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 Submitted by: *Alma Mejorado*

Report Submitted on: *July 30, 2021*

Report due by *04/30/2021*, covering the MCE's network from *04/01/2021 – 06/30/2021*, FY*21* Q*4*

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2021 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and 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 (June 2021 version).

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

Fiscal Year Quarter Reported	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2020-21 Q4	July 2021	June 30, 2021
FY 2021-22 Q1	October 2021	September 30, 2021
FY 2021-22 Q2	January 2022	December 31, 2021
FY 2021-22 Q3	April 2022	March 31, 2022

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0621* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0621* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2021, for the quarterly report due to the Department on July 30, 2021).
- 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, 2021, for the quarterly report due to the Department on July 30, 2021).
  - 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	138,634	N/A	141,269	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	510	N/A	501	N/A
Primary care practitioners accepting new members	502	98.4%	494	98.8%
Primary care practitioners offering after-hours appointments	158	31.0%	162	32.3%
New primary care practitioners contracted during the quarter	5	1.0%	4	0.8%
Primary care practitioners that closed or left the MCE's network during the quarter	0	0.0%	13	2.6%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
Health Colorado, Inc. (HCI) works to ensure that RAE 4 Primary Care Medical Provider (PCMP) network has a sufficient number of providers to serve members based on the maximum distance for county classification. During this reporting period, there was a slight decrease in the number of practitioners as PCMP locations reported staffing changes. HCI maintained a network of providers across the region in number and type of PCMPs for covered services that is accessible to members. HCI met time and distance standards for the majority of the membership during the reporting period but continue to see a very low number of obstetricians and gynecologists providers that serve as primary care providers. HCI continues to face two (2) major challenges to meet the time and distance standard as defined by HSAG, which are inherent to the geography of R4 region. These are: ➢ **Absence of additional Primary Care Practitioners that offer gynecology services within the time/distance standard within rural and frontier counties to recruit for contracting.** Obstetricians and gynecologists in HCI's counties generally do not perform primary care services including those that are part of contracted organizations such as Catholic Health Initiatives (Centura). The PCMPs refer to obstetricians and gynecologists as a specialty, not as part of primary care. Therefore, the primary care network does not reflect these practitioners within the region. ➢ **Pueblo County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30-minute radius**. Despite HCI's successful recruitment of three (3) PCMPs located in Pueblo County in the last two quarter (SOCO Primary Care Clinic, Steel City Pediatrics, and Comfort Care Family Practice), HCI remains at ninety-nine (99%) percent coverage in the county. Since the majority of the practitioners are in the city of Pueblo, Medicaid members residing on the southern border of the county (which would more accurately define as a rural community than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are no available Primary Care Practitioners to meet the requirement. As a result, one (1%) percent of HCI members residing in Pueblo County do not have two (2) providers within the time and distance standard.

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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. **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
This quarter, HCI contracted with two (2) additional practices SOCO Primary Care Clinic in Pueblo, and San Luis Valley Behavioral Health Group in Alamosa. Furthermore, HCI expects a third location, Summit Primary Care in Pueblo, to complete affiliation to the network in August 2021. HCI reviewed the Enrollment Summary Report and did not identify new providers for potential providers into the network. The majority of the locations were specialty providers that do not meet the PCMP criteria. HCI identified PCMP Provider IDs associated with contracted PCMPs and contacted those PCMPs to review the Provider IDs not affiliated. Of those that have been validated, the Provider IDs are part of specialty clinics that do not meet PCMP criteria. Catholic Health Initiatives (Centura) will be affiliating a PCMP Provider ID 9000166853 for the RHC location 1338 Phay Avenue in Canon City in the following quarter. However, the current clinic/group Provider IDs will be de-affiliated with the intention of all services going through the RHC Provider ID. The addition of new practices offers HCI members additional choices within the network and increased access. The COVID-19 pandemic has required healthcare practitioners to make changes to the way they deliver services. Our region has seen a dramatic increase in the adoption of telehealth platforms. PCMPs implemented telehealth as a result of COVID pandemic. The Practice Transformation team completed PCMP annual practice assessments, which asked practices about telehealth usage. HCI identified one-hundred and two (102) PCMP practices offer telehealth services in some capacity. This was almost four-hundred (386%) percent increase in telehealth services from the beginning of the fiscal year 2021-2022. While some practices have begun to move away from telehealth and are seeing more patients in the office, there continues to be some apprehension for patients to be seen in the office and therefore telehealth continues as an option for patients. Furthermore, some practices in rural and frontier counties that have adopted telehealth, they are not sure how much longer to offer telehealth appointments. Members in rural and frontier areas have limited reliable internet access or often prefer face-to-face care. HCI will continue to work with PCMPs to understand member and provider experience for utilization of telehealth services. We deem this important to gauge the sustainability of the technology and lasting impact on service delivery. Due to the data collected and provided on the file *R4_Network_INDIV_20210730* being limited to the practice level and not at the individual level, the capacity field for the individual provider is blank, thus limiting this report.

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	138,634	N/A	141,269	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG" or BLANK)	1,923	N/A	1,911	N/A
Behavioral health practitioners accepting new members	1,894	98.5%	1,911	100%
Behavioral health practitioners offering after-hours appointments	570	29.6%	547	28.6%
New behavioral health practitioners contracted during the quarter	127	6.6%	120	6.3%
Behavioral health practitioners that closed or left the MCE's network during the quarter	121	6.3%	132	6.9%

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	6	11
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	70	100
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	7	15
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	202	360
Total SUD treatment facilities offering ASAM Level 3.7 services	6	7
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	84	203

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	10	11
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	178	191
Total SUD treatment facilities offering ASAM Level 3.7 WM services	3	5
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	60	195

Table 2C-Establishing and Maintaining the MCE Network: Behavioral Health Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
HCI maintained a network of providers across the region in number and type of behavioral health practitioners to assure that all covered services will be accessible to members immediately. HCI primarily has rural and frontier regions, practitioners are limited in the region to meet one-hundred (100%) percent time and distance standards for all provider levels. Although HCI has a strong network of practitioners, with particular attention to the geographic area of Region 4, HCI met less than one-hundred (100%) percent access in some areas due to: ➢ **Appropriate time/distance standard for members in counties outside the region, especially frontier counties.** In rural and frontier areas it is a challenge to recruit and retain practitioners when there are a very small number of members seeking services. Members in these areas that need additional provider options beyond the network, HCI considers Single Case Agreements (SCAs) when appropriate; however, the use of SCAs for HCI members for out of the region providers has been limited which suggests HCI is meeting the needs of its members through its contracted network.

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
➢ **Pueblo County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30-minute radius**. HCI's network of behavioral health providers in Pueblo County met ninety-nine (99%) percent of standards. Since the majority of the practitioners are in the city of Pueblo, members residing on the southern border of the county (which could more accurately be defined as a rural community than urban) have limited practitioners in a thirty (30) mile radius. In those areas, there are not sufficient behavioral health providers to meet requirements. ➢ **Contracted facilities are included in the report, but not part of GeoAccess Compliance report.** First, HCI has contracts with hospitals and facilities that do not crosswalk to a behavioral health criteria. As part of the *CO Network Adequacy_Network Crosswalk Definitions_0621*, Psychiatric Residential Treatment Facilities (PRTFs, PROVCAT BF142) criteria changed to require that facilities have specific *Interchange* provider types and specialty codes. As a result, the number of PRTFs reduced from seventy-six (76) distinct locations on the last quarterly report to only two (2) locations in this quarterly report. At least six (6) locations that mapped to PRTFs in previous quarterly report no longer map to any behavioral health criteria. Second, there are hospitals and facilities that remain uncategorized. The inability to crosswalk these facilities to a behavioral health criterion affects the accurate assessment of geographic access to care in the network in *GeoAccess Compliance*. Third, HCI refined its categorization of BG110 and BG125 to ensure that accurate Taxonomy pulled for practices, which led additional facilities, or practices to be uncategorized. ➢ **Lack of overall Psychiatric Residential Treatment Facilities, Psychiatric Hospitals, and Psychiatric Units in Acute Care Facilities.** In frontier and rural counties, Colorado has limited facilities to meet the time/distance standards especially for a large part of HCI region. A significant number of contracted facilities that offer critical residential and inpatient services to the HCI membership are not represented appropriately in the quarterly reports. The manner in which facilities are categorized into a behavioral health provider type affects the overall representation of the geographic access to care in the network. HCI's network has also been impacted by the temporary closure of Tennyson Center for Children's youth residential center, which limits overall access to these services. Its residential program continues to be closed to new members. HCI received report from Tennyson that they are pending and official decision on reopening the residential program. Future reports will document available updates to this facility's status.

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

- **Lack of incentive for prescribers to contract.** HCI continues to be concerned about the requirement to have a network of prescribers after the billing changes in the Uniform Service Coding Standards Manual for Evaluation & Management (E&M) Codes. Since prescribers who do not meet the Behavioral Health Specialty Provider Criteria are required to bill Fee-For-Service for Evaluation & Management (E&M) Codes, they no longer have an incentive to contract with HCI thus HCI has stopped recruiting these providers to join the network. Additionally, the current *CO Network Adequacy_Network Crosswalk Definitions_0621* does not categorize Physician Assistants (PAs) that have a Drug Enforcement Administration (DEA) waiver and can prescribe medications. In the current report, there are twenty-six (26) PAs with prescriber capabilities that are uncategorized in the report.

HCI continued efforts on recruiting, contracting, and credentialing providers for the SUD benefit expansion that was effective on January 1, 2021. HCI developed a statewide network of twenty-four (24) contracted providers with sixty-six (66) service locations across all licensure levels, with the exception of residential SUD treatment delivered to those suffering from cognitive impairments (ASAM level 3.3) due to the lack of licensed facilities in the region. Of the contracted providers, sixteen (16) providers with thirty (30) service locations completed credentialing and included in the file *Network_FAC* and *GeoAccess Compliance*. Network staff are supporting these facilities with the completion of their Health First Colorado Medicaid enrollment and credentialing applications to join the network. This includes Mental Health Partners, Sobriety House, Valley Hope Association, Regents of the University Colorado (ARTS), Mile High Behavioral Health Care, Peak View Behavioral Health, Denver Health Hospital Authority, and Community Reach Center. An additional four (4) providers are currently negotiating contracts including: CeDAR, Northpoint Colorado, SummitStone Health Partners, West Pines Behavioral Health. HCI will continue to monitor utilization, network access, and provider Medicaid enrollment to determine the need to recruit additional SUD providers into the network. To ensure access to services and reduce administrative burden, providers who sign a contract and are undergoing the credentialing process have an abridge process for SCAs, specifically the contracted rates are honored, and the provider is not required to sign SCAs for each service that meets medical necessity. Providers negotiating their contracts may request SCAs to serve new or on-going Members until contract negotiations are complete.

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Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe.

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

For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.

CHP+ MCO, Medicaid MCO, RAE

Notwithstanding the extensive efforts to build a robust SUD network, HCI did not meet time and distance standards across the urban, most rural, and most frontier counties in the region for the new SUD benefit. This issue persists even if we account for the contracted facilities in the contracting or credentialing process. There is an overall lack of sufficient SUD treatment facilities across all ASAM levels located within the region, which affects the ability to meet the standard. Within the region, there are six (6) SUD treatment providers, which has not changed from previous quarterly report. These includes:

- HCI partners Health Solutions and Southeast Health Group,
- Crossroads Turning Point with multiple contracted locations in Pueblo and Alamosa counties,
- Resada located in Bent County, and
- Advantage Treatment Center located in Alamosa and Bent counties.

HCI implemented an SUD Workgroup that includes partner CMHCs to monitor utilization of and access to SUD treatment services. The SUD Workgroup is using utilization, claims and network data to identify network needs and identify solutions to expand access for a full continuum of SUD services within the HCI counties.

For its overall behavioral health network, HCI continued to pursue the following strategies to fill the gaps for behavioral health services within the region:

- **Tracked utilization, SCA data, and historical claims information to identify providers who are currently providing services to Health First Colorado (Medicaid) Members.** As part of the on-going monitoring of the SCA data, HCI is working to recruit providers that have agreed to multiple SCAs in the previous six (6) months. During the reporting period, three (3) providers met the criteria and are being pursued for contracting or being assisted to complete credentialing, Chelsea Davis, Nicole Festa, and Ida Seiferd.

- **Monitored operational processes to successfully credential recruited behavioral health providers.** Network staff continued to monitor and support providers through education on the application process and outreach to ensure accurate documentation.

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
Expanded utilization of telehealth services throughout the region for specialty services and members located in our rural and frontier areas. HCI has seen an increase in the adoption of telehealth services for behavioral health care. During the reporting period, sixty-four (64) providers reported to offer telehealth services. This is a two-hundred and twenty (220%) percent increase of behavioral health providers offering the services from the twenty (20) providers reported in the first quarter report. HCI's network of telehealth providers are within the State of Colorado. Based on the utilization of the service, we identify that a majority of providers are leveraging telehealth to enhance services for Medicaid members and offer safe alternatives during the COVID-19 pandemic. Providers that are rendering care through telehealth are utilizing it as an additional option for members, especially larger groups, or facilities. Some solo providers have shifted to rendering most services via telehealth as this affords providers more flexibility and lower overhead costs. HCI retained the expanded use of telehealth services for the near future. This has allowed providers to continue to build capacity for a sustainable telehealth service program. HCI continues to monitor the changing environment of telehealth to identify further ways to support providers in expanding these services. Additionally, HCI is continuing to monitor utilization and, if appropriate, renew engagement with providers outside the State of Colorado to increase access to care.

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Table 3A-Establishing and Maintaining the MCE Network: Specialty Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO				
Total members	N/A	N/A	N/A	N/A
Total specialty care practitioners (i.e., PROVCAT codes beginning with "SV" or "SG")	N/A	N/A	N/A	N/A
Specialty care practitioners accepting new members	N/A	N/A	N/A	N/A
Specialty care practitioners offering after-hours appointments	N/A	N/A	N/A	N/A
New specialty care practitioners contracted during the quarter	N/A	N/A	N/A	N/A
Specialty care practitioners that closed or left the MCE's network during the quarter	N/A	N/A	N/A	N/A

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

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

3. Network Changes and Deficiencies

Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes in MCE Networks related to quality of care, competence, or professional conduct.

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, HCI did not experience a change in its network related to quality of care, competence, or professional conduct.

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

Table 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
Primary Care Providers are required to maintain established office/service hours and access to appointments for new and established Medicaid members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. Practices audited in the previous reporting period and did not meet the availability standards will receive a follow up audit to monitor access. Of the thirty-three (33) locations audited: • One-hundred (100%) percent (or thirty-three (33) locations) offer same day appointments • Seventy-four (74%) percent (or twenty-three (23) locations) reported availability within standard for a new Medicaid member. • Two (2) providers report not accepting new members at this time. • Ninety-one (91%) percent (or thirty (30) locations) reported availability within standards for an established Medicaid member. • Seventy (70%) percent (or twenty-three (23) locations) met all the standards. • The availability of appointments within standards for new members changed from eighty-two (82%) percent to seventy-four (74%) percent from the audit last quarter. Many providers are prioritizing appointments for established members within the seven (7) day standard and taking fewer new patients as caseloads reach capacity.

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
Behavioral health providers are expected to maintain access to appointments with standards established by the State of Colorado. The standards indicate providers should have appointment availability for members within seven (7) days of request, and urgent access is available within twenty-four (24) hours from the initial identification of need. Practices audited via phone surveys in the previous reporting period that did not meet the availability standards will be subject to a follow-up audit to monitor access. Of the twenty-one (21) providers audited: • Twenty-one (21%) percent reported availability within standards for new Medicaid members. • Twenty-four (24%) percent reported availability within standards for established Medicaid members. • Twenty-four (24%) percent reported offering urgent appointments (within 24 hours of the request). • Fourteen (14%) percent reports offering emergent services (within fifteen (15) minutes by phone or one (1) hour face-to-face). Of the providers who do not offer emergent services, they report referring members to Colorado Crisis Services, another behavioral health colleague, or the emergency department. For those referring members to the emergency department education was offered regarding referring members to appropriate emergent behavioral health crisis resources. • Twenty-one (21%) percent met all the standards. The availability of appointments within standards for new members changed from twenty-seven (27%) percent from the audit last quarter, representing a reduction of six (6%) percent. The reduction is reportedly attributed to full caseloads with providers continuing to cite increases in volume due to COVID. Providers also report continued member engagement in services.

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. 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 data for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report results for all members regardless of county residence.

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

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

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

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has one (1) urban county, Pueblo, which is the residence of the majority of HCI's membership. The requirement for an urban county is to have one-hundred (100%) percent coverage of two (2) providers within thirty (30) miles or thirty (30) minutes. Behavioral Health In Pueblo County, HCI had ninety-nine (99%) percent coverage within standards for all behavioral health categories with the exception of Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities (ninety-five (95%) percent). HCI met one-hundred (100%) percent of the standard for the majority of the urban counties outside HCI's geographic area. HCI had approximately ninety to ninety-nine (90-99%) percent coverage in Adams, Arapahoe, El Paso, Jefferson, and Weld counties for General Psychiatrists and Other Psychiatric Prescribers, General Behavioral Health, General SUD Treatment Practitioner, Pediatric Psychiatric, and other Psychiatric Prescribers, and/or Pediatric Substance Abuse Disorder Provider. The only areas that had less than ninety (90%) percent coverage was in Elbert and Clear Creek counties for HCI with seventy-five (75%) percent coverage for Pediatric SUD Treatment Practitioner, and fifty (50%) percent coverage in Clear Creek for General SUD Treatment Practitioner. Should members in these counties need additional provider options from those available, HCI will consider SCAs, when appropriate. Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for a large part of the HCI region. In most counties one of these facilities is within the time and distance, however, there is no option for two (2) facilities as required by the standards. In Pueblo County, HCI will continue to work with Parkview Medical Center to resolve operational issues, and to make best attempts to agree on financial terms. *SUD benefit* - HCI provides the full continuum of SUD benefits for Medicaid members. Although HCI did not meet one-hundred (100%) percent coverage for members in Pueblo County by service level, HCI did have a strong level of coverage. HCI had coverage in the following areas: ninety-eight (98%) percent coverage for Clinically Managed Low-Intensity Residential Services (ASAM level 3.1), Clinically Managed High-Intensity Residential Services (ASAM level 3.5), Medically Monitored Intensive Inpatient Services (ASAM level 3.7), and Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM). HCI had zero (0%) percent coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3), and Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM) due to lack of licensed facilities that cover the time/distance within the region.

Physical Health

Although HCI has added PCMPs located in Pueblo to the network, HCI has not been able to reach one-hundred (100%) percent coverage for members within the time/distance requirement for any Network Categories. HCI conducted a GeoAccess analysis and found that almost one-hundred percent (99.7% to 99.9%) percent of the members in Pueblo had coverage in all categories. The exception was Gynecology, OB/GYN (PA) with zero (0%) percent coverage. HCI has not been able to find in the county Physician Assistants (PA) that serve as primary care with Gynecology, OB/GYN specialty in the area.

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 rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has nine (9) counties that qualify as rural counties, including Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande. Rural counties require coverage of two (2) providers with the distance of forty-five (45) minutes or forty-five (45) miles for PCMPs and sixty (60) minutes or sixty (60) miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each rural county. Behavioral Health HCI met one-hundred (100%) percent of standards for all its rural counties within the region. For counties outside the region, HCI improved overall access this reporting period with the majority of the areas meeting one-hundred (100%) percent of the standard. The exceptions are the following counties which had above ninety (90%) percent coverage: • General SUD Treatment Practitioner – Archuleta, Eagle, Grand • Pediatric SUD Treatment Practitioner – Eagle and Grand The following counties outside of the region had coverage less than ninety (90%) percent: • General SUD Treatment Practitioner – Garfield and Routt • Pediatric SUD Treatment Practitioner – Garfield and Routt Psychiatric Units in Acute Care Facilities within standard distances are limited for all rural counties with HCI members. In most counties one (1) of these facilities is within the time and distance, however, there is no option for two (2) facilities as required by the standards.

SUD benefit - HCI contracted with available facilities in its rural counties, as well as any facilities in surrounding counties. HCI contracted with Advantage Treatment Center located in Alamosa County for Clinically Managed High-Intensity Residential Services (ASAM level 3.5) which improved access to one-hundred (100%) percent in Alamosa, Conejos, Prowers, and Rio Grande counties from zero coverage in previous report. Additionally, Otero county improved coverage to ninety-one (91%) from forty (40%) percent in previous quarter for ASAM level 3.5. The other levels of care remained the same from previous report.

- Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
  - One-hundred (100%) percent in Crowley and Otero Counties
  - Ninety-four (94%) percent in Fremont County
  - Seventy-eight (78%) percent in Prowers County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, and Rio Grande Counties
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3)
  - Zero (0%) percent across the frontier counties due to no licensed facilities.
- Clinically Managed High-Intensity Residential Services (ASAM level 3.5)
  - Ninety-seven (97%) percent in Crowley County
  - Ninety-four (94%) percent in Fremont County
  - Zero (0%) percent in Chaffee and Lake counties
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)
  - Ninety-seven (97%) percent in Crowley County
  - Ninety-four (94%) percent in Fremont County
  - Forty (40%) percent in Otero County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, Prowers, and Rio Grande counties
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
  - One-hundred (100%) percent in Alamosa, Conejos, Crowley, Otero, and Rio Grande
  - Ninety-seven (97%) percent in Fremont County
  - Seventy-eight (78%) percent in Prowers County
  - Zero (0%) percent in Chaffee and Lake County
- Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
  - Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.

<u>Physical Health</u>

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

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

Additionally, eight (8) of the nine (9) counties had one-hundred (100%) percent coverage of members within the time/distance for Adult Primary Care (PA), Family Practitioner (PA), and Pediatric Primary Care (PA). For the exception, Prowers had these provider types and ninety-nine (99%) percent coverage.

HCI had good coverage across the region for Gynecology, OB/GYN (MD, DO, NP): one-hundred (100%) percent coverage in Alamosa, Chaffee, Crowley, Fremont, Lake, and Otero; ninety-nine (99%) percent

coverage in Prowers; ninety-three (93%) coverage in Rio Grande, and eighty-five (85%) coverage in Conejos County. However, for Gynecology, OB/GYN (PA), HCI had zero (0%) percent coverage in all rural counties. If a member needs services with providers outside of those available in the area, then HCI, through a care coordinator, connects the member with the closest available provider and assists the member with transportation, if necessary, and will offer telehealth services, when appropriate.

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 frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE

HCI has nine (9) frontier counties, which are Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache. Standards for members residing in a frontier county require two (2) providers within sixty (60) minute or sixty (60) miles for a PCMP, and ninety (90) minutes or ninety (90) miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each frontier county.
 	
Behavioral Health
For the behavioral health network, the nine (9) frontier counties met the time/distance and ratios requirement for all the Network Categories. The majority of the frontier counties outside RAE Region 4 for members met the access for all Network Categories. The exceptions are General SUD Treatment Practitioners in Moffat and Rio Blanco, and Pediatric SUD Treatment Practitioner in Moffat. Should members in these counties need additional provider options from those available, HCI will consider SCAs or offer telehealth services, when appropriate.
 	
Psychiatric Units in Acute Care Facilities within standard distance and ratio is limited for all frontier counties for HCI members. In most counties one (1) of these facilities is within the time and distance, however, there is no option for two (2) facilities as required by the standards.
 	
SUD benefit - HCI contracted with available facilities within and surrounding counties in of its frontier region. HCI contracted with Advantage Treatment Center located in Alamosa County for Clinically Managed High-Intensity Residential Services (ASAM level 3.5) which improved access to one-hundred (100%) percent in all frontier counties except Las Animas and Saguache counties which had ninety-nine (99%) percent coverage. The other levels of care remained the same from previous report.
Based on the analysis, HCI had limited coverage for members in frontier counties by service level.
• Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
  ○ One-hundred (100%) percent in Bent, Custer and Huerfano
  ○ Ninety-seven (97%) percent in Las Animas County

  - Ninety (90%) percent in Kiowa County
  - Sixty-six (66%) percent in Baca County
  - Less than fifty (50%) percent in Saguache and Zero (0%) percent in Mineral County
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3)
  - Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)
  - One-hundred (100%) percent in Custer and Huerfano
  - Ninety-six (96%) percent in Las Animas County
  - Less than fifty (50%) percent in Costilla and Saguache
  - Zero (0%) percent in Baca, Kiowa, and Mineral
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
  - One-hundred (100%) percent in Bent, Costilla, Custer, Huerfano, Las Animas and Mineral
  - Ninety-nine (99%) percent in Saguache County
  - Ninety (90%) in Kiowa County
  - Sixty-six (66%) percent in Baca
- Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
  - Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.

Physical Health

HCI met one-hundred (100%) percent coverage of members within the time/distance across the majority of the nine (9) frontier counties for all provider types. Family Practitioner (PA) coverage in Baca, Kiowa and Las Animas was at ninety-nine (99%) percent. HCI had strong coverage across the region for Gynecology, OB/GYN (MD, DO, NP): one-hundred (100%) percent coverage in Bent, Costilla, Custer, Huerfano, and Saguache, ninety-nine (99%) percent coverage in Kiowa and Las Animas, seventy-seven (77%) coverage in Baca County, and zero (0%) percent coverage in Mineral County. However, for Gynecology, OB/GYN (PA), HCI had seventy-five (75%) percent coverage in Saguache, and zero (0%) percent coverage in all other frontier counties. If a member needs services with providers outside of those available in the area, then HCI, through a Care Coordinator, connects the member with the next closest available provider and assists the member with transportation, and offer telehealth services, when appropriate.

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Appendix A. Single Case Agreements (SCAs)

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

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

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	[redacted]
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	[redacted]
CHP+ MCO, Medicaid MCO, RAE					
Brown-Alford, Michelle	29179564	Arapahoe	BV132	Licensed Professional Counselors (LPCs)	[redacted]
Davis, Chelsea	9000168563	El Paso	BV132	Licensed Professional Counselors (LPCs)	[redacted]
Festa, Nicole	9000166266	Adams	BV080	Licensed Addiction Counselors (LACs)	[redacted]
Galaska, Deborah	47233877	El Paso	BV120	Psychologists (PhD, PsyD) - General	[redacted]
Kuik, Dennis	9000176514	El Paso	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
Myers, Carol	47510501	El Paso	BV132	Licensed Professional Counselors (LPCs)	[redacted]
Ransford, Lisa	9000141769	Arapahoe	BV080	Licensed Addiction Counselors (LACs)	[redacted]
Rye, Kathleen	90422546	Jefferson	BV103	Psychiatric CNS - General	[redacted]

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
Samaro, Stacey	9000186377	Pueblo	BV120	Psychologists (PhD, PsyD) - General	[redacted]
Seiferd, Ida	23371218	Fremont	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
Sheffer, Brody	9000189424	Pueblo	BV132	Licensed Professional Counselors (LPCs)	[redacted]
Thomas, Sorin	25188321	Boulder	BV132	Licensed Professional Counselors (LPCs)	[redacted]

Table A-2-Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
CHP+ MCO, Medicaid MCO, RAE
Out-of-network providers are able to request SCAs to render services for HCI members for the purpose of continuity of care or specialty services that are not available through the current network. The twelve (12) individual providers who received SCAs during the reporting period are being monitored for SCA volume to identify potential recruitment. Of those three (3) providers met the criteria and are being pursued for contracting or being assisted to complete credentialing, these providers are Chelsea Davis, Nicole Festa, and Ida Seiferd. As additional SUD providers completed credentialing and joined the network, the need for SCAs has diminished. SUD providers negotiating their contracts and continue to request SCAs to serve on-going or new members. Contracted providers pending credentialing did not require SCAs. The process improved transitions of care, increased provider satisfaction, and reduced administrative burden. HCI is monitoring SCAs for the new SUD benefit to identify potential providers for recruitment.

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.