



**COLORADO**

**Department of Health Care  
Policy & Financing**

# Network Adequacy Quarterly Report Template

Managed Care Entity: *Colorado Access*

Line of Business: *RAE 3*

Contract Number: *19-107514A13*

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Report due by *04/28/2023*, covering the MCE's network from *01/01/2023 – 03/31/2023*, FY22-23 Q3

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# 1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the March 2023 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 (December 2022 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 2022-23 Q1	October 2022	September 30, 2022
FY 2022-23 Q2	January 2023	December 31, 2022
FY 2022-23 Q3	April 2023	March 31, 2023
FY 2022-23 Q4	July 2023	June 30, 2023

## Definitions

- “MS Word template” refers to the *CO Network Adequacy\_Quarterly Report Word Template\_F1\_0323* document.
- “MS Word MCE Data Requirements” refers to the *CO Network Adequacy\_MCE\_DataRequirements\_F1\_1222* 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) <i>(Hospitals, Pharmacies, Imaging Services, Laboratories)</i>	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 <i>(RAEs’ network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)</i>	X		X
Ancillary Physical Health Services <i>(Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy)</i>	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.

## 2. Network Adequacy

### 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., March 30, 2023, for the quarterly report due to the Department on April 28, 2023).
- 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., March 30, 2023, for the quarterly report due to the Department on April 28, 2023).
  - 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
<i>Sample</i>	0	0.0%	0	0.0%
<b>CHP+ MCO, Medicaid MCO, RAE</b>				
Total members	386671	N/A	385579	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with “PV” or “PG”)	3663	N/A	2737	N/A
Primary care practitioners accepting new members	2261	61.73%	2125	77.64%
Primary care practitioners offering after-hours appointments	52	1.42%	51	1.86%
New primary care practitioners contracted during the quarter	13	.355%	41	1.50%
Primary care practitioners that closed or left the MCE’s network during the quarter	6	.164 %	22	.804%

**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**

Colorado Access (COA) monitors its primary care medical provider (PCMP) clinic sites across Region 3 to ensure adequate clinic to member ratio coverage. COA continues to review and grow its PCMP network to ensure all covered services are accessible to members without unreasonable delay. COA’s practice facilitators and the Provider Network Services (PNS) team are regularly engaged with providers and quickly respond to barriers providers could face which may impact access to care. Through this high touch interaction, practice facilitators and network managers are quickly able to see turnover in provider offices and help support onboarding of specific new hires with training focused on Health First Colorado (Colorado’s Medicaid program) rules and regulations, such as the access to care standards.

Every contracted Region 3 PCMP has an assigned practice facilitator from COA’s Practice Support Team. As a part of their engagement with providers, the facilitators monitor attribution, closed panels and capped attribution as they work to support providers in increasing their engagement with their attributed members, which aligns with the primary care value-based payment utilization component. COA has implemented new performance dashboards to help providers focus on priorities to help mitigate burnout and provide a more efficient way to review data and metrics. In addition, practice support staff aid providers in maximizing funding potential in the value-based payment program. On a monthly basis, COA staff share a newly designed scorecard with providers that reflects their performance across all value-based payment measures. With this scorecard, providers are able to compare themselves against similar providers and quickly identify opportunities for improvement.

Practice facilitators and network managers track member attribution rates at the practice level and gauge provider capacity leading to an increase or decrease in cap limits. Decreases in cap limits are most commonly associated with staff turnover and the inability to fill vacancies with qualified individuals. For some practices, this challenge has remained constant over the last three years. COA recognizes the current capacity and workforce shortages experienced by network practices. COA continues to support providers’ business operations and staffing needs in a variety of ways. COA provides resources to reduce burnout professionally and operationally, and regularly promotes resources tied to physical and behavioral health support in COA’s provider newsletters, the *Provider Update* and *Navigator*. COA has also positioned its practice supports and PNS provider-facing teams to train, educate and leverage core COA programs to support providers. These programs include contracting support, access to care standards, telehealth support, data and value-based care programs and incentives.

The Practice Support and Quality teams continue to convene PCMP workgroups to focus on key performance indicators. Depression screening is the focus of the current group, which was convened in the fall of 2022 and will continue through June 2023. Participants share best practices, challenges and barriers impacting their

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**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**

work, and determined an improvement plan for the depression screen and follow-up measures using data to help inform their action steps.

Additionally, the Practice Support team has implemented bi-monthly Provider Resource Groups within the COA Provider Network. The Provider Resource Groups allow providers to stay informed on different topics that can be applied to their day-to-day operations. In February, a Provider Resource Group took place focused on the Continuous Coverage Unwind. The attendees of the presentation were invited to partake in a conversation regarding the current state of the Public Health Emergency (PHE) and the end of the continuous coverage requirement. Updates on the renewal process and data were shared during the session. An open conversation also took place allowing providers to share the support they need in response to changes. The upcoming Provider Resource Groups will feature guest presenters from the Alliance for HPV Free Colorado and the Behavioral Health and Wellness Program at the University of Colorado.

Regarding family planning services, COA has worked directly with reproductive health providers (OB/GYN) in Region 3 to develop a value-based payment model focused on family planning services. The newly developed Reproductive Health Model went live in July 2022. COA believes this will support growth, provider satisfaction and sustainability within the reproductive health network.

During Q2 State Fiscal Year 2022-2023, 99.43% of the COA Region 3 PCMP networks reported data on family planning services and 99.98% of Region 3 members were attributed to these sites. The average rate of family planning services, as reflected on a claim, across the Region 3 PMCP network during this time was 12.58%, with a higher rate of 17.92% observed in the reproductive health provider cohort. Due to claims runout, data is reported on a three-month lag, which is why the previous quarter is included in this report.

It is important to note that the network’s ability to provide family planning services extends well beyond the number of contracted OB/GYN providers. Family planning services are made available to all members, both women and men, through their primary care providers, as family planning is not limited to women's health services. Therefore, COA has a very robust network of providers who perform family planning services.

Regarding telehealth, COA continues to provide services to improve access. COA educates providers on new telehealth rules through webinars and provider resource groups hosted by its Practice Support team. COA also continues to promote the use of telehealth services in its provider newsletters which helps educate providers on new telehealth policies or coding updates. Lastly, COA’s provider directory lists providers that offer telehealth services.

Through its telehealth platform, COA’s Virtual Care Collaboration and Integration (VCCI) Program continues to enhance access to health care within participating network providers. In Q3, the VCCI Program partnered

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**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**

with the Pediatric Care Network to pilot VCCI with four of its primary care practice sites. Trainings and protocols have been completed for these sites which have started to utilize VCCI for consults and referrals. The VCCI program allows PCMPs to refer members to be seen for short-term/brief intervention treatment over telehealth by VCCI clinicians and psychiatrists either within the primary care setting or directly in the member’s home. The VCCI Program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member’s medical home. The VCCI Program includes an eConsult component that allows its participating PCMPs to directly query a VCCI psychiatrist via asynchronous HIPAA-secure email for a rapid response to their psychiatric questions. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care, and works with COA care management to coordinate connections to primary care and manage referrals to long-term care and other resources as needed. The VCCI Program incorporated further updates to its online scheduling provider portal, based on feedback from its primary care provider (PCP) partners, to increase efficiency for patient referrals and the sharing of clinical information through this HIPAA-secure web-based platform. Within this provider portal, scheduling, progress notes, consent forms, and demographic information can be shared to optimize the coordination of member care with VCCI’s participating PCMPs.

In order to address the recent challenges in telehealth utilization, COA’s telehealth team is working to make changes to the VCCI model that will allow the organization to work with larger practices and expand access for COA members. VCCI continues to prioritize working with PCMPs to coordinate care and connect members with care managers. The COA telehealth team is actively engaged in conversations with the community to better understand community DE&I needs and continues working with providers to ensure telehealth providers are reflective of the diverse needs and identities of COA members. The telehealth team is also working with the COA internal DE&I team to increase utilization of VCCI services among marginalized communities and practices.

**TERMINATIONS:**

All terminations were roster clean-ups or life events.

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



Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
<i>Sample</i>	0	0.0%	0	0.0%
<b>CHP+ MCO, Medicaid MCO, RAE</b>				
Total members	386671	N/A	385579	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with “BV” or “BG”)	8189	N/A	7747	N/A
Behavioral health practitioners accepting new members	5317	64.93%	1268	16.37%
Behavioral health practitioners offering after-hours appointments	98	1.20%	108	1.39%
New behavioral health practitioners contracted during the quarter	109	1.33%	146	1.88%
Behavioral health practitioners that closed or left the MCE’s network during the quarter	32	.391%	77	.994%

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

Requirement	Previous Quarter	Current Quarter
	Number	Number
<i>Sample</i>	0	0
<b>RAE</b>		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	10	10
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	11	11
Total SUD treatment facilities offering ASAM Level 3.7 services	4	4
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	8	9
Total SUD treatment facilities offering ASAM Level 3.7 WM services	3	4

**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 recognizes the current capacity and workforce shortages experienced by behavioral health practices. COA continues to support providers’ business operations and staffing needs in a variety of ways. COA provides resources to reduce burnout professionally and operationally, and regularly promotes resources tied to physical and behavioral health support in COA’s provider newsletters, the *Provider Update* and *Navigator*. COA has also positioned its practice supports and PNS provider-facing teams to train, educate and leverage core COA programs to support providers. These programs include contracting support, access to care standards, telehealth support, data, and value-based care programs and incentives.

Regarding telehealth, COA continues to provide services to improve access to behavioral health. COA educates providers on new telehealth rules through webinars and provider resource groups hosted by its Practice Support team. COA also continues to promote the use of telehealth services in its provider newsletters which helps educate providers on new telehealth policies or coding updates. Lastly, COA’s provider directory lists providers that offer telehealth services.

The Virtual Care Collaboration and Integration (VCCI) Program at COA continues to provide increased access to behavioral health care for its participating network providers. In Q3, the VCCI Program partnered with the Pediatric Care Network to pilot VCCI with four of its primary care practice sites. Trainings and protocols have been completed for these sites which have started to utilize VCCI for consults and referrals. The VCCI program allows PCMPs to refer members to be seen for short-term/brief intervention treatment over telehealth by VCCI clinicians and psychiatrists either within the primary care setting or directly in the member’s home. The VCCI Program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member’s medical home. The VCCI Program includes an eConsult component that allows its participating PCMPs to directly query a VCCI psychiatrist via asynchronous HIPAA-secure email for a rapid response to their psychiatric questions. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care and works with COA care management to coordinate connections to primary care and manage referrals to long-term care and other resources as needed. The VCCI Program continues to expand and evolve its services to meet the increased need for behavioral health care. The VCCI Program incorporated further updates to its on-line scheduling provider portal, based on feedback from its PCMP partners, to increase efficiency for patient referrals and the sharing of clinical information through this HIPAA-secure web-based platform. Within this provider portal, scheduling, progress notes, consent forms, and demographic information can be shared to optimize the coordination of member care with VCCI’s participating PCMPs.

In order to address the recent challenges in telehealth utilization, COA’s telehealth team is working to make changes to the VCCI model that will allow the organization to work with larger practices and expand access for

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 members. VCCI continues to prioritize working with PCMPs to coordinate care and connect members with care managers to support holistic care. The COA telehealth team is actively engaged in conversations with the community to understand community DE&I needs and continues working with providers to ensure telehealth providers are reflective of the diverse needs and identities of COA members. The telehealth team is also working with the COA internal DE&I team to increase utilization of VCCI services among marginalized communities and practices.

The “accepting new patients” number has decreased due to Truven being the data source in prior reports. However, Truven should not have been considered the source of truth for this data as it does not capture data specific to COA. The code has been updated to pull the data directly from COA’s claims system, HRP. In Q3, there were 6,678 Behavioral Health providers in the Independent Provider Network (IPN).

**ASAM levels**

COA continues to contract with existing and new substance use disorder (SUD) providers at all ASAM levels. Providers must pass a clinical quality review process in order to become contracted as a SUD provider. There are currently 17 contracted providers who offer residential and detox levels of care to COA members.

**Barriers**

In Q3, COA continued to experience some barriers related to behavioral health that could negatively impact its ability to maintain a sufficient network for behavioral health services in Adams, Arapahoe, Douglas and Elbert Counties. All time and distance standards are met with the exception of SUD facilities at ASAM levels 3.3, 3.7 and 3.7 WM. According to the geoaccess report, 0% of these meet time and distance standards.

**Mitigating barriers**

COA continues to provide telehealth services to improve access. COA educates providers on new telehealth rules through webinars and provider resource groups hosted by its Practice Support team. COA is also promoting the use of telehealth in its provider newsletters which help educate providers on new telehealth policies or coding updates. COA’s provider directory lists providers that offer telehealth services. At this time, COA does not capture telehealth service data. On January 6, 2023, the Network Adequacy Validation workgroup (a monthly meeting with all RAEs present and led by Sandi Wetenkamp of the Department) began discussion about how to capture telehealth data and is working toward integrating the data into the quarterly report.

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**

**Mitigating Barriers - Attestation Process for unlicensed/pre-licensed clinicians to render services**

Colorado Access participates with the other RAEs to permit unlicensed/pre-licensed clinicians to render services to Health First Colorado members. The standards identified in the process are intended to safeguard the public while also maintaining the integrity of the health care profession. The greatest priority of the RAEs is maintaining a high clinical standard of care for members. The newly aligned standards will help ensure that unlicensed providers within mental health organizations and integrated care settings are receiving appropriate supervision and oversight, with the goal of quality member care that also supports expanding the workforce pipeline. A provider group will complete an initial attestation (with annual follow-up) that underscores adherence to established standards in conjunction with regular audit activities.

**Other Support**

Due to the lack of Colorado-based inpatient eating disorder clinics that currently accept Health First Colorado, COA has contracted with Walden Behavioral Health out of Boston, MA to offer behavioral health care to COA members who require eating disorder services.

COA provides pre-contracting and ongoing coaching support to its behavioral health network. COA continues to utilize two behavioral health practice facilitators to offer application support for providers struggling to meet quality metrics. Practice facilitators are meeting individually with providers who have an application in progress to create or improve administrative practices and procedures, develop new workflows to improve authorization procedures and/or transitions of care, develop and organize training plans and requirements and develop clinical oversight processes. At this time, COA continues to permit all SUD providers who are validated by the State, and not yet contracted with COA, to render SUD treatment and receive out-of-network rates.

As of December 2022, COA requires ASAM level 3.1 and higher providers to complete clinical reviews in order to contract. Prospective providers must meet a minimum of 18 Quality measures as a condition of participation. Providers that fall short of any of these measures are invited to attend a remediation meeting with behavioral health facilitators to enhance and, if necessary, create new policies, procedures and workflows that adhere to COA standards. When remediation is complete, providers may re-apply. COA practice facilitators will continue to provide support to ASAM level 1 and 2.1 providers as needed or by request. Each ASAM level of care has unique requirements.

**TERMINATIONS:** All terminations were roster clean-ups or life events.

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**

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
<i>Sample</i>	0	0.0%	0	0.0%
<b>CHP+ MCO, Medicaid MCO</b>				
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**

<p><b>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.</b></p> <p><b>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.</b></p>
<p><b>CHP+ MCO, Medicaid MCO</b></p>
<p>N/A to the Region 3 report.</p>

### 3. Network Changes and Deficiencies

#### Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes or deficiencies in MCE Networks related to access to care.

**Table 4–Network Changes: Discussion**

<p>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.</p> <p><b>Note:</b> 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.</p>
<p><b>CHP+ MCO, Medicaid MCO, RAE</b></p>
<p>Internal quality, compliance and provider engagement departments monitor the network and track providers related to quality of care, competence, and professional conduct. COA has not experienced a change in the network this quarter.</p>

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

<p>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:</p> <p>Did the MCE notify the Department, in writing, within ten (10) business days of the change?</p> <p>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?</p> <p>Was the change due to a practitioner/practice site/entity’s failure to receive credentialing or re-credentialing from the MCE?</p>
<p><b>CHP+ MCO</b></p>
<p>N/A to the Region 3 report.</p>

## 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**

<p><b>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?</b></p> <p><b>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?</b></p>
<p><b>CHP+ MCO</b></p>
<p>N/A to the Region 3 report.</p>

**Table 7—CHP+ MCO Discontinue Services to an Entire County: Discussion**

<p><b>Did the MCE discontinue providing covered services to members within an entire county within the MCE’s service area?</b></p> <p><b>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?</b></p>
<p><b>CHP+ MCO</b></p>
<p>N/A to the Region 3 report.</p>

**Table 8—CHP+ MCO Provider Network Changes: Discussion**

<p><b>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?</b></p> <p><b>If the MCE answered “yes”, did the MCE notify the Department, in writing, of the change?</b></p>
<p><b>CHP+ MCO</b></p>
<p>N/A to the Region 3 report.</p>



## 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.
<b>CHP+ MCO, Medicaid MCO, RAE</b>
<p>As documented in previous Network Adequacy reports, COA has relied on the Access to Care program to monitor its contracted providers’ compliance with access to care standards. Over the past few quarters, COA has had the opportunity to evaluate the impact of the Access to Care program in order to further align this monitoring tool with additional network management efforts. During this review process, COA observed the unprecedented challenges faced by providers based on the environment surrounding the pandemic. Providers have been vocal about increased issues of staff shortages, high staff turnover, shortened office hours due to illnesses and provider burnout.</p> <p>Considering the pressures on providers, COA is expanding its ability to evaluate and monitor access to care standards. This evolved model is built upon data and outcomes obtained from the Access to Care program and, specifically, data trends in practices that were not passing the standards for which they were being tested. It was recognized that rotating staff in the front office significantly contributed to challenges in adhering to the access to care standards. As a result, this new model will consist of a collaborative training program with providers that is targeted towards all aspects of access to care requirements, including a specific dedication to training front office staff on Health First Colorado rules. COA believes that regular and consistent office training is the key to understanding and adhering to program requirements and will help practices be more successful with completing COA network monitoring programs, such as Access to Care.</p> <p>In Q3, COA continued its enhanced training program for access to care standards targeting specific areas of practice to ensure all staff understand and adhere to the standards. Examples include training on appointment scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. This training is conducted in person preferably (virtual if necessary) and includes leave-behind materials. Providers are randomly selected to participate in this COA-led training. All training will be available on COA’s Learning Management System (LMS) and will be accessible to all providers at any time.</p> <p>Each practice staff member who sets patient appointments will be asked to complete the training. Each staff member has three attempts to pass the training test. Once a practice has received the training, they will be referred to COA’s Quality department for the assessment portion of the program. COA conducts mock telephone calls or online inquiries to providers that mirror common member behavior to test consistency of provider behavior and availability of services. All test calls are based on validated scripts built internally by COA and describe specific scenarios tied to access to care standards outlined in the contract. COA has both adolescent and adult call scripts. For practices that are unable to be assessed via telephone calls or online</p>

inquiries, the Quality team will collaborate with the practice to complete a Third Next Available Appointment request, a Quality Management industry standard for the monitoring of access to care.

Each provider receives a summary report of their performance and relevant findings. If practices fail the assessment portion of the program, indicating that they are unable to meet access to care timeliness standards and contractual agreements, the Quality department may identify an opportunity for quality improvement. The purpose of this opportunity is to offer support, education and resources to practices for process improvement. This allows practices to develop and implement a practice-specific quality improvement plan that will improve access to care for members. COA assists practices with the creation of a quality improvement plan that is completed and approved within approximately 30 days after receiving results and implemented within 60 days after approval. The intent is to better understand what barriers practices are experiencing and to assist practices in creating an individualized improvement plan with the knowledge of these existing barriers.

As mentioned above, practices are randomly selected to participate in COA-led access to care training. The COA Quality team will randomly select practices for inclusion in the training. The Quality department uses a stratified process to select 50 behavioral health (BH) or physical health (PH) providers and forwards them to the PNS team so the providers can train prior to being secretly shopped. The Quality team is responsible for selecting the providers and the PNS team is responsible for training. During Q3, the PNS team underwent a staff transition, so no PH providers were trained or assessed by Quality. However, in Q4, PNS will train PH providers and results will be provided in the next report.

**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**

As documented in previous Network Adequacy reports, COA has relied on the Access to Care program to monitor its contracted providers’ compliance with Access to Care standards. Over the past few quarters, COA has had the opportunity to evaluate the impact of the Access to Care program in order to further align this monitoring tool with additional network management efforts. During this review process, COA observed the unprecedented challenges faced by behavioral health providers based on the environment surrounding the pandemic. Providers have been vocal about increased issues of staff shortages, high staff turnover, shortened office hours due to illnesses and provider burnout.

Considering the pressures on providers, COA is expanding its ability to evaluate and monitor access to care standards. This evolved model is built upon data and outcomes obtained from the Access to Care program and, specifically, data trends in practices that were not passing the standards for which they were being tested. It was recognized that rotating staff in the front office significantly contributed to challenges in adhering to the access to care standards. As a result, this new model will consist of a collaborative training program with providers that is targeted towards all aspects of access to care requirements, including a specific dedication to training front office staff on Health First Colorado rules. COA believes that regular and consistent office training is the key to understanding and adhering to program requirements and will help practices be more successful with completing COA network monitoring programs, such as Access to Care.

COA has continued its enhanced training program for Access to Care standards targeting specific areas of practice to ensure all staff understand and adhere to the standards. Examples include training on appointment

scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. This training is conducted in person preferably (virtual if necessary) and includes leave-behind materials. Providers are randomly selected to participate in this COA-led training. Any practice that experiences turnover in staff key to access to care compliance (front office, office manager etc.) will have training scheduled for all new staff within two weeks of notification. All training will be available on COA's Learning Management System (LMS) and will be accessible to all providers at any time.

Each practice staff member who sets patient appointments will be required to complete the training. Once a practice has received the training, they will be referred to COA's Quality department for the assessment portion of the program. COA conducts mock telephone calls or online inquiries to providers that mirror common member behavior to test consistency of provider behavior and availability of services. All test calls are based on validated scripts built internally by COA and describe specific scenarios tied to access to care standards outlined in the contract. COA has both adolescent and adult call scripts. For practices that are unable to be assessed via telephone calls or online inquiries, the Quality team will collaborate with the practice to complete a Third Next Available Appointment request, a Quality Management industry standard for the monitoring of access to care.

Each provider receives a summary report of their performance and relevant findings. If practices fail the assessment portion of the program, indicating that they are unable to meet access to care timeliness standards and contractual agreements, the Quality department may identify an opportunity for quality improvement. The purpose of this opportunity is to offer support, education and resources to practices for process improvement. This allows practices to develop and implement a practice-specific quality improvement plan that will improve access to care for members. COA assists practices with the creation of a quality improvement plan that is completed and approved within approximately 30 days after receiving results and implemented within 60 days after approval. The intent is to better understand what barriers practices are experiencing and to assist practices in creating an individualized improvement plan with the knowledge of these existing barriers.

As mentioned above, practices are randomly selected to participate in COA-led Access to Care training. The COA Quality team will randomly select practices for inclusion in the training. The Quality department uses a stratified process to select 50 behavioral health (BH) providers and forwards them to the PNS team so the providers can train prior to being secret shopped. The Quality team is responsible for selecting the providers and the PNS team is responsible for training.

During Q1 State Fiscal Year 2022-23, the PNS team conducted Access to Care training courses on 18 practice sites. Overall, COA is consistently monitoring areas of failure to identify themes to enhance its training programs. Sixteen of the trained practices have been assessed for adherence to timeliness standards. Four practices passed, eight practices are currently completing a Third Next Available Appointment Request, three practices did not meet Access to Care Timeliness Standards, and one practice was found to need education around voicemail best practices. During Q2 State Fiscal Year 2022-23, the PNS team conducted Access to Care training for 19 SUD providers. Eighteen of those providers are currently undergoing assessment. Assessment results for these providers will be provided in the next update. In Q3, a list of large provider practices who have both physical and behavioral health claims on file was created. Fourteen large provider practices will receive Access to Care training next quarter. Most of these large entities have call centers and multiple clinic locations, so assessments will most likely be done by Third Next Available Appointment Requests rather than mock calls to their facilities. Results for these providers will be included in the next update.

In addition to the Access to Care program, COA’s Contracting team provides additional funding to community mental health centers (CMHCs). This supports CMHCs in hiring additional staff to help with operations and clinical work, which results in greater access to services.

Access to Care Program Metrics: 2022-2023				
Quarter	Practices Trained:	Training Results	Practices Secret Shopped:	Secret Shopper Results
Q3 (January - March)	<i>*Due to Staff transitions, no new providers were trained during Q3.</i>	<i>*19 SUD providers were trained in Q2 and 19 BH providers were trained in Q1.</i>	Results correspond to the 19 BH providers trained in Q1.  16 providers in this subset were assessed.	<i>BH providers:</i> Passed: 4 Completing TNAAs: 8 Failed: 3 Require education: 1

## 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. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health 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**

COA continually monitors its network adequacy, and the Contracting and PNS teams work closely with the Care Management department to address any areas of concern. When there is a need in the network, COA actively recruits providers in those areas. COA also continues to receive requests from new providers wanting to join the network; if eligible, COA makes every effort to add them to its panel of providers. COA has hired a Provider Recruitment Program Manager to develop, implement, and direct a data driven strategy to recruit and maintain a provider network of culturally responsive providers based on the needs of COA members in their communities.

Currently, through a data driven process, the provider recruitment program is determining the status of all providers, with particular focus on primary care and behavioral health. The PNS team continues to outreach providers that have not submitted a claim in the last 18 months to ensure they are still in business and accepting Health First Colorado members, and to discuss what their capacity is for increasing access to appointments. This information is shared with Care Management, Customer Service, and Utilization Management departments to increase referrals to these identified providers.

Below are the categories of unmet providers. The percentages are with which the categories are met.

**Adams:**

Network Category	% With Access
Pediatric SUD Treatment Practitioner	99
General SUD Treatment Practitioner	99.9
Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals	94.4
SUD Treatment Facilities-ASAM 3.1	98.9
SUD Treatment Facilities-ASAM 3.3	0
SUD Treatment Facilities-ASAM 3.5	99.2
SUD Treatment Facilities-ASAM 3.7	0
SUD Treatment Facilities-ASAM 3.2 WM	97.6
SUD Treatment Facilities-ASAM 3.7 WM	0
Pediatric Primary Care Practitioner (MD,DO)	99.9
Pediatric Primary Care Practitioner (PA)	99.9

Adult Primary Care Practitioner (MD, DO)	99.9
Adult Primary Care Practitioner (PA)	99.9
Family Practice Practitioner (MD, DO)	99.9
Family Practice Practitioner (PA)	99.9

**Arapahoe:**

Network Category	% With Access
Pediatric SUD Treatment Practitioner	98.9
General SUD Treatment Practitioner	99.3
Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals	98.7
SUD Treatment Facilities-ASAM 3.1	99.2
SUD Treatment Facilities-ASAM 3.3	0
SUD Treatment Facilities-ASAM 3.5	99
SUD Treatment Facilities-ASAM 3.7	0
SUD Treatment Facilities-ASAM 3.2 WM	97
SUD Treatment Facilities-ASAM 3.7 WM	0

**Douglas:**

Network Category	% With Access
Family Practitioner (MD, DO, NP, CNS)	99.9
Adult Primary Care Practitioner (MD, DO, NP)	99.9
Adult Primary Care Practitioner (PA)	99.9
Pediatric SUD Treatment Practitioner	99.9
Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals	98.7
SUD Treatment Facilities-ASAM 3.1	99.2
SUD Treatment Facilities-ASAM 3.3	0
SUD Treatment Facilities-ASAM 3.5	99
SUD Treatment Facilities-ASAM 3.7	0
SUD Treatment Facilities-ASAM 3.2 WM	46.1
SUD Treatment Facilities-ASAM 3.7 WM	0

**Elbert:**

Network Category	% With Access
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Pediatric Primary Care Practitioner (MD, DO, NP)	99.5	
Pediatric Primary Care Practitioner (PA)	99.5	
Family Practitioner (MD, DO, NP, CNS)	99.2	
Family Practitioner (PA)	99.2	
Adult Primary Care Provider (MD, DO, NP)	99	
Adult Primary Care PA	99	
Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals	83.2	
SUD Treatment Facilities-ASAM 3.1	96.4	
SUD Treatment Facilities-ASAM 3.3	0	
SUD Treatment Facilities-ASAM 3.5	96	
SUD Treatment Facilities-ASAM 3.7	0	
SUD Treatment Facilities-ASAM 3.2 WM	89.6	
SUD Treatment Facilities-ASAM 3.7 WM	0	

**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. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health 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**

Region 3 does not have any rural areas.

**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. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health 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**

Region 3 does not have any frontier areas.

## 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
<i>Franklin Q. Smith</i>	<i>0000000</i>	<i>Denver</i>	<i>PV050</i>	<i>Adult Only Primary Care</i>	■
<i>Chrysalis Behavioral Health</i>	<i>0000000</i>	<i>Baca</i>	<i>BF085</i>	<i>SUD Treatment Facility, ASAM Levels 3.1 and 3.3</i>	■
<b>CHP+ MCO, Medicaid MCO, RAE</b>					
Cornell Corrections of California, Inc.	42679249	Douglas	BV100R	Residential Treatment Center	■
Courage to Change Counseling	9000208173	Arapahoe	BV080	Licensed Addiction Counselor	■
Lakeland Hospital Acquisition, LLC	9000191672	Weld, Arapahoe	BV140	Mental Hospital	■
Melissa Frick	9000200771	Weld	BV132R	Licensed Professional Counselor	■
Rolling Hills Hospital, LLC	9000183237	Arapahoe, Adams	BV140	Mental Hospital	■
Texas San Marcos Treatment Center	9000206609	Arapahoe	BV100R	Residential Treatment Center	■
UHS of Wyoming, Inc.	9000164152	Arapahoe	BV140	Mental Hospital	■

**Table A-2–Practitioners with SCAs: Discussion**

<p><b>Describe the MCE’s approach to expanding access to care for members with the use of SCAs.</b></p> <p><b>Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.</b></p>
<p><b>CHP+ MCO, Medicaid MCO, RAE</b></p>
<p>When necessary, COA enters into a single case agreement (SCA) with a non-participating provider based on requests from its Utilization Management and/or Care Management department. Once an SCA is complete, COA contacts the provider to ask if they are interested in joining the network or amending their contract to add the service. If interested, COA follows its usual policy and procedures with respect to the contracting process.</p>

## 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*

## 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.