COLORADO
Department of Health Care Policy & Financing

Annual Practice Support, Transformation and Communication Report
Instructions and Narrative Report

RAE Name	Colorado Community Health Alliance
RAE Region #	7
Reporting Period	SFY23-24
Date Submitted	July 22, 2024
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Purpose: Regional Accountable Entities (RAEs) are responsible for improving health outcomes and increasing value in their respective regions through supporting their Provider Networks. As part of that responsibility, RAEs are required to maintain necessary communications with network providers and provide them practice support and transformation.

Instructions: In the narrative section below please concretely describe your achievements/successes, challenges, and any plans for change in strategy relative to:

- the types of information and administrative, data & technology **support** and trainings provided to network providers, including promoting the use of telehealth solutions and the Dept.-adopted eConsult platform (once adopted);
- the practice **transformation**, to advance the Whole-Person Framework and to implement the Population Management Strategy, provided to network providers; and
- your **communication**, both proactive and responsive, with network providers and other health neighborhood partners as dictated by section 3.9.2 of the contract and other oversight entities, as well as promoting communication among network providers.

RAEs may attach samples of communications and/or hyperlinks to online communications.

Practice Support:

Achievements/Successes

Throughout state fiscal year 2023-2024 (SFY23-24), Colorado Community Health Alliance (CCHA) successfully implemented its practice support strategies as outlined in the Network Management Strategic Plan. Leveraging the multidisciplinary team, CCHA collaborated with primary care and behavioral health (BH) providers in numerous ways, with the vision of aligning providers to the goals of the Accountable Care Collaborative (ACC) program and implementing initiatives to help providers increase their capacity and quality of services provided to Health First Colorado members. CCHA promotes network development and provides ongoing support to practices to ensure the provider network can effectively meet the needs of our enrolled Health First Colorado members. As outlined in our Network Management Strategic Plan, CCHA's practice support team, comprised of network managers, practice transformation coaches (PTCs), population health, care coordinators, community health strategists, and informaticists, functioned as an aligned team in SFY23-24 to operationalize CCHA's strategies for practice support and transformation. Strategies included collaborating with the provider network on Key Performance Indicator (KPI) measures, Behavioral Health Incentive Program (BHIP) measures, and other performance improvement initiatives. Highlights from SFY23-24 include:

- KPI Strategies – CCHA distributed all earned KPI funds to network providers and community partners in SFY23-24.
    - CCHA's Provider Incentive Program was focused exclusively on KPI performance for Accountable Care Network (ACN) providers and KPI performance plus ongoing performance improvement activities for primary care medical providers (PCMPs).
    - CCHA created KPI visualization and member-level reports for PTCs to use with PCMPs, which are more actionable for targeted KPI improvement efforts
    - PTCs collaborated with high-volume practices to help providers focus on promoting well visits and re-engaging members who missed appointments.
    - CCHA assessed practices to understand depression screening use, billing, and workflows to determine how best to support practices in improving this measure moving forward and identify opportunities around education of proper coding.
    - CCHA continues working with the Department of Health Care Policy and Financing (HCPF) and ACN practices to understand how KPIs are calculated and where there are calculation disparities (particularly with well visits).
- BHIP Strategies – CCHA distributed $2.62 million to BH providers for quality metric performance and community incentive projects.
    - CCHA continued to expand the Behavioral Health Quality Incentive Program to providers to improve outcomes on pre-established regional performance targets, such as discharge from psychiatric inpatient placement, and engagement in substance use disorder (SUD) treatment. Incentive payments are offered to reward high-performing providers for their contributions in meeting or exceeding benchmarks on measures.
    - CCHA maintained the Behavioral Health Facility Incentive Program to improve outcomes on discharge from inpatient placement and reduce hospital readmissions.
    - Practice transformation coaches collaborated with high-volume BH providers to understand measurement benchmarks and improve performance.

CCHA continues to serve as a central point of contact for network providers regarding Medicaid services and programs and other regional resources that are available to members. Offering robust services, including general information, administrative support, training, data systems and technology support, and practice transformation, CCHA staff collaborate with providers in a variety of ways. Further, CCHA has established mechanisms to align priorities among the network via our administrative payment model and various incentive programs that encourage collaboration with the network.

Tools and Resources

- Practice support team – The diverse roles that make up CCHA's practice support team, including network manager, PTCs, population health, care coordinators, community health strategists and informaticists, continued to serve as trusted resources for our network providers.
- Provider Portal – CCHA continues using our provider portal to share data securely with physical health (PH) providers and to allow them to pull their own data at their convenience.
- Secure File Transfer Protocol (SFTP) – CCHA provides an SFTP connection for faster distribution of health data to notify attributed behavioral health care coordinators/providers of relevant information on members' clinical care and service level utilization including data regarding redetermination of eligibility during the Public Health Emergency (PHE) Unwind.
- PowerBI – CCHA utilizes this software to create data visualizations and reports to support practices in quality improvement (QI) meetings and internally to drive program and initiative performance based on member and population health needs.
- Availity – As CCHA's Designated Electronic Data Interchange (EDI) Gateway, Availity allows BH providers to submit applications for network participation, submit demographic change requests, upload rosters, verify member's eligibility and benefits, submit authorization requests, share supporting documentation, verify claims status and payment information efficiently, conveniently and securely.
- Find Help – CCHA offers a social determinant of health (SDOH) resource search engine to BH providers through CCHA's Find Help Community Resource Link. Providers can assess SDOH needs, search for resources and submit referrals for community-based organizations through the CCHA Find Help site.
- Communication Resources – Including comprehensive website resources, printed materials, and targeted special bulletins, CCHA offers a broad array of communication resources to network providers, as further detailed in our Communication Plan.
- Care Coordination Programs and Referrals – CCHA continues to incentivize practices to develop their own evidence-based programs to support population health management for their attributed members. This is supplemented by CCHA's care coordination programs. Providers submit referrals to CCHA to facilitate additional support to help meet member needs and fill gaps.

In addition to offering a variety of tools and resources to network providers, CCHA works to receive continual feedback regarding areas of need/opportunities for CCHA to better serve network providers. In SFY23-24, CCHA conducted the annual BH provider satisfaction survey. Notable highlights include:

- Statistically significant improvement in overall satisfaction, increasing 'Very Satisfied' or 'Satisfied' responses by 38.9% since 2021 when the survey was initially conducted.
- Statistically significant improvement in provider enrollment, increasing 'Very Satisfied' or 'Satisfied' responses by 24.6% since 2021.
- Statistically significant improvement in all dimensions of care coordination – timeliness, accuracy, information clarity and information sufficiency – increasing 'Very Satisfied' or 'Satisfied' responses by 24.6% since 2021.
- A new measure for SFY23-24, compared to the other health plans serving Medicaid in Colorado, providers ranked CCHA as follows: 27% say Top Performer and 88.7% say Top Performer or average performer.

CCHA is encouraged by these year-over-year positive responses and will continue striving for improvements in provider satisfaction. Further, CCHA launched its inaugural PCMP and Community Partner survey in May 2023 to assess satisfaction in working with CCHA. CCHA used the results to identify opportunities to improve our operations, enhance provider satisfaction, and inform future strategies. For instance, we enhanced our provider onboarding process and provider portal training to better track staff turnover and ensure new practice staff know how to access and use available reports to support population management for their attributed members.

In SFY23-24, CCHA provided informational and administrative practice support to the network covering a broad range of priority areas for the State, including:

- Public Health Emergency (PHE) Continuous Coverage Unwind (CCU) Support – CCHA developed a user guide with timeline information to educate network providers about the member redetermination process. To further support identifying members, the monthly roster files shared with all physical health network providers include member redetermination dates, and other information used to support this process. Providers received a guide on how they can utilize the additional data to help engage members. CCHA also created a script for PCMPs to use in patient portal messaging, on the phone and in-office to help direct members to appropriate community resources to renew or reapply for Medicaid benefits if necessary. PTCs escalated specific members for review with our partners at the Boulder Department of Health and Human Services to seek guidance on what is needed to support the member's case through the renewal process. In Region 7, Peak Vista, one of our ACN providers, received 2023 Community Incentive Program (CIP) funding to support direct member CCU outreach.
- Provider Revalidation – As part of ongoing efforts to support providers in revalidation processes, CCHA includes revalidation information in monthly provider newsletters to help them 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. CCHA also has an internal workflow for supporting providers who request direct assistance with understanding the revalidation process and status of their revalidation application, which helps prevent unnecessary lapses in enrollment.
- Telehealth Policy Updates – CCHA continues to support the use of telemedicine to deliver quality behavioral health services. Providers can bill procedure codes that are eligible to bill per their contract or outlined in the Telemedicine Services Exception Code Appendix. Information about the continuation of the expanded definition of

telemedicine, inclusive of telephone-only and live chat modalities, and billing/coding guidance is posted to the CCHA website and is periodically communicated in newsletters and bulletins.

- Customer Service & Provider Inquiry Response Time – In a continual effort to improve customer service experience, CCHA prioritized implementing new contract requirements outlining a two-day turnaround response time for provider inquiries. Over this year, CCHA has implemented tracking on this requirement and continues to report outcomes through our Call Line Statistics report.
- Provider Orientation – Network manager continues to offer orientation to newly contracted PCMP providers, offering information on topics such as the CCHA Provider Portal, including a demonstration and training on how to pull member reports, financial reports, how to submit care coordination referrals, ordering materials, etc. CCHA also offers BH provider orientation, a provider education series, and Open Mic sessions that support onboarding BH providers and sharing current Medicaid information.
- Provider Information – Maintaining provider information to support providing the most up-to-date information for CCHA's Find A Provider tool. CCHA frequently reminds providers to keep their information updated via our provider newsletters. Additionally, staff continue to conduct the annual Office Systems Review (OSR) process for the PCMP network to maintain updated information, which also allows providers to voluntarily include information about practitioners' race/ethnicity and any special populations they serve (such as transgender, people with disabilities, minorities, shared race or ethnicity, human immunodeficiency virus (HIV) positive, obesity, SUD, high-risk pregnancy, non-English speakers, etc.).
- eConsult – CCHA engaged the provider network to learn about and encourage adoption of the eConsult platform ahead of the February 2024 go-live date. Efforts proved successful as a PCMP provider within CCHA's network was the first Health First Colorado provider to use the State-designated platform. CCHA also initiated plans in collaboration with Safety Net Connect, the State's eConsult vendor, to further promote use of the eConsult platform and to ensure interested providers are supported with educational and technical resources to meet their needs.

Provider education remains a priority for CCHA to ensure accurate and relevant information is shared with network providers, particularly as the state and national landscape has changed throughout the COVID-19 pandemic and the PHE Continuous Coverage Unwind. During SFY23-24, CCHA distributed educational materials and training to providers on an ongoing basis through various channels, including the CCHA website, print communications (provider manuals, newsletters, etc.), virtual trainings (such as recorded webinars), provider orientations and open forums, email blasts, and the CCHA Provider Portal. CCHA offered education and trainings on a wide range of topics this year, outlined below.

- Disability & cultural competency trainings – CCHA provides various cultural competency trainings and resources on our website, including the Caring for Diverse Populations Toolkit, My Diverse Patients Training site, Lesbian, Gay, Bisexual, Transgender (LGBT) terminology and pronoun guides, and LGBT Hotline information. This information is regularly promoted in our provider newsletter and behavioral health bulletin. Additionally, CCHA hosted a live webinar, "Under The Skin: The Hidden Toll of Racism on American Lives and on the Health of Our Nation," which was open to all staff and providers and required for practices eligible for PCMP Incentive Program participation.

Overall, the live webinar was attended by more than 350 representatives from our provider network and CCHA staff, and the recorded webinar continues to be available on demand.

- Health First Colorado Provider Academy – CCHA promotes training on a variety of topics as part of the Health First Colorado Provider Academy, which is highlighted in our provider newsletter and includes a monthly feature on various provider trainings and resources related to member care. Topics included:
    - Medicaid Benefits and Services (including an overview webinar, detail on dental benefits, Health First Colorado Nurse Advice Line, highlights on benefit changes such as family planning benefit expansion, Supplemental Nutrition Assistance Program (SNAP) benefit updates, etc.)
    - Chronic Pain Centers of Excellence Opioid Education Trainings for Primary Care Providers (PCPs)
    - Free Screening, Brief Intervention and Referral to Treatment (SBIRT) Training
    - BH Roster Automation Template and Rules of Engagement Training
    - Envision: You – a training grant program for BH providers working with lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) individuals
    - Training and Technical Assistance (TTA) Program
    - Treatment Approaches for Pregnant Persons with Opioid Use Disorder
    - Co-Occurring Treatment
    - HCPF Office Hours
    - Crisis Professional Curriculum Modules in the Behavioral Health Administration's (BHA) OwnPath Learning Hub
    - Extension for Community Health Outcomes (ECHO) Colorado – Newcomer Health Series
    - My Diverse Patients
    - Grievances and Appeals
    - Colorado Medicaid Standards for Unlicensed Practitioners Policy
    - Access to Care Standard Requirements
    - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) webinar training
    - Caring for Diverse Populations Toolkit
    - My Inclusive Practice – Improving Care for LGBTQIA+ Patients
    - Thriving Not Just Surviving: Youth Mental Health in Today's World
    - Thriving Not Just Surviving: Navigating Challenging Times as a Clinician
    - Department of Health and Human Services (HHS) Cultural Competency Trainings
    - Question, Persuade, Refer (QPR) Suicide Prevention Gatekeeper Training
    - Advance Care Planning
- BH Provider Education Series – CCHA implemented engagement and training opportunities for BH providers in SFY23-24, including:
    - BH Provider Education Series – Focusing on a specific topic each month (including Availity Tools and Overview, coding manual changes, chart documentation standards, claims billing errors, and BH provider manual review), CCHA staff provide up-to-date information on current initiatives, changing policies/programs and other topics as requested.
    - Open Mic Sessions – Offering 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.
    - To make our resources more accessible, we combined our Open Mic series and Provider Education sessions starting in April. This combined approach helps us provide education more efficiently and effectively while receiving valuable provider input.
- BH Provider Bulletin – Continued to publish this monthly communication resource to provide 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.

In SFY23-24, CCHA also leveraged the previously outlined outreach strategies to engage and train the BH network on new initiatives and changes to policies that impact the network. Topics included:

- Member Co-pay Reduction
- Directed Payments Fee Schedule
- Member Dismissal Policy for BH Providers
- Autism Spectrum Disorder Coverage Clarification
- Interim Billing for Hospitals with Long-Term Stays Clarification
- Updated Clinical Practice Guidelines
- Important Billing Changes Effective January 1, 2024
- New Specialty Types for SUD
- Neuro/Psychological Testing Policy Change
- Updated Milliman Care Guidelines (MCG)

Challenges

There were several key events this year that significantly impacted network providers' ability to collaborate in new/additional initiatives. Workforce shortages and high turnover rates that have materialized throughout the COVID-19 pandemic continue to affect the provider network's ability to focus on continuous quality improvement initiatives. This is further compounded by significant decreases in the volume of members resulting from the Continuous Coverage Unwind, which has reduced providers' per-member, per-month payments and exacerbated financial strain among providers. Finally, known statewide gaps in specialized programming across the state such as BH respite, adolescent SUD, residential treatment center (RTC), and eating disorder services continue to have an impact on the network. While we continue to work to address these challenges through initiatives such as the PHE CCU and the High Intensity Outpatient Services Program (HIOP) expansion, CCHA recognizes the impact these events had on the network over the course of this fiscal year.

Plans for Change in Strategy

Based on the above accomplishments, CCHA is encouraged that our foundational strategies for supporting our provider network are successful to help ensure effective care delivery, meet member needs, reduce barriers and duplication, and furthering progress to achieve ACC goals and performance. As the healthcare landscape continues to shift, CCHA will continue to evolve its strategies to achieve these goals. Planned practice support strategy shifts for SFY24-25 include:

- CCHA plans to distribute its annual PCMP and Community Partner Satisfaction Survey in the fall to assess strengths and identify opportunities to improve our operations, enhance provider satisfaction, and adapt future strategies.
- CCHA will leverage Performance Pool funding to increase practice engagement and use of the State eConsult platform.
- CCHA will structure our strategies to support the evaluation, development, and execution of practice support activities and resources needed for transitioning to ACC 3.0.

Practice Transformation:

Achievements/Successes

CCHA's practice transformation efforts align with the goals of the ACC to enhance the region's capacity to offer comprehensive Medical Home services and increase the utilization of wellness and preventive services among Health First Colorado members to ultimately improve health outcomes and reduce costs. CCHA PTCs help carry out strategies that support network participation in value-based programs and State initiatives such as Alternative Payment Models (APMs) and use of the eConsult platform by engaging practices in training, providing educational resources/tools, and facilitating change management activities. These practice transformation efforts aim for continuous improvement among the network as the ACC evolves with more focus on value-based care.

Provider Financial Support and Incentives

CCHA offered financial support and incentive programs in SFY23-24 to further incent the goals of the ACC, continuing to tailor programs to the evolving needs/priorities of our local communities and the State. Specifically, CCHA distributed funds through the following initiatives:

Tiered Payment Model (PCMPs)
CCHA maintained the tiered payment model for PCMPs for SFY23-24, as aligned with CCHA's Population Management Framework. Through this model, CCHA distributed enhanced funding and resources to aid PCMPs who care for our most complex members and further incentivized providers who offer condition management programming on select conditions. Providers who are contracted at Level 2 (referred to as PCMP+) offer condition management programs to establish more referral relationships with relevant specialists/PCMPs. Level 3 (ACN) providers receive an additional rate to also provide care coordination services to delegated members. In SFY23-24, CCHA had 27 of PCMP+ (Level 2) providers and recruited additional qualified Level 1 practices to contract at the higher level. CCHA completed PCMP contracting for SFY24-25; 28 PCMP practices will participate in the Region 7 network as PCMP+ providers beginning July 1, 2024. All ACN providers will also continue as Level 3.

PCMP Incentive Program
CCHA remains committed to distributing 75% of earned KPI incentive dollars back to PCMPs through the PCMP Incentive Program (the remaining 25% is distributed to community partners or providers through the Community Incentive Program described below). Provider performance is weighted across categories for practice transformation, key performance indicators and cost

and utilization. PCMPs with attribution of 300 members or greater and rural providers are eligible for CCHA's incentive program.

- In SFY23-24, CCHA paid $2,099,574.85 in incentives to practices in Region 7.
- In alignment with our commitment to promoting health equity, CCHA included a requirement that providers attend/view the recording of CCHA's diversity, equity, and inclusion (DEI) webinar, "Under The Skin: The Hidden Toll of Racism on American Lives and on the Health of our Nation," in February to be eligible for KPI incentive payments for the rest of the calendar year.
- To encourage providers to remain focused on well care and prevention as the healthcare field transitions away from PHE operations, CCHA carried forward elements in the PCMP Incentive Program in calendar year (CY) 2024 to allocate more dollars to KPI performance.
- CCHA updated the program this year to coach practices with 500 or more attributed members. Practices with attribution between 300-500 members are supported by our Clinical Outcomes and Performance Care Coordination team.

BH Quality Provider Incentive Program (BHQIP)
CCHA has implemented the BHQIP, which provides incentives to eligible BH network providers to support quality care and service to its Medicaid members with BH needs. Centered around improving clinical quality indicators and health outcomes, and a focus on prevention and appropriate follow-up, the BHQIP creates efficiencies, reduces inappropriate utilization, and increases the value of services. Providers participating in the program who meet pre-determined quality, service, and utilization goals are eligible to receive incentive payments annually.

BH Facility Incentive Program (BHFIP)
In CY2024, CCHA continued the Behavioral Health Facility Incentive Program, with participation from seven hospitals with value-based quality metrics on readmission rates and outpatient follow-up.

Through May 2024, CCHA distributed $2.62 million in incentive payments to providers and community partners in both regions based on performance, leveraging earned BHIP dollars from the State. Distributions included:

- $818,420 distributed to incentivize integrated behavioral health and increase rates of depression screening.
- CCHA further expanded BH incentive programs and enrolled 50 providers in the BHQIP and BHFIP for CY2024.

High Intensity Outpatient Services Program (HIOP)
In support of Senate Bill (SB) 19-222 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.

- 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, Adaptation and Development after Persecution

and Trauma (ADAPT), Trauma Systems Therapy (TST), Functional Family Therapy (FFT).

- Eleven behavioral health providers were selected to receive a total of $2 million in in the first-round distribution of High Intensity Outpatient Program funding.
- CCHA received an additional $1.714 million in funding for each region in a second round of distribution for the High Intensity Outpatient Program. New awardees were chosen to support expansion of services to youth & families, rural, and diverse populations.
- A total of $7,094,000 has been disbursed to 31 providers in Region 6 and Region 7 to support the expansion of High Intensity Outpatient Services.
- CCHA's Practice Transformation Coaches have been instrumental in providing guidance, support, and training to grantees. The PTCs have provided one-on-one education, online tools, and resources to help providers succeed with these projects. They have also assisted providers in linking members to CCHA care coordinators as needed.
- Six new providers were recruited and contracted to the CCHA behavioral health provider network to deliver High Intensity Outpatient services.

Community Incentive Program (CIP)

Established to fund innovative projects that address high-priority community and member needs, CCHA's CIP re-invests 25% of earned KPI funding for innovative services and supports beyond what is covered by Health First Colorado benefits or to support organizations with starting a new resource or service. For 2023 and 2024, CIP focus areas included PHE unwind activities, DEI activities, behavioral and physical health access, supports and services for children and families, and SDOH.

- In CY2023, CCHA distributed $2.9 million across both regions to 21 entities in Region 6 and 19 entities in Region 7 to fund unique projects. Key themes of the work included Continuous Coverage Unwind outreach, education and support, education and training to expand the healthcare workforce, behavioral health resources and referrals, and supporting members to address social determinants of health needs.
- In CY2024, CCHA is projected to award $1.3 million to ten entities in Region 6 and eight entities in Region 7. Awardees include:
    - Ascending to Health Respite Care is using funding to support a step-down recuperative program for recently discharged members experiencing homelessness.
    - Colorado Springs Fire Department's Community and Public Health Division is using funding to bolster its Transition Assistance Program for individuals experiencing homelessness and substance use disorders and/or BH needs upon release from jail as they re-enter the community.

CCHA Member Incentive Program

In SFY23-24, CCHA launched a re-design of the Healthy Rewards Member Incentive Program. This program will continue through SFY24-25, where members can earn financial incentives for completing health care services, including prenatal and postpartum visits, well-child checks, and behavioral health seven-day follow-up visits after mental health (MH) inpatient hospitalization and emergency department (ED) visits for MH or SUD. Our provider network and care coordinators will support member enrollment in the Healthy Rewards site, and members can order a gift card of their choosing for the incentives they earn. Through this program, along

with practice transformation support and other improvement efforts, we strive to improve member engagement in their health with their PCMP or BH providers.

Practice Transformation Coaching

In alignment with our incentive programs, CCHA practice transformation coaches work directly with practices to continue quality improvement activities among the physical and behavioral health networks. PTCs work with practices by sharing QI tools, aiding in establishing QI teams, and supporting them to meet ACC initiatives, such as understanding and participating in the APM and meeting the KPI and BHIP performance metrics. Highlights of CCHA's SFY23-24 coaching activities include:

Primary Care Medical Provider (PCMP) Network:

- Performance Improvement – PTCs continued monthly QI meetings with coached practices to discuss practice initiatives and establish workflows, review performance, and maintain practice information. To encourage PCMP network providers to focus on well-care and prevention as the health care field transitions away from PHE operations, the CY2024 PCMP Incentive Program is focused on KPI performance and, for practices working with a PTC, QI activities. Further, CCHA facilitated QI meetings with several PCMP practices this year across Regions 6 and 7.
- KPI Performance and Strategies – Given trends in KPI performance and challenges meeting the pre-established targets as set by HCPF, CCHA PTCs prioritized KPI performance with practices over the course of this SFY, focusing collaborations on high-volume providers and helping practices brainstorm and implement strategies for continued improvement. While CCHA continued to struggle achieving the established performance targets for many KPIs this year, coaches achieved great success in the following collaborations:
    - Depression Screening – CCHA assessed practices to understand depression screening use, billing, and workflows to understand how best to support practices in improving this measure moving forward and identified opportunities around education of proper coding.
    - KPI Reports – As previously mentioned, CCHA created KPI visualization and member-level reports for PTCs to use with PCMPs, which are more actionable for targeted KPI improvement efforts. Additionally, CCHA streamlined KPI project tracking internally, so the PTC team can review progress on all KPI projects and use results for annual planning/where to focus efforts with practices.
    - Behavioral Integration Grant – Several CCHA practices were selected to participate in the BH Integration Grant. PTCs began working with those practices on integration goals and documenting progress on their efforts, using training and resource tools offered by the State.
    - Oral Evaluation and Dental Services – PTCs collaborated with several practices to conduct Plan-Do-Study-Act (PDSA) cycles for improving dental screenings and services. In Region 7, PTCs identified a new dental partner that is actively supporting engagement with a pediatric PCMP next door. This partnership is exploring how the two can use a shared scheduling system to support scheduling dental appointments directly before or after the well-child check occurs. The goals of this collaboration are to improve well visit and oral evaluation KPI

performance and reduce the burden on families to get their children seen at multiple office visits.
    - Child and Adolescent Well Visits and Vaccinations – created actionable member-level report for members 0-30 months to help providers identify members that are "on track" to meet the measure and members where action is needed. It focuses their efforts and makes member-level data more approachable. Some practices have created templates for outreach, are testing recall systems and gearing up for additional engagement opportunities this summer. Further, coaches are supporting practices in connecting to Vaccines for Children (VFC) program workflows. PTCs participated in a statewide COVID-19 vaccination collaborative, brainstorming how to use state data around all vaccines.
- Care Coordination Referrals – PTCs continued to educate practices on CCHA's care coordination services and process for referring complex high-need members to CCHA. CCHA has targeted select high-volume PCMPs to increase referrals and bi-directional communication.
- Alternative Payment Model – In Q2, CCHA collaborated with Contexture (the regional health information exchange) for 2023 APM data and supporting practices in completing their 2023 attestations for structural measures. In Q3, coaches worked with practices to select measures for the 2024 APM. PTCs continue to support practices around APM related quality improvement, including sharing data and facilitating tracking any workflow changes. Additionally, PTCs provided education to PCMPs around opportunities to participate in APM2 and changes related to the prescriber tool APM.
- Network Adequacy Monitoring – PTCs and network manager continued ongoing network adequacy monitoring tasks, including completing the annual Office Systems Review (OSR) tool to maintain current provider information including whether the provider is accepting new Medicaid members. Additionally, PTCs and network manager complete appointment timeliness assessments among the network, as collected through the Third Next Available Appointment (3NA) process.
- Health Equity Collaborations – CCHA's cross-department health equity group, comprised of PTCs, population health, community health strategist, and care coordination staff, among others, continued engaging network providers in identifying local health equity gaps, underlying causes and potential interventions. For example, we held discussions with local ACNs and PCMPs representing diverse backgrounds to learn about current DEI initiatives, best practices, cultural awareness and responsiveness, gaps in care, and how CCHA can align and support these efforts.

<u>Behavioral Health (BH) Network:</u>

- BH Coaching – CCHA BH Practice Transformation Coaches (PTCs) advanced our transformation efforts across the provider network. Coaches supported a total of 139 behavioral health practices this year, with 69 in Region 7, helping to resolve claims processing issues, improve quality metric performance and develop improvement projects for the High Intensity Outpatient Program.
- 411 audit – Provided all 182 providers who participated in this audit with a scorecard with their specific results to help promote ongoing improvements in the accuracy of encounter data and audit submissions. Educational materials outlining standards, common errors and a Self-Audit checklist were distributed to guide providers on

recommended corrections. A Provider Education Series presentation was held to review results and findings with providers and further support improvement efforts.

- Expanding high intensity outpatient services to youth, adults and families in Region 7 to distribute funding to partners targeting expansion of High-Fidelity Wraparound, BH respite, eating disorder treatment, neurofeedback, SUD and BH Intensive Outpatient Program (IOP), trauma treatment, and mobile response unit. Through the High Intensity Outpatient Scope of Work (SOW), CCHA received State approval to award two rounds of funding to provide a wide array of services for CCHA members. There are currently ten robust projects supporting intensive outpatient services to youth and families including Kids Crossing, Dale House Project, Palome, Patterson Center for Resiliency, Consultants for Children, Collective Health Partners, Peak Vista, Center for Secure Attachment, Animal Assisted Therapy, and Special Kids Special Families. ED Care will provide eating disorder treatment; Crisalida and Bright Space are working with diverse populations; Bloom Wellness and Conifer Counseling are serving rural populations; Diversus Health, Sunrise Counseling and Recovery Unlimited are providing SUD services.
- Performance Improvement Projects (PIP) – CCHA partnered with Community Mental Health Centers (CMHCs) on PIPs to define and enhance clinical pathways to support members' transition out of psychiatric inpatient placement and facilitate timely access to outpatient behavioral health aftercare. Data and performance analysis are currently underway to inform the SFY24-25 PIP strategy.
- CMHC Collaboration Meetings – Staff continued to collaborate with Carelon and the CMHC on an ongoing basis, at least quarterly, to enhance coordination among the crisis system, with a focus on improving collaboration, communication, data sharing, etc.
- BHIP Quality Improvement SFY2023 – CCHA achieved benchmark improvements for one of five measures. CCHA is reviewing performance details to determine disbursement and working with the State to calibrate incentive measure performance calculations.

Population Health & Condition Management Activities

As described in detail in the SFY23-24 Population Management Strategic Plan, CCHA's Population Management Program is built upon understanding the populations served, aligning interventions to meet members' needs, supporting providers, and forming strong community partnerships. Further, CCHA applies feedback from the Program Improvement Advisory Committee (PIAC) to develop, evaluate, and modify CCHA's population health interventions.

Throughout SFY23-24, CCHA's teams provided diverse methods of support to drive population health strategies among our provider network. Highlights include:

- Care Coordination - CCHA continues to use its member referral workflow to clearly outline timelines and communication expectations for staff, network providers and community partners when sending or receiving referrals to CCHA to support timely communication of member needs.
- Data sharing - CCHA shared member-level data with network providers to help practices prioritize members. Shared data includes elements such as:
    - Member stratification, including detailed data and complex member lists to practices to support identifying their complex high-need and high-cost members who may benefit from care coordination and wrap-around services or refer them to CCHA for care coordination
    - Member demographic information

  - Pass/fail status for HCPF KPIs
  - Last A1c reading, if available
  - Less than one visit per year with their PCMP
  - Members with recent hospitalization or emergency department utilization, including those who received care for a mental health condition
  - Medicaid renewal date
- Referrals to Community Partners - CCHA continues working with providers and the broader health neighborhood and community to identify existing programs and collaborations to promote connecting members to needed services to support whole-person health.
  - CCHA partners with different community organizations to expand the types of resources/programs available and offer linkages for members to help address SDOH. For example, CCHA continues to partner with Project Angel Heart (PAH) to offer medically tailored meals to members with diabetes who discharge from the hospital. This program aims to reduce readmission and ensure members have access to nutritious meals tailored to their condition. Our analysis indicates great success at reducing health care costs for members receiving this support, and we expanded the program to include high-risk maternity members and their dependents.
- Health Equity - CCHA developed and implemented our Health Equity Plan to formalize strategies to improve health equity in four focus areas: COVID-19, Maternity, Behavioral Health and Wellness/Prevention. Our interventions are designed to leverage resources at the member, provider, community organization, and staff levels to produce both immediate and long-term results to reduce identified health disparities for our members.

CCHA works to improve member health outcomes by developing and evaluating evidence-based interventions and programs to support condition management for complex members, diabetes, and maternity. In addition, CCHA continues to leverage the expertise of its provider network, referral relationships with the health neighborhood and community, and its person-centered care coordination model as a multi-prong approach to helping members manage their health.

- **Complex:** CCHA's complex member definition and stratification process remained stable for SFY23-24, as initially implemented in the fall of 2021. CCHA continues to collaborate among the network regarding our most complex high-need members, encouraging referrals and collaborative complex case reviews where indicated. CCHA delegates outreach and care coordination to ACNs (Level 3) for their attributed members, and Case Management Agencies (CMAs, formerly Single Entry Points (SEPs) and Community Centered Boards (CCBs)) support outreach and care plan development to shared complex members. Specifically, CCHA works with the entities to share monthly stratified member lists, standardize workflows, and establish bi-directional communication expectations for collaboration around complex members. Entities are reporting outcomes of care coordination activities to CCHA, allowing CCHA to maintain oversight through quarterly monitoring. CCHA has provided ongoing education to these entities and regularly hosts complex member case reviews to provide coordinated resources and reduce duplication regarding complex members who cross multiple systems.
- **Chronic Condition Management Program**: CCHA continued its chronic disease management program, which supports members with chronic conditions and provides enhanced condition management services to members experiencing a broader array of

conditions. In Q3, chronic disease management support was integrated into in all of our care coordination teams' processes, further improving our whole-person approach to care management.

- **Maternity:** Our strategy for outreaching high-risk pregnant women to help connect them to prenatal care, care coordination, and maternal-fetal medicine (MFM) specialists, when appropriate, remained ongoing. We continued to work with providers to increase access to perinatal services. Additionally, we partnered with organizations such as Elephant Circle and Colorado Community Doulas to provide doula services and other supports for our pregnant members to reduce disparities and improve outcomes.

CCHA recognizes that the provider network is the most effective at engaging members in managing their chronic conditions, as many members prefer receiving support at a place of service that they trust. Through CCHA's tiered payment methodology, CCHA continues to incentivize practices to develop their own evidence-based programs to support population health management for their attributed members. In alignment with HCPF's priority areas, CCHA's tiered payment model incentivizes practices to focus on members with diabetes, maternity, asthma, and complex needs, and encourages Level 2 and 3 providers who offer condition management programs to establish more referral relationships with relevant specialists and PCMPs who have expertise in a specific area, such as diabetes management, or obstetrics and gynecology (OB/GYN).

- To support standardized delivery of member experience and place of service access, CCHA conducted leadership meetings with each ACN monthly and as needed. The meetings facilitate strategy alignment with CCHA and ACN providers to meet members' care coordination needs and strengthen collaboration at various levels of our respective organizations.
- CCHA's external care coordination programs supervisor facilitates ongoing case consultation processes and provides clinical guidance and support to ACN providers regarding care coordination/management processes and improvement.

Update on SFY23-24 Practice Support & Transformation Goals

In our SFY23-24 Network Management Strategic Plan, we defined process and outcome goals to measure our continued commitment to quality. We are pleased to report the following progress.

- 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: CCHA aligned measurement of this goal with the quarterly PCMP Incentive Program performance, which determines whether practices earned a payment for that quarter by participating in two or more quality meetings. CCHA surpassed the goal for every quarter.

Quarter	Region 7 Performance
1	66.67%
2	61.67%
3	76.92%

4	72.72%

- 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.
  - Update: CCHA supported our PCMP network to learn about and encourage use of the eConsult platform that launched in February 2024. We're proud to report that one of our practices was the first in the state to use it. CCHA surveyed our provider network approximately four months after the eConsult launch and determined that 9.26% of providers either are in process or have already begun using the platform, and 51.85% of providers are interested in doing so. Full results are listed in the attached data spreadsheet. In May, CCHA submitted our eConsult Plan, outlining our strategies for engaging and incentivizing our PCMP network to incorporate the eConsult platform into their practice in partnership with the state vendor, Safety Net Connect (SNC). Our Plan was approved, and CCHA will continue to work with SNC to outreach and incentivize providers using the approved funding.
- Number of providers receiving behavioral health practice transformation coaching.
  - Goal: Increase number of BH providers receiving coaching by 10%.
  - Update: 139 providers received behavioral health practice transformation coaching support, an 8.15% increase from last year.
- Scorecard performance out of 100 points for providers who participate in Behavioral Health Incentive programs
  - Goal: Increase average scorecard performance in incentive programs by 5 points.
  - Update: Average scorecard performance for SFY23-24 was 40.1 of 100 points. In SFY22-23 the average performance was 49.7 of 100 points. This is a decrease in average scorecard performance of 19.9%. CCHA did not reach its performance coaching improvement goal. CCHA will explore what types of interventions are most successful in driving scorecard improvement and share with providers in coaching sessions during the next year.

- Outcome Measures[1]:
  - 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 SFY23-24 KPI Specification document.
    - Update: Per HCPF's payment reports, CCHA met this goal in Q1, meeting three KPIs, and surpassed in Q2, meeting four KPIs. CCHA expects to receive final numbers for Q3 in September and Q4 in December 2024.

[1] Claims-based metrics for Q3Q4 are underreported due to incomplete claims run-out at the time of submission of this report.

        - Goal: Achieve improvement benchmarks on three (3) Behavioral Health Incentive measures in SFY23-24.
        - Update: CCHA achieved benchmark improvements for one of the ten BHIP measures in SFY23.
    - 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.
        - Update: CCHA has been able to meet this measure, however only using supplemental data sets from the PCMPs. This indicates to us that depression screenings and follow-up are happening; however, the coding isn't working. CCHA continues to work with PCMPs to improve billing and coding processes to reflect the good work that is actually being done.
    - 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.
        - Update: In Q1Q2, 98.68% of members with chronic conditions who engaged in a CCHA condition management program were connected to healthcare services. In Q3Q4, that number remained steady at 98.45%.
    - 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.
        - Update: In Q1Q2, 30.59% of members with diabetes had at least one HbA1c test completed within the last year. In Q3Q4, performance is 32.21% to date. CCHA believes this does not accurately reflect true performance due to our limited access to laboratory data.
    - 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.
        - Update: CCHA did not achieve improvement goals for follow-up appointment within 7 days from discharge from inpatient placement in SFY23.
    - Number of members who receive a BH screening upon entering foster care
        - Goal: CCHA will achieve the improvement target as defined in the SFY23-24 BHIP Specification document.
        - Update: CCHA did not achieve improvement goals for BH screening within 30 days upon entering foster care in SFY23.

Challenges:

As noted above, various factors impacted the provider network this year including ongoing workforce shortages and decreased member attribution, which caused many providers to divert

focus and resources from well care and improvement efforts toward response to practice sustainability needs.

Network Access - CCHA continues to experience known gaps in certain BH specialty services such as adolescent residential treatment centers (RTCs), adolescent SUD, respite and eating disorder services, which impact the network's ability to connect members with needed services. CCHA's High Intensity Outpatient Program funding described above has helped to address this access, and CCHA staff continue to coordinate with members to find solutions through wraparound care. CCHA continues to explore options to enhance network capacity for specialized programming and address remaining gaps through transformation efforts.

Continuous Coverage Unwind (CCU) – Because many members disenrolled from Medicaid during the CCU, member attribution decreased significantly for many PCMPs, which resulted in reduced per-member, per-month payments. This created financial strain and has made it harder for practices to invest resources into engaging their Medicaid population or grow their processes to meet evolving needs related to KPIs or other VBP programs.

Data Challenges – Discrepancies between the KPI Specification Document and the Colorado Data Analytics Portal (CDAP) affected CCHA efforts to set appropriate PCMP Incentive Program goals among the network and reach KPI goals. This discrepancy was particularly impactful in Region 7 where the KPI Specification Document showed goals 10% lower than the CDAP, which ultimately led to missed incentives for the network as the CDAP target goals were unmet. To help prevent this moving forward, CCHA is working to understand and replicate CDAP calculations internally, which will help right-size incentive program targets; however, there continues to be a 4-7% difference between CCHA and CDAP calculations.

Limited Prenatal Services - For Prenatal Services in general (which directly impacts the Prenatal KPI), there are fewer OB/GYN providers accepting Medicaid members, and they have reported this is due to reimbursement rates dropping for Medicaid. We are also aware that some large health systems intend to close their OB/GYN clinics in the coming months due to financial constraints. This has put a major strain on the network and access to care for pregnant members. Members have been reporting that wait times can be four to six months for an obstetrical appointment, which is a major health risk and negatively impacts our KPI performance.

Plans for Change in Strategy:

As demonstrated in the above successes and achievements, CCHA has made significant strides towards advancing the Whole-Person Framework and implementing our population health strategies with our provider network. CCHA continues to evolve to meet the needs of our region and changing priorities, and plans to implement the following shifts in strategy:

- PCMP Incentive Program – CCHA will continue to align its incentive program with the State KPIs to drive performance rates among the network.
- High Intensity Outpatient Program – CCHA has distributed funding to the selected organizations to expand access to high intensity outpatient services in a community-based setting.

  - BH PTCs have been supporting awardees throughout the grant period to review deliverables and to ensure program goals to promote the expansion or development of high intensity outpatient BH services for members are being met.
  - CCHA will continue supporting awardees to develop sustainability plans for ongoing high intensity outpatient services beyond the grant period to fill the gap in service delivery for CCHA members.
- CCU Support – To help mitigate the effects of the challenges listed above related to the CCU, CCHA plans to use State-approved funding to support BH and PH providers to:
  - Help fund staff for outreach and one-on-one member eligibility support using a whole household approach to support members to complete their Medicaid renewal packets and maintain their benefits. This category of funding would be used to help compensate practices for after-hours/overtime that may be incurred to participate in training and conduct outreach with members.
  - Provide funding to help retain clinical providers, minimize staff turnover and prevent a reduction in hours of operations.
- Access Improvement - With the conclusion of the PHE Unwind, CCHA has established policies to maximize appropriate access to telehealth care and continues to analyze telehealth utilization and evaluate its role in increasing access. In SFY24-25, CCHA will explore options to expand telehealth utilization and how it could help increase timely access to behavioral health specialty care.

SFY24-25 Goals

Guided by our strategies outlined in this Plan, CCHA will track the following metrics in SFY24-25 to evaluate our efforts in Practice Support and Transformation.

- Process Measures:
  - Number of practices who participate in at least eight quality meetings annually
    - Goal: At least 50% of practices eligible for the PCMP Incentive Program will participate in at least two quality meetings quarterly.
  - Increase adoption and engagement of the eConsult platform
    - Goal: Strategize with HCPF to encourage adoption and implementation of the eConsult tool.
  - 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 SFY24-25 KPI Specification document.
    - Goal: Achieve improvement benchmarks on three (3) Behavioral Health Incentive measures in SFY24-25.
  - Number/percent of members aged 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 SFY24-25 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: Due to our limited access to laboratory data, CCHA will adjust this goal to 32% of members with a diagnosis of diabetes have at least one HbA1c done in the last 12 months.

Provider Communications:

Achievements/Successes:

CCHA successfully implemented its provider communication strategy in SFY23-24, tailoring each communication initiative based on the nature of the messaging, target audience and timeframe for communication. CCHA's broad array of communication methods (also known as vehicles) support engaging with the network in a multi-prong approach, including newsletters, special bulletins, email blasts, online and printed materials, social media, direct outreach via phone/email, webinars, open mic calls, town-halls and/or in-person meetings and joint operating committees.

New Communication Solutions in SFY23-24

- Diversity Equity and Inclusion - In our commitment to addressing the often overlooked complexities of racial health disparities, we have prioritized communicating this critical issue to our providers. One notable initiative is our webinar titled, "Under The Skin: The Hidden Toll of Racism on American Lives and on the Health of Our Nation." This webinar, featuring esteemed speaker Linda Villarosa, provided a platform to delve into the profound impact of racism on both individuals and public health. By hosting such events, CCHA was able to raise awareness, foster dialogue, and empower providers with knowledge and resources to address racial health disparities in their practice.

  Moreover, CCHA recognizes the importance of ongoing education and training on diversity and inclusion within health care settings. We actively communicate opportunities for providers to engage in relevant training programs. For instance, we promote Continuing Medical Education (CME) courses available on platforms like MyDiversePatients.com, which offer insights and strategies for providing culturally competent care.
- New Provider Tools Webpage Layout - In response to feedback and to better streamline the provider experience, CCHA has split the content on our Provider Tools webpage into two distinct pages tailored to better meet providers' needs. There are now dedicated pages for physical health providers and behavioral health providers. The new layout aims to reduce scrolling and enhance navigation, ensuring that providers can effortlessly access the tools, forms, and resources necessary for delivering optimal care to our members. While specific content now resides on either the physical health or behavioral health provider pages, information pertinent to both audiences remains accessible on CCHAcares.com/providertools.

- BH Provider Education Series – CCHA is committed to providing a broad communication and learning network for our behavioral health providers. To make our resources more accessible, we've combined our Open Mic series and Provider Education sessions. This combined approach helps us provide education more efficiently and effectively and gather valuable provider feedback.

Emerging Issues and Crisis Communications

CCHA remains agile in its approach to provider communication, consistently adapting to meet the evolving needs of the regional, state, and national landscapes. Over the years, our regions have encountered significant events prompting CCHA to pivot swiftly, ensuring effective communication of pertinent information and meaningful engagement with both our provider network and members on timely issues.

- Update Your Address Campaign – CCHA continued to support HCPF's campaign to gather and maintain accurate member information by regularly promoting member print materials, a webinar training, website information, and including information in provider newsletters and behavioral health bulletins. Additionally, CCHA has allocated funds to several community organizations through our Community Incentive Program to support these efforts. These organizations play a vital role in assisting members with updating their addresses and maintaining enrollment in Health First Colorado. By investing in these partnerships, CCHA has amplified the campaign's impact.
- Crisis Communication Plan – Following 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. This plan serves as a robust framework for communication expectations, guiding our leadership in responding to unforeseeable events in a thoughtful, coordinated, and intentional manner. By continually updating and reviewing this plan, CCHA ensures its readiness to support our members, provider network, and the broader community during times of crisis.

In addition to the new communication strategies implemented in SFY23-24, as listed above, CCHA maintained the remaining communication strategies as outlined in our Communication Plan. Highlights from our communication efforts in SFY23-24 include:

- Website – CCHA's website remains a central location for providers to receive information from CCHA. As described above, in response to feedback and to better streamline the provider experience, CCHA has split the content on our Provider Tools webpage into two distinct pages tailored to better meet providers' needs. There are now dedicated pages for physical health providers and behavioral health providers.
- Provider Newsletter— CCHA effectively disseminated monthly behavioral health bulletins and provider newsletters, supplemented by quarterly specialist newsletters and ad hoc messaging. These communications served to deliver updates on pertinent and current topics to our providers. Newsletters have proven to be a successful avenue for CCHA to engage with our network, consistently maintaining an above-average open rate throughout SFY23-24 of 47%, surpassing the industry standard of just below 35%.
- Ad Hoc Email Blasts – CCHA provided additional email blasts to promptly address emerging communication needs. Notable communications included notifications and reminders regarding behavioral health education opportunities, updates on HCPF's data and security incident, notifications about provider payment errors and announcements

of funding opportunities. Additionally, email blasts were utilized to share essential information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines, Community Incentive Program recipients, DEI training opportunities, updates on claims issues, and enhancements to our provider tools page.

Update on SFY23-24 Communication Plan Goals

In our SFY23-24 Network Management Strategic Plan, we defined process and outcome goals to measure our continued commitment to quality. We are pleased to report the following progress:

- Process measures:
  - Publish and distribute CCHA monthly newsletter
    - Goal: CCHA will publish at least ten (10) newsletters in SFY23-24.
    - Update: CCHA exceeded this goal by distributing 12 provider newsletters.
  - Publish and distribute frequent behavioral health provider bulletins
    - Goal: CCHA will publish at least ten (10) behavioral health provider bulletins in SFY23-24.
    - Update: CCHA exceeded this goal by distributing 12 BH provider bulletins.
- 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 50.2% 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 43.4% 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: In Region 7, 58.4% of PCMP practices with portal access used the portal in the first half of the SFY, and 39.82% of practices used it during the second half of the SFY. CCHA did not meet the goal in Region 7 for the latter half of the year. We will continue to collaborate with the network to identify issues in accessing the portal. We also speculate some fluctuation in practices accessing the portal may be attributed to direct practice support and information being provided directly by CCHA staff.

Challenges:

Though CCHA strives to communicate clearly and effectively with all of our stakeholders, applying lessons learned and industry best practices, we are continually learning how to best accomplish this with our diverse provider community in an ever-changing environment. Challenges we have encountered this year include:

- Stakeholders have provided feedback that the amount of information on CCHA's website can sometimes be overwhelming and hard to search/navigate. CCHA appreciates this feedback and has made updates to help improve our stakeholders' experience.
- There is an abundance of behavioral health information to communicate. We are working to make the information in the BH bulletins completely specific to behavioral health providers and as concise as possible.
- Although we were successfully above the industry average on each newsletter, we still strive to improve our click rate. We intend to encourage providers to click on links by providing more information about the link. For example, if the document links to a large document, we will specify the pages where providers can find valuable information.
- As the Department may know, initially in December 2022 and then again in March 2024, the Office of Civil Rights issued guidance clarifying tracking technologies that power web analytics tools like Google Analytics may put organizations at risk of violating the Health Insurance Portability and Accountability Act (HIPAA). At guidance issuance, CCHA quickly acted to disable Google Analytics on its site. Unfortunately, without Google Analytics, CCHA is unable to track website site traffic which was a powerful tool for identifying widely used resources and pages. After extensive research and vendor comparisons, CCHA has identified a HIPAA-compliant tool for website analytics and looks forward to implementing this technology in 2025.

Plans for Change in Strategy:

CCHA is proud of the accomplishments we have made this year in support of effective communication with our provider network. We will continue to evolve our strategies to address challenges to optimize provider communication, including incorporating the following:

- CCHA will continue to alert our network of new and evolving state priorities and policy changes. We recognize the impact such updates can have on how providers are able to care for our members and remain committed to serving as a reliable source of information.
- Based on feedback from provider meetings and website analytics, CCHA will continue to work on our website to ensure it's structured in the most user-friendly way that allows providers to access all the necessary tools and resources.

SFY24-25 Goals

Guided by our strategies outlined in this Plan, CCHA will track the following metrics in SFY24-25 to evaluate our efforts.

- Process Measures:
  - Publish and distribute CCHA monthly newsletter
    - Goal: CCHA will publish at least ten (10) newsletters in SFY24-25.
  - Publish and distribute frequent behavioral health provider bulletins
    - Goal: CCHA will publish at least ten (10) behavioral health provider bulletins in SFY24-25.
- 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.