COLORADO
Department of Health Care Policy & Financing

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 *07/29/2022*, covering the MCE's network from *04/01/2022 – 06/30/2022*, FY*22*Q*4*

—Final Copy: June 2022 Release—

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2022 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_0622* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0622* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2022, for the quarterly report due to the Department on July 29, 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., June 30, 2022, for the quarterly report due to the Department on July 29, 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	148,929	N/A	151,387	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	517	N/A	501	N/A
Primary care practitioners accepting new members	510	98.6%	494	98.6%
Primary care practitioners offering after-hours appointments	165	31.9%	165	32.9%
New primary care practitioners contracted during the quarter	2	0.4%	2	0.4%
Primary care practitioners that closed or left the MCE's network during the quarter	0	0.0%	18	3.6%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
Health Colorado, Inc. (HCI) works to ensure that the Primary Care Medical Provider (PCMP) network has a sufficient number of providers to serve members based on the maximum distance for county classification. Within HCI's rural and frontier counties, there are a limited number of provider practices, which significantly limits PCMP recruitment opportunities. The lack of a sufficient number of practitioners within the time/distance standard by licensure level is particularly evident for PCMPs that offer gynecology services or serve pediatric populations. Based on HCI's geoaccess analysis, HCI achieved one-hundred percent (100%) coverage for Pediatric Primary Care (MD, DO, NP). However, Pueblo County,our only county that has an urban designation, has one percent (1%) of HCI members who do not have two (2) providers within the time or distance standard for the other physical health provider types. HCI's geoaccess analysis is lower than the geoaccess analysis conducted by Health Services Advisory Group (HSAG), HCPF's vendor. HSAG determined HCI met the time and distance standards for all PCMP provider types. The discrepancy may be due to the differences in the settings of QuestAnalytics application and any clean up processes for member addresses implemented in the analysis to calculate whether a provider was within time or distance standard. HCI will work with HSAG to review the analysis process and align methodologies to reduce discrepancy in findings. HCI continues to recruit PCMPs within the region to expand the network where possible. HCI continued from previous reporting period to outreach to Advanced Practice Headache and Primary Care Clinic, and Family Center of Colorado to join the network in Pueblo County. HCI did not receive response during the reporting period. Since they have claims data demonstrating that they do serve Medicaid members, HCI will seek additional methods of outreach to discuss joining the network. HCI will collaborate with other providers or community stakeholders who have a relationship with both HCI and the PCMPs to identify the correct contacts at the PCMPs and introduce them to HCI.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay.

Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.

If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.

CHP+ MCO, Medicaid MCO, RAE

For family planning services, HCI ensures members understand and have access to these services, which are provided by an appropriate physical health provider. Members are educated on available family planning benefits and how to access those services within and outside of HCI's network during member onboarding sessions, through our website, and via member notifications. Additionally, PCMPs that do not offer family planning within their practice refer members to practitioners who do offer the services. Our Member Services Department assists members to find a provider that provides family planning services through Health First Colorado's Find a Provider website. To help ensure timely access to services, HCI monitors member complaints related to family planning services. During the reporting period, there were no recorded complaints regarding family planning services access. Further, HCI reviews family planning utilization data to monitor providers in the region rendering the services. Based on the review of state claims data for family planning services, the top twenty (20) providers account for almost three-quarters of the utilization (70.1%). Of those top twenty providers, sixteen (16) are PCMPs that are part of the HCI network (or 80% of the top 20 providers). The sixteen (16) PCMP locations are as follows:

- Parkview Ancillary Services (3 locations)
- Lutheran Hospital Association of San Luis Valley (2 locations)
- Catholic Health Initiatives Colorado (2 locations)
- Pueblo Community Health Center
- Southern Colorado Clinic
- Arkansas Valley Region Medical Center
- Salida Hospital District
- Valley-Wide Health Systems
- Rocky Mountain Planned Parenthood
- Richard Rivera
- Trinidad Area Health Association
- Prowers County Hospital District

HCI monitors the availability of telehealth services by surveying providers on their capacity to offer telehealth and by analyzing utilization through claims data. In Q3 FY2022, telehealth utilization was 4.2% of paid physical health claims. Due to data lag, Q4 FY2022 data is not yet available.

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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	148,929	N/A	151,387	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,291	N/A	3,307	N/A
Behavioral health practitioners accepting new members	3,291	100%	3,307	100%
Behavioral health practitioners offering after-hours appointments	1,024	31.1%	1,066	32.2%
New behavioral health practitioners contracted during the quarter	188	5.7%	154	4.6%
Behavioral health practitioners that closed or left the MCE's network during the quarter	61	1.9%	138	4.2%

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	20	24
Total SUD treatment facilities offering ASAM Level 3.3 services	0	1
Total SUD treatment facilities offering ASAM Level 3.5 services	23	29
Total SUD treatment facilities offering ASAM Level 3.7 services	13	17
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	14	16
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	5

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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 behavioral health practitioners in number and practitioner types to ensure that all covered services are accessible to members. For behavioral health practitioners and/or facilities in which HCI did not have a sufficient network was a result of specific barriers, as detailed below. First, there is a lack of overall Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities within the state to meet the time/distance standards for a large part of HCI's region. Second, Parkview Medical Center (Parkview), which is located in our region, closed their inpatient psychiatric in June 2022. This creates limitations in ensuring access to inpatient services for members in the region. HCI continues contract discussions with Parkview during this reporting period for outpatient behavioral health services, which are behavioral health services they continue to offer within the region. Third, there is an overall lack of sufficient SUD treatment facilities across all ASAM levels within the region, which significantly affects our ability to meet the time/distance standard. Particularly, Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3) and Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7WM) are not available in the region. When members need this level of care, HCI coordinates transportation for services outside of the region. Fourth, there are not a sufficient number of behavioral health providers in all areas where members reside to have two (2) providers within the time and distance standard. Pueblo County, although designated as urban, has territories that are more rural where a practitioner is not within the thirty (30) miles/thirty (30) minute radius. Per the RAE agreement with HCPF, if fewer than two (2) providers exist in a particular area, standards for member choice/proximity to providers are not required. Fifth, Psychiatrists and Other Psychiatric Prescribers are required as part of 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.

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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
Sixth, HCI's geoaccess analysis on Tables 11 -13 below had different findings for SUD ASAM levels in some counties compared to the geoaccess analysis conducted by Health Services Advisory Group (HSAG), HCPF's vendor. Specifically, HSAG determined HCI had lower coverage of members based on time or distance standards for the following levels of care by county: • Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1) in Pueblo County • Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM) in Chaffee, and Lake counties. • Clinically Managed High-Intensity Residential Services (ASAM Level 3.5) in Otero County HSAG determined HCI had higher coverage of members based on time or distance standards for the following levels of care by county: • Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1) in Kiowa and Saguache Counties • Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM) in Kiowa County The discrepancies may be due to the differences in the settings of QuestAnalytics application and any clean up processes for member addresses implemented in the analysis to calculate whether a provider was within time or distance standard. HCI will work with HSAG to review the analysis process and align methodologies to reduce discrepancy in findings. Whenever possible, HCI leverages telehealth services to ensure access to care and overcome the barriers noted. HCI monitors telehealth services availability by requesting that providers report their capacity to offer telehealth services as part of their demographic data and through claims data. For Q3 FY2022, a fifth (20%) of all paid services were rendered via telehealth. Due to a claims data lag, telehealth data is not yet available for Q4 FY2022.

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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
As of FY21-22 Q4, HCI's provider network has fully integrated the ASAM levels of care into their assessment and treatment services. Providers have demonstrated significant improvement in their documentation and adherence to authorization procedures as a result of HCI's continued training efforts during Utilization Management (UM) reviews. Providers also have shown improved coordination of care with the RAE and other treatment providers. Most providers now are familiar with the Medicaid enrollment process but can be referred to appropriate resources when needed. Workforce shortages continue to be a concern throughout the state, limiting program capacity in some instances. HCI continues to support state and local efforts to address these shortages. HCI's Clinical Department requests that SUD facilities inform us if the facility is unable to place referred members in covered levels of care due to a lack of bed capacity. HCI tracks bed capacity internally to manage placements. The ability to track bed availability by ASAM level of care is challenging. HCI works closely with its provider network and the MSOs to stay informed about changes in bed capacity. However, it is difficult to obtain accurate real-time data about bed availability. Data sharing is hampered by the legal restrictions imposed by HIPAA and 42 CFR, Part 2 and the lack of a statewide bed tracking resource. In such cases, members might be placed on a waitlist, if that is an option and 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 have access to outpatient treatment and case management services.

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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	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

3. Network Changes and Deficiencies

Network Changes

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

Table 4–Network Changes: Discussion

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 would adversely affect service delivery, availability, or capacity within the provider network. As part of the standard provider data management process, PCMPs reported changes in the number of practitioners within PCMP locations, which are reflected in the reduction from 517 to 501 practitioners from the previous report. HCI is monitoring the capacity of availability as outlined in Table 9 - Physical Health Appointment Timeliness Standards. For the behavioral health network, HCI experienced anticipated changes in the network resulting from standard network fluctuations. During the reporting period, HCI had 138 behavioral health practitioners leave the network and 154 unique behavioral health practitioners join the network. This was largely due to increased credentialing of new providers, as well as, facilities reporting staffing changes in their services locations. Further, HCI did identify practitioners from the previous report that do not appear in the report due to having closed their practice to accepting new Medicaid members.

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

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

Table 6–CHP+ MCO Inadequate Access to PCPs: Discussion

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

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

Table 9–Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Access to Care standards for Health First Colorado members are reviewed by HCI through auditing contracted Primary Care Provider locations within the RAE 4 Region once a year. HCI contacts Primary Care Providers first by email and then by telephone call to gather Access to Care standards data. If the HCI is unable to connect with a Primary Care Provider, then HCI searches the internet to find better contact information. If additional current contact information is available, HCI calls or emails the Primary Care Provider to request Access to Care information. Primary Care Providers within HCIs RAE 4 region are asked four (4) questions regarding Access to Care standards. • Appointment availability for new Health First Colorado members within seven (7) days of request. • Appointment availability for established Health First Colorado members within seven (7) days of request. • Urgent access appointment availability within twenty-four (24) hours. • Well Care appointment availability within one (1) month after the request; unless an appointment is required sooner to ensure the provision of screenings in the accordance with the Department's accepted Bright Futures schedule. HCI recognizes telehealth appointments count towards Health First Colorado member appointment availability Access to Care standards.

PCMP Audit Reporting Period	Q1	Q2	Q3	Q4
PCMP Total Locations Audited Counts	28	28	28	28
New Health First Colorado Routine/Non-Urgent appointment within Seven (7) days Met Requirements	18	16	18	24
Established Health Colorado Routine/Non-Urgent appointment within seven (7) days	18	17	24	25

Next Available Met Requirements				
Urgent Access 24 hours Met Requirements	21	18	26	25
Well-Care Access 1 month Met Requirements	NA	NA	24	25
Follow up audits from previous quarters (re-audits)	NA	NA	0	12
All Requirements Met	NA	NA	NA	12

*NA means Not Applicable

HCI reports Access to Care standards pass or fail results to all Primary Care Providers that were audited during the Q4 FY 21-22. If HCI did not receive a response from any Primary Care Provider, then a letter was mailed. Primary Care Providers that failed the audit will be re-audited in ninety (90) days. If any Primary Care Provider fails the re-audit, then the provider may be placed on a corrective action plan if necessary.

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 conducts an Access to Care standards audit with contracted Behavioral Health Provider locations within the RAE 4 Region. Each Behavioral Health Provider location is audited for Access to Care standards annually. Providers are outreached by email first, then by telephone call to collect Access to Care results. Behavioral Health Providers within HCIs RAE 4 region are asked three (3) questions regarding Access to Care standards. • Appointment availability for new members within seven (7) days of request. • Appointment availability for established members within seven (7) days of request. • Urgent appointment access availability either within fifteen (15) minutes by phone or within one (1) hour face-to-face Urban/Suburban areas and within two (2) hours after contact in Rural/Frontier areas). HCI considers telehealth visits an acceptable appointment service for Health First Colorado members.

BH Audit Reporting Period	Q1	Q2	Q3	Q4
BH Total Locations Audited Counts	20	21	20	18
New Health First Colorado Routine/Non-Urgent appointment within seven (7) days Met Requirements	9	8	7	11
Established Health First Colorado Routine/Non-Urgent appointment within seven (7) days Met Requirements	14	15	9	12
Urgent Access 24 hours Met Requirements	12	14	9	10
Follow up audits from previous quarters (re-audits)	NA	NA	11	12
All Requirements Met	NA	NA	4	11

*NA means Not Applicable

HCI contacts all audited Behavioral Health Providers to report Access to Care standards findings. If a provider was unable to meet the Access to Care standards, HCI outreaches to providers. HCI educates and informs Behavioral Health Providers of an Access to Care standards re-audit in ninety (90) days. Behavioral Health Providers may be required to produce a corrective action plan to HCI if they fail the Access to Care standards re-audit.

5. Time and Distance Standards

Health Care Network Time and Distance Standards

Supporting contract reference: The MCE shall ensure that its network has a sufficient number of practitioners, practice sites, and entities who generate billable services within their zip code or within the maximum distance for their county classification. The MCE must use GeoAccess or a comparable service to measure the travel time and driving distance between where members live and the physical location of the practitioners/practice sites/entities in the MCE's Region.

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

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

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

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

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Table 11–Urban Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific contracted urban counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has one (1) urban county, Pueblo, where almost half (47%) of HCI's membership resides. The requirement for an urban county is to have one-hundred percent (100%) coverage of two (2) providers within thirty (30) miles or thirty (30) minutes. Mental Health Services In Pueblo County, HCI had ninety-nine percent (99%) coverage within standards for Psychiatrists and other Psychiatric Prescribers, and Behavioral Health for all ages. HCI had ninety-six percent (96.2%) coverage for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. This is consistent with the results of the previous quarterly reports. SUD Services HCI maintained ninety-nine percent (99%) coverage for SUD Treatment Practitioners for all ages. HCI maintained ninety-eight percent (98%) 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 percent (0%) 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 a lack of providers that have the license level within the standard time and distance. This is consistent with the results from the previous quarterly reports. HCI's geoaccess analysis had different findings for SUD ASAM 3.1 compared to the geoaccess analysis conducted by Health Services Advisory Group (HSAG), HCPF's vendor. The discrepancies may be due to the differences in the settings of QuestAnalytics application and any clean up processes for member addresses implemented in the analysis to calculate whether a provider was within time or distance standard. HCI will work with HSAG to review the analysis process and align methodologies to reduce discrepancy in findings. Physical Health HCI achieved one-hundred percent (100%) coverage for Pediatric Primary Care (MD, DO, NP) for this reporting period. HCI maintained ninety-nine percent (99%) coverage for all other physical health provider levels and

ages with the exception of Gynecology, OB/GYN (PA) acting as PCMP. HCI had zero percent (0%) coverage. HCI has not been able to find Physician Assistants (PAs) in the county that serve as primary care with Gynecology, OB/GYN specialty. There was no significant change in PCMP network during the reporting period. These findings are different compared to the geoaccess analysis conducted by Health Services Advisory Group (HSAG), HCPF's vendor. The discrepancies may be due to the differences in the settings of QuestAnalytics application and any clean up processes for member addresses implemented in the analysis to calculate whether a provider was within time or distance standard. HCI will work with HSAG to review the analysis process and align methodologies to reduce discrepancy in findings.

HCI ensures access to care for members residing in Pueblo where it does not meet the time/distance requirements by offering providers with telehealth services. In addition, HCI's Care Coordination staff connects 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 contracted rural counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE

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 full 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.
 	
Mental Health Services HCI met one-hundred percent (100%) 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. This is consistent with the results of the previous quarterly reports.
 	
SUD Services
HCI met access standards for SUD Treatment Practitioners 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 percent (100%) in Crowley and Otero Counties
  ○ Ninety-seven percent (97.3%) in Fremont County
  ○ Eighty percent (80.7%) in Prowers County

- Zero percent (0%) in Alamosa, Chaffee, Conejos, Lake, and Rio Grande Counties
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)
  - Zero percent (0%) across the frontier counties due to no licensed facilities.
- Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
  - One-hundred percent (100%) in Alamosa, Conejos, Prowers and Rio Grande
  - Ninety-eight percent (98.8%) in Crowley County
  - Ninety-seven percent (97.3%) in Fremont County
  - Ninety-four percent (94.1%) in Otero County
  - Zero percent (0%) in Chaffee and Lake Counties
- Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
  - Ninety-seven percent (97%) in Crowley County
  - Ninety-six percent (96.9%)in Fremont County
  - Forty-one percent (40.8%) in Otero County
  - Zero percent (0%) in Alamosa, Chaffee, Conejos, Lake, Prowers, and Rio Grande Counties
- Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM)
  - One-hundred percent (100%) in Alamosa, Conejos, Crowley, Lake, Otero, and Rio Grande
  - Ninety-seven percent (97.3%) in Fremont County
  - Eighty percent (80.7%) in Prowers County
  - Thirty-eightpercent (38%) in Chaffee County
- Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7WM)
  - Nine-three percent (93%) in Fremont County
  - Zero percent (0%) all other frontier counties due to no licensed facilities that cover the time/ distance for the region.

The significant change was in Lake County which improved to meet the requirement for Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM).

HCI's geoaccess analysis had different findings for SUD ASAM 3.5 in Otero county, and ASAM Level 3.2WM in Lake and Chaffee counties compared to the geoaccess analysis conducted by Health Services Advisory Group (HSAG), HCPF's vendor. The discrepancies may be due to the differences in the settings of QuestAnalytics application and any clean up processes for member addresses implemented in the analysis to calculate whether a provider was within time or distance standard. HCI will work with HSAG to review the analysis process and align methodologies to reduce discrepancy in findings.

<u>Physical Health</u>

HCI maintained one-hundred percent (100%) 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 percent (100%) coverage of members within the time/distance (i.e., 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 ninety-nine percent (99%) coverage for these provider types.

Access to a Gynecologist that provides primary care, OB/GYN (MD, DO, NP) by county, included one-hundred percent (100%) coverage in Alamosa, Chaffee, Crowley, Fremont, Lake and Otero; ninety-nine percent (99%) coverage in Prowers; and ninety-three percent (93%) coverage in Rio Grande and Conejos counties. HCI improved in coverage within Otero and Conejos counties for OB/GYN (MD, DO, NP) during this reporting period.

However, for Gynecology, OB/GYN (PA), HCI had zero percent (0%) coverage in all rural counties. There was no significant change in PCMP network during the reporting period.

HCI ensures access to care for members residing in rural counties where we do 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.

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Table 13–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific contracted frontier counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE

HCI has nine (9) frontier counties, including Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache counties. Standards for members residing in a frontier county require full coverage of 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.
 	
Mental Health Services
HCI met one-hundred percent (100%) of standards for all our frontier counties for Behavioral Health as well as Psychiatrists and other Psychiatric Prescribers for all ages. HCI met access to Psychiatric Hospital or Psychiatric Units in Acute Facilities for Custer county. This was an improvement from previous quarterly reports. HCI did not meet access to Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities in all other rural counties within the region.
 	
SUD Services
HCI met access standards for SUD Treatment Practitioners 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 percent (100%) in Bent, Custer, and Huerfano Counties
  ○ Ninety-eight percent (98.8%) in Las Animas County
  ○ Ninety-seven percent (97.4%) in Kiowa County
  ○ Sixty-nine percent (68.8%) in Baca County
  ○ Fifty-six percent (56%) in Saguache County
  ○ Less than fifty percent (50%) to zero percent (0%) in Costilla and Mineral Counties.
• Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)
  ○ Zero percent (0%) across the frontier counties due to no licensed facilities
• Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
  ○ One-hundred percent (100%) in Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Mineral, and Saguache Counties
  ○ Ninety-nine percent (99%) in Las Animas County
• Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
  ○ One-hundred percent (100%) in Custer and Huerfano Counties
  ○ Ninety-seven percent (97%) in Las Animas County
  ○ Eighty percent (80.2%) in Bent County

  - Less than fifty percent (50%) to zero percent (0%) in Baca, Costilla, Kiowa, Mineral, and Saguache Counties
- Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM)
  - One-hundred percent (100%) in Bent, Costilla, Custer, Huerfano, Las Animas, Mineral, and Saguache Counties
  - Eighty-nine percent (97.4%) in Kiowa County
  - Sixty-nine percent (68.8%) in Baca County
- Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7WM)
  - One-hundred percent (100%) in Custer County
  - Zero percent (0%) all other counties due to no licensed facilities that cover the time/ distance for the region

HCI improved access for ASAM Level 3.7WM in Custer County. HCI's geoaccess analysis had different findings for SUD ASAM 3.1 in Kiowa and Saguache counties, and ASAM Level 3.2WM in Kiowa county compared to the geoaccess analysis conducted by Health Services Advisory Group (HSAG), HCPF's vendor. The discrepancies may be due to the differences in the settings of QuestAnalytics application and any clean up processes for member addresses implemented in the analysis to calculate whether a provider was within time or distance standard. HCI will work with HSAG to review the analysis process and align methodologies to reduce discrepancy in findings.

Physical Health

HCI had a strong physical health network during the reporting in the frontier counties with one-hundred percent (100%) 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)

For Family Practitioners (PA), HCI had one-hundred percent (100%) coverage of members in Bent, Costilla, Custer, Huerfano, Mineral, Kiowa, and Saguache Counties; ninety-nine percent (99%) coverage in Las Animas; and seventy-seven percent (77%) coverage in Baca County.

For in-network PCMPs that are Gynecologist, OB/GYN (MD, DO, NP), HCI had one-hundred percent (100%) coverage of members in Bent, Costilla, Custer, Huerfano, Kiowa, and Saguache Counties; ninety-nine percent (99%) coverage in Las Animas County; seventy-eight percent (78%) coverage in Baca County; and fifty-four percent (54.4%) in Mineral County. However, for Gynecology, OB/GYN (PA), HCI had zero percent (0%) coverage in all frontier counties, except Saguache, which had sixty-seven percent (67.5%) coverage. There was no significant change in PCMP network during the reporting period.

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

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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-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*	[redacted]
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	[redacted]
CHP+ MCO, Medicaid MCO, RAE					
ASHBY, ERIN	82084858	Pueblo	BV120	Psychologists (PhD, PsyD) - General	[redacted]
CASSADY, JESSACA	12323080	La Plata	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
SMITH, HEATHER	02126834	Adams	BV132	Licensed Professional Counselors (LPCs)	[redacted]
WEGELIN, CHERYL	9000160354	Pueblo	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
JOHNSTOWN HEIGHTS BEHAVIORAL HLTH	9000197846	Weld	BF085	ASAM Level 3.7 WM	[redacted]
VALLEY HOPE ASSOCIATION	9000187267	Douglas	BF085	ASAM Level 3.1	[redacted]
VALLEY HOPE ASSOCIATION	9000187267	Douglas	BF085	ASAM Level 3.5	[redacted]

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 when 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 reaches out to high-volume providers and recruits them to join the network. Of the four (4) providers that rendered services through SCAs, two (2) providers are part of Parkview Ancillary and participating in contract negotiations. Additionally, the two (2) facilities with SCAs, Valley Hope Association and Johnstown Heights Behavioral Health, joined the network during the reporting period.

Appendix B. Optional MCE Content

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

Instructions for Appendices

To add an image:

- Go to "Insert" and click on "Pictures".
- Select jpg file and click "Insert".

To add an additional Appendix:

- Go to "Layout" and click on "Breaks".
- Select "Next Page" and a new page will be created.
- Go to "Home" and select "HSAG Heading 6".
- Type "Appendix C." and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

Optional MCE Content

Free text

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Appendix C. Optional MCE Content

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