COLORADO
Department of Health Care Policy & Financing

FY 2019–2020 Network Adequacy Quarterly Report Template

Managed Care Entity: *Health Colorado, Inc.*

Line of Business: *RAE*

Contract Number: *19-107515*

Contact Name: *Cathy Michopoulos*

Report Submitted by: *Alma Mejorado*

Report Submitted on: *February 3, 2020*

Report Resubmitted on: *April 13, 2020*

Report Resubmitted on: *April 28, 2020*

Report due by 1/30/2020, covering the MCE's network from 10/1/2019 – 12/31/2019, SFY 2020 Q2

—Final Copy—

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Health Care Policy & Financing

Contents

COLORADO
Department of Health Care Policy & Financing

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 (1)		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	123,166	N/A	121,451	N/A
Total practitioners (2)	508	N/A	372	N/A
Practitioners accepting new members(2)	496	97.64%	365	98.12%
Practitioners (or practices) offering after-hours appointments(2)	149	29.33%	117	31.45%
New practitioners contracted during the quarter(2)	125	24.61%	0	0%
Practitioners that closed or left the MCE's network during the quarter(2)	0	0%	1	0%
Total behavioral health practitioners(2)	862	N/A	1,969	N/A
Behavioral health practitioners accepting new members(2)	862	100%	1,969	100%

Requirement	Previous Quarter [1]		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners (or practices) offering after-hours appointments[2]	55	6.38%	446	22.65%
RAE				
Total PCMP practice sites	117	N/A	110	N/A
PCMP practice sites accepting new members	115	98.29%	109	99.1%
PCMP practice sites offering after-hours appointments	17	14.53%	17	15.45%

(1) Data reported on the section "Previous Quarter" is based the data stated on the Network Adequacy report for the first quarter of fiscal year 2020. Reduction on the counts from first to second quarter is due to how the locations were calculated from one quarter to the next. Duplicate count of locations and individual providers were removed in the version two submission of the second quarter report.

(2) Data reported is individual practitioners only.

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
Behavioral Health Network HCI continues to enhance its established regional and statewide network of behavioral health providers to comply with the network access to care standards. The network includes contracts and relationships with essential community providers including Community Mental Health Centers (CMHCs), FQHCs, RHCs, community safety-net clinics, as well as, a number of private/non-profit providers and substance use disorder (SUD) providers in the region. In the previous network adequacy report, HCI identified opportunities to improve the network and increase access in the region: 1- Recruit pediatric behavioral health providers located in counties including Conejos, Mineral and Saguache 2- Recruit SUD providers located in counties with limited or no SUD providers including Conejo, Costilla, Las Animas, Mineral and Saguache. As a result, HCI furthered the following recruitment strategies to address network gaps during the second quarter of the year: 1- Provider Relations utilizes current listings of Health First Colorado participating providers and Department of Regulatory Agency (DORA) registry to identify providers within the region.

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.

The majority of the providers with service locations in the rural and frontier counties identified through these listings are associated with the local Community Mental Health Center (CMHC). However, the research on DORA registry yielded data of potential independent providers not associated with CMHCs including 13 providers in Trinidad (Las Animas County), and one provider in San Luis (Costilla), Creede (Mineral), and Crestone (Saguache), respectively. The majority of these providers are not a Health First Colorado enrolled provider based on available information. There were no independent providers found in Conejo through the research on the DORA registry. Provider Relations is currently conducting outreach to the identified providers to invite them to join the network. Since these providers are currently not serving Medicaid members, Provider Relations will orient the providers and their staff on Health First Colorado and Health Colorado, Inc., as well as, the Medicaid Enrollment process. Interested providers will receive technical assistance to complete their Medicaid Enrollment, and offered support through the Beacon credentialing and contracting process so they can successfully join the network.

2- Track utilization, single case agreement data, and historical claims information to identify providers who are currently providing services to Health First Colorado Members

Provider Relations conducts monthly reviews of the single case agreement (SCA) data to identify non-contracted providers who are currently providing services to HCI assigned members. The previous report identified three (3) providers in the region that would be outreached for potential recruitment. Provider Relations outreached these providers and are currently in discussion to initiate the credentialing process to join the network. Provider Relations continues to outreach HCA Health One, a non-contracted hospital to join the network. During this reporting period, eight (8) new providers requested SCAs of which, four (4) providers were outreached to join the network and are in the credentialing process to become network providers. However, the remaining four (4) non-contracted providers are initiating work with HIC members through SCAs only, and as Provider Relations identifies this type of provider, they are using that as an opportunity to introduce HCI, learn about their services and recruit them to join the network as a provider.

3- For services in counties where behavioral health providers are limited, HCI has network providers that offer telehealth services to members in our rural and frontier areas.

There has been an increased interest from Medicaid enrolled providers to offer telehealth services. They report using telehealth services when patients are not able to travel long distances to keep their appointment. Telehealth allows providers to serve members residing outside their city or driving distance and expand access to care within a reasonable time. Telehealth providers are available to all HCI members in the region upon request.

4- Improved operational processes to successfully credential providers recruited to join the network

During the last reporting quarter, Beacon implemented new processes to streamline the credentialing application through an online system and added new staffing. Separately, the Provider Relations Department hired a dedicated staff resource in Colorado to assist providers through the credentialing process. Once fully trained, the staff will track providers through the completion of credentialing, communicate with providers on the status of their application, assist with any required documentation, and coordinate across departments. These improvements will assist with recruitment by addressing provider concerns with undertaking a lengthy and cumbersome credentialing process by providing transparency on the status of their application.

Physical Health Network

COLORADO
Department of Health Care Policy & Financing

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.

HCI has a network of PCPs that cover all counties of the RAE region. This network includes contracts with essential community providers including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), in addition to private and non-profit Medicaid enrolled PCPs that serve both adults and children.

HCI continues to explore ways to identify and recruit providers to enhance and maintain a sufficient network. Based on the data from this reporting period, there is a weakness across the region for Gynecology, OB/GYN providers of all levels including physicians and physician assistants. It limits the ability to serve members of all ages and genders without unreasonable delay. HCI will focus on identifying the available providers in the region with this expertise and recruit them to serve Medicaid members.

Provider Relations reviews the Medicaid Enrollment data of non-contracted providers to identify PCMP practices in the Region offering services to Medicaid members that are not a part of the network. Additionally, Provider Relations collaborates with other HCI departments to identify providers in the region for recruitment. As a result, in the last quarter, the C-PAC team (Colorado Psychiatric Access & Consultation for Adults and Kids) shared with Provider Relations a practice enrolled in C-PAC services currently not contracted as a PCP provider for Health Colorado, Canon City Family Medicine in Canon City. Provider Relations is coordinating with C-PAC team to leverage their established relationship to conduct outreach to the practice for recruitment into the network.

HCI has identified a need to increase access to care with network providers to ensure covered services are available to members without unreasonable delay. HCI initiated strategies to improve extended or weekend availability in the previous quarter:

1- Conduct a cross-reference of the provider with other sources such as Medicaid provider directory website to validate accuracy of extended or weekend availability;
2- Use provider forums to educate and discuss with provider methods and resources to increase extended or weekend availability in their practices; and
3- Target providers based on provider type without availability to review options available to provider and members that ensure access to care within the network.

During the reporting period, the focus was primarily on cross-referencing the provider with other sources to validate the information. The provider Town Hall in October 24, 2019 delivered information Medicaid Enrollment (i.e. Revalidation) and Data Analytics Portal which did not cover access to care. Providers received a communication on access to care standards and provider support calls in the following quarter will include a review of the standards. Future reports will offer information in the outcomes of the general and targeted provider education. HCI is monitoring the response of providers and the data to evaluate their effectiveness and adjust strategies accordingly to increase access to care within the network.

COLORADO
Department of Health Care Policy & Financing

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[3]	
Indian Health Care Providers	0
School Based Health Centers (SBHC)	0
Federally Qualified Health Centers (FQHC)	66
Rural Health Clinics (RHC; not applicable to Medicaid MCO)	56
Substance Use Disorder Clinics	41
Hospitals	276
Community Mental Health Centers (CMHC)	285
Essential Community Providers (ECP; not applicable to Medicaid MCO) [4]	0
Other-Primary Care Providers	51
Other-Behavioral Health Providers	204
CHP+ MCO, Medicaid MCO	
Pharmacies	N/A
CHP+ MCO, Medicaid MCO, RAE[5]	
Providers capable of billing both Medicare and Medicaid	3,006

(3) The data reported is at the PH and BH service locations (i.e. practice sites and entities).

(4) There were no reported ECPs in the network due to being reported in other provider types (i.e. FQHCs and CMHCs) based on the hierarchy.

(5) The data reported includes PH and BH service locations and individual provider.

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
On behalf of HCI, Beacon monitors the network to ensure that providers are available to Members, and that the provider network contains the specialties necessary to accommodate the needs of Members across all ages, levels of ability, gender identities and cultural identities. HCI monitors overall provider network patient load using a comprehensive system for monitoring patient load and overall network capacity. PCPs are able to update their capacity by notifying HCI to temporarily close their panels to new members or geographic

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.

attribution, and/or change their panel size. In those cases, HCI updates the State's portal, monthly reports, and the following edition of the provider directory.

RAE Region 4 is comprised of 19 counties of which only one is an urban county, however, there are nine (9) rural counties and nine (9) frontier counties. The availability of behavioral health and primary care providers in rural and frontier counties are limited, especially those with capacity to serve all members including those with specialized training and expertise across all ages, levels of ability, gender identities and cultural identities.

Beacon accomplishes the monitoring of the network through periodic network adequacy review regarding the availability of providers who meet or exceed the cultural needs of Medicaid members by:

- Using an updated and accurate list, in assessing the number of providers with expertise in key culturally based populations;
- Determining number of members, by county, through the enrollment file, within the key population groups;
- Determining any existing gap by a comparison of availability of providers as well as reviewing findings in Member and Family Affairs surveys or through contacts/surveys with advocacy organization of key populations; and
- Increasing capacity of providers who meet or exceed cultural needs of Medicaid members through specialized provider training on Cultural Competency.

For behavioral health providers, Beacon engaged specialty provider groups and facilities based on the identified need through the network monitoring, such as providers who have:

- A unique specialty or clinical expertise;
- License to prescribe in all areas: APRN/APN, NP, PA, MD/DO (Board Certified Child and Adult Psychiatrists);
- Capability to treat in a foreign language, ASL, and/or, have specific cultural experience;
- Capability of billing both Medicare and Medicaid;
- Practice located in regional organization's service areas considered rural or frontier where there are fewer providers;
- Telehealth, especially for prescriber services;
- Alignment with primary care and co-located in an integrated model;
- Capability to serve unique populations and disorders;
- Specialties such as Intellectual Disabilities, Autism, Members with Traumatic Brain Injuries or other groups that provide behavioral health services in addition to their non-covered specialty. Also, providers with experience in specialty care, long-term services and supports (LTSS) providers, managed service organizations and their networks of substance use disorder providers, dental and other ancillary providers; or
- Behavioral health providers that span inpatient, outpatient, and all other covered mental health and substance use disorder services.

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
Beacon, on behalf of HCI, monitors if there are sufficient providers in the network with the ability for physical access, reasonable accommodations, and accessible equipment for members with physical or other disabilities. Provider data in the Beacon systems is used to identify provider locations as accessible in the provider directory and to count the number of providers that meet the requirements in the network adequacy analysis. Provider Relations has trainings available on the RAE 4 website to educate providers on how they can directly update their demographic information through Beacon's Provider Portal and CAQH, which includes reporting the physical access and/or accessible equipment information for each of their practice locations. Additionally, Beacon integrates data from CAQH to maintain accurate records for network providers in the Beacon's system that in turn populates the Provider Directory and network adequacy analysis. Finally, Provider Relations conducts on-going phone outreaches to providers that do not have a CAQH profile to validate the information on the Provider Directory, particularly PCP practices. Since Beacon does not credential the PCP practices, on behalf of HCI, then they are not subject to CAQH review. As a result, Beacon requests update from the PCP practices and validates the information through the National Provider Identifier (NPI) Registry Public Search website and HCPF Medicaid Enrollment Lists. Beacon adopted new strategies during the previous quarter to increase accessibility and access to care for members: 1- Use a Provider Town Hall to educate and discuss with providers methods and resources to increase accessibility in their practices; 2- Offer to practices without accessible facilities to conduct individual practice assessment using the Disability Competent Care Assessment (DCC) Tool; and 3- Cross-reference the provider data with other sources to validate accuracy of accessible facilities. During the reporting period, the focus was primarily on cross-referencing the provider with other sources to validate the information. Future reports will offer information in the outcomes of the general and targeted provider education. HCI is monitoring the response of providers and the data to evaluate their effectiveness and adjust strategies accordingly to increase access to care within the network.

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.
Providers that want to learn more about physical access and/or accessible equipment for practice locations may request Provider Relations staff to conduct an assessment of their facilities for members with physical and other disabilities. There were no requests for these assessments during the reporting period and the assessments will continue to be promoted at provider support calls. This is an opportunity to engage with the practices and increase accessible facilities in the network.

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
Health Colorado, Inc., RAE Region 4, maintained the network with no changes in quality of care, competence or professional conduct that required notification to the Department during the reporting period. One location in Crowley sold to a Valley-Wide Health System, Inc. and is in the process of obtaining Medicaid ID and affiliating as a Health Colorado, Inc. location. As a result, HCI had one less PCMP location during this reporting period. HCI is working with Valley-Wide to affiliate the location for the upcoming reporting period. In the meantime, services and access to care have continued with no negative access impact. For behavioral health providers, Health Colorado, Inc. (HCI) has been working to refine the reporting logic after the first submission of the Quarter 2 Network Adequacy Report in preparation for the Quarter 3 Network Adequacy Report. We shifted the analysis of behavioral health provider data to the local reporting team to align with how it is being done for the primary care side. The benefit of having the data reporting locally is that the team is more familiar with the network providers and Colorado requirements. We streamlined the process for validation and adjustments to the logic to enhance the quality of the reporting. As a result of these changes, HCI conducted an in-depth review of the reporting logic This analysis identified the need to adjust the logic for the Quarter 3 Report. While this was underway, we received the feedback from the first submission of the Quarter 2 Report. This feedback was incorporated into the adjustments of the logic for both Quarters. Overall, the changes to the logic included: • Data cleaned to remove duplicate providers due to name spelling and other data entry errors • Data cleaned to validate Medicaid IDs and exclude providers missing Medicaid IDs • Distinguish licensure levels for LPC and LCSW • Reviewed and updated the categories to capture additional applicable licensure levels • Reviewed and updated the logic to better capture unlicensed staff under Community Mental Health Centers

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.
The changes outlined above resulted in a net increase of 86 individual behavioral health providers for the Quarter 2 Report. The first submission reported 1,883 individual providers, and the second submission reported 1,969 individual providers. HCI conducted an analysis to determine the impact the changes had in the variance between the two submissions. A total of 211 providers were removed due to: duplicate records (73), missing Medicaid IDs (85), or changes to the code (53). However, a total of 297 providers were added to the report due to changes to the reporting logic (67), and changes to the facility staff rosters (230). The highest impact was the changes to the facility staff rosters; therefore, we conducted a deeper analysis. We identified that the roster changes submitted by the facilities were retroactive to cover the reporting period, which is why they appeared in the second submission. Facilities may retroactively report staff providers to process a clean claim. Facilities are required to include a rendering provider NPI for a clean claim. HCI has stronger confidence in the data reported in the second submission. We are continuing to enhance the data collection, as well as, the reporting methodology. We will address new findings through HCI's internal process and guidance from the Department.

Table 5-CHP+ MCO Network Volume Changes and Notification: Discussion

If the MCE experienced at least a five percent (5%) increase or decrease in its network in a thirty (30) calendar day period, describe the change and answer the following questions: Did the MCE notify the Department, in writing, within ten (10) business days of the change? Was the change due to a provider's request to withdraw; was the change due to the MCE's activities to obtain or retain NCQA accreditation? Was the change due to a provider's failure to receive credentialing or re-credentialing from the MCE?
CHP+ MCO
N/A

COLORADO
Department of Health Care Policy & Financing

interChange Policies

Supporting contract reference: The MCE shall employ measures to help ensure that the MCE and all of their contracted, ordering or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating provider.

- Retroactively enrolled or providers with a pending contract status are not available to offer services and should be excluded from this discussion.

Table 6-CHP+ MCO *interChange* Policies: Discussion

1. Does the MCE employ measures to help ensure all contracted, ordering, or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating provider? **2. Did the MCE have a health care provider that was no longer identified as a participating provider in the *interChange*?** **If the MCE answered "yes" to Requirement 2 above, did the MCE terminate its health care provider contracts for provision of services to members with contracted providers?**
CHP+ MCO
N/A

COLORADO
Department of Health Care Policy & Financing

Inadequate Network Policies

Supporting contract reference: If the MCE fails to maintain an adequate network that provides Members with access to PCPs within a county in the MCE's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible Members by providing the MCE a thirty (30) calendar day written notice.

Table 7-CHP+ MCO Inadequate Access to PCPs: Discussion

Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area? **If the MCE answered "yes", did the Department designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members?**
CHP+ MCO
N/A

Table 8-CHP+ MCO Discontinue Services to an Entire County: Discussion

Did the MCE discontinue providing covered services to members within an entire county within the MCE's service area? **If the MCE answered "yes", did the MCE provide no less than sixty (60) calendar days prior written notice to the Department of the MCE's intent to discontinue such services?**
CHP+ MCO
N/A

Table 9-CHP+ MCO Provider Network Changes: Discussion

Did the MCE experience an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network? **If the MCE answered "yes", did the MCE notify the Department, in writing, of the change?**
CHP+ MCO
N/A

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
Primary care providers (PCPs) and behavioral health providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially-insured or public fee-for-service-insured individuals), and that services are available twenty-four hours a day, seven days a week, when medically necessary. Access to care standards, set by the State of Colorado, require all participating PCPs to have availability for members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. The Provider Network Subcommittee approved the policy to monitor access to care standards across the physical health and behavioral health networks during the reporting period. The policy specifies all Primary Care Provider are audited every six (6) months. Providers that do not meet standards receive education and are reviewed within 90 days of initial contact to ensure compliance is achieved. Provider Relations will conduct an audit of network providers in the third quarter of 2020. The date for the audit was postponed from the projected date offered in the previous report. The additional time allowed the subcommittee to approve the policy and Provider Relations to communicate providers about the access to care standards through an educational alert in December 2019. The second audit, scheduled for third quarter of 2020, will serve as a follow up to monitor that the practice has become compliant. Primary care providers will receive direct communication on their results and provide education on the standards. HCI is working with practices to educate them on the wait time requirements, review reason for deficiency, and discuss potential methods to correct it. A follow up audit will be conducted within 90 days after conducting targeted education to monitor that the practice has become compliant. All PCPs in the network will be audited every six-months for monitor network compliance to the access to care standards.

Table 11-Behavioral Health Appointment Timeliness Standards

COLORADO
Department of Health Care Policy & Financing

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
Behavioral health providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially-insured or public fee-for-service-insured individuals), and that services are available twenty-four hours a day, seven days a week, when medically necessary. Access to care standards, set by the State of Colorado, require all participating behavioral health providers to have availability for members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. Provider Network Subcommittee approved the policy to monitor access to care standards across the physical health and behavioral health networks during the reporting period. The policy specifies five percent (5%) of the behavioral health provider network within the region is audited each month on a rotating basis. Providers that do not meet standards receive education and are reviewed within 90 days of initial contact to ensure compliance is achieved. Provider Relations conducted the first audits of network providers in December of 2019. In December 2019, 12 locations (5%) of behavioral health network within the region were contacted via phone to survey access to care standards. Out of the 12 audited behavioral health providers, only a third (33%) met all the standards. Providers within in these locations had same day and routine appointment for established members (50%) and new members (17%). The providers surveyed were located in Buena Vista, Canon City, Pueblo, Salida, Trinidad and Walsenburg. In order to improve access to care, Provider Relations will be communicating with behavioral health providers on the results and provide education on the standards. More importantly, providers will receive focused attention to identify the barriers causing the deficiency, including review of the practice's policy for new members, and potential methods to achieve compliance and ensure member access to care for members. Providers will be re-audited within 90 days of receiving education and results regarding access to care compliance.

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
Beacon uses the latest Quest Analytics, an industry-standard application, to conduct a geographic access (geoaccess) mapping analysis for time and distance from member residence driving to the closest available provider based on the county classification. This application is also used to calculate the provider to member ratios at region and county level by provider type. The provider data that was used in this report was pulled directly out of the physical health and behavioral health databases hosted by Beacon Health Options, on behalf of HCI. The data was pulled directly out of the

database using the SQL editor Toad. The requested data elements for the Individual PH Practitioner and Individual BH Practitioner tabs are available in the databases and were pulled directly. This is also the case for the Practice Sites and the Entity Locations tabs. The Members by County tab was a simple calculation of enrolled Members by their county of residence broken out per the Members by County Instructions. The Provider Locations by County tab was calculated by summing the number of locations by their county name per the instructions of the Provider Locations by County Instructions.

As for the HCPF Network Categories, we began by conducting a quality check of provider NPIs and taxonomy codes using various methods. For the NPI quality check, we verified all NPIs in our provider data against the list of NPIs in the monthly ATN report to confirm those providers had valid NPIs. Additionally, there was a manual review of provider taxonomy codes against the NPPESS data to ensure correct taxonomy codes. Once the quality checks were completed, we used the HSAG technical specification document (*FY2019-20 Network Adequacy Validation (NAV) Crosswalk Definitions for Network Data Mapping; December 4, 2019 Version*) to define provider groupings. This was done using the provider's taxonomy code and the provider's degree or credentials. This allowed us to roll-up our provider counts by provider group code.

The technical tools used to complete this reporting requirement were Toad as well as Microsoft Excel. Toad was used to pull the data from Beacon Health Options databases and, where appropriate, conducted the data aggregation calculations. The results of this aggregation were manually entered into the designated Network Adequacy template, which is in an Excel file format.

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
HCI has one urban county, Pueblo, in which nearly all adult and pediatric members in the county have access PCPs and behavioral health providers within 30 miles or 30 minutes. The exception is access to Pediatric Primary Care Mid-Level or Gynecology, OB/GYN Physician Assistants within the required distance. HCI will use Health First Colorado participating providers and Department of Regulatory Agency (DORA) registry to identify licensed OB/GYN Physicians and Physician Assistants within the region for recruitment.

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
HCI has a number of counties that qualify as rural counties, which require coverage with the distance of 45 minutes or 45 miles for PCPs and 60 minutes or 60 miles for behavioral health providers. HCI met the time and distance requirement for majority of the provider types in each rural county. The exception is access to specific provider types: • Gynecology, OB/GYN Physicians – Crowley, Lake, and Otero • Gynecology, OB/GYN Physician Assistants – Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande • Pediatric Primary Care Mid-Level – Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande • Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities – Crowley, Otero, and Prowers • Psychiatric Residential Treatment Facilities – Chaffee, Crowley, Fremont, Otero, and Prowers HCI will use Health First Colorado participating providers and Department of Regulatory Agency (DORA) registry to identify licensed OB/GYN Physicians and Physician Assistants within the region for recruitment. However, access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the rural and frontier regions. This will require work with the Department and community partners to address.

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.**
CHP+ MCO, Medicaid MCO, RAE
Members residing in a frontier county requires time and distance access to PCPs within 60 minute or 60 miles and 90 minutes or 90 miles for behavioral health providers. HCI met the time and distance requirement for majority of the provider types in each frontier county. The exception is access to specific provider types: • Gynecology, OB/GYN Physician Assistants – Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache

- Pediatric Primary Care Mid-Level – Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache
- Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities – Las Animas County
- Psychiatric Residential Treatment Facilities – Las Animas County

HCI will use Health First Colorado participating providers and Department of Regulatory Agency (DORA) registry to identify licensed OB/GYN Physicians and Physician Assistants within the region for recruitment.

However, access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the rural and frontier regions. This will require work with the Department and community partners to address.

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
Health Colorado, Inc. lists the Provider Directory on the following URL https://www.healthcoloradorae.com/members/find-a-provider/. A member can contact Member Services to request the provider directory in paper form and electronic form by calling 888-502-4185, TTY 800-432-9553. The data is edited when providers report a change through Beacon provider portal or by calling Provider Relations. When HCI identifies a change, the provider is contacted to verify the information and submit any appropriate changes. The Provider Directory in the HCI website is updated at least once a month.

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.