COLORADO
Department of Health Care Policy & Financing

FY 2019–2020 Network Adequacy Quarterly Report Template

Managed Care Entity: *Health Colorado, Inc.*

Line of Business: *RAE*

Contract Number: *19-107515*

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Report due by 4/30/2020, covering the MCE's network from 1/1/2020 – 3/31/2020, FY Q3

—Final Copy—

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1. Instructions for Using the Network Adequacy Quarterly Report Template

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

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

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

Definitions

- "MS Excel template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Excel Template_F1_0320* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_0320* document.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.
- A "practice site" 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.

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

Network Category	CHP+ MCO	Medicaid MCO	RAE
Facilities (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	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., March 31, 2020, for the quarterly report due to the Department on April 30, 2020).
- To count practitioners:
  - Include each unique practitioner contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2020, for the quarterly report due to the Department on April 30, 2020).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

Define unique 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/PCMP Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	121,451	N/A	120,176	N/A
Total primary care practitioners/PCMP practitioners	372	N/A	433	N/A
Primary care practitioners/PCMP practitioners accepting new members	365	98.12%	432	99.77%
Primary care practitioners/PCMP practitioners offering after-hours appointments	117	31.45%	160	36.95%
New primary care practitioners/PCMP practitioners contracted during the quarter	0	0%	82	18.94%
Primary care practitioners/PCMP practitioners that closed or left the MCE's network during the quarter	1	0%	21	4.85%

Table 1B-Establishing and Maintaining the MCE Network: Primary Care/PCMP Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners/PCMP practice sites to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
Health Colorado, Inc. (HCI) has a network of PCPs that cover all counties of the RAE region and meets the time and distance standards for all type of primary care practitioners. This network includes contracts with essential community providers such as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), in addition to private and non-profit Medicaid enrolled PCMPs that serve both adults and children. The exception is OBGYN providers that are also primary care practitioners. There were five (5) new practice sites that are reported in the third quarter from the previous report. Out of those, three (3) practice sites were affiliated during the reporting period. Currently contracted PCPs added locations as follows: 1- Valley-Wide Health Systems added a location in Ordway. This is the same practice site from the terminated PCP, Centennial Family Health Center. 2- Pueblo Community Health Center added one of their existing locations in Pueblo 3- Centura Health added a location in Pueblo West As for the remaining two (2) locations, we identified that these practice sites were affiliated before the reporting period; however, they were not reported in the previous report. Pueblo Women's Center is a location under Parkview Ancillary Group that is no longer providing primary care services at the location. Some of their providers were transitioned to another location to continue to render services. The members were re-attributed to other PCP practices based on the State's attribution methodology. HCI continues to validate and update providers that are part of PCMP practices to appropriately report the primary care practitioners that are also OB/GYN providers. Across the region, there is a shortage of primary care practitioners that are also OB/GYN providers which limits the ability to serve Members within the PCMP setting. During the reporting period, HCI outreached to the contracted practices serving adults and women to validate their practitioner roster who offer OB/GYN services. This process identified 11 OB/GYN providers not previously listed in Alamosa, Salida, and Pueblo areas. HCI implemented a strategy to review the Enrollment Summary Report that has information of providers with claims history with Medicaid Members and includes non-contracted providers. HCI used this data to identify PCMP practices within the 19 counties that had claims history for more than 100 Medicaid Members within Region 4 and had a PCMP Medicaid ID. HCI identified a family practice, Canon City Family Medicine in Canon City. Additionally, the practice has a contract with Colorado Psychiatric Access and Consultation for Adults & Kids (CPAC). The practice was outreached for recruitment to join the network as a PCMP; however, they declined to participate stating they were not interested. We will be following up with the practice to

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners/PCMP practice sites to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
understand their lack of interest and address their concerns for recruitment in the future. HCI will continue to review Enrollment Summary Report data as it may change for potential providers to recruit. HCI consistently monitors contracted PCMPs ability to ensure compliance of access to care standards. As a result, the focus was primarily on notifying the providers about the results of their access to care audit. Providers will be re-audited to monitor their compliance and track the effectiveness of the outreach. Additionally, few practices are open to offer extended hours due to the resources needed to provide proper coverage. HCI will be updating the outreach strategy based on provider feedback, level of compliance, and best practices to improve access within the network.

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	121,451	N/A	120,176	N/A
Total behavioral health practitioners	1,969	N/A	2,069	N/A
Behavioral health practitioners accepting new members	1,969	100%	2,069	100%
Behavioral health practitioners offering after-hours appointments	446	22.65%	474	22.91%

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Table 2B-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.
CHP+ MCO, Medicaid MCO, RAE
HCI continues to enhance its established regional and statewide network of behavioral health providers to comply with the network access to care standards. Overall, HCI has a robust network for behavioral health to meet the needs of the membership. HCI continues to recruit providers using the following strategies to strengthen the network, specifically to increase substance use disorder (SUD) and pediatric behavioral health providers within the rural and frontier counties. 1- Utilizing current listings of Health First Colorado (Medicaid) participating providers and Department of Regulatory Agency (DORA) registry to identify providers within the region. HCI outreached providers identified through the listings of Health First Colorado participating providers and the Department of Regulatory Agency (DORA) Registry. The majority of the providers with service locations in the rural and frontier counties identified through these listings are associated with the local Community Mental Health Centers (CMHCs). Additionally, the providers not associated with CMHCs were not Health First Colorado enrolled providers based on the available information. The outreach has had limited success as these providers are currently not serving Health First Colorado (Medicaid) Members and have limited incentive to join the network. Provider Relations will continue to outreach these providers for recruitment and learn more effective approaches to recruit providers to serve Medicaid Members. 2- Tracking utilization, Single Case Agreement (SCA) data, and historical claims information to identify providers who are currently providing services to Health First Colorado (Medicaid) Members. Provider Relations has focused recruitment efforts on providers that are actively serving HCI assigned Members through SCAs. As part of the on-going monitoring of the SCA data, Provider Relations is actively outreaching providers that have received four (4) or more SCAs in the previous six (6) months. During the reporting period, there were 23 providers that rendered services through SCAs of which, six (6) providers were seeing four (4) or more Members. The efforts and feedback from providers are continually reviewed to track progress for the recruitment. This process helps identify and address potential barriers to recruit specific provider (e.g., rates). Of the six (6) providers identified, three (3) are currently in the credentialing process, one (1) is affiliated with a CMHC, and two (2) are pending response to attempted outreaches. This is also an opportunity to better understand the gaps in specialty services within the network (e.g., psychiatrists) and prioritize their recruitment. 3- For services in counties where behavioral health providers are limited, HCI has network providers that offer telehealth services to Members in our rural and frontier areas. There has been an increased interest from Medicaid enrolled providers to offer telehealth services. They report using telehealth services when Members are not able to travel long distances to keep their appointment. Telehealth providers are available to all HCI Members in the region upon request.

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.
CHP+ MCO, Medicaid MCO, RAE
As a result of the COVID-19 crisis, which began at the end of the third quarter, telehealth has become a stronger focus to ensure behavioral health access. HCI is working closely with providers to educate them on telehealth requirements, billing, and documentation. This has been driven through Provider Alerts, dedicated webpage with updated information, and weekly provider support calls to address specific provider questions. We expect that Member and provider exposure to telehealth during this crisis will increase their comfort level with the technology. This may help expand Member request for telehealth and providers' willingness to offer these services moving forward, which may increase utilization overall. HCI will continue to monitor the changing environment of telehealth to support providers as they build capacity and sustainability. 4- Improving operational processes to successfully recruit and report behavioral health providers. For the past two quarters, HCI has implemented changes to its operational process with the goal of gaining efficiency in our credentialing process. We have seen net increase of 100 providers from the report due to operational changes as well as validating facility provider rosters. HCI implemented new credentialing processes including: • Credentialing application through an online system; • Added new credentialing staff; • Implemented process to monitor applications through the process and identify potential barriers for successful credentialing; and • Dedicated resource to communicate with providers on the status of their application, assist with any required documentation, and coordinate across departments. These improvements have improved our ability to address provider concerns by providing transparency on the status of their application. At the end of the reporting period, there were 168 behavioral health individual providers and facilities in the credentialing process. This was a slight increase from 128 providers at then of the previous quarter, which may be attributed to overall increase of providers of new providers in the network. Furthermore, HCI increased education and outreach to facilities (a.k.a. Entities), FQHCs, and CMHCs to submit data of the staff providers that have joined and left their facilities (a.k.a. Entities) on a monthly basis. Receiving the facility data on an increased frequency allows for increase auditing of their staff providers for future reports. A large percentage of the behavioral health services rendered to Members are provided through HCI's partner CMHCs. HCI worked with the CMHCs to update their licensed and unlicensed staff providers in the system. Although unlicensed staff providers are not applied to the ratios and time/distance analysis, it shows the receipt of this data has allowed to more accurately assess the capacity of the CMHCs.

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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		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.
CHP+ MCO, Medicaid MCO
N/A

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Categories Included in Network

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

Table 4A-Categories in Network: Discussion

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE
HCI monitors the network to ensure that providers are available to Members, and that the provider network contains the specialties necessary to accommodate the needs of Members across all ages, levels of ability, gender identities, and cultural identities. HCI monitors overall provider network patient load using a comprehensive system for monitoring patient load and overall network capacity. PCMPs are able to update their capacity by notifying HCI to temporarily close their panels to new Members or geographic attribution, and/or change their panel size. In those cases, HCI updates the State's portal, monthly reports, and the following edition of the provider directory. HCI serves 19 counties, of which, only one (1) county is classified as urban. There are, however, nine (9) rural counties and nine (9) frontier counties. The availability of behavioral health and PCMPs in rural and frontier counties is limited, especially those with the capacity to serve all Members, including those with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities. The majority of the services are met through staff providers within the safety-net providers in the region that offer culturally sensitive physical and behavioral health services. This includes: ▪ Partner CMHCs Health Solutions, San Luis Valley Behavioral Health Group, Solvista Health, and Southeast Health Group; ▪ FQHCs, including our partner Valley-Wide Health Systems; and ▪ Rural Health Centers. HCI accomplishes the monitoring of the network through periodic network adequacy review regarding the availability of providers who meet or exceed the cultural needs of Medicaid Members by: • Using an updated and accurate list to assess the number of providers with expertise in key culturally based populations; • Determining the number of members, by county, through the enrollment file within the key population groups; and • Determining any existing gap by a comparison of availability of providers as well as reviewing findings in Member and Family Affairs surveys or through contacts/surveys with advocacy organization of key populations. HCI identified need through the network monitoring for specialty provider groups and facilities who have:

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with practitioners/practice sites/entities with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE
• A unique specialty or clinical expertise; • A license to prescribe in all areas: APRN/APN, NP, PA, MD/DO (Board Certified Child and Adult Psychiatrists); • Capability to treat in a foreign language, ASL, and/or have specific cultural experience; • Capability of billing both Medicare and Medicaid; • A practice located in HCI's service area that is considered rural or frontier where there are fewer providers; • Telehealth, especially for prescriber services; • Alignment with primary care and co-located in an integrated model; • Capability to serve unique populations and disorders; • Specialties such as Intellectual Disabilities, Autism, Members with Traumatic Brain Injuries, or other groups that provide behavioral health services in addition to their non-covered specialty. Also, providers with experience in specialty care, long-term services and supports (LTSS), managed service organizations and their networks of SUD providers, dental and other ancillary providers; and • Behavioral health providers that span inpatient, outpatient, and all other covered mental health and SUD services. HCI engages with these providers to recruit and maintain them within the network through rate negotiations, provider training, and collaborative relationships. During the reporting period, HCI discussed rate negotiations with one facility and reviewing the rates for CMHCs for the upcoming fiscal year. HCI conducted targeted training with eight (8) individual providers, groups and facilities. In addition, HCI supported 23 providers which reported denied claims concerns. For this providers, HCI conducted a review of their denied claims for root cause analysis, developed plan of action for resolution, provided training on claims processes, and continue to maintain communication with the provider until their concern is resolved.

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Access for Special Populations

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

Table 5-Access for Special Populations: Discussion

Describe the methods used by the MCE to count practitioners/practice sites/entities as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.
CHP+ MCO, Medicaid MCO, RAE
HCI monitors if there are sufficient providers in the network with the ability to provide appropriate physical access, reasonable accommodations, and accessible equipment for Members with physical or other disabilities. Provider data in HCI's systems is used to identify provider locations as accessible in the provider directory and to count the number of providers that meet the requirements in the network adequacy analysis. HCI continues to cross-reference providers with Colorado PEAK website and Managed Care Organization (MCO) Affiliate data offered by HCPF to validate the information. Future reports will offer information on the outcomes of the general and targeted provider education. HCI is monitoring the response of providers and the data to evaluate their effectiveness and adjust strategies accordingly to increase access to care within the network. Through Provider Support Calls and Town Halls, HCI will educate and discuss methods and resources to increase accessibility at their practices. Providers that want to learn more about physical access and/or accessible equipment for practice locations may request to receive an assessment of their facilities for Members with physical and other disabilities. There were no requests for these assessments during the reporting period. The assessments will continue to be promoted at provider support calls. This is an opportunity to engage with the practices and increase accessible facilities in the network. HCI has trainings available on the website to educate behavioral health providers on how they can directly update their demographic information through HCI's Provider Portal and, for behavioral health providers, Council for Affordable Quality Healthcare (CAQH), which includes reporting the physical access and/or accessible equipment information for each of their practice locations. Additionally, HCI integrates data from CAQH to maintain accurate records for behavioral health providers in HCI's system. That, in turn, populates the Provider Directory and network adequacy analysis. Finally, HCI conducts on-going phone outreaches to behavioral health providers that do not have a CAQH profile to validate the information in the Provider Directory. The number of providers with no CAQH profile has reduced significantly. At the end of the reporting period, there were 368 providers that did not have a CAQH profile and required a phone outreach.

Describe the methods used by the MCE to count practitioners/practice sites/entities as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.
CHP+ MCO, Medicaid MCO, RAE
Since HCI does not credential the PCMP practices, PCMPs are not subject to CAQH review. As a result, HCI requests updates from the PCMP practices through an electronic Provider Verification Form and validates the information through the National Provider Identifier (NPI) Registry Public Search website and HCPF Medicaid Enrollment Lists. The information collected through this process is loaded to HCI systems. That, in turn, populates the Provider Directory and network adequacy analysis. During the reporting period, all contracted PCMP practices receive outreach via email and/or phone to validate their information.

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 6-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
HCI, the RAE for Region 4, did not experience a change in its network in regard to quality of care, competence, or professional conduct. As such, no notification to the Department was required during the reporting period.

Table 7-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
N/A

interChange Policies

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

- Retroactively enrolled or practitioners/practice sites/entities with a pending contract status are not available to offer services and should be excluded from this discussion.

Table 8-CHP+ MCO *interChange* Policies: Discussion

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

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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 9-CHP+ MCO Inadequate Access to PCPs: Discussion

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

Table 10-CHP+ MCO Discontinue Services to an Entire County: Discussion

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

Table 11-CHP+ MCO Provider Network Changes: Discussion

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

Appointment Timeliness Standards

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

Table 12-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
PCMPs are expected to maintain established office/service hours and access to appointments within the standards established by HCI and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all HCI network providers are convenient to the population served and do not discriminate against Members (e.g., hours of operation may be no less than those for commercially insured or publicly insured, fee-for-service individuals), and that services are available 24 hours a day, seven days a week when medically necessary. Access to care standards, set by the state of Colorado, require all participating PCMPs to have availability for Members within seven (7) days of request, and that urgent access is available within 24 hours from the initial identification of need. The PCMP access to care audits is every six (6) months. The audit was scheduled to be performed during the reporting period; however, it was postponed due to updates to the internal process to conduct the audit. The access to care audits are currently underway and findings will be reported at the next quarterly report. The COVID-19 crisis, which began at the end of the third quarter, has changed access to care for physical health services. Providers that offer services which are able to be delivered via telehealth, are expanding telehealth services to ensure access. HCI is working closely with providers to educate them on telehealth requirements, billing, and documentation. This has been driven through Provider Alerts, a dedicated webpage with updated information, and weekly provider support calls to address specific provider questions. However, many practices report a reduction in services creating immediate access to available appointments.

Table 13-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
Behavioral health providers are expected to maintain established office/service hours and access to appointments within the standards established by HCI and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all HCI network providers are convenient to the population served and do not discriminate against Members (e.g., hours of operation may be no less than those for commercially insured or publicly insured, fee-for-service individuals), and that services are available 24 hours a day, seven days a week when medically necessary. Access to care standards, set by the state of Colorado, require all participating behavioral health providers to have availability for Members within seven (7) days of request, and that urgent access is available within 24 hours from the initial identification of need. As a result of the COVID-19 crisis behavioral health providers are primarily providing services via telehealth. Many providers have implemented telehealth who previously had not considered offering telehealth and are reporting successes with members engaging in telehealth services. HCI continued to conduct outbound phone calls to survey access to care. A total of 34 provider locations were audited during the reporting period. Of those contacted, six (6) provider locations met all of the standards. Most of the providers did not meet the requirement to offer an appointment within seven (7) days of request. HCI sent notices to behavioral health providers on the results and information on the standards. Providers are scheduled to be re-audited within 90 days of receiving the results regarding access to care compliance. Providers that continue to not meet the requirement will receive a request to submit a correction action plan.

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

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

There are two levels of primary care practitioners: primary practitioners that can bill as individuals (e.g., MDs, DOs, and NPs) and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

A practitioner/practice site/entity should only be counted one time in the MS Excel template tabs; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under the Family Practitioner category.

Table 14-Software Package Used for Time and Distance Calculations

List and describe the software package(s) and/or processes that your MCE uses to calculate practitioner/practice site/entity counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed. If your MCE does not use driving distances when calculating time and distance results, describe the method used.
CHP+ MCO, Medicaid MCO, RAE
HCI uses the latest Quest Analytics, an industry-standard application, to conduct a geographic access (GeoAccess) mapping analysis for time and distance starting from the Member's residence and driving to the closest available provider based on the county classification. This application is also used to calculate the provider-to-member ratios at the regional and county level by provider type.

The provider data that was used in this report was pulled directly from the physical health and behavioral health databases The Members by County tab was a simple calculation of enrolled Members by their county of residence broken out per the Members by County Instructions. The Provider Locations by County tab was calculated by summing the number of locations by their county name per the instructions of the Provider Locations by County Instructions.

For the HCPF Network Categories, HCI began by conducting a quality check of provider National Provider Identifiers (NPIs) and taxonomy codes. HCI compared all NPIs in the provider data against the list of NPIs in the monthly Managed Care Organization (MCO) Affiliate report from the State to confirm those providers had valid NPIs. Additionally, there was a review of provider taxonomy codes against the National Plan & Provider Enumeration System (NPPESS) NPI Registry to ensure correct taxonomy codes. Once the quality checks were completed, we used the HSAG technical specification document (*FY2019-20 Network Adequacy Validation (NAV) Crosswalk Definitions for Network Data Mapping; December 4, 2019 Version*) to define provider groupings. This was done using the provider's taxonomy code and the provider's degree or credentials. This allowed HCI to roll-up provider counts by provider group code.

HCI continues to refine the reporting logic for behavioral health after the first submission of the Quarter 2 Network Adequacy Report for this reporting period. We shifted the analysis of behavioral health provider data to the local reporting team to align with how it is conducted for primary care. The benefit of having the data analyzed locally is that the team is more familiar with the network providers and Colorado requirements. HCI streamlined the process for validation and adjustments to the logic to enhance the quality of the reporting. As a result of these changes, HCI conducted an in-depth review of the logic that identified the need to adjust the report logic, as well as incorporated HCPF's feedback from the first and second submissions of the Quarter 2 Report. Overall, changes to the logic included:

- Data cleaned to remove duplicate providers due to name spelling and other data entry errors;
- Data cleaned to validate Medicaid IDs and exclude providers missing Medicaid IDs;
- Distinguish licensure levels (LPC and LCSW);
- Reviewed and updated the categories to capture additional applicable licensure levels; and
- Reviewed and updated the logic to better capture unlicensed staff in CMHCs.

The changes outlined were incorporated into the second Quarter 2 submission and expanded for this reporting period. Through continued validation efforts, recruitment and data collection efforts by facility staff providers (see Table 2B), HCI report a net increase of 100 individual behavioral health providers from the previous report to the current report.

HCI reviewed the entities listed with "mental hospital" and "psychiatric residential treatment facility." We identified that the logic pulled some of the entities as "mental hospital" or "psychiatric residential facility" due to the combination of the facility's licensure, taxonomy, and specialty. We verified the logic to pull the correct licensure, taxonomy, and specialty combination that aligns with the appropriate HCPF Category Code. HCI updated the report for the identified entity locations and updated the BH Location by County, BH Ratios and Time/Distance tabs, accordingly. For the fourth quarter report, HCI is continuing to validate the logic to ensure individual practitioners, practice sites, and entities are categorized with the most appropriate HCPF Category Code based on latest HSAG Crosswalk.

Managing the provider data for completeness and accuracy is a continuous process. HCI has various mechanisms in place to capture and correct data discrepancies and audit the provider information entered into the system. HCI anticipates a minimal margin of error in the data accuracy each quarter. HCI is continuing to enhance the data collection and reporting methodology to reduce the margin error. There are two areas with behavioral health data that HCI is continuing to improve for the next reporting period. First, reduce the practitioners that appear with multiple records for similar service locations or similar names. HCI identified 49 of the 2,069 unique behavioral health providers in the report that have similar service locations and names which indicates potentially duplicate records. While this represents less than 3% of the total records, HCI still wants to improve the data wherever possible. These records are in the process of review and validation with the provider to update, as appropriate, for the following quarter. Second, HCI is working to improve the Medicaid ID data for individual providers, specifically facilities' staff providers. Historically, facility staff providers were not included in the network adequacy report. As a result of the new reporting requirement, HCI identified that the collection of the data for facility staff providers was not complete. This report has providers with multiple Medicaid IDs or sharing the same Medicaid ID with other providers, which is not in accordance with the HSAG guidelines. HCI has put in place a process to request the data from facilities and audit the facility staff Medicaid ID provided. Any inconsistencies found will be reviewed with the facility to correct and resubmit. HCI anticipates this process will increase accuracy for future quarterly reports. HCI will address new findings through our internal process and guidance from the Department.

The technical tools used to complete this reporting requirement included Toad and Microsoft Excel. Toad was used to pull the data from HCI's databases and, where appropriate, conduct the data aggregation calculations. The results of this aggregation were manually entered into the designated Network Adequacy template, which is in an Excel file format.

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has one urban county, Pueblo, in which nearly all adult and pediatric Members in the county have access to PCMPs and behavioral health providers within 30 miles or 30 minutes. The exception is access to primary care providers that are also Gynecology, OB/GYN Physician Assistant as there are zero (0) providers under this provider type in the region. During the reporting period, HCI worked with network PCMP practices to update the providers in their practice locations to correctly report all practitioners within their practice. HCI was successful in updating the number of mid-level practitioners that provide pediatric services within the PCMP practices. Furthermore, HCI was successful in identifying Gynecology, OB/GYN physicians within the existing network PCMP practices. This resulted in a clearer portrayal of the network in the reported number and access to practitioners in the county.

Although Network Adequacy guidelines identify our region has a need for OB/GYN Physician Assistants within Pueblo County, practices report preference of nurse midwives over OB/GYN PA due to supervision requirements. Practitioners that provide both Primary Care and OB/GYN services are assigned under the Family Practitioner category. Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the HCI region. This will require work with the Department and community partners to address.

Table 16–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has a number of counties that qualify as rural counties, which require coverage with the distance of 45 minutes or 45 miles for PCMPs and 60 minutes or 60 miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each rural county. For Physical Health, HCI worked with network PCMP practices to validate provider roster to identify new providers and ensure accurate reporting. HCI was successful in this initiative and identified existing and new practitioners for the following provider types: • Pediatric Primary Care Mid-Level in Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande counties Practitioners that provide both Primary Care and OB/GYN services are assigned under the Family Practitioner category. This may have impacted the number of sufficient practitioners of all levels that offer gynecological services in the rural counties for: • Gynecology, OB/GYN Physicians • Gynecology, OB/GYN Physician Assistants Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the HCI region. This will require work with the Department and community partners to address.

Table 17–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Members residing in a frontier county require time and distance access to PCPs within 60 minute or 60 miles, and 90 minutes or 90 miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each frontier county. For Physical Health, HCI worked with network PCP practices to update the providers in their practice locations to identify any new practitioners. HCI was successful in identifying existing and new mid-level practitioners for pediatric services in Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache counties. The exception is access to Gynecology, OB/GYN Physician Assistant as there are zero (0) providers under these provider types in the network. Practitioners that provide both Primary Care and OB/GYN services are assigned under the Family Practitioner category, which may impact the number of sufficient providers. HCI will continue to use Health First Colorado participating providers and Department of Regulatory Agency (DORA) Registry to identify licensed OB/GYN Physicians and Physician Assistants within the region for recruitment. Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the HCI region. This will require work with the Department and community partners to address.

Network Directory

Supporting contract reference: For each of the following practitioner/practice site/entity types covered under this contract the MCE must make the following information on the MCE's network practitioners/practice sites/entities available to the enrollee in paper form upon request and electronic form:

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

Table 18-Network Directory: Discussion

Please list the MCE's website URL. **Is the MCE practitioner/practice site/entity network information updated at least monthly?** **Did the MCE make the network practitioners'/practice sites'/entities' information available to the enrollee in paper form upon request and electronic form?**
CHP+ MCO, Medicaid MCO, RAE
HCI lists the Provider Directory on the following URL https://www.healthcoloradorae.com/members/find-a-provider/. Members can contact Member Services to request the provider directory in paper form and electronic form by calling 888-502-4185, TTY 800-432-9553. The provider directory data is updated when providers report a change through the provider portal or by calling Provider Relations. When HCI identifies a change, the provider is contacted to verify the information and submit any appropriate changes. The Provider Directory on the HCI website is updated at least once a month.

COLORADO
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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-A and A-B below to list individual practitioners with SCAs and describe the MCE's use for SCAs.

Table A-A-Practitioners with SCAs: Data

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Primary Care*
CHP+ MCO, Medicaid MCO, RAE				
BOWER, ALEC	9000144126	Fremont	BV100	Psychiatrists
BRADY, JAMES	78756022	Otero	BV100	Psychiatrists
BURKHARDT, LAURA	9000155380	Alamosa	BV130	Licensed Clinical Social Workers (LCSWs)
CHRISTENSEN, RYAN	20888350	El Paso	BV100	Psychiatrists
COOPER, MARY	9000161758	Huerfano	BV131	Licensed Marriage & Family Therapists (LMFTs)
DAVIS, CHELSEA	9000168563	El Paso	BV132	Licensed Professional Counselors (LPCs)
DEBORD, SARAH	68917503	Weld	BV100	Psychiatrists
DOBIN, JONATHAN	9000173467	Pueblo	BV100	Psychiatrists
DSCHAAK, TYLER	9000175947	Pueblo	BV100	Psychiatrists
ELLIAS, JEREMIAH	53351771	Pueblo	BV100	Psychiatrists
GERVAIS, JACK	73872369	Summit	BV100	Psychiatrists
HILL, SHONDA	9000169698	Pueblo	BV130	Licensed Clinical Social Workers (LCSWs)
HOSLER, GREG	91587760	Fremont	BV100	Psychiatrists
HUTCHINSON, ERIC	9000146379	El Paso	BV120	Psychologists (PhD, PsyD) - General
JARAMILLO-FORD, CARLA	1631357	El Paso	BV103	Psychiatric CNS – General
JOHNSON, CHRISTOPHER	22230068	El Paso	BV100	Psychiatrists
JURGENS, WILLIAM	1307057	Otero	BV100	Psychiatrists
KUNG, SHIRLEY	75581710	Summit	BV100	Psychiatrists
LEE, GARRETT	120740	Larimer	BV100	Psychiatrists

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
LETO, STEVEN	83182250	Pueblo	BV100	Psychiatrists
LINS JR, ROBERT	72224843	Fremont	BV100	Psychiatrists
LYONS, CASEY	9000174813	Fremont	BV100	Psychiatrists
MALDONADO, RYAN	79587801	Adams		Uncategorized Practitioner
MARUSKA, MICHAEL	9000166469	Pueblo	BV100	Psychiatrists
MAY, IAN	9000152745	Pueblo	BV100	Psychiatrists
MENEFEE, JULIE	18525539	Larimer		Uncategorized Practitioner
MONDY, MARIAN	9000175089	Pueblo	BV130	Licensed Clinical Social Workers (LCSWs)
MORTENSEN, D KILEY	90002075	Boulder	BV100	Psychiatrists
MYERS, CAROL	47510501	El Paso	BV132	Licensed Professional Counselors (LPCs)
NUMSEN, PAUL	39785327	Fremont	BV100	Psychiatrists
PALLINI, MICHAEL	9000174196	Pueblo	BV100	Psychiatrists
PANKO, CASEY	31701230	Larimer	BV102	Psychiatric NPs
PHELAN, THAYER	9000104603	Larimer	BV100	Psychiatrists
ROCKLER, KENDALL	9000162728	Pueblo	BV100	Psychiatrists
SCHULTZ, JANICE	9000149674	Pueblo	BV132	Licensed Professional Counselors (LPCs)
SCHWED, AUTUMN	9000170800	Jefferson	BV100	Psychiatrists
SEIFERD, IDA	23371218	Fremont	BV130	Licensed Clinical Social Workers (LCSWs)
SHARP, WILLIAM	94051224	Summit	BV100	Psychiatrists
WEST, JENNIFER	9000175002	El Paso	BV100	Psychiatrists
WISINSKI, BRANDON	9000174172	Fremont	BV100	Psychiatrists
WISNIEWSKI, MICHAEL	67372279	Jefferson	BV100	Psychiatrists
WOLF, RYAN	31505244	Larimer		Uncategorized Practitioner
YANG, GEORGE	85520284	Fremont	BV100	Psychiatrists

Table A-B-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
Out-of-network providers are able to request SCAs to render service for HCI Members for the purpose of continuity of care or specialty services that are not available through the current network (e.g., psychiatrists). Additionally, providers who are undergoing the credentialing process may request SCAs to start working with HCI Members. The majority of the providers who rendered services through an SCA during the reporting period have initiated the credentialing process. HCI monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process. Providers in the credentialing process and are using SCAs to render services are monitored to ensure they complete credentialing and formally join the network.

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.