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 *10/31/2022*, covering the MCE's network from *7/1/2022 – 09/30/2022*, FY23Q1

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the September 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 2022 version).

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

Fiscal Year Quarter Reported	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2022-23 Q1	October 2022	September 30, 2022
FY 2022-23 Q2	January 2023	December 31, 2022
FY 2022-23 Q3	April 2023	March 31, 2023
FY 2022-23 Q4	July 2023	June 30, 2023

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0922* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0922* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2022, for the quarterly report due to the Department on October 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., September 30, 2022, for the quarterly report due to the Department on October 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	151,387	N/A	152,996	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with “PV” or “PG”)	501	N/A	504	N/A
Primary care practitioners accepting new members	494	98.6%	497	98.6%
Primary care practitioners offering after-hours appointments	165	32.9%	165	32.7%
New primary care practitioners contracted during the quarter	2	0.4%	3	0.5%
Primary care practitioners that closed or left the MCE’s network during the quarter	18	3.6%	0	0.0%

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) has a network of Primary Care Medical Providers (PCMP) which contains a sufficient number of providers to serve members based on the maximum distance for county classification. HCI continues to face barriers in meeting the time/distance standard for PCMPs who offer gynecology services as well as those who serve pediatric populations. This is a result of the limited number of provider practices, which significantly reduces PCMP recruitment opportunities. During FY22, HCI identified two PCMP locations in Pueblo for potential recruitment: Advanced Practice Headache and Primary Care Clinic, and Family Center of Colorado. HCI conducted outreach to these PCMPs, which did not yield any responses. HCI subsequently inquired with other providers and community stakeholders to identify alternative approaches for contacting the PCMPs to discuss potential contracting. As of the end of this reporting period, HCI has not achieved the desired outcome. HCI will continue to pursue methods of outreaching these PCMPs to share information about joining the network. HCI implements several strategies to ensure members understand and have access to family planning services, which are provided by an appropriate physical health provider. These strategies are as follows: 1. Utilize member onboarding sessions and materials to educate members on available family planning benefits and how to access those services within and outside of HCI's network. 2. Assist members with finding a provider who offers family planning services through Health First Colorado's *Find a Provider* website. 3. Support PCMPs who do not provide family planning within their practice by offering them resources on how to refer members to practitioners who do offer the services. 4. Monitor member complaints related to family planning services. During this reporting period, there were no recorded complaints regarding access to family planning services. 5. Review family planning utilization data available from the State. Family planning usage was analyzed this quarter using available claims data. According to state claims data for family planning services, 3,612 members received family planning services during Q4 of FY22. A majority of those members (2,987, or 83%) obtained services within RAE Region 4. HCI contracted PCMPs are rendering these services. Other providers that are offering the services included in the data were provided by facilities such as hospitals, imaging, and urgent care centers, which would not fit the criteria for PCMPs. HCI monitors the availability of telehealth services by surveying providers on their capacity to offer telehealth and by analyzing telehealth utilization through claims data. In Q4 FY22, telehealth utilization accounted for 3.23% of paid physical health claims. Due to a lag in claims data, Q1 FY23 data is not yet available.

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	151,387	N/A	152,996	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,307	N/A	3,297	N/A
Behavioral health practitioners accepting new members	3,307	100%	3,297	100%
Behavioral health practitioners offering after-hours appointments	1,066	32.2%	1,080	32.8%
New behavioral health practitioners contracted during the quarter	154	4.6%	97	2.9%
Behavioral health practitioners that closed or left the MCE's network during the quarter	138	4.2%	107	3.2%

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	24	27
Total SUD treatment facilities offering ASAM Level 3.3 services	1	3
Total SUD treatment facilities offering ASAM Level 3.5 services	29	31
Total SUD treatment facilities offering ASAM Level 3.7 services	17	18
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	16	19
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	8

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 types to ensure that members have access to all covered services. During the reporting period, HCI maintained the same level of access that it had the previous quarter. Behavioral health practitioners and/or facilities for which HCI did not possess a sufficient network experienced specific contributing barriers as delineated below. To start, the state does not have enough psychiatric residential treatment facilities, psychiatric hospitals, or psychiatric units in acute care facilities to satisfy the time/distance standards for a sizable portion of HCI's region. The closing of Parkview Medical Center's inpatient psychiatric unit in June 2022 inhibited member access to inpatient services in the region. In addition, prescribers who do not fit into the Behavioral Health Specialty Provider criteria must bill fee for service (FFS) for Evaluation & Management (E&M) codes. As a result, there is no incentive for prescribers to contract with HCI. Since HCI's capitated services included in the agreement do not contain E&M codes, HCI ceased contract conversations with Parkview Ancillary Group for outpatient behavioral health services during the reporting period. E&M codes are the main services offered by their practitioners; therefore, they did not see any advantage to going through the contracting and credentialing process. They plan to keep using SCAs for the minimal services they offer under HCI's capitated services. A general shortage of adequate SUD treatment facilities across all ASAM levels within the region also substantially impacts our capacity to comply with the time/distance standard. Specifically, Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3) and Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7WM) are not offered in the region. For members in need of this level of care, HCI arranges transportation so that they may obtain services in another region. Finally, there are not enough Behavioral Health Providers in the region to have two providers within the time/distance standard. Pueblo County maintains an urban designation; however, it contains rural areas which do not have a practitioner within the 30 miles/30 minutes radius. According to the RAE agreement with HCPF, standards for member choice/proximity to providers are not necessary in a specific area if fewer than two providers are located in that area.

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 utilizes telehealth services when feasible in order to secure access to care and overcome the barriers described previously. HCI asks providers to share their telehealth capabilities through claims data and as part of their demographic data in an effort to monitor the availability of telehealth services. For Q4 FY22, 13.7% of all paid services, by cost, were delivered through telehealth. Telehealth data for Q1 FY23 is not yet available because of a lag in claims data. Overall, telehealth utilization has decreased from one third (33%) of all paid services at the beginning of the fiscal year (Q1 FY22). However, the rate remains higher than pre-pandemic levels at 1% to 2% of utilization. HCI expects telehealth modality to continue to be a crucial component of the network which will help ensure timely access and member choice, particularly for members residing in rural and frontier portions of the RAE 4 region. The providers in HCI's network have thoroughly incorporated the ASAM levels of care into their evaluation and treatment services. As a result of HCI's focused training endeavors during Utilization Management (UM) reviews, providers' documentation and observance of authorization procedures continues to show substantial progress. Providers participated in care coordination with the RAE and other treatment providers, and most providers exhibited an understanding of the Medicaid enrollment process. When necessary, providers may be referred to applicable resources by the Clinical Department. HCI is continuing work to assist with state and local efforts to address workforce shortages. These shortages remain a concern throughout the state, inhibiting the capacity of programming in some cases. In the event that a SUD facility cannot place referred members into covered levels of care because it does not have enough beds, HCI's Clinical Department requested to be informed in an effort to track bed capacities internally and manage placements. In collaboration with the provider network and the Managed Services Organizations (MSOs), HCI strives to track bed availability by ASAM level of care. However, the prevention of data sharing due to legal constraints established by HIPAA and 42 CFR, Part 2 as well as the absence of a statewide bed tracking system make it difficult to gather real-time information regarding bed availability. If a bed is not available and it is found to be a clinically safe alternative, a member may be put on a waitlist during which time they can still be connected with outpatient treatment and case management services. If it is found to be more easily accessible, the member may instead receive approval for a higher level of care.

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
There were no unanticipated deficiencies or material changes to the primary care or behavioral health networks that could negatively impact service delivery, availability, or capacity within the provider network.

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

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Inadequate Network Policies

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

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

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

HCI analyzes access to care standards for Health First Colorado members within Region 4 by auditing the physical locations of contracted PCMPs once a year. HCI PCMPs are asked about the following four issues during the audit:

1. Appointment availability for new Health First Colorado members within seven days of request.
2. Appointment availability for established Health First Colorado members within seven days of request.
3. Urgent access appointment availability within 24 hours of request.
4. Well care appointment availability within one month after the request, unless an appointment is required sooner to ensure the provision of screenings in accordance with HCPFs accepted Bright Futures schedule.

HCI outreaches PCMPs within Region 4 through email and telephone calls. In the event that HCI is unable to connect with a PCMP to obtain audit results, HCI staff searches the internet for updated contact information to achieve successful outreach.

Telehealth appointments are included in access to care standards for Health First Colorado members.

PCMP Audit Reporting Period	Q1 Audits	Q2 Audits	Q3 Audits	Q4 Audits
PCMP Total Locations Audited Counts	34	NA	NA	NA
New Health First Colorado Routine/Non-Urgent appointment within seven days Met Requirements	6	NA	NA	NA
Established Health Colorado Routine/Non-Urgent appointment within seven days Next Available Met Requirements	9	NA	NA	NA
Urgent Access 24 hours Met Requirements	16	NA	NA	NA
Well-Care Access 1 month Met Requirements	15	NA	NA	NA
Follow up audits from previous quarters (re-audits)	5	NA	NA	NA
All Requirements Met	5	NA	NA	NA

*NA means Not Applicable

PCMPs who were audited during Q1 FY23 were notified of pass or fail results. Any PCMPs who failed the access to care audit were notified that a re-audit would take place in 90 days. Findings from these re-audits will be reported in the Q3 FY23 report.

In Q1 FY23, 28 PCMPs failed the new Health First Colorado member appointment availability within seven days requirement, and 25 PCPMs failed the established Health First Colorado member appointment availability within seven days requirement. Eighteen PCMPs failed urgent appointment availability within 24 hours of the request, and 19 PCMPs failed well care appointment availability within one month of the request. PCMPs who failed to respond to the audit are included in the failed access to care audit calculations.

HCI has identified an increase in the number of PCMPs who are not meeting the access to care standards. HCI has discovered that this is because PCMPs are experiencing staff shortages and/or increased member appointment needs.

HCI trains providers on access to care standards through HCI roundtable webinars which are then posted to HCI's website. These provider trainings took place in July 2022 and December 2022.

When necessary, HCI will place PCMPs on a corrective action plan if failed results reoccur. HCI re-audited five PCMPs this quarter and all five of them passed the 90-day re-audit.

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

Within Region 4, HCI audits contracted Behavioral Health Providers by locations in order to better understand access to care for Health First Colorado members. Behavioral Health Providers are audited annually through email and telephone calls.

Behavioral Health Providers within HCIs RAE 4 region are asked about the following three matters regarding access to care standards:

1. Appointment availability for new members within seven days of request.
2. Appointment availability for established members within seven days of request.
3. Urgent appointment access availability either within 15 minutes by phone, or within one hour face-to-face for urban/suburban areas and within two hours face-to-face for rural/frontier areas.

Access to care appointment standards include telehealth visits for Health First Colorado members.

BH Audit Reporting Period	Q1 Audits	Q2 Audits	Q3 Audits	Q4 Audits
BH Total Location Audited Counts	34	NA	NA	NA
New Health First Colorado Routine/Non-Urgent appointment within seven days Met Requirements	29	NA	NA	NA
Established Health First Colorado Routine/Non-Urgent appointment within seven days	22	NA	NA	NA

Met Requirements				
Urgent Access 24 hours Met Requirements	30	NA	NA	NA
Emergency Access By phone within 15 minutes after the initial contact, including TTY accessibility; in-person within one hour of contact in urban and suburban areas, in-person within two hours after contact in rural and frontier areas.	25	N/A	N/A	N/A
Follow up audits from previous quarters (re-audits)	4	NA	NA	NA
All Requirements Met	2	NA	NA	NA

*NA means Not Applicable

After HCI audits Behavioral Health Providers for Q1 FY23 within RAE Region 4, HCI sends a letter to each Behavioral Health Provider containing their individual pass or fail results. The letter includes information regarding access to care standards. If a Behavioral Health Provider fails the access to care audit, then a re-audit will occur in 90 days. Findings from these re-audits will be reported in the Q3 FY23 report.

In Q1 FY23, five Behavioral Health Providers failed the new Health First Colorado routine/non-urgent appointment availability within seven days requirement, and twelve failed the established routine/non-urgent appointment availability within seven days requirement. Two Behavioral Health Providers failed the urgent access for members within 24 hours, and nine failed the emergency access availability audit.

HCI has identified an increase in the number of Behavioral Health Providers who are not meeting the access to care standards. HCI has discovered that this is because Behavioral Health Providers are experiencing staff shortages and/or increased member appointment needs.

HCI trains providers on access to care standards through HCI roundtable webinars which are then posted to HCI's website. These provider trainings took place in July 2022 and December 2022.

If failed results reoccur, HCI may be required to produce a corrective action plan (CAP). HCI re-audited four Behavioral Health Providers and two passed the re-audit. The two Behavioral Health Providers who failed the re-audit were reviewed by the Quality Oversight Care Committee (QOCC) and it was determined that, instead of a CAP, the providers' panels would be closed to new referrals. Letters were sent to both Behavioral Health Providers explaining the QOCC's decision to close providers' panels to new referrals.

5. Time and Distance Standards

Health Care Network Time and Distance Standards

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

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

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

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

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

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific contracted urban counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Physical Health For PCMPs, the requirement for urban counties is to have 100% coverage of two providers within 30 miles or 30 minutes. HCI missed the standards across licensure levels, with 99.9% coverage for all PCMP types except for Gynecology, OB/GYN (PA) acting as PCMP. HCI had 0% coverage, having been unable to find Physician Assistants (PAs) in Pueblo County who serve as PCMPs with a Gynecology, OB/GYN specialty. Mental Health Services Within the urban county of Pueblo, HCI is required to have 90% coverage of two mental health providers within 30 miles or 30 minutes. In Pueblo County, HCI met the standard for Psychiatrists and other Psychiatric Prescribers, as well as Behavioral Health for all ages. HCI did not meet the standard for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities because there is not a facility located within the required distance. SUD Services HCI is required to have 100% coverage of two SUD practitioners and one facility for SUD and psychiatric services within 30 miles or 30 minutes. HCI did not meet the standard across the Provider Type. HCI had 99.9% coverage for SUD Treatment Practitioners for all ages as well as almost full coverage for ASAM 3.1 (98.5%), ASAM 3.2 WM (98.5%), ASAM 3.5 (99.2%), and ASAM 3.7 (99.2%). HCI had no coverage (0%) for ASAM 3.3 and 3.7 WM. HCI ensures access to care for members residing in Pueblo where the time/distance requirements are not met by offering providers who utilize telehealth services. In addition, HCI's Care Coordination staff connects members to transportation and other resources that allow them to access services outside of 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

Physical Health
For PCMPs, the requirement for rural counties in the region is to have 100% coverage of two providers within 45 minutes or 45 miles. HCI maintained 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)
- Adult Primary Care (PA)
- Pediatric Primary Care (PA)

Additionally, Family Practitioner (PA) had 100% coverage of members within the time/distance requirement for eight of the nine counties (i.e., Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, and Rio Grande). The exception was Prowers County, which had 99.9% coverage for these provider types.

Access to a Gynecologist who provides primary care, OB/GYN (MD, DO, NP) by county included 100% coverage in Alamosa, Chaffee, Crowley, Fremont, Lake and Otero; 99% coverage in Prowers and Conejos counties; and 95.4% coverage in Rio Grande County. However, for Gynecology, OB/GYN (PA), HCI had 0% coverage in all rural counties. There was no significant change in PCMP network during the reporting period.

Mental Health Services
In rural counties, HCI is required to have 90% coverage of two providers within 60 minutes or 60 miles for mental health practitioners. HCI met the standard for Psychiatrists and other Psychiatric Prescribers, as well as Behavioral Health for all ages.

HCI did not meet the standard for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities because there is not a facility located within the required distance for rural counties in the region.

SUD Services
HCI is required to have 100% coverage of two SUD practitioners and one facility for SUD and psychiatric services within 60 minutes or 60 miles. HCI met access standards for SUD Treatment Practitioners for all ages and maintained access to care for SUD higher level services within the region:

- Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
    - Crowley and Otero Counties: 100%

  - Fremont County: 97.9%
  - Prowers County: 82.9%
  - Alamosa, Chaffee, Conejos, Lake, and Rio Grande Counties: 0%
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)
  - Across the frontier counties: 0% due to no licensed facilities
- Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
  - Alamosa, Conejos, Prowers and Rio Grande Counties: 100%
  - Crowley County: 99.6% and Otero County: 99.9%
  - Fremont County: 97.9%
  - Chaffee and Lake Counties: 0%
- Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
  - Crowley County: 99%
  - Fremont County: 97.6%
  - Otero County: 45.3%
  - Alamosa, Chaffee, Conejos, Lake, Prowers, and Rio Grande Counties: 0%
- Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM)
  - Alamosa, Conejos, Crowley, Lake, Otero, and Rio Grande Counties: 100%
  - Fremont County: 97.8%
  - Prowers County: 82.9%
  - Chaffee County: 38.5%
- Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7WM)
  - Fremont County: 93%
  - All other frontier counties: 0% due to no licensed facilities that cover the time/ distance for the region.

In order to guarantee access to care for members living in Pueblo where the time/distance requirements are not met, HCI offers providers who utilize telehealth services. HCI's Care Coordination staff also arranges transportation and links to other resources which allow members to obtain services outside of Pueblo.

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

Physical Health

For PCMPs, the requirement for frontier counties in the region is to have 100% coverage of two providers within 60 minutes or 60 miles. HCI had a strong physical health network during the reporting in the frontier counties with 100% coverage of members within the time/distance requirements 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 100% coverage of members in Bent, Costilla, Custer, Huerfano, Mineral, Kiowa, and Saguache Counties; 99% coverage in Las Animas; and 82.2% coverage in Baca County.

For in-network PCMPs that are Gynecologists, OB/GYN (MD, DO, NP), HCI had 100% coverage of members in Bent, Costilla, Custer, Huerfano, Kiowa, and Saguache Counties; 99% coverage in Las Animas County; 91.9% in Mineral County, and 84.5% coverage in Baca County. However, for Gynecology, OB/GYN (PA), HCI had 0% coverage in all frontier counties, except Saguache, which had 98.1% coverage and Custer with 47.8%. Both Saguache and Custer counties increased in access from the previous reporting period.

Mental Health Services

HCI is required for its rural counties to have 90% coverage of two mental health practitioners within 90 minutes or 90 miles. HCI met the standard for Psychiatrists and other Psychiatric Prescribers as well as Behavioral Health for all ages.

HCI did not meet the standard for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities because there is not a facility located within the required distance.

SUD Services

HCI is required to have 100% coverage of two SUD practitioners and one facility for SUD and psychiatric services within 90 minutes or 90 miles. HCI met access standards for SUD Treatment Practitioners for all ages and maintained access to care for SUD higher of level services within the region:

- Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
  - Bent, Custer, and Huerfano Counties: 100%
  - Las Animas County: 99.9%
  - Kiowa County: 96.8%
  - Baca County: 88.7%
  - Saguache County: 57.8%
  - Costilla and Mineral Counties: <50% to 0%
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)
  - Across the frontier counties: 0% due to no licensed facilities
- Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
  - Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Mineral, and Saguache Counties: 100%
  - Las Animas County: 99.4%
- Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
  - Custer and Huerfano Counties: 100%
  - Las Animas County: 98.4%
  - Bent County: 85.9%
  - Saguache County: 61.1%
  - Costilla County: 52.6%
  - Baca, Kiowa, and Mineral Counties: <50% to 0%
- Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM)
  - Baca, Bent, Costilla, Custer, Huerfano, Las Animas, Mineral, and Saguache Counties: 100%
  - Kiowa County: 96.8%
  - Baca County: 88.7%
- Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7WM)
  - Custer County: 100%
  - All other counties: 0% due to no licensed facilities that cover the time/distance for the region

In order to guarantee access to care for members living in frontier counties where the time/distance requirements are not met, HCI offers providers who utilize telehealth services. HCI's Care Coordination staff also arranges transportation and links to other resources which allow members to obtain services outside of the county in which they reside.

Appendix A. Single Case Agreements (SCAs)

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

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

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	
CHP+ MCO, Medicaid MCO, RAE					
ABERG-MAES, JEANNINE	9000142361	Chaffee	BV131	Licensed Marriage & Family Therapists (LMFTs)	
ASHBY, ERIN	82084858	Pueblo	BV120	Psychologists (PhD, PsyD) - General	
BINDSEIL, RICHARD	64238334	Boulder	BV100	Psychiatrists	
BRADLEY, JOHN	92970311	Boulder	BV100	Psychiatrists	
MORTENSEN, D KILEY	90002075	Boulder	BV100	Psychiatrists	
ROSQUIST, SARAH	29817501	Boulder	BV100	Psychiatrists	
SMITH, HEATHER	02126834	Adams	BV120	Psychologists (PhD, PsyD) - General	
WEGELIN, CHERYL	9000160354	Pueblo	BV130	Licensed Clinical Social Workers (LCSWs)	
SCL HEALTH- FRONT RANGE INC	98851365	Jefferson	BF085	ASAM Level 3.7 WM	

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 continued to utilize SCAs to ensure access to care for members by approving SCA requests for out-of-network providers when: 1. The specialty service is not available through the current network, 2. The member is located outside of the time/distance standard for service, 3. The member has an established relationship with the provider and it is deemed necessary for purposes of continuity of care, or 4. The provider is actively engaged in the contracting and credentialing process, which allows providers to start serving HCI members while they complete the process. HCI reviewed SCA utilization data to upgrade practitioners with SCAs to full network practitioners when there is a trend of high utilization. HCI reached out to high-volume providers and recruited them to join the network. Of the eight providers who rendered services through SCAs, four providers are part of a hospital group and two are finalizing their contract and credentialing process. Additionally, SCL Health-Front Range, Inc., the only facility with an SCA, 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

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.