COLORADO

Department of Health Care Policy & Financing

FY 2019–2020 Network Adequacy Quarterly Report Template

Managed Care Entity: *Colorado Access*

Line of Business: *RAE3*

Contract Number: *19-107514A3*

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Report Submitted on: *01/31/20*

Report due by 1/31/2020, covering the MCE's network from 10/1/2019 – 12/31/2019, SFY Q2

—Final Copy—

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Contents

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the fiscal year (FY) 2019-20 Network Adequacy Crosswalk Definitions (December 4, 2019 version).

The practitioners, practice sites, and entities included in the quarterly NA report will include ordering, referring, and servicing contractors that provide care through a Colorado Medicaid or CHP+ MCE. To ensure consistent data collection across MCEs, each MCE must use this HCPF-approved report template (MS Word and MS Excel templates) to present the MCE's quarterly NA report and data for the corresponding practitioners, practice sites, and entities. Report due dates will align with those outlined in the MCE's contract, unless otherwise stated.

Fiscal Year Quarter Reported	Months Included in the Report
FY 2019-20 Q2	October, November, December
FY 2019-20 Q3	January, February, March
FY 2019-20 Q4	April, May, June
FY 2020-21 Q1	July, August, September

Definitions

- "MS Excel template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Excel Template_F1_1219* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_1219* document.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.
- A "practice site" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service.
- An "entity" refers to a hospital, pharmacy, imaging services, and laboratories.

COLORADO
Department of Health Care Policy & Financing

Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business.

This report template contains a comprehensive list of NA requirements for the CHP+ MCO, Medicaid MCO, and RAE lines of business. Each table in this MS Word document contains a header row which confirms the applicable line(s) of business for each response. The table below shows expected network categories by MCE type. The accompanying MS Excel spreadsheet contains tabs in which network data can be imported (e.g., member counts, ratio results, time/distance calculation results).

Network Category	CHP+ MCO	Medicaid MCO	RAE
Facilities (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X	
Prenatal Care and Women's Health Services	X	X	X
Primary Care Providers (PCPs)	X	X	X
Physical Health Specialists	X	X	
Behavioral Health Specialists	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

- Contact the MCE's Department contract manager or specialist for data submission instructions and assistance with questions or access to HCPF's FTP site.

Establishing and Maintaining the MCE Network

Supporting contract reference: The MCE shall maintain a network that is sufficient in numbers and types of providers to assure that all covered services to members will be accessible without unreasonable delay. The MCE shall demonstrate that it has the capacity to serve the expected enrollment in that service area.

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
- To count practitioners/practices/entities ("providers"):
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.
  - Define unique practices or entities by de-duplicating records by location such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.

Table 1A-Establishing and Maintaining the MCE Network: Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	*265991*	*N/A*	*240549* [1]	*N/A*
Total practitioners	*2626*	*N/A*	*1972* [2]	*N/A*
Practitioners accepting new members	*272*	*10*	*570*	*29*
Practitioners (or practices) offering after-hours appointments	*112*	*4.2*	*192*	*9.7*
New practitioners contracted during the quarter	*N/A*	*N/A*	*47*	*2.4*
Practitioners that closed or left the MCE's network during the quarter	*N/A*	*N/A*	*24*	*1.2*
Total behavioral health practitioners	*N/A*	*N/A*	*648*	*N/A*
Behavioral health practitioners accepting new members	*N/A*	*N/A*	*187*	*28.6*

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners (or practices) offering after-hours appointments	*N/A*	*N/A*	*61*	*9.4*
RAE				
Total PCMP practice sites	*N/A*	*N/A*	*183*	*N/A*
PCMP practice sites accepting new members	*N/A*	*N/A*	*117*	*64*
PCMP practice sites offering after-hours appointments	*N/A*	*N/A*	*10*	*5.5*

Table 1B-Establishing and Maintaining the MCE Network: Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of providers to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
COA has a large provider network of providers both in number and type for PCMPs and BH. We continue to grow the network and ensure that all covered services continue to be accessible to our members without reasonable delay. Although there is a shortage of Medicaid providers in Elbert county, for this quarter, there were no barriers to maintain a sufficient network in number and type of providers to assure that all covered services were accessible to our members without reasonable delay.

Categories Included in Network

Supporting contract reference: The MCE shall ensure that its contracted networks are capable of serving all members, including contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

- To count practitioners/practices/entities ("providers") for Table 2A:
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.
  - Define unique practices or entities by de-duplicating records by location such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.
  - Do not include Federally Qualified Health Centers (FQHCs) when counting Essential Community Providers (ECPs).

- Use the following hierarchy for determining unique providers, with the narrowest definition first (e.g., if a School Based Health Center [SBHC] is also an FQHC or Rural Health Clinic [RHC], report it under the SBHC row in Table 2A):
  - Indian Health Care Providers (i.e., a healthcare program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization)
  - SBHC
  - FQHC
  - RHC
  - Substance Use Disorder Clinics (*interChange* Provider Type 64)
  - Hospitals
  - Community Mental Health Centers (CMHC)
  - Essential Community Providers
    - ECPs include all other private providers that cannot be qualified as a FQHC or SBHC; i.e., Providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of the patient population. To be designated as an "ECP", the provider must demonstrate that it meets the requirements defined in Section 25.5-5-404(2) C.R.S.
  - Other-Primary Care Providers
  - Other-Behavioral Health Providers
- The providers capable of billing both Medicare and Medicaid category may duplicate providers counted in the categories described above.

Table 2A-Categories in Network: Data

Requirement	Total In-Network
Sample	*0*
CHP+ MCO, Medicaid MCO, RAE	
Indian Health Care Providers	*0*
School Based Health Centers (SBHC)	*11*
Federally Qualified Health Centers (FQHC)	*3*
Rural Health Clinics (RHC; not applicable to Medicaid MCO)	*N/A*
Substance Use Disorder Clinics	*31*
Hospitals	*9*
Community Mental Health Centers (CMHC)	*4*
Essential Community Providers (ECP; not applicable to Medicaid MCO)	*N/A*

Requirement	Total In-Network
Other-Primary Care Providers	*N/A*
Other-Behavioral Health Providers	*N/A*
CHP+ MCO, Medicaid MCO	
Pharmacies	*N/A*
CHP+ MCO, Medicaid MCO, RAE	
Providers capable of billing both Medicare and Medicaid	*Data not available at the time of report. Will adjust our process to include this requirement in future reports.*

Table 2B-Categories in Network: Discussion

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE
Colorado Access continues to recruit substance use disorder (SUD) providers, recognizing that there is a state-wide SUD provider shortage. Beyond that, COA did not experience any barriers affecting our ability to serve all members with access to providers with specialized training and expertise. As part of our state-wide SUD recruitment efforts to identify and add new providers, Colorado Access adds individual providers to contracted provider groups and facilities licensed by OBH. Within those facilities there are multiple individual providers. Additionally, Colorado Access is outreaching to SUD providers state-wide. We monitor access and potential barriers through our customer service, care management, and UM departments, and have not received any member grievances for this quarter.

COLORADO
Department of Health Care Policy & Financing

Access for Special Populations

Supporting contract reference: The MCE shall have the ability to meet the needs of members in special populations. When establishing and maintaining its networks, MCEs shall take the following into consideration: members access to transportation and whether the location provides physical access and accessible equipment for members with disabilities. The MCE shall have the ability to meet the needs of members with limited English proficiency.

Table 3-Access for Special Populations: Discussion

Describe the methods used by the MCE to count providers as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.
CHP+ MCO, Medicaid MCO, RAE
Colorado Access surveys the availability of physical access and/or accessible equipment via the Professional Provider Agreement Application. Providers indicate the availability of an ADA accessible approach to the entrance of the building/office, ADA and van-accessible parking spaces with signage, exam room accessibility and medical equipment for individuals with disabilities, and ability to communicate with individuals who have hearing, vision, speech or cognitive disabilities. This information is reflected in Colorado Access's provider directory. Members with disabilities can find locations with physical access and accessibility equipment by checking the provider directory. Members can also call Colorado Access customer service and care management departments for help locating a provider that meets their unique disability needs.

3. Network Changes and Deficiencies

Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes in MCE Networks related to quality of care, competence, or professional conduct.

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
For this quarter, there were no positive or negative changes to the network related to quality of care, competence or professional conduct.

COA Note: Tables 5-9 do not apply to the RAE and therefore have been removed from this document.

Appointment Timeliness Standards

Supporting contract reference: The MCE shall provide coverage of emergency and non-urgent medical services. The MCE shall have written policies and procedures describing how members can receive coverage of emergency services or urgently needed services while temporarily absent from the MCE's service area.

Table 10-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Colorado Access monitors timeliness requirements for members' access to physical health services through our Secret Shopper program and the Customer Service, Care Management, and Member Grievance Departments. If a member notifies Colorado Access of an appointment timeliness issue, the Provider Relations team is notified, and the concern is addressed with the provider. If the issue continues, the Quality and Compliance teams are notified to take further action, such as placing the provider on a corrective action plan (CAP). *In the reporting quarter, Colorado Access did not receive any concerns about appointment timeliness.*

Table 11-Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Colorado Access monitors timeliness requirements for members' access to behavioral health services through our Secret Shopper program and the Customer Service, Care Management, and Member Grievance Departments. If a member notifies Colorado Access of an appointment timeliness issue, the Provider Relations team is notified, and the concern is addressed with the provider. If the issue continues, the Quality and Compliance teams are notified to take further action, such as placing the provider on a corrective action plan (CAP).

5. Time and Distance Standards

Health Care Network Time and Distance Standards

Supporting contract reference: The MCE shall ensure that its network has a sufficient number of practitioners, practice sites, and entities who generate billable services within their zip code or within the maximum distance for their county classification. The MCE must use GeoAccess or a comparable service to measure the travel time and driving distance between where members live and the physical location of the providers in the MCE's Region.

Enter detailed time and distance results in the MS Excel template. Use Tables 13, 14, and 15 for additional relevant information regarding the MCE's compliance with time and distance requirements. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care.

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).
- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

There are two levels of primary care practitioners, primary practitioners that can bill as individuals (e.g., MDs, DOs, and NPs) and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the tables below. ***A provider should only be counted one time in the tables below; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under Family Practitioner.***

Table 12-Software Package Used for Time and Distance Calculations

List and describe the software package(s) and/or processes that your MCE uses to calculate provider counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed. **If your MCE does not use driving distances when calculating time and distance results, describe the method used.**
CHP+ MCO, Medicaid MCO, RAE
Our Time/Distance Summary by Network Category and County has data input and software applications. For the data input, we have providers in network and members enrolled in the line of business and in the reporting period of this report, ending December 31, 2019. Our providers in network constitute unique practitioners, practice sites and entity locations, where we have de-duplicated practitioners that work in multiple locations by their Medicaid ID's. Our members data pulled from the January 1st snapshot of Truven, held unique RAE members that reside in the

providers' counties of Region 3. We use the following the software and process to calculate provider counts and time/distance results:

1. *GeoCoder (Version 4,4,0,0) from Optum Inc. to assign geo-codes and geo names to our provider and member data, and;*
2. *GeoNetworks (Version 2017 1,0,0) from Optum Inc. to calculate driving times and distances based on access standards for each network category. The geo-coding was based on addresses, where we provided the full addresses of members in each county and providers in each network category, so that we can get a better estimate of time and distance. In some instances, (i.e. Elbert county) the nearest location to a member residing in a specific county may be outside of this member's county of residence but within the time/distance standard.*

When we run the report, we use the "Accessibility Matrix" template of GeoNetworks, where we created Accessibility Matrix pages for each of the applicable provider groups/HCPF network categories for RAE. This template provides us with member and provider counts, member counts which are within and not within time and distance access standards for their respective county classifications. We also assigned access standards for each of these provider groups/network categories, based on our contract with the Department. Key points on the report run:

1. *The software classifies our members into its own counties and county classifications as U (urban), R (rural) and F (frontier) based on their zip codes and other address info;*
2. *Time and distance calculations have been made by the software based on its classification of members and providers into their respective counties and county classifications;*
3. *In the time and distance calculations, driving distance and driving time were assumed.*

Table 13–Urban Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
The only county that is outside time/distance standards is Elbert County which continues to be an issue due to a lack of validated providers willing to participate in Medicaid. Please find attached GeoAccess report which demonstrates that we meet time/distance requirements for members within Elbert county using surrounding counites by zip code. Our customer service department has not received any calls regarding access to care

issues for members residing within Elbert county. For the remainder of the counties in RAE 3, COA has a well-established provider network in the urban counties and meets the time/distance requirements based on GeoAccess reports and information reported by our customer service and care management departments. We had no customer services grievances filed in this quarter. We continue to ensure access to care for our members by adding providers to our network on a regular basis. The contracting department responds promptly to requests to add providers to our network from our customer service, care management, provider relations and UM departments, as well as from individual provider requests. Additionally, as large provider groups add practitioners, we work expeditiously to process their information and enter it into our systems and directory to ensure access to these new providers by our members. If we identify a gap in the network, or when we need to augment the network for members who need access to a specific provider for continuity of care purposes, we outreach to providers and invite them to request an application to join the network or in some instances enter into a single case agreement (SCA).

Table 14–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
N/A

Table 15–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. *List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.*
N/A

Network Directory

Supporting contract reference: For each of the following provider types covered under this contract the MCE must make the following information on the MCE's network providers available to the enrollee in paper form upon request and electronic form:

- Provider's name as an individual or entity, as well as any group affiliations,
- Business street address,
- Telephone number,
- Electronic mail address,
- Website URLs, as appropriate,
- Specialties, as appropriate,
- Whether network providers will accept new enrollees,
- The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training,
- Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

Table 16-Network Directory: Discussion

Please list the MCE's website URL. **Is the MCE provider network information updated at least monthly?** **Did the MCE make the network providers' information available to the enrollee in paper form upon request and electronic form?**
CHP+ MCO, Medicaid MCO, RAE
https://coadirectory.info/search-member *1. Yes, the Colorado Access provider network directory is updated daily with additions, changes, and terminations to the provider network. The directory is refreshed every evening and updates are reflected in the online directory the next day.* *2. Yes, Colorado Access provides network provider information in paper and electronic form upon request from the member. The provider network directory is always available online via the Colorado Access website.*

Appendix A. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.

Instructions for Appendices

To add an image:

- Go to "Insert" and click on "Pictures".
- Select jpg file and click "Insert".

To add an additional Appendix:

- Go to "Layout" and click on "Breaks".
- Select "Next Page" and a new page will be created.
- Go to "Home" and select "HSAG Heading 6".
- Type "Appendix C." and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

Optional MCE Content

Free text

Appendix B. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.

[1] *In utilizing the two tools that provide time and distance calculations, (GeoAccess and GeoNetworks), we noticed that when we processed the file though GeoNetworks, there were processing errors which caused invalid member zip codes. This resulted in the data omitting approximately 30,000 members across all lines of business due to the invalid zip codes. We are working with our vendors on a solution, that we will implement for the next quarter's report.*

[2] *During the transition from the previous reporting template to the new template, we found that many of our providers were omitted from the spreadsheets submitted for this quarter. We endeavor to work on this process to ensure an accurate representation and count for the next quarter's report.*