisis Services and mental health centers.

Further, CCHA care coordinators meet with FRHP, MHP and JCMH quarterly to support collaboration between CCHA and the mental health centers, provide cross-system training and education on the crisis system, offer support in navigating services through the statewide crisis line, walk-in centers, crisis stabilization units, mobile services, and/or respite, and to review diversion documents to educate care coordinators on how to support members in utilizing Colorado Crisis Services.

CCHA will collaborate and investigate areas of opportunity as HCPF and the Behavioral Health Administration (BHA) work to create a more unified and coordinated crisis system, which may include enhanced data sharing to drive collaboration at the member and population-levels. One challenge that affects collaboration across the crisis system includes that RAEs and CMHCs do not have timely access to crisis service utilization data, including ASOs and the statewide Crisis Services hotline. Without this information, it is difficult to assess and identify escalating needs with our membership and respond quickly to those needs for client safety. As the State explores creating more unified encountering of crisis systems utilization and improve data access, CCHA encourages a statewide protocol and coordinated structure for submission of data to the RAEs to generate the most seamless care model across the various contracts and regions. CCHA will continue to participate in ongoing stakeholder meetings with the BHA to understand opportunities for improvement.

<u>Community Partnerships and Interagency Initiatives:</u>

CCHA collaborates with community initiatives such as Longmont Public Safety Department, which oversees the crisis response case management team that outreaches members who have accessed services through the local hospital EDs with high acuity behavioral health needs and connect them to intensive resource navigation and case management. CCHA also exchanges monthly ED high utilizer member lists for outreach.

CCHA participates in the Metro Denver Partnership for Health's Behavioral Health Community Ambassador Program, which is a partnership with community ambassadors to reduce stigma associated with mental health among Latinx and African American adults in the metro Denver region. The goal is to encourage individuals to access help early to prevent a behavioral health crisis. Trusted ambassador organizations receive funding to increase capacity to address mental health and related stigma, promote and evaluate anti-stigma messages within communities, and provide structured feedback on communication strategies to inform future funded activities. Further, CCHA is funding the mental health ambassador program through the 2023 CIP, which is providing funds for five additional ambassadors to participate in the program.

SFY22-23 Goals Outcomes

CCHA works with each entity to identify unique goals to promote the goals of the ACC, align efforts, and to ultimately improve health outcomes for Health First Colorado members. CCHA has tracked the following metrics to evaluate efforts and identify opportunities for improvement. We are pleased to present the following updates we achieved in SFY22-23.

- Process measures:
    - Continue to create more efficient referral pathways for services, with the aim to improve access and member experience.
        - Goal: CCHA will formalize workflows with at least two (2) organizations via an MOU in the next six (6) months.
        - Update: In Q1Q2, CCHA signed letters of intent with 31 practices and two community organizations for COVID-19 efforts, signed letters of intent with our SEPs/CCBs for our 2023 SEP/CCB Incentive Program, drafted one MOU with partner organizations, and executed 21 Community Incentive Program awardee contracts for the 2023 award cycle. In Q3Q4, CCHA executed the drafted MOU and also signed a partnership agreement with Metro Denver Partnership for Health.
    - Identify and support more community organizations and collaborations that support equity, diversity, and inclusion initiatives focused on reducing health disparities through financial support, staff resources (ex.: vaccine outreach/access activities)

        - Goal: CCHA will establish relationships with a minimum of five (5) community-based organizations in SFY22-23.
        - Update: CCHA surpassed this goal and established relationships with eleven new community organizations, including focus areas of health equity advocacy, maternal/newborn health, behavioral health, and justice-involved members.
    - Be an active participant and attend monthly CMP/ISST meetings
        - Goal: CCHA will attend at least ten (10) CMP/ISST meetings over this next fiscal year.
        - Update: CCHA exceeded this goal in each region by attending more than ten meetings, with primary collaboration focused on the larger counties in our region.
    - Meet with Signal and the CMHCs at least quarterly to enhance coordination among the crisis system, with a focus on improving collaboration, communication, data sharing, etc.
        - Goal: CCHA will participate in at least four (4) collaboration meetings in SFY22-23.
        - Update: CCHA met this goal. We participated in four meetings with Signal and our CMHCs throughout the fiscal year to support crisis system coordination.
    - Outreach and engage Maternal Fetal Medicine (MFM) clinics in our regions with the goal to support shared complex members.
        - Goal: CCHA will engage at least two (2) MFM clinics through presentations, resource sharing, and referral processes in SFY22-23.
        - Update: Community liaisons and care coordinator supervisors outreached OB/GYNs and MFM practices to provide education on how CCHA can support their CCHA patients by providing care coordination, connecting members to community resources to address health-related social needs, and providing free health education information to members. CCHA encouraged these providers to sign up to our Specialty Care Provider Newsletter mailing list to receive information from CCHA on an ongoing basis regarding our services and how to refer members to CCHA.
- Outcome measures:
    - Improve health outcomes and access to services for members releasing from Department of Corrections (DOC).
        - Goal: CCHA will meet the performance target for Behavioral Health Engagement for Members Releasing from State Prisons, as defined by the SFY22-23 KPI Specification document.
        - Update: On June 23rd, CCHA received the final SFY21-22 payment with revised DOC payments. This document shows that Region 6 achieved a rate of 20.38%. We are still awaiting final performance for SFY22-23.
    - Continue to improve coordination with SEPs/CCBs to reduce duplication of services and support shared members.

        - Goal: CCHA will review at least three (3) member cases each month during complex case staffings.
        - Update: CCHA met this goal and continued to hold monthly complex case reviews throughout the year. On average, we discussed more than three members per month. In SFY23-24, we will modify this goal to align with the 2023 SEP/CCB Incentive Program to review the 1-3 cases per month.
    - Expand access to telehealth services in rural areas by continuing to set up kiosks with local organizations, that can provide members with access to telehealth services, including behavioral health.
        - Goal: CCHA will identify three (3) additional partners to utilize iPad telehealth kiosks in SFY22-23.
        - Update: We were unable to identify new partnerships for the telehealth kiosks in SFY22-23, however, CCHA renewed MOUs with the existing four kiosks placed and will continue to monitor those services.
    - Improve timely access to services and health outcomes for prenatal and postpartum members. Prenatal and Postpartum Care: Timeliness of Prenatal Care (National Quality Forum (NQF) 1517).
        - Goal: CCHA will achieve the tier 1 goal for the Prenatal and Postpartum Care KPI as defined in the SFY22-23 KPI Specification document.
        - Update: CCHA had previously defined goals for Timeliness of Prenatal and Postpartum Care measures, however, we modified these goals to align with the announced KPI for prenatal engagement. In Q1, CCHA met the tier 2 goal, performing at 59.59%. In Q2, CCHA met the tier 1 goal, achieving 59.72%. In Q3, CCHA again met tier 2, with a rate of 60.88%. While we are waiting for Q4 results from the Data Analytics Portal (DAP), our internal projections show that we will again meet tier 2 for prenatal care in Q4 with a rate of 64.75%.

SFY23-24 Goals

CCHA works with each entity to identify unique goals to promote the goals of the ACC, align efforts, and to ultimately improve health outcomes for Health First Colorado members. Below are examples of current goals for SFY23-24.

- Process measures:
    - Continue to create more efficient referral pathways for services, with the aim to improve access and member experience. Partnerships in alignment with our health equity focus areas will be prioritized, including maternity, prevention, immunizations, and behavioral health.
        - Goal: CCHA will formalize strategic partnerships via an MOU with at least at least two (2) community organizations.
    - Distributing funds via the Community Incentive Program to fund more community organizations and collaborations that support equity, diversity, and inclusion initiatives focused on reducing health disparities.
        - Goal: CCHA will fund and partner with a minimum of five (5) community-based organizations in SFY23-24.

- Collaborate with the BHA, ASOs and MSOs on upcoming programmatic changes aimed at increasing coordinated access to behavioral health care, including coordination of Crisis Services, the new Mobile Crisis Benefit, and other legislative changes impacting the behavioral health network.
  - Goal: CCHA will participate in at least four (4) collaboration meetings in SFY23-24.
- Outreach and engage providers and community organization that serve pregnant members in marginalized communities in our regions to increase outreach and engagement.
  - Goal: CCHA will engage at least two (2) community partners through presentations, resource sharing, and referral processes in SFY23-24.
- Number of PIAC meetings that occurred during the reporting period
  - Goal: CCHA will host four meetings per calendar year.
- Number of organizations that participate in CCHA's PIAC meetings
  - Goal: To ensure diversity of participation, all PIAC meetings will include at least two individuals from each sector (dental, behavioral health, primary care, community, hospital, long-term services and supports (LTSS)).
- Partner with the DHS departments in our region to streamline the Health First Colorado member eligibility and renewal processes and facilitate ongoing bi-directional communications.
  - Goal: CCHA will establish an escalation process with each county DHS office in our region to streamline resources, reduce duplication, and ensure that eligibility issues are handled timely to support members through the Continuous Enrollment Unwind.

- Outcome measures:
  - Improve health outcomes and access to services for members releasing from Department of Corrections (DOC).
    - Goal: CCHA will meet the performance target for Behavioral Health Engagement for Members Releasing from State Prisons, as defined by the SFY23-24 Performance Pool Specification document.
  - Continue to improve coordination with SEPs/CCBs to reduce duplication of services and support shared members.
    - Goal: CCHA will review one to three member cases each month during complex case reviews, with focus on ensuring developed care plans and promoting preventative services, including well-care, oral health, and behavioral health services.
  - Improve timely access to services and health outcomes for prenatal and postpartum members:
    - Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF 1517).
      - Goal: CCHA will achieve the tier 1 goal for at least one quarter as defined in the SFY23-24 KPI Specification document.
    - Prenatal and Postpartum Care: Postpartum Care (NQF 1517)

- Goal: CCHA will achieve the tier 1 goal for at least one quarter as defined in the SFY23-24 KPI Specification document.

5. Admin Payments and Incentives

Overall Approach

CCHA understands that certain members require a higher level of care and transitioned to a tiered per-member per-month (PMPM) payment structure that compensates providers for additional interventions provided to medically complex members. Under this payment arrangement, effective July 1, 2021 of SFY 2021-22, and continuing through June 30, 2024, PCMPs receive an administrative PMPM payment for attributed members based on member complexity and engagement in care per the Member Payment Categories outlined below.

Member Payment Categories

Complex Priority Members

New members or members who have had a service with any provider/provider type within the previous 18 months and satisfy any of the following criteria:

- Members with annual costs of $25,000 or more
- Members with a diabetes mellitus diagnosis who have high physical and behavioral health needs and who are not institutionalized
- Members with an asthma diagnosis who have high physical and behavioral health needs and who are not institutionalized
- Members who are pregnant
- Members under the age of two (2) who were born prematurely
- Members who receive long-term services and supports from a Home and Community Based Services waiver
- Members who were incarcerated in a Department of Corrections facility within the past year
- Members involved in foster care

*Note: CCHA's Complex Priority payment category differs from the approved complex definition CCHA uses for the purposes of complex care management and extended care coordination. Specifically, the Complex Priority payment category is inclusive of a broader population, which includes complex members as well as members with emerging needs.

Engaged Members
Engaged members are new members or members who have had a service with any provider/provider type within the previous 18 months and who are not identified as complex priority members.

Non-utilizers
Non-utilizers are members with no claims history available within the previous 18 months of continuous enrollment.

PCMP Payment Levels
The PMPM rate for each payment category is dependent on each PCMP's contracted rate level. Qualified PCMPs (those contracted with CCHA for at least one year as of July 1, 2023) with a high volume of membership had the opportunity to contract at a higher payment level with demonstration of enhanced practice services that address chronic and complex conditions. Below is a summary of the requirements for each payment level.

- PCMP Practices | Level 1 Payments
    - Base payment level
    - PCMP meets requirements for network participation
- PCMP+ Practices | Level 2 Payments
    - Advanced payment level
    - Practice has comprehensive condition management services and reports on members engaged in asthma, diabetes, complex, and/or maternity care
- ACN Providers | Level 3 Payments
    - Advanced payment level
    - Practice has comprehensive condition management services and reports on members engaged in asthma, diabetes, complex, and/or maternity care
    - Provides comprehensive care coordination services and reports on members engaged in care coordination activities

ACN Performance Monitoring
CCHA delegates the provision of care coordination and outreach to ACN practices for their attributed members, including members with complex care needs. CCHA is ultimately accountable for these members and monitors and evaluates ACN providers' performance of contracted responsibilities on an ongoing basis through the following activities:

- Designate a single point of contact for ACNs to oversee care coordination support functions, providing ACNs with assistance on questions, real-time consultative support on member cases and escalated care coordination issues, referral support and training resources as needed.

- Care coordination case audits to review ACN care coordination activities, including policies and procedures, workflows and documentation practices.
- Monitoring and assessment of shared cases, to monitor volume and type of ACN cases that CCHA is supporting. This shared case assessment process helps identify potential data issues and training needs.
- Engagement and participation in annual External Quality Review Organization audits as needed
- Review overall performance on KPIs and Provider Incentive Program metrics
- Monitor timely submission of reports and data requests
- Maintain standing and ad hoc meetings, including:
    - Monthly meetings with the ACN to discuss performance and operations related to care coordination responsibilities, collaborative efforts, support needs, and general successes/challenges, and quality initiatives
    - Participation in regional PIAC meetings
    - Specific meetings on quality/performance

CCHA also supports and monitors ACN practices through the Provider Incentive Program. ACN practices must achieve performance goals to receive incentive payments earned as a region. Among additional metrics that help drive performance, ACN providers must achieve target goals for engaging their complex high-need members in extended care coordination (ECC).

SFY22-23 Goals Outcomes

CCHA is committed to quality in the services we provide to the community and has tracked the following metrics to evaluate efforts and identify opportunities for improvement. We are pleased to present the following updates we achieved in SFY22-23.

- Process Measures:
    - Increase awareness among the provider network of CCHA's definition of complex high-need members, and outline expectations for referrals.
        - Goal: CCHA will continue to engage and educate providers on CCHA's population stratification model. Through consultations with providers by PTCs, CCHA will identify communication barriers/needs, and develop messaging that can be used for outreach and training.
        - Update: CCHA continued to engage providers regarding CCHA's population management model and care coordination services throughout the year in a variety of ways. First, CCHA continued to promote and establish referral processes for CCHA care coordination among the network, including through single points of contact, newsletter articles and the provider manual. Second, CCHA established a position to serve as a single point of contact for CCHA's ACN providers regarding care coordination support. This position is

responsible for supporting care coordination case audits and real-time case consultations to support collaboration around complex high-need members.

- Outcome Measures:
    - Pay providers for medical home services and incentivize increased value and alignment with the goals of the ACC.
        - Goal: CCHA will review its incentive program measures on an annual basis and update as needed.
        - Update: CCHA's Provider Incentive Program was updated to focus exclusively on KPI performance for Accountable Care Network providers and KPI performance plus ongoing performance improvement activities for primary care medical providers.

SFY23-24 Goals

CCHA is committed to quality in the services we provide to the community and will track the following metrics to evaluate efforts and identify opportunities for improvement.

- Process Measures:
    - Educate and support providers during the Public Health Emergency (PHE) Continuous Coverage Unwind process to support continuous enrollment of both providers and members, and preserve continuity of care.
        - Goal: Monitor network capacity as the PHE Continuous Coverage Unwind continues and providers experience fluctuations in attribution. Adjust practice support services as needed, including assessing communications, technical assistance and financial models to support continuity during this transition.

- Outcome Measures:
    - Pay providers for medical home services and incentivize increased value and alignment with the goals of the ACC.
        - Goal: CCHA will review its incentive program measures on an annual basis and update as needed.

TOTAL PRACTICES OR AGENCIES ELIGIBLE FOR ARRANGEMENT PROGRAM					TOTAL NUMBER OF PRACTICE SITES: 137			
Type of Arrangement	**Arrangement Description**	**PMPM ($)**	**KPI ($)**	**Performance Pool ($)**	**Number of Participating Practice Sites**	**Percentage of Total Practice Sites**	**Eligibility requirements for practice participation**	**Additional Comments**
Tiered administrative per-member per-month (PMPM) payment for non-utilizers	All PCMPs receive a $0 PMPM for non-utilizers, members with no claims history within the previous 18 months of continuous enrollment and who are not identified as complex priority	$0.00			137	100.00%	Must be a PCMP contracted with the RAE	
Tiered Level 1 administrative PMPM payment for engaged members	Level 1 PCMPs receive a $1 PMPM for engaged members who have claims history within the previous 18 months and are not identified as complex priority	$1.00			75	54.7%	Must be a PCMP contracted with the RAE	
Tiered Level 1 administrative PMPM payment for complex priority members	Level 1 PCMPs receive a $3 PMPM for all complex priority members	$3.00			75	54.7%	Must be a PCMP contracted with the RAE	

Tiered Level 2 administrative PMPM payment for engaged members	Level 2 PCMP+ practices receive a $3 PMPM for engaged members who have claims history within the previous 18 months and are not identified as complex priority	$3.00			46	33.57%	Must be a PCMP+ provider contracted with the RAE	PCMP+ providers are qualified for Level 2 payments based on enhanced practice services that address chronic and/or complex conditions.
Tiered Level 2 administrative PMPM payment for complex priority members	Level 2 PCMP+ practices receive a $6 PMPM for all complex priority members	$6.00			46	33.57%	Must be a PCMP+ provider contracted with the RAE	PCMP+ providers are qualified for Level 2 payments based on enhanced practice services that address chronic and/or complex conditions.
Tiered Level 3 administrative PMPM payment for engaged members	Level 3 Accountable Care Network (ACN) providers receive a $6.50 PMPM for engaged members who have claims history within the previous 18 months and are not identified as complex priority	$6.50			16	11.67%	Must be an ACN provider contracted with the RAE	ACNs are qualified providers delegated by CCHA to fulfill the responsibilities of care coordination and population health management for their assigned members.

Tiered Level 3 administrative PMPM payment for complex priority members	Level 3 Accountable Care Network (ACN) providers receive a $9 PMPM for all complex priority members	$9.00			16	11.67%	Must be an ACN provider contracted with the RAE	ACNs are qualified providers delegated by CCHA to fulfill the responsibilities of care coordination and population health management for their assigned members.

KPI Incentive Program	Using incentive payments CCHA earns for achieving KPI Tier 1 or Tier 2 goals, CCHA will distribute 75% of earnings to providers and 25% to community partners through CCHA's PIAC.	$0.00	Total funds change from quarter to quarter		Number of providers and community partners changes from quarter to quarter		Must be contracted with CCHA and actively engaged with CCHA initiatives as defined in the performance goals. Practice must have 300 or more CCHA members averaged per quarter by location identification (ID) or be located in rural community. Community partner must participate in the PIAC.	

Performance Pool Fund	Using incentive payments CCHA earns for meeting performance pool metric requirements, CCHA will distribute funds to network and community partners to support the goals outlined in the performance pool deliverables.			Total funds to be determined	Number of providers and community partners will be dependent on the amount earned from HCPF		Must be contracted with CCHA and actively engaged with CCHA initiatives as defined in the performance goals; or otherwise enter into an MOU with CCHA to complete a formalized scope of work.	