Network Adequacy Quarterly Report Template

—Draft Copy: December 2021 Release—

COLORADO
Department of Health Care
Policy & Financing

Contents

1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the December 2021 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, or RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (September 2021 version).

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

Fiscal Year Quarter Reported	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2021-22 Q2	January 2022	December 31, 2021
FY 2021-22 Q3	April 2022	March 31, 2022
FY 2021-22 Q4	July 2022	June 30, 2022
FY 2021-22 Q1	October 2021	September 30, 2021

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_1221* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0921* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service, excluding single case agreement (SCA) practitioners.
- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. The MCE should update the highlighted, italicized data fields on the cover page of this template to reflect their contact information, contract information, and report dates associated with the current report submission.

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

Network Category	CHP+ MCO	Medicaid MCO	RAE
Facilities (Entities) (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X	
Prenatal Care and Women's Health Services	X	X	X
Primary Care Providers (PCMPs)	X	X	X
Physical Health Specialists	X	X	
Behavioral Health Specialists (*RAEs' network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021*)	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

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

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., December 30, 2021, for the quarterly report due to the Department on January 31, 2022).
- 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., December 30, 2021, for the quarterly report due to the Department on January 31, 2022).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

Define unique practice sites by de-duplicating records by location, such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.

Table 1A–Establishing and Maintaining the MCE Network: Primary Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	143,848	N/A	146,326	N/A
Total Primary Care Medical Practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	514	N/A	515	N/A
Primary Care Medical Practitioners accepting new members	507	98.6%	508	98.6%
Primary Care Medical Practitioners offering after-hours appointments	165	32.1%	165	32.0%
New Primary Care Medical Practitioners contracted during the quarter	22	4.3%	8	1.5%
Primary Care Medical Practitioners that closed or left the MCE's network during the quarter	9	1.8%	7	1.3%

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 Medical 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

Health Colorado, Inc. (HCI) works to ensure that Primary Care Medical Provider (PCMP) network has a sufficient number of providers to serve members based on the maximum distance for county classification.

In Pueblo County, although it has an urban designation, has territories in the southern border that are more rural and a practitioner is not within thirty (30) miles/thirty (30) minute radius. Since the majority of the practitioners are in the city of Pueblo, Medicaid members residing on the southern border of the county have limited practitioners within a thirty (30) mile radius. In those areas, there are no available PCMPs to meet the requirement. As a result, one (1%) percent of HCI members residing in Pueblo County do not have two (2) providers within the time and distance standard.

There are a limited number of providers in rural and frontier counties, creating a lack of recruitment opportunities. The lack of sufficient practitioners within the time/distance standard by practice level within rural and frontier counties to recruit for contracting, specifically primary care providers that offer gynecology services or serve the pediatric population.

HCI ensures members' have access to family planning services offered by appropriate physical health providers by educating members on their family planning benefits and how they can access them within and outside the network during member onboarding sessions, website, and notifications. Additionally, PCMPs that do not offer family planning within their practice refer members to practitioners who do offer the services. Finally, Member Services assists members find a provider that renders family planning services through Health First Colorado's Find a Provider website. HCI monitors member complaints for potential access issues to family planning services. During the reporting period, there were no recorded complaints regarding family planning services access.

HCI monitors the availability of telehealth services by surveying the providers on their capacity to offer telehealth. HCI utilizes PowerBI as a tool to analyze claims data and extrapolate telehealth utilization in primary care settings for wellness versus acute services. Based on the claims data available for the past twelve (12) months, HCI saw that the use of telehealth in primary care settings is very limited (about 1% of paid claims for those services). This aligns with the feedback received from providers. Although they offer telehealth services, they have reduced the use of telehealth services for primary care as members prefer in-person services.

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	143,848	N/A	146,326	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,097	N/A	3,164	N/A
Behavioral health practitioners accepting new members	3,097	100%	3,164	100%
Behavioral health practitioners offering after-hours appointments	988	31.9%	963	30.4%
New behavioral health practitioners contracted during the quarter	1,385	44.7%	269	8.5%
Behavioral health practitioners that closed or left the MCE's network during the quarter	197	6.3%	202	6.4%

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

Requirement	Previous Quarter	Current Quarter
	Number	Number
Sample	*0*	*0*
RAE		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	18	19
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	353	495
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	22	22
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	617	617
Total SUD treatment facilities offering ASAM Level 3.7 services	13	13
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	444	444

Requirement	Previous Quarter Number	Current Quarter Number
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	13	14
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	239	381
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	5
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	195	195

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

HCI maintained a network of providers across the region for many of the behavioral health practitioner types to assure that all covered services are accessible to members. For the type of behavioral health practitioner or facilities for which HCI did not have sufficient network was a result of specific barriers.

First, there is a lack of overall Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities within State to meet the time/distance standards for a large part of the HCI region.

Second, Parkview Medical Center (Parkview), which is located within our region, terminated their contract in September 2020. HCI engages with Parkview to address barriers to bring them into the network. HCI's goal is to initiate contract discussions with Parkview in the third quarter of the fiscal year. In the meantime, HCI continues to work with them through Single Case Agreements (SCAs), when medically appropriate, to ensure member care.

Third, there is an overall lack of sufficient SUD treatment facilities across all ASAM levels located within the region, which affects the ability to meet the standard.

> **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

Fourth, there are not sufficient behavioral health providers in all areas where members reside to have two (2) providers within the time and distance standard. Pueblo County, although it has an urban designation, has territories that are more rural where a practitioner is not within thirty (30) miles/thirty (30) minute radius.

Fifth, Psychiatrists and Other Psychiatric Prescribers are required in the network. However, prescribers who do not meet the Behavioral Health Specialty Provider Criteria are required to bill fee-for-service for Evaluation & Management (E&M) Codes. This has resulted in prescribers no longer having an incentive to contract with HCI. As a result, HCI has ceased recruitment for prescribers.

HCI leverages telehealth services to ensure access to care and overcome the barriers noted above, whenever possible. HCI monitors telehealth services availability by requesting that providers report offering telehealth services as part of their demographic data. The data of services under telehealth for this quarter was not available due to claims data lag. In the previous quarter, HCI's third of overall services was under telehealth services.

HCI worked the first year to implement the ASAM levels of care for SUD treatment. HCI's barriers include supporting providers to understand and implement authorization and documentation requirements and ensuring that practice sites are enrolled in Medicaid based on their level of care. Additionally, SUD facilities reported staffing shortages, which limits their capacity for services. Finally, HCI faces barriers in treatment for members who are justice involved. When the member has court-ordered treatment as a condition of release, HCI and the CMHC have approached the Managed Service Organization (MSO) to assist in transitioning the member to ensure appropriate care is provided. However, there is no data shared to inform HCI of other placement issues at any level of care with similar scenarios which impacts justice involved members in accessing services or timely release.

HCI's Clinical Department requests that SUD facilities inform if they are unable to place referred members in covered levels of care due to lack of bed capacity. This is information is tracked internally to manage placements. In such cases, members might be placed on a waitlist, if it is an option that is clinically safe. Alternatively, the member might be approved for a higher level of care, if it is more readily available. While on the waiting list, members would have access to outpatient treatment and case management services.

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	N/A	N/A
Total specialty care practitioners (i.e., PROVCAT codes beginning with "SV" or "SG")	N/A	N/A	N/A	N/A
Specialty care practitioners accepting new members	N/A	N/A	N/A	N/A
Specialty care practitioners offering after-hours appointments	N/A	N/A	N/A	N/A
New specialty care practitioners contracted during the quarter	N/A	N/A	N/A	N/A
Specialty care practitioners that closed or left the MCE's network during the quarter	N/A	N/A	N/A	N/A

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

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

Network Changes

<u>Supporting contract reference:</u> 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

If the MCE experienced an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. **Note: If the MCE experienced an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
HCI did not experience unexpected changes in the primary care network that could affect service delivery, availability, or capacity within the provider network. For behavioral health network, HCI experienced anticipated changes in the network resulting from facilities reporting changes to their staff providers, as well as, providers completing the credentialing process. Due to the Marshall Fire at the end of the quarter, Centennial Peaks temporarily evacuated and closed the facility. HCI worked with HCPF, Centennial Peaks, and local facilities to safely evacuate and admit members to other mental health facilities.

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

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

Inadequate Network Policies

<u>Supporting contract reference:</u> If the MCE fails to maintain an adequate network that provides Members with access to PCMPs 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 PCMPs: Discussion

Did the MCE fail to maintain an adequate network that provides members with access to PCMPs 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 7—CHP+ MCO Discontinue Services to an Entire County: Discussion

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

Table 8—CHP+ MCO Provider Network Changes: Discussion

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

Appointment Timeliness Standards

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

Table 9–Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
HCI reviews Primary Care Medical Providers Access to Care for Health First Colorado members. Access to Care standards include appointment availability for new members and established Health First Colorado members within seven (7) days of request, and urgent access availability within twenty-four (24) hours. For Health First Colorado members, Access to Care includes telehealth availability. HCI audits Primary Care Medical Providers Access to Care through a two (2) outreach attempt process.   First outreach by email, and second outreach by telephone call. If a PCMP does not respond to an email or telephone call outreach attempts, HCI searches websites and social media for provider contact information. This process has improved HCI's ability to contact Primary Care Providers for audit information. HCI completed an Access to Care audit of twenty-eight (28) Primary Care Medical Provider practices this Quarter 2 FY2022.   - Ten (10) Primary Care Medical Provider practice locations failed to respond to the audit.   - Eighteen (18) Primary Care Medical Provider practice locations offer same day appointments.   - Sixteen (16) Primary Care Medical Provider practice locations reported availability within seven (7) days of request standard for a new Health First Colorado member.   - Seventeen (17) Primary Care Medical Provider practice locations reported availability within seven (7) days of request standard for an established Health First Colorado member.   - Sixteen (16) Primary Care Medical Provider practice locations reported meeting all the standards.   HCI will follow up with providers that did not respond to the Access to Care audit. For PCMPs who failed the audit, they will be educated on the Access to Care standards and re-audited within ninety (90) days. If appropriate, PCMPs may be placed on a corrective action plan. HCI's new and established Health First Colorado member appointment availability with PCMP access to care survey includes well visits. In the future, HCI will call out well visit appointment availability specifically.

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
HCI reviews Behavioral Health Providers Access to Care for Health First Colorado members. Access to Care standards include appointment availability for new members and established Health First Colorado members within seven (7) days of request, and urgent access availability either within fifteen (15) minutes by phone or within one (1) hour if face-to-face (two (2) hours for urban/frontier areas). For Health First Colorado members, Access to Care includes telehealth availability. Behavioral Health Providers receive audits from HCI through outreach in a two (2)-attempt process. The first outreach is by email, and the second outreach by telephone. HCI continues to outreach by searching websites and social media for provider contact information. This process has improved HCI's ability to contact Behavioral Health Providers for audit information.   This Quarter 2 FY 2022, HCI completed an Access to Care audit of twenty-one (21) Behavioral Health Provider practices.   • Four (4) Behavioral Health Provider practice locations failed to respond to the audit. Fourteen (14) Behavioral Health Provider practice locations offer same day appointments.   • Eight (8) Behavioral Health Provider practice locations reported availability within seven (7) days of request standard for a new Health First Colorado member.   • Fifteen (15) Behavioral Health Provider practice locations reported availability within seven (7) days of request standard for an established Health First Colorado member.   • Six (6) Behavioral Health Provider practice locations reported meeting all the standards.   HCI will follow up with Behavioral Health Providers that did not respond to the Access to Care audit. Behavioral Health Providers that failed the audit will be educated on the Access to Care standards and re-audited within ninety (90) days. If appropriate, providers may be placed on a corrective action plan.

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 Medical 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 <u>contracted urban</u> 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 <u>contracted urban</u> Colorado counties where the MCE does not meet the time/distance requirements.

CHP+ MCO, Medicaid MCO, RAE

HCI has one (1) urban county, Pueblo, which is the residence of the majority of HCI's membership. The requirement for an urban county is to have one-hundred (100%) percent coverage of two (2) providers within thirty (30) miles or thirty (30) minutes.

Mental Health Services
In Pueblo County, HCI had ninety-nine (99%) percent coverage within standards for Psychiatrist and other Psychiatric Prescribers as well as Behavioral Health for all ages. HCI had ninety-five (95%) percent coverage for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. This is consistent with the results of previous quarterly report.

SUD Services
HCI maintained ninety-nine (99%) percent coverage for SUD Treatment Practitioners for all ages. HCI maintained ninety-eight (98%) percent access in Pueblo County in the following SUD services:
- Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
- Clinically Managed High-Intensity Residential Services (ASAM level 3.5)
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)

HCI had zero (0%) percent coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3) and Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM) due to lack of providers that have the license level within the standard time and distance. This is consistent with the results of previous quarterly report.

Physical Health
HCI maintained ninety-nine (99%) percent coverage for all physical health provider levels and ages with the exception of Gynecology, OB/GYN (PA) acting as PCMP with zero (0%) percent coverage. HCI has not been able to find Physician Assistants (PA) in the county that serve as primary care with Gynecology, OB/GYN specialty in the area.

HCI ensures access to care for members residing in Pueblo where it does not meet the time/distance requirements by offering telehealth services. In addition, HCI's Care Coordination staff connect members to transportation and other services to ensure they can access services that are outside Pueblo.

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 <u>contracted rural</u> 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 <u>contracted rural</u> Colorado counties where the MCE does not meet the time/distance requirements.

CHP+ MCO, Medicaid MCO, RAE

HCI has nine (9) counties that qualify as rural counties, including Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande. Rural counties require coverage of two (2) providers with the distance of forty-five (45) minutes or forty-five (45) miles for PCMPs and sixty (60) minutes or sixty (60) miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each rural county.

<u>Mental Health Services</u> HCI met one-hundred (100%) percent of standards for all its rural counties within the region for Behavioral Health as well as Psychiatrists and other Psychiatric Prescribers for all ages. HCI did not meet access to Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities.

<u>SUD Services</u>
HCI met access standards for SUD Treatment Practitioner for all ages. HCI maintained access to care for SUD higher of level services within the region:
- Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
  - One-hundred (100%) percent in Crowley and Otero Counties
  - Ninety-four (94%) percent in Fremont County
  - Seventy-eight (78%) percent in Prowers County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, and Rio Grande Counties
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3)
  - Zero (0%) percent across the frontier counties due to no licensed facilities.
- Clinically Managed High-Intensity Residential Services (ASAM level 3.5)
  - One-hundred (100%) percent in Alamosa, Conejos, Prowers and Rio Grande
  - Ninety-eight (98%) percent in Crowley County
  - Ninety-four (94%) percent in Fremont County
  - Ninety-one (91%) percent in Otero County
  - Zero (0%) percent in Chaffee and Lake Counties
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)
  - Ninety-seven (97%) percent in Crowley County
  - Ninety-four (94%) percent in Fremont County
  - Forty (40%) percent in Otero County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, Prowers, and Rio Grande Counties
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
  - One-hundred (100%) percent in Alamosa, Conejos, Crowley, Otero, and Rio Grande

- o   Ninety-seven (97%) percent in Fremont County
  - o   Seventy-eight (78%) percent in Prowers County
  - o   Zero (0%) percent in Chaffee and Lake County
- Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
  - o   Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.

Physical Health

HCI maintained one-hundred (100%) percent coverage of members within the time/distance for:

- Adult Primary Care (MD, DO, NP)
- Family Practitioner (MD, DO, NP)
- Pediatric Primary Care (MD, DO, NP)

Additionally, eight (8) of the nine (9) counties had one-hundred (100%) percent coverage of members within the time/distance (Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, and Rio Grande) for:

- Adult Primary Care (PA)
- Family Practitioner (PA)
- Pediatric Primary Care (PA)

The exception was Prowers County, which had these provider types at ninety-nine (99%) percent coverage.

Access to gynecologist that provide primary care, OB/GYN (MD, DO, NP) by county, including one-hundred (100%) percent coverage in Alamosa, Chaffee, Crowley, Fremont, and Lake; ninety-nine (99%) percent coverage in Prowers and Otero; ninety-three (93%) percent coverage in Rio Grande, and ninety-one (91%) percent coverage in Conejos County. However, for Gynecology, OB/GYN (PA), HCI had zero (0%) percent coverage in all rural counties.

If fewer than two (2) providers exist in a particular area, standards for member choice/proximity to providers are not required.

HCI ensures access to care for members residing in rural counties where it does not meet the time/distance requirements by offering telehealth services. In addition, HCI's Care Coordination staff connect members to transportation and other services to ensure they can access services.

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template.

List the specific <u>contracted frontier</u> 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 <u>contracted frontier</u> Colorado counties where the MCE does not meet the time/distance requirements.

CHP+ MCO, Medicaid MCO, RAE

HCI has nine (9) frontier counties, which are Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache. Standards for members residing in a frontier county require two (2) providers within sixty (60) minutes or sixty (60) miles for a PCMP, and ninety (90) minutes or ninety (90) miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each frontier county.

Mental Health Services
HCI met one-hundred (100%) percent of standards for all its frontier counties within the region for Behavioral Health as well as Psychiatrists and other Psychiatric Prescribers for all ages. HCI did not meet access to Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities.

SUD Services
HCI met access standards for SUD Treatment Practitioner for all ages. HCI maintained access to care for SUD higher of level services within the region:
- Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
  - One-hundred (100%) percent in Bent, Custer, and Huerfano Counties
  - Ninety-six (96%) percent in Las Animas County
  - Ninety (90%) percent in Kiowa County
  - Sixty-six (66%) percent in Baca County
  - Less than fifty (50%) percent to zero (0%) percent in Costilla, Mineral, and Saguache Counties.
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3)
  - Zero (0%) percent across the frontier counties due to no licensed facilities.
- Clinically Managed High-Intensity Residential Services (ASAM level 3.5)
  - One-hundred (100%) percent in Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Mineral, and Saguache Counties.
  - Ninety-nine (99%) percent in Las Animas County
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)
  - One-hundred (100%) percent in Custer and Huerfano Counties
  - Ninety-six (96%) percent in Las Animas County
  - Seventy-nine (79%) percent in Bent County
  - Less than fifty (50%) percent to zero (0%) percent in Baca, Costilla, Kiowa, Mineral, and Saguache Counties.

- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
    - One-hundred (100%) percent in Bent, Costilla, Custer, Huerfano, Las Animas, Mineral, and Saguache Counties.
    - Ninety (90%) percent in Kiowa County
    - Sixty-eight (68%) percent in Baca County
- Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
    - Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.

Physical Health

HCI had a strong physical health network during the reporting in the frontier counties with one-hundred (100%) percent coverage of members within the time/distance for:

- Adult Primary Care (MD, DO, NP)
- Adult Primary Care (PA)
- Family Practitioner (MD, DO, NP)
- Pediatric Primary Care (MD, DO, NP)
- Pediatric Primary Care (PA)

Exception was Las Animas with 99% coverage for Adult Primary Care (MD, DO, NP), Adult Primary Care (PA), and Family Practitioner (MD, DO, NP).

For Family Practitioner (PA), HCI had one-hundred (100%) percent coverage of members in Bent, Costilla, Custer, Huerfano, Mineral, Kiowa, and Saguache Counties; ninety-nine (99%) percent coverage in Las Animas; and seventy-six (76%) percent coverage in Baca County.

For in-network PCMPs that are Gynecologist, OB/GYN (MD, DO, NP), HCI had one-hundred (100%) percent coverage of members in Bent, Costilla, Custer, Huerfano, Kiowa, and Saguache Counties; ninety-nine (99%) percent coverage in Las Animas; seventy-seven (77%) percent coverage in Baca County; and sixty-one (61%) percent in Mineral County. However, for Gynecology, OB/GYN (PA), HCI had zero (0%) percent coverage in all frontier counties, except Saguache, which had seventy-four (74%) percent coverage.

If fewer than two (2) providers exist in a particular area, standards for member choice/proximity to providers are not required.

HCI ensures access to care for members residing in frontier counties where it does not meet the time/distance requirements by offering telehealth services. In addition, HCI's Care Coordination staff connect members to transportation and other services to ensure they can access services.

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

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

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	■
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	■
CHP+ MCO, Medicaid MCO, RAE					
ASHBY, ERIN	82084858	Pueblo	BV120	Psychologists (PhD, PsyD) - General	■
CALDERON, ANGELA	9000150372	Pueblo	BV132	Licensed Professional Counselors (LPCs)	■
DAVIS, CHELSEA	9000168563	El Paso	BV132	Licensed Professional Counselors (LPCs)	■
HUMES, KENDAL	9000159112	Alamosa	BV080	Licensed Addiction Counselors (LACs)	■
KOCH, JAYLYNNE	11750090	El Paso	BV132	Licensed Professional Counselors (LPCs)	■
KUIK, DENNIS	9000176514	El Paso	BV130	Licensed Clinical Social Workers (LCSWs)	■
SEIFERD, IDA	23371218	Fremont	BV130	Licensed Clinical Social Workers (LCSWs)	■
SMITH, HEATHER	02126834	Adams	BV120	Psychologists (PhD, PsyD) - General	■
WATLEY, MELISSA	9000163609	Fremont	BV080	Licensed Addiction Counselors (LACs)	■
YATES, KARLA	9000175371	El Paso	BV130	Licensed Clinical Social Workers (LCSWs)	■
JEFFERSON CENTER FOR MENTAL HEALTH	9000130227	Jefferson	BF085	ASAM Level 3.5	■

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
NEW BEGINNINGS RECOVERY CENTER	48863505	Arapahoe	BF085	ASAM Level 3.5	▮
SUMMITSTONE HEALTH PARTNERS	9000190608	Larimer	BF085	ASAM Level 3.5	▮

Table A-2–Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs.
Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.

CHP+ MCO, Medicaid MCO, RAE

HCI uses SCAs to expand access to care for members by approving SCA requests for out-of-network providers when the specialty service is not available through the current network, the member is located outside the time/distance standard for service, or the member has an established relationship with the provider and deemed necessary for purposes of continuity of care. Additionally, HCI uses SCAs when providers are actively engaged in the contracting and credentialing process. This allows providers to start serving HCI members while they complete the process.

HCI reviews SCA utilization data to upgrade practitioners with SCAs to a full network practitioner when there is a trend of high utilization. HCI outreaches to high volume providers and offers them to join the network.

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.