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Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: Colorado Access

Line of Business: RAE 3

Contract Number: 19-107514A8

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Report due by *10/29/2021,* covering the MCE's network from *07/01/2021– 09/30/2021*, FY*21* Q1

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the September 2021 release of 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, or RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (September 2021 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	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2021-22 Q1	October 2021	September 30, 2021
FY 2021-22 Q2	January 2022	December 31, 2021
FY 2021-22 Q3	April 2022	March 31, 2022
FY 2021-22 Q4	July 2022	June 30, 2022

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0921* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0921* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  – MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- 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" or "practice" 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, excluding single case agreement (SCA) practitioners.
- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

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. The MCE should update the highlighted, italicized data fields on the cover page of this template to reflect their contact information, contract information, and report dates associated with the current report submission.

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 spreadsheets contain 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 (Entities) (*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 *(RAEs' network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)*	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 practitioners/practice sites 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., September 30, 2021, for the quarterly report due to the Department on October 29, 2021).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2021, for the quarterly report due to the Department on October 29, 2021).
  - 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 practice sites 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: Primary Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	334842	N/A	340239	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	4254	N/A	4499	N/A
Primary care practitioners accepting new members	2899	68.15%	3071	68.26%
Primary care practitioners offering after-hours appointments	1543	36.27%	1568	34.85%
New primary care practitioners contracted during the quarter	83	1.95%	142	3.13%
Primary care practitioners that closed or left the MCE's network during the quarter	51	1.20%	62	1.37%

Table 1B–Establishing and Maintaining the MCE Network: Primary Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.
CHP+ MCO, Medicaid MCO, RAE
COA monitors our PCMP clinic sites across the RAE 3 region to ensure adequate clinic to member ratio coverage. Colorado Access (COA) continues to review and grow its primary care provider network, on a regular basis, to ensure all covered services continue to be accessible to members without unreasonable delay. Over the reporting period, issues of workforce retention and burnout have been noted among providers in our network. These issues have the potential to impact access to care as providers may find it necessary to cut back on available appointments and office hours. COA recognizes this provider struggle and has distributed emergency funding to help support providers' business operations and staffing needs. In addition, COA has shared information about a support group for health care providers and front-line staff offered through the HeartLight Center with PCMP practices; works through our marketing department to include webinar/online meeting information tied to mental health support in the COVID-19 Provider Update; and has shared a seven-week, Project ECHO training course with practices, titled Past the Pandemic: Mental Well-Being for You and Your Patients. Every contracted RAE 3 PCMP has an assigned Practice Facilitator who meets at least monthly with their assigned providers. As a part of their engagement with providers, the facilitators monitor attribution assignments, closed panels, and capped attribution as they work to support providers in increasing their engagement with their assigned members which also aligns with the primary care value-based payment utilization component. Because COA's Practice Facilitators, along with our Provider Network Managers (formally Provider Relations Representatives), are so regularly engaged with providers, they are able to quickly respond to any barriers providers could face which may impact access to care. To determine the providers who provide family planning services, COA pulled claims data from Truven. The family planning (FP) flag within the report for those providers has been added. We are not confident that the Truven data adequately represents the COA network of providers who provide family planning services, so we are establishing an internal process to track this data in our system. Family planning is, however, a standard part of all primary care providers' scope of work, so while the FP "flag" may not be indicated on all applicable providers currently, we feel strongly that our members have more than adequate access to family planning services.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay.   **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.**   **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
We continue to educate providers on the new telehealth rules through webinars and provider resource groups hosted by our practice support team. We are also promoting the use of telehealth in our provider newsletter, the Navigator.   COA captures telehealth services as a datapoint from our network providers and has begun listing this information in our provider directories to further increase access to care for members. For RAE 3, we currently have 512 providers who have submitted a physical health telehealth claim in the last 12 months to current.

Table 2A–Establishing and Maintaining the MCE Network: Behavioral Health Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	334842	N/A	340239	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	6385	N/A	6118	N/A
Behavioral health practitioners accepting new members	4036	63.21%	4531	63.47%
Behavioral health practitioners offering after-hours appointments	1453	22.76%	1574	22.05%
New behavioral health practitioners contracted during the quarter	180	2.82%	152	2.48%
Behavioral health practitioners that closed or left the MCE's network during the quarter	45	.70%	179	2.92%

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Table 2B–Establishing and Maintaining the MCE Network: Substance Use Disorder (SUD) Treatment Facilities

Requirement	Previous Quarter	Current Quarter
	Number	Number
Sample	*0*	*0*
RAE		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	3	3
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	100	100
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	4	4
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	227	236
Total SUD treatment facilities offering ASAM Level 3.7 services	4	4
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	72	72
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	4	4
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	183	183
Total SUD treatment facilities offering ASAM Level 3.7 WM services	3	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	45	45

Table 2C–Establishing and Maintaining the MCE Network: Behavioral Health Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
COA monitors our behavioral health providers to ensure more than adequate provider to member ratio coverage. Colorado Access (COA) continues to review and grow its behavioral health provider network to ensure that all covered services continue to be accessible to members without unreasonable delay. While the size and scope of COA's behavioral health therapy network is more than adequate, there are acknowledged gaps in certain specialty types such as SUD and Psychiatry that COA is aware of and actively working to improve where possible. In an effort to improve our behavioral health network, targeted recruitment efforts are underway that will focus on identifying any licensed providers in the state who are not already contracted with COA. In addition to these recruitment efforts, thorough vetting processes are also in place to ensure COA adds only high-quality providers to our network. This quarter saw an increase in terminated providers from the previous quarter. This was due to larger groups, such as Community Mental Health Centers, that have been cleaning up their rosters and informing COA of providers that are no longer part of their group. COA continues to encourage providers to render services via telehealth by promoting it in our provider newsletter, the Navigator. We are also continuing to educate providers on the new and changing rules of telehealth through webinars and provider resource groups hosted by our Practice Support team and making our telehealth program team available for questions. Through these efforts, we have seen a marked increase in telehealth utilization. We continue to see that roughly 1/3 of all behavioral health claims are for telehealth. Additionally, COA provides members with information on which providers in our network have telehealth availability through our customer service department and our online provider directory. In addition to the behavioral health providers who are providing telehealth services, Colorado Access has a Virtual Care Collaboration and Integration (VCCI) Program that provides increased access to mental health care for its participating network providers. The VCCI Program allows PCMP's to refer members to be seen for short-term treatment over telehealth by VCCI clinicians and psychiatrists. The VCCI Program also incorporated an eConsult component to its service menu during this time and started training its primary care practices on how to use this service. The eConsult component allows PCMP's to directly query a psychiatrist via asynchronous HIPAA-secure

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services. For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.
CHP+ MCO, Medicaid MCO, RAE
email for a rapid response to their psychiatric questions. During this quarter we added one new primary care practice to our VCCI program in RAE 3. Colorado Access is continuing to contract with existing and new SUD providers for the recently implemented ASAM levels. While we have a strong network of non-residential SUD providers, the residential SUD network is not as robust. Our goal is to not only recruit residential SUD programs, but recruit quality programs. As a result of our proactive clinical review process, it is taking longer to increase our network. We currently have nine SUD facilities in our COA Clinical Review Process that evaluates their clinical readiness to serve Health First Colorado members. As these providers pass the Clinical Review process they will be added to the network. COA currently captures the number of SUD beds per facility during the contracting process. This helps to identify open beds available for placement and monitor capacity to determine if our network continues to be adequate. COA continues to grow our behavioral health network on a regular basis and in a manner that promotes both the quantity and quality of the providers that we bring into our network. COA does not take an "any willing provider" approach to behavioral health provider expansion. We take the time to review providers who enter the contracting process and ensure that we are bringing in high quality providers in an attempt to ensure the best care possible for our members. As we add providers with ASAM levels of care to our network some barriers we have experienced come in the form of inadequate quality reviews during the contracting process. For more concerning quality issues, COA temporarily suspends the contracting process while our Practice Facilitators (who have been well coached on behavioral health clinical quality measures) work with the provider to correct identified issues before continuing and completing the contracting process. For minor issues identified, the provider is allowed to complete the contracting process but still receives the same support from the Practice Facilitator to resolve those concerns. While temporarily suspending the contracting process to resolve certain quality issues can slow the time in which COA adds SUD providers to our network, we feel that adding this additional time to ensure a higher quality network is in the best interest of our members, COA and the Department.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
Additionally, to help address any network adequacy needs while COA adds more SUD providers to our network, we have an out of network fee schedule that allows out of network providers to serve our members without going through the single case agreement process in an attempt to speed access to care for our members. Pre-authorization rules still apply for out of network providers. COA is currently reviewing our SUD reimbursement rates with the intent of establishing a new, more competitive rate structure as a mechanism to increase the level of providers interested in becoming COA contracting providers. Colorado Access's Virtual Care Collaboration and Integration (VCCI) Program has continued to expand and evolve its services to meet the increased need for behavioral health care due to the pandemic. To meet patients where they are, the VCCI Program allows its participating primary care providers the option to allow VCCI clinical services to be rendered to their patients over telehealth within the primary care setting or directly into the patients' home or safe space. When the services are delivered to a patient in their home or safe space, a technology test and technical training is performed before every patient is scheduled to ensure that patient has the appropriate bandwidth and technical literacy to receive telehealth services. To increase timeliness and efficiency, and based on the feedback from our providers, the VCCI Program has added an on-line portal that allows its participating primary care providers to make referrals and schedule patients through the portal without needing to call over the phone. The HIPAA-secure portal also allows the participating primary care practices to view shared documentation, such as Progress Notes and Consents, and monitor their utilization of the program. The VCCI Program has also expanded its scope to allow Colorado Access Care Managers to make referrals to VCCI for Colorado Access members that are unconnected to behavioral health care. These members also receive the technical test/training before the telehealth session is scheduled within their home or safe space. The impact of these changes has resulted in a 57% increase in total utilization of VCCI services compared to Q4 2020, this increase in utilization is expected to continue as more primary care practices participate in the program and start utilizing the on-line portal.

Table 3A–Establishing and Maintaining the MCE Network: Specialty Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO				
Total members		N/A		N/A
Total specialty care practitioners (i.e., PROVCAT codes beginning with "SV" or "SG")		N/A		N/A
Specialty care practitioners accepting new members				
Specialty care practitioners offering after-hours appointments				
New specialty care practitioners contracted during the quarter				
Specialty care practitioners that closed or left the MCE's network during the quarter				

Table 3B–Establishing and Maintaining the MCE Network: Specialty Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of specialty care practitioners to assure that all covered services will be accessible to members without unreasonable delay. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.
CHP+ MCO, Medicaid MCO
NA

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 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, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. Note: If the MCE experienced 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 during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period 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.

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 practitioner/practice site/entity'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 practitioner/practice site/entity's failure to receive credentialing or re-credentialing from the MCE?
CHP+ MCO
There was not a 5% or greater increase or decrease to the provider network this reporting quarter.

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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 6–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
NA

Table 7–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
NA

Table 8–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
NA

4. Appointment Timeliness Standards

Appointment Timeliness Standards

Supporting contract reference: The MCE shall ensure its network is sufficient so that services are provided to members on a timely basis.

Table 9–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 assesses the provider network for contract compliance annually through its provider assessment tool. Each Colorado Access Practice Support Facilitator works with their assigned practices to thoroughly review components of the contract annually and ensure provider compliance. Assessment of Access to Care Standards will be completed as part of the State Fiscal Year (SFY) 21-22 assessment module implemented in August 2021. Through this module, providers with appropriate electronic medical record (EMR) capabilities will report out the Third Next Available Report, and/or complete a self-reported survey on these standards. **Program Description** Colorado Access's Quality Department conducts an independent testing program to routinely monitor provider compliance with Access to Care standards outside of the aforementioned annual assessment process. This is known as the Secret Shopper program. Through this program, Colorado Access monitors Access to Care standards quarterly by conducting calls to providers that mirror common member behavior. This is done to better understand the member experience and test the consistency of provider behavior and availability of services offered. Colorado Access also assesses providers electronically via provider websites that offer online scheduling capability. Provider selection for Secret Shopper calls is based primarily on random selection from quarterly claim volume stratification. However, the Quality Department may also select providers based on information received from other internal departments including but not limited to Care Management, Customer Service, and Compliance. Colorado Access currently has two arms of the Secret Shopper program. Colorado Access assesses physical and behavioral health providers utilizing internal employees. For the substance use disorder (SUD) benefit, Colorado Access sub-contracts out to Signal Behavioral Health. The SUD arm of the Secret Shopper program was launched during Q3 of SFY20-21 to optimize call efficiency and collaborate with another contracting entity to ensure overall provider quality. The SUD Secret Shopper program has grown over the first three quarters of the sub-contract with Signal Behavioral Health and now assesses residential, outpatient, intensive out-patient (IOP), and withdrawal management services. Following the end SFY 21-22 Q2, the sub-contract with Signal Behavioral

Health will have been operational for a 12-month period, at which point Colorado Access will be assessing the effectiveness and opportunities of this partnership. Colorado Access will then share lessons learned with the Department.

All Secret Shopper program assessments use internally developed scripts that describe specific scenarios tied to access to care standards outlined in the contract. Prior to implementation, all scripts are reviewed and signed off on by clinical leadership. Colorado Access includes both physical and behavioral health scenarios, as well as pediatric and adult scenarios, to ensure population diversity is accounted for in the monitoring of how standards are applied. By utilizing an independent monitoring system that does not rely on self-reported performance by the provider, Colorado Access can more confidently validate provider behavior and the experience of its membership and can more readily support providers with actionable opportunities for improvement when gaps are identified. Colorado Access's experience in this space has highlighted variations that can occur across staff at provider practices, and specifically between practice leadership (who are knowledgeable on the practice's policies) and the frontline office staff (who are implementing the policies daily). The Secret Shopper Program allows Colorado Access to further connect with various staff across a clinic system and work alongside the practice to support opportunities for improvement.

At the end of each quarterly program roll out, each provider receives a summary report of their performance and relevant findings. Providers that are identified as not meeting contractually required access to care standards are placed on a Corrective Action Plan (CAP) to address the deficiencies. In Q4 of SFY 20-21, Colorado Access also began issuing Request for Additional Information (RFAI) letters for providers who Colorado Access identified as either: 1) having potential challenges with adhering to contractual requirements but more information was needed; or 2) where administrative challenges were noted as part of the call process. RFAI's can be in addition to CAPs, depending on the standards being tested with a provider. Additionally, in Q1 SFY21-22, Colorado Access implemented a Third Next Available Appointment (TNAA) template based on national best practice standards. Providers with identified administrative barriers preventing full evaluation of Access to Care standards via the Secret Shopper program are now asked to submit the TNAA report for validation.

Colorado Access identifies TNAA as a type of RFAI for reporting purposes, and TNAA RFAI can be in addition to or in the absence of other types of RFAI for providers. In Table 1 below, providers with a TNAA are included in the "Providers issued RFAI" column; in Table 2, the TNAA and all other types of RFAI are distinguished by interactions. As indicated by the data, these new changes will allow increased network monitoring and provider accountability. Additionally, in SFY 21-22 Q1, if any RFAI received back from providers indicates non-adherence to contractual standards, Colorado Access will follow up with the practice at that time to discuss a CAP.

Providers are asked to return RFAI's, TNAAs and/or CAP plans back to Colorado Access within 15 calendar days of issuance. Colorado Access provides guidance to providers on what is expected in the CAP, including what specific activities may need to be completed and timelines for completion. Colorado Access requests implementation of the CAP plan be completed by the end of the next quarter of the SFY, with providers then being re-enrolled in the Secret Shopper program to test the

effectiveness of the intervention activities put in place by the practice. At the start of SFY 21-22, Colorado Access enhanced its follow up support with providers who are on CAPs. This enhanced work follows the above-described CAP operations with two additional requirements: 1) Colorado Access will outreach the provider approximately one month prior to CAP implementation completion due date to inquire if providers are still on track for implementing their approved and planned interventions; and 2) Colorado Access will inquire if any barriers have been identified that will prevent successful implementation. Should barriers be communicated, Colorado Access will provide technical assistance via practice facilitators to support the provider in successful CAP implementation. The intention of this pro-active check-in is to increase CAP success and ensure recognition with the provider network around the impact of larger health provider shortages and resulting impacts effecting the healthcare environment in Colorado.

Table 10–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
Program Description Colorado Access's Quality Department conducts an independent testing program to routinely monitor provider compliance with Access to Care standards outside of the aforementioned annual assessment process. This is known as the Secret Shopper program. Through this program, Colorado Access monitors Access to Care standards quarterly by conducting calls to providers that mirror common member behavior. This is done to better understand the member experience and test the consistency of provider behavior and availability of services offered. Colorado Access also assesses providers electronically via provider websites that offer online scheduling capability. Provider selection for Secret Shopper calls is based primarily on random selection from quarterly claim volume stratification. However, the Quality Department may also select providers based on information received from other internal departments including but not limited to Care Management, Customer Service, and Compliance. Colorado Access currently has two arms of the Secret Shopper program. Colorado Access assesses physical and behavioral health providers utilizing internal employees. For the substance use disorder (SUD) benefit, Colorado Access sub-contracts out to Signal Behavioral Health. The SUD arm of the Secret Shopper program was launched during Q3 of SFY20-21 to optimize call efficiency and collaborate with another contracting entity to ensure overall provider quality. The SUD Secret Shopper program has grown over the first three quarters of the sub-contract with Signal Behavioral Health and now assesses residential, outpatient, intensive out-patient (IOP), and withdrawal management services. Following the end SFY 21-22 Q2, the sub-contract with Signal Behavioral Health will have been operational for a 12-month period, at which point Colorado Access will be

assessing the effectiveness and opportunities of this partnership. Colorado Access will then share lessons learned with the Department.

All Secret Shopper program assessments use internally developed scripts that describe specific scenarios tied to access to care standards outlined in the contract. Prior to implementation, all scripts are reviewed and signed off on by clinical leadership. Colorado Access includes both physical and behavioral health scenarios, as well as pediatric and adult scenarios, to ensure population diversity is accounted for in the monitoring of how standards are applied. By utilizing an independent monitoring system that does not rely on self-reported performance by the provider, Colorado Access can more confidently validate provider behavior and the experience of its membership and can more readily support providers with actionable opportunities for improvement when gaps are identified. Colorado Access' robust experience in this space has highlighted variations that can occur across staff at provider practices, and specifically between practice leadership (who are knowledgeable on the practice's policies) and the frontline office staff (who are implementing the policies daily). The Secret Shopper Program allows Colorado Access to further connect with various staff across a clinic system and work alongside the practice to support opportunities for improvement.

At the end of each quarterly program roll out, each provider receives a summary report of their performance and relevant findings. Providers that are identified as not meeting contractually required access to care standards are placed on a Corrective Action Plan (CAP) to address the deficiencies. In Q4 of SFY 20-21, Colorado Access also began issuing Request for Additional Information (RFAI) letters for providers who Colorado Access identified as either: 1) having potential challenges with adhering to contractual requirements but more information was needed; or 2) where administrative challenges were noted as part of the call process. RFAI's can be in addition to CAPs, depending on the standards being tested with a provider. Additionally, in Q1 SFY21-22, Colorado Access implemented a Third Next Available Appointment (TNAA) template based on national best practice standards. Providers with identified administrative barriers preventing full evaluation of Access to Care standards via the Secret Shopper program are now asked to submit the TNAA report for validation.

Colorado Access identifies TNAA as a type of RFAI for reporting purposes, and TNAA RFAI can be in addition to or in the absence of other types of RFAI for providers. In Table 1 below, providers with a TNAA are included in the "Providers issued RFAI" column; in Table 2, the TNAA and all other types of RFAI are distinguished by interactions. As indicated by the data, these new changes will allow increased network monitoring and provider accountability. Additionally, in SFY 21-22 Q1, if any RFAI received back from providers indicates non-adherence to contractual standards, Colorado Access will follow up with the practice at that time to discuss a CAP.

Providers are asked to return RFAI's, TNAAs and/or CAP plans back to Colorado Access within 15 calendar days of issuance. Colorado Access provides guidance to providers on what is expected in the CAP, including what specific activities may need to be completed and timelines for completion. Colorado Access requests implementation of the CAP plan be completed by the end of the next quarter of the SFY, with providers then being re-enrolled in the Secret Shopper program to test the effectiveness of the intervention activities put in place by the practice. At the start of SFY 21-22,

Colorado Access enhanced its follow up support with providers who are on CAPs. This enhanced work follows the above-described CAP operations with two additional requirements: 1) Colorado Access will outreach the provider approximately one month prior to CAP implementation completion due date to inquire if providers are still on track for implementing their approved and planned interventions; and 2) Colorado Access will inquire if any barriers have been identified that will prevent successful implementation. Should barriers be communicated, Colorado Access will provide technical assistance via practice facilitators to support the provider in successful CAP implementation. The intention of this pro-active check-in is to increase CAP success and also ensure recognition with the provider network around the impact of larger health provider shortages and resulting impacts effecting the healthcare environment in Colorado.

Table 1

LOB	Interactions*	Population and Standard of Care Assessed	Providers Assessed+	Providers issued CAP's+	Providers issued RFAI+
All	5	Adult Behavioral Health Non-urgent, symptomatic	2	1	1
All	2	Adult Behavioral Health Outpatient Follow-up after hospitalization	1	0	0
All	2	Pediatric Behavioral Health: Non-urgent, symptomatic	1	1	0
All	4	Adult Physical Health: Urgent	3	0	3
All	18	Adult Physical Health: Non-urgent, symptomatic	9	3	3
All	7	Adult Physical Health: Routine	5	1	1
All	10	Pediatric Physical Health: Urgent	6	1	2
All	8	Pediatric Physical Health: Non-urgent, symptomatic	6	0	1
All	3	Pediatric Physical Health: Routine	3	0	1
All	3	Adult and Adolescent Substance Use Intensive Outpatient: Non-urgent, symptomatic	1	1	0

All	4	Adult Substance Use Withdrawal Management	2	0	0
All	2	Adult and Adolescent Substance Use Outpatient: Non-urgent, symptomatic	1	0	0
Total	**68**	**--**	**22**	**7**	**8**

Interaction Outcome*	Number of Interactions*	Percentage of all Interactions
Appointment is offered and meets Access to Care Standard	24	35.29%
Violate Access to Care Standards	5	7.35%
Unable to assess if Access to Care Standards were met	27	39.71%
Violate other Colorado Access Policies & Procedures or community standards	6	8.82%
CAP Required	12	17.65%
Protocols/resources for appointment scheduling result in additional treatment barriers/overall poor member experience (i.e. inefficiencies in call system IT infrastructure)	9	13.24%
Third Next Available Appointment Requested	10	14.71%
All other Requests for Additional Information	6	8.82%

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 practitioners/practice sites/entities in the MCE's Region.

Enter time and distance compliance results (e.g., "Met" or "Not Met") in the MS Excel template. Use Tables 11, 12, and 13 for additional relevant information regarding the MCE's compliance with time and distance requirements in its contracted counties, including region-specific contracted counties for RAEs' behavioral health networks. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care. For physical health time and distance requirements, MCEs are only required to report compliance with minimum time and distance requirements for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report compliance with minimum time and distance requirements for all members regardless of county residence.

- 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, NPs, and CNS') and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

A practitioner/practice site/entity should only be counted one time in the MCE's data submission for each associated network category (PROVCAT code). If a practitioner provides primary care for adult and pediatric members at a specific location, count the practitioner once under the Adult Primary Care Practitioner PROVCAT code, once under the Pediatric Primary Care Practitioner PROVCAT code, and once under the Family Practitioner PROVCAT code. For example, a primary care nurse practitioner (NP) that serves adult and pediatric members can be categorized with the PV063, PV064, and PV065 PROVCAT codes. That practitioner will then be counted for the minimum network standards for pediatric primary care practitioner (NP) (PV064 and PV065); adult primary care practitioner (NP) (PV063 and PV064); and family practitioner (NP) (PV064).

Table 11–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 contracted 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 its contracted urban Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
Colorado Access continually monitors our network adequacy, and the contracting and provider relations departments work closely with our care management team to address any areas of concern. When there is a need in the network, we actively recruit providers in those areas. COA also continues to get requests from new providers wanting to join the network, and if eligible we make every effort to add them to our panel of providers. COA has a committee dedicated to the recruitment and retention of providers. Currently, the committee is determining the status of all the providers with particular focus on primary care and behavioral health. The provider relations team is reaching out to providers that have not submitted a claim in the last 18 months to ensure they are still in business, taking Medicaid members and what their capacity is to increase their utilization. This information is shared with our internal departments of Care Management, Customer Service and Utilization Management as a means to increase referrals to these identified providers. In the areas of SUD, Colorado Access is continuing to contract with existing and new SUD providers at all ASAM levels for the network. We continue to increase the number of both SUD facilities and beds at all ASAM levels. We currently have 11 SUD facilities in our COA Clinical Review Process that evaluates their clinical readiness to serve Health First Colorado members. As these providers pass the Clinical Review process, they will be added to the network.

Table 12–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 contracted 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 its contracted rural Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
NA

Table 13–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 contracted 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 its contracted frontier Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
NA

Appendix A. Single Case Agreements (SCAs)

Individual practitioners with single case agreements (SCAs) are not counted as part of the MCE's health care network and should be excluded from tabulations in the body of this MS Word report and the associated MS Excel report(s). However, the Department acknowledges the role of SCAs in mitigating potential network deficiencies and requests that the MCE use Tables A-1 and A-2 below to list individual practitioners or SUD treatment facilities with SCAs and describe the MCE's use of SCAs.

Table A-1–Practitioners and SUD Treatment Facilities with SCAs: Data

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	█
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	█
CHP+ MCO, Medicaid MCO, RAE					
Centennial Peaks Hospital	10886753	Boulder	BV140	Mental Hospital	█
Children's Hospital Colorado	9000164954	Adams	BF141	General Hospital with a Psych Unit	█
HMIH Cedar Crest	9000175278	Out of State	BV100R	Residential Treatment Center	█
Katherine Yant, LCSW	9000165905	Denver	BV130	Licensed Clinical Social Worker	█
Texas Health Presbyterian Dallas	95019030	Out of State	BF141	General Hospital with a Psych Unit	█

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA

Table A-2–Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
CHP+ MCO, Medicaid MCO, RAE
When necessary, COA enters into a SCA with a non-participating provider (based on requests from our UM and/or Care Management department). Once a SCA is completed, we will reach out to the provider to ask them if they are interested in joining the network or amending their contract to add the service. If interested, we follow our usual policy and procedures with respect to the contracting process.

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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.

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

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Appendix C. Optional MCE Content

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