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*

Contact Name: *Lori Roberts*

Report Submitted by: *Alma Mejorado*

Report Submitted on: *July 31, 2023*

Report Resubmitted on: *October 12, 2023*

Report due by *07/31/2023* covering the MCE's network from *04/01/2023– 06/30/2023*, FY*23* Q*4*

*—Final Copy: June 2023 Release—*

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# Contents

COLORADO
Department of Health Care Policy & Financing

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

This document contains the June 2023 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, or RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (December 2022 version).

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

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

## Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0623* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_1222* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

## Report Instructions

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

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

| Network Category | CHP+ MCO | Medicaid MCO | RAE |
|---|---|---|---|
| Facilities (Entities)<br>(*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<br>*(RAEs' network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)* | X | | X |
| Ancillary Physical Health Services<br>(*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, 2023, for the quarterly report due to the Department on July 31, 2023).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2023, for the quarterly report due to the Department on July 31, 2023).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

| Requirement | Previous Quarter | | Current Quarter | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| *Sample* | *0* | *0.0%* | *0* | *0.0%* |
| **CHP+ MCO, Medicaid MCO, RAE** | | | | |
| Total members | 157,322 | N/A | 154,289 | N/A |
| Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG") | 493 | N/A | 488 | N/A |
| Primary care practitioners accepting new members | 486 | 98.6% | 481 | 98.5% |
| Primary care practitioners offering after-hours appointments | 163 | 33.1% | 161 | 33.0% |
| New primary care practitioners contracted during the quarter | 3 | 0.6% | 4 | .82% |
| Primary care practitioners that closed or left the MCE's network during the quarter | 5 | 1.0% | 9 | 1.8% |

COLORADO
Department of Health Care Policy & Financing

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

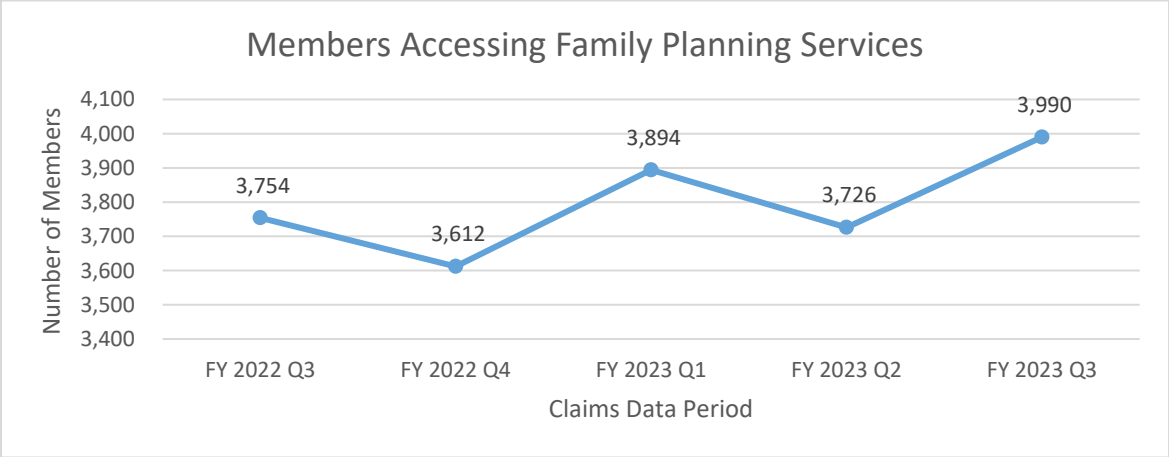
| **Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay.**<br>**Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.**<br>**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) maintains a network of Primary Care Medical Providers (PCMP), which consists of providers that serve members based on the maximum distance for county classification.<br><br>During Q4 of FY23, HCI successfully contracted with Wayne Hudson DO Integrated Medical Practice, located in Lamar County. HCI is seeking new opportunities to strengthen the network, including adding new PCMPs. This will be reported on in FY24.<br><br>HCI continues to utilize the strategies described in previous reports, which support members in understanding and obtaining access to family planning services provided by an appropriate physical health provider. These strategies are as follows:<br><br>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.<br>2. Assist members with finding a provider who offers family planning services through Health First Colorado's *Find a Provider* website.<br>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.<br>4. Monitor member complaints related to family planning services. During this reporting period, there were no recorded complaints regarding access to family planning services.<br>5. Review family planning utilization data available from the state.<br><br>HCI utilized available claims data to evaluate family planning usage on a quarterly basis. The latest available state claims data for family planning services revealed that 3,990 members received family planning services during Q3 of FY23. This was an uptick from the previous quarter, and an overall 6.2% change from 3,754 members accessing family planning services during Q3 of FY22 (**Figure 1**). There is no indication of changes in the availability of services for members during this period. The increase may be attributed to changes in membership. |

**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**




*Note: Data for FY23 Q4 is not available to report.*

**Figure 1**

HCI works to ensure that the barriers outlined above are minimized so members can obtain needed services. One strategy that HCI utilized to minimize barriers is the promotion of telehealth. HCI continues to evaluate PCMPs on a yearly basis regarding their utilization of telehealth. Further, HCI has a partnership with Care on Location to provide services to regional members for physical health services. HCI includes Care on Location as a resource for members on the HCI website. In Q3 of FY23, telehealth utilization for physical health services accounted for 3.4% of the total claims paid through Fee-For-Service (FFS) Medicaid. Data for Q4 of FY23 was not available due to claims data lag.

COLORADO
Department of Health Care Policy & Financing

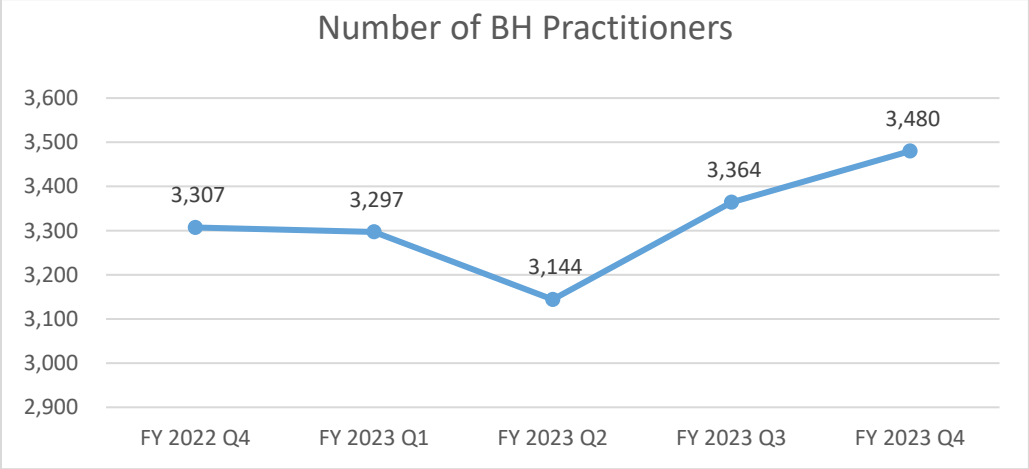
**Table 2A–Establishing and Maintaining the MCE Network: Behavioral Health Data**

| Requirement | Previous Quarter | | Current Quarter | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| *Sample* | *0* | *0.0%* | *0* | *0.0%* |
| **CHP+ MCO, Medicaid MCO, RAE** | | | | |
| Total members | 154,981 | N/A | 154,289 | N/A |
| Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG") | 3,144 | N/A | 3,480 | N/A |
| Behavioral health practitioners accepting new members | 3,144 | 100% | 3,480 | 100% |
| Behavioral health practitioners offering after-hours appointments | 1,180 | 37.5% | 1,450 | 41.7% |
| New behavioral health practitioners contracted during the quarter | 176 | 5.6% | 200 | 5.8% |
| Behavioral health practitioners that closed or left the MCE's network during the quarter | 335 | 10.6% | 80 | 2.3% |

**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 | 27 | 27 |
| Total SUD treatment facilities offering ASAM Level 3.3 services | 3 | 3 |
| Total SUD treatment facilities offering ASAM Level 3.5 services | 32 | 35 |
| Total SUD treatment facilities offering ASAM Level 3.7 services | 20 | 21 |
| Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management) | 22 | 22 |
| Total SUD treatment facilities offering ASAM Level 3.7 WM services | 11 | 12 |

**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.**<br>**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.**<br>**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** |
| During FY 2023, HCI maintained a network of behavioral health practitioners in number and types to ensure that members have access to all covered services. HCI enhanced the network through an open network. As illustrated in **Figure 2**, HCI increased the number of practitioners by 5.2% from Q4 of FY22 to Q4 of FY23.<br>  <br><br>**Figure 2**<br>Further, HCI continued to monitor the behavioral health penetration rate during this reporting period. As shown in **Figure 3**, HCI maintained a stable penetration rate during FY23. |

**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**

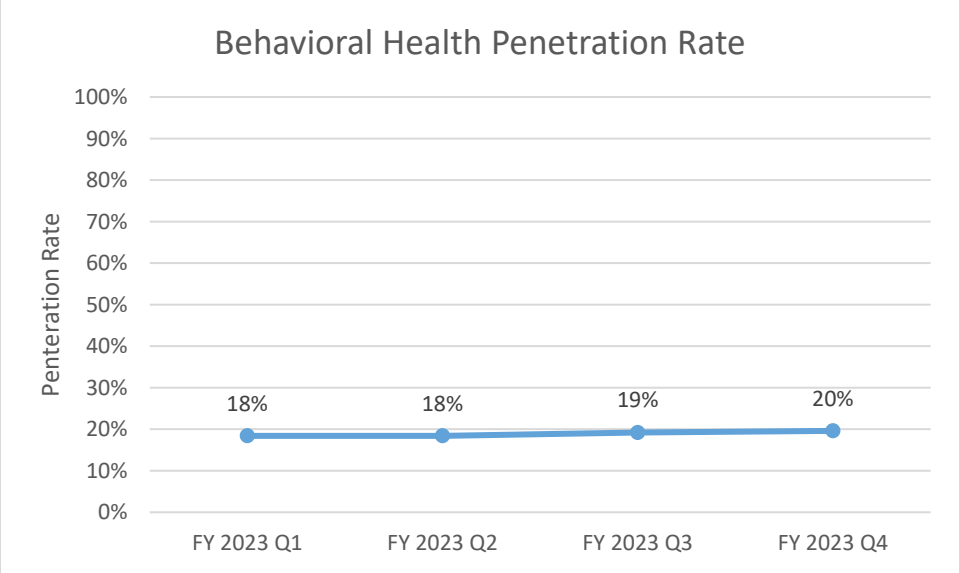



**Figure 3**

Despite the growth in behavioral health practitioners, some counties did not meet access to care standards for one or more provider or facility type at the beginning of the year. These counties continued to be a weakness for HCI with barriers noted below. These barriers were communicated throughout the fiscal year.

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. As previously reported, the closing of Parkview Medical Center's inpatient psychiatric unit in June of 2022 continues to inhibit member access to inpatient services in the region.

| **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.**<br>**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.**<br>**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** |
| 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. This continues to result in prescribers having no incentive 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 this 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.<br><br>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.<br><br>Finally, there are not enough behavioral health providers in the region to have two providers within the time/distance standard. This challenge has been described in previous reports. 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.<br><br>HCI offered telehealth services throughout the fiscal year and added new telehealth providers with the goal of bolstering members' access to covered services. In Q3 of FY23, 12% of all service costs were rendered through telehealth (data for Q4 of FY23 is not currently available due to data lag). Telehealth utilization has been stable over the past year.<br><br>As described in previous reports, 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. |

| **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.**<br>**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.**<br>**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** |
| 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.**<br>**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.**<br>**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's PCMP network experienced changes due to provider retirement, organization mergers, location consolidations, and/or ownership changes. The changes were communicated to HCPF following the notification process. During Q4 of FY23, Michael T. Rendler, MD (Medicaid ID 71871853) terminated as a PCMP because Dr. Rendler's individual Medicaid enrollment was denied. Affordable Health Clinic (Medicaid ID 82531579) terminated as a PCMP after the practice was sold to Omnicare Health Solutions. Members continued to receive services with the same practitioners within the same location. Further, HCI is engaging with Omnicare Health Solutions to bring them into the network. For these situations, HCI coordinated communication with the practice to notify members about the changes, including instructions on how to contact HCI for assistance in obtaining a new PCMP.<br><br>HCI did experience two behavioral health facility terminations. In both situations, the changes did not lead to network deficiencies or material changes to the behavioral health network that affected service delivery, availability, or capacity within the network.<br><br>Chanda Center for Health (CAS ID 986308), located in Lakewood, submitted a voluntary termination effective May 31, 2023. Based on review of services offered and service location, HCI members will experience minimum impact to access to care for Chanda Center for Health. Further, there was no current utilization history requiring members to be transitioned from their services.<br><br>Nuleaf Counseling Center (CAS ID 1041131), located in Sterling, terminated effective May 3, 2023 due to no response to the recredentialing process. HCI conducted outreaches via mail, phone, and email; all communications were returned as not delivered. Further, HCI conducted a claims review to identify any members who would require transition, and there were zero claims submitted in past 12 months. |

**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:<br>Did the MCE notify the Department, in writing, within ten (10) business days of the change?<br>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?<br>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* |

COLORADO
Department of Health Care Policy & Financing

## 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?**<br>**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?**<br>**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?**<br>**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 conducts an access to care audit set forth by Health First Colorado for contracted PCMPs by location within Region 4. HCI outreaches contracted PCMPs through email and telephone calls to complete the audit. The access to care survey results are reviewed by HCI to provide an understanding of Health First Colorado members' access to care availability. HCI focuses on the following four key areas within the provider survey:<br><br>• Appointment availability for new Health First Colorado members within seven days of the request<br>• Appointment availability for established Health First Colorado members within seven days of the request<br>• Urgent access appointment availability within 24 hours of the request<br>• 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 HCPF's accepted Bright Futures schedule.<br><br>HCI considers both in-person and telehealth appointment types to meet 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 | 29 | 33 | 19 |
| New Health First Colorado Routine/Non-Urgent appointment within seven days Met Requirements | 6 | 11 | 7 | 1 |
| Established Health Colorado Routine/Non-Urgent appointment within seven days Next Available: Met Requirements | 9 | 18 | 7 | 1 |
| Urgent Access 24 hours: Met Requirements | 16 | 18 | 7 | 1 |
| Well-Care Access one month: Met Requirements | 15 | 16 | 7 | 1 |

| 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** |

| | | | | |
|---|---|---|---|---|
| Follow up audits from previous quarters (re-audits) | 5 | 1 | 1 | 17 |
| All Requirements Met | 5 | 1 | 1 | 17 |

Following the access to care audit, HCI notifies PCMPs of their pass or fail audit results. PCMPs who failed the access to care audit were notified that a re-audit would take place in 90 days. Findings from this re-audit will be reported in the Q2 FY24 report.

In Q4 of FY23, 18 PCMPs failed the new Health First Colorado member appointment availability within seven days requirement. Eighteen PCPMs failed the established Health First Colorado member appointment availability within seven days, and 18 PCMPs failed urgent access appointment availability within 24 hours of the request. Finally, 18 PCMPs failed the well care appointment availability within one month requirement.

PCMPs' failures to respond to the audit are included in the failed access to care audit calculations.
If a PCMP has failed the access to care re-audit, then HCI may request a Corrective Action Plan (CAP) from the PCMP. HCI trains providers on access to care standards through HCI roundtable webinars. The webinars and presentations are available on HCI's website.

**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 monitors Health First Colorado members' access to care through auditing contracted behavioral health providers by locations within Region 4. HCI outreaches behavioral health providers by email and telephone calls to report their access to care standards. The access to care standards for behavioral health providers include:

- Appointment availability for new members within seven days of the request
- Appointment availability for established members within seven days of the request.
- Urgent appointment access availability within 24 hours, and emergency access 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.

COLORADO
Department of Health Care Policy & Financing

**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 accepts both telehealth and in-person appointment types to meet access to care standards.

| BH Audit Reporting Period | Q1 Audits | Q2 Audits | Q3 Audits | Q4 Audits |
|---|---|---|---|---|
| **BH Total Location Audited Counts** | 34 | 36 | 39 | 40 |
| New Health First Colorado Routine/Non-Urgent appointment within seven days: Met Requirements | 29 | 13 | 15 | 12 |
| Established Health First Colorado Routine/Non-Urgent appointment within seven days: Met Requirements | 22 | 13 | 15 | 13 |
| Urgent Access 24 hours: Met Requirements | 30 | 3 | 13 | 11 |
| 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 | 3 | 11 | 4 |
| Follow up audits from previous quarters (re-audits) | 4 | 2 | 7 | 33 |
| All Requirements Met | 2 | 1 | 6 | 26 |

HCI notifies each behavioral health provider within Region 4 of their access to care pass or fail results. The notification includes information regarding access to care standards. Behavioral health providers are re-audited in 90 days if the provider fails the first access to care audit.

In Q4 of FY23, 28 behavioral health providers failed the new Health First Colorado routine/non-urgent appointment availability within seven days requirement, and 27 failed the established routine/non-urgent appointment availability within seven days requirement. Twenty-nine behavioral health providers failed the urgent access for members within 24 hours, and 36 failed the emergency access availability.

HCI may require a behavioral health provider to create a CAP if the provider has failed both audits. HCI sent a letter to the failed re-audit provider as they did not respond to the phone call and email outreach. The Quality Oversight Care Committee (QOCC) will review the behavioral health provider that failed the re-audit once outreach is completed.

HCI trains providers on access to care standards through HCI Roundtable webinars. The webinar and presentation are available on HCI's website.

# 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).

COLORADO
Department of Health Care Policy & Financing

**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.**<br>**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.**<br>**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 urban county, Pueblo County, within its region. Almost half (47.6%) of HCI's members reside in this county. As indicated in Tables 2A-2C above, HCI added behavioral health practitioners and SUD providers throughout the year, particularly during Q4. However, due to the location of the new services this did not yield changes in the analysis of the network time and distance standards.

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 the majority of PCMP types.

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Pueblo, CO | Adult Primary Care (MD, DO, NP) | 99.9% |
| Pueblo, CO | Adult Primary Care (PA) | 99.9% |
| Pueblo, CO | Pediatric Primary Care (MD, DO, NP) | 99.9% |
| Pueblo, CO | Pediatric Primary Care (PA) | 99.9% |
| Pueblo, CO | Family Practitioner (MD, DO, NP) | 99.9% |
| Pueblo, CO | Family Practitioner (PA) | 99.9% |

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.

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Pueblo, CO | General Psychiatrists and Other Psychiatric Prescribers | 99.9% |
| Pueblo, CO | General Behavioral Health | 99.9% |
| Pueblo, CO | Pediatric Psychiatrists and Other Psychiatric Prescribers | 99.9% |
| Pueblo, CO | Pediatric Behavioral Health | 99.9% |
| Pueblo, CO | Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities | 0.0% |

| **Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template.**<br>**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.**<br>**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** |
| SUD Services<br>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 this Provider Type. |

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Pueblo, CO | General SUD Treatment Practitioner | 99.9% |
| Pueblo, CO | Pediatric SUD Treatment Practitioner | 99.9% |
| Pueblo, CO | SUD Treatment Facilities, ASAM 3.1 | 98.4% |
| Pueblo, CO | SUD Treatment Facilities, ASAM 3.2 WM | 98.4% |
| Pueblo, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Pueblo, CO | SUD Treatment Facilities, ASAM 3.5 | 99.2% |
| Pueblo, CO | SUD Treatment Facilities, ASAM 3.7 | 99.2% |
| Pueblo, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.1% |

In order to guarantee access to care for members living in urban 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.

**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.**<br>**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.**<br>**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** |
| The following nine rural counties are located within the HCI region: Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande Counties. As indicated in Tables 2A-2C above, HCI added |

| **Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template.**<br>**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.**<br>**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** |

behavioral health practitioners and SUD providers throughout the year, particularly during Q4. However, this did not yield significant changes in the analysis of the network time and distance standards, due to the location of the new services.

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 standards for Adult Primary Care (MD, DO, NP), Family Practitioner (MD, DO, NP), Pediatric Primary Care (MD, DO, NP), Adult Primary Care (PA), and Pediatric Primary Care (PA).

HCI did not meet standards for the following by less than one percent:

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Prowers, CO | Family Practitioner (PA) | 99.8% |

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. This remained unchanged from the previous report.

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. This remained unchanged from the previous report.

SUD Services

As detailed in the previous report, 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 with the exception of the following:

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Alamosa, CO | SUD Treatment Facilities, ASAM 3.1 | 0.0% |
| Alamosa, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Alamosa, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |

COLORADO
Department of Health Care Policy & Financing

| Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template.<br>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.<br>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** | | |
| Alamosa, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Chaffee, CO | SUD Treatment Facilities, ASAM 3.1 | 0.0% |
| Chaffee, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Chaffee, CO | SUD Treatment Facilities, ASAM 3.5 | 0.0% |
| Chaffee, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Chaffee, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Conejos, CO | SUD Treatment Facilities, ASAM 3.1 | 0.0% |
| Conejos, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Conejos, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Conejos, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Crowley, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Crowley, CO | SUD Treatment Facilities, ASAM 3.5 | 99.9% |
| Crowley, CO | SUD Treatment Facilities, ASAM 3.7 | 99.1% |
| Crowley, CO | SUD Treatment Facilities, ASAM 3.7 WM | 1.4% |
| Fremont, CO | SUD Treatment Facilities, ASAM 3.1 | 97.9% |
| Fremont, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Fremont, CO | SUD Treatment Facilities, ASAM 3.5 | 97.9% |
| Fremont, CO | SUD Treatment Facilities, ASAM 3.7 | 97.6% |
| Fremont, CO | SUD Treatment Facilities, ASAM 3.7 WM | 95.5% |
| Lake, CO | SUD Treatment Facilities, ASAM 3.1 | 0.0% |
| Lake, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Lake, CO | SUD Treatment Facilities, ASAM 3.5 | 0.0% |
| Lake, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Lake, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Otero, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Otero, CO | SUD Treatment Facilities, ASAM 3.5 | 99.9% |
| Otero, CO | SUD Treatment Facilities, ASAM 3.7 | 46.2% |
| Otero, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |

**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**

| | | |
|---|---|---|
| Prowers, CO | SUD Treatment Facilities, ASAM 3.1 | 94.3% |
| Prowers, CO | SUD Treatment Facilities, ASAM 3.2 WM | 94.3% |
| Prowers, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Prowers, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Prowers, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Rio Grande, CO | SUD Treatment Facilities, ASAM 3.1 | 0.0% |
| Rio Grande, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Rio Grande, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Rio Grande, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |

In order to guarantee access to care for members living in rural 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 that allow members to obtain services outside of the county in which they reside.

**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 counties that meet the definition of frontier Colorado counties. These counties are Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache Counties. As indicated in Tables 2A-2C above, HCI added behavioral health practitioners and SUD providers throughout the year, particularly during Q4. However, this did not yield significant changes in the analysis of the network time and distance standards, due to the location of the new services.

**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. As previously reported, HCI had a strong physical health network in the frontier counties during this reporting period 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)

HCI did not meet standards for the following:

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Baca, CO | Family Practitioner (PA) | 82.4% |
| Las Animas, CO | Family Practitioner (PA) | 99.9% |

Mental Health Services

HCI is required for its frontier 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. This remained the same from the previous report.

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 continued to meet access standards for SUD Treatment Practitioners for all ages and maintained access to care for SUD higher level services within the region. Further, HCI increased access in Kiowa County for ASAM 3.1 and ASAM 3.2 WM, which both met 100% coverage. Baca County experienced an increase in percentage of coverage for ASAM 3.1 and ASAM 3.2 WM, although it did not meet 100% coverage. There was no change in facilities and HCI attributed the improvement to membership changes.

COLORADO
Department of Health Care Policy & Financing

**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**

The following table lists the counties that did not meet access by Provider Type:

| County | Provider Type | Percentage Coverage |
|---|---|---|
| Baca, CO | SUD Treatment Facilities, ASAM 3.1 | 96.1% |
| Baca, CO | SUD Treatment Facilities, ASAM 3.2 WM | 96.1% |
| Baca, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Baca, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Baca, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Bent, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Bent, CO | SUD Treatment Facilities, ASAM 3.7 | 85.1% |
| Bent, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Costilla, CO | SUD Treatment Facilities, ASAM 3.1 | 43.2% |
| Costilla, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Costilla, CO | SUD Treatment Facilities, ASAM 3.7 | 53.8% |
| Costilla, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.4% |
| Custer, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Huerfano, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Huerfano, CO | SUD Treatment Facilities, ASAM 3.7 WM | 87.6% |
| Kiowa, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Kiowa, CO | SUD Treatment Facilities, ASAM 3.7 | 6.2% |
| Kiowa, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.5% |
| Las Animas, CO | SUD Treatment Facilities, ASAM 3.1 | 99.9% |
| Las Animas, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Las Animas, CO | SUD Treatment Facilities, ASAM 3.5 | 99.4% |
| Las Animas, CO | SUD Treatment Facilities, ASAM 3.7 | 98.6% |
| Las Animas, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.1% |
| Mineral, CO | SUD Treatment Facilities, ASAM 3.1 | 0.0% |
| Mineral, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |
| Mineral, CO | SUD Treatment Facilities, ASAM 3.7 | 0.0% |
| Mineral, CO | SUD Treatment Facilities, ASAM 3.7 WM | 0.0% |
| Saguache, CO | SUD Treatment Facilities, ASAM 3.1 | 58.9% |
| Saguache, CO | SUD Treatment Facilities, ASAM 3.3 | 0.0% |

**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**

| | | |
|---|---|---|
| Saguache, CO | SUD Treatment Facilities, ASAM 3.7 | 62.1% |
| Saguache, CO | SUD Treatment Facilities, ASAM 3.7 WM | 35.0% |

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

COLORADO
Department of Health Care Policy & Financing

# 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** | | | | | |
| FARRAR, JOCELYN | 9000210901 | El Paso | BV130 | Licensed Clinical Social Workers (LCSWs) | |
| KOSLOSKE, AMBER | 9000210152 | El Paso | BV120 | Psychologists (PhD, PsyD) - General | |
| LATHAM, TAMARA | 41585810 | El Paso | BV130 | Licensed Clinical Social Workers (LCSWs) | |
| ORTIZ, ZINA | 17687543 | Denver | BV132 | Licensed Professional Counselors (LPCs) | |
| TRUJILLO, SARAI | 9000151267 | Chaffee | BV130 | Licensed Clinical Social Workers (LCSWs) | |
| VALLEJO, MICHAEL | 9000188809 | El Paso | BV130 | Licensed Clinical Social Workers (LCSWs) | |
| WEGELIN, CHERYL | 9000160354 | Pueblo | BV130 | Licensed Clinical Social Workers (LCSWs) | |

**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 utilizes SCAs for out-of-network providers to meet specific member needs. HCI approves SCA requests when a member lives outside of the time/distance standard for service, when a specialty service is not available through the existing network, or when a member has a relationship with the provider. In specific situations, |

| **Describe the MCE's approach to expanding access to care for members with the use of SCAs.**<br>**Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.** |
|---|
| **CHP+ MCO, Medicaid MCO, RAE** |
| SCAs may also be approved by HCI so that providers who are actively engaged in the contracting and credentialing process can serve members while they are completing the process if the provider meets the above listed SCA criteria.<br><br>HCI monitors SCA utilization data for high-volume providers. HCI contacts providers with more than five SCAs in a quarter to discuss the possibility of joining the network. If the provider elects to join the network, HCI offers the provider instructions regarding the credentialing procedures and oversees the application process through completion. |

# 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.