COLORADO

Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: Colorado Access
Line of Business: RAE 5
Contract Number: 19-107517A8
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Report due by *1/31/2022,* covering the MCE's network from *10/01/2021– 12/31/2021*, FY21-22 Q2

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1. Instructions for Using the Network Adequacy Quarterly Report Template

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

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

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

Definitions

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

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

Report Instructions

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

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

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

Questions

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

Establishing and Maintaining the MCE Network

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

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

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	136531	N/A	141600	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	4050	N/A	4229	N/A
Primary care practitioners accepting new members	2892	71.41%	3023	71.48%
Primary care practitioners offering after-hours appointments	1326	32.74%	1303	30.81%
New primary care practitioners contracted during the quarter	77	1.90%	97	2.29%
Primary care practitioners that closed or left the MCE's network during the quarter	56	1.38%	38	.89%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
Colorado Access (COA) monitors its Primary Care Medical Provider (PCMP) clinic sites across region 5 to ensure adequate clinic to member ratio coverage. COA continues to review and grow its PCMP network, on a regular basis, to ensure all covered services continue to be accessible to members without unreasonable delay. As with the previous reporting period, issues of workforce retention and burnout have been noted among providers in the network. These issues have the potential to impact access to care as providers may find it necessary to cut back on available appointments and office hours. COA recognizes this struggle and continues to distribute emergency funding to help support providers' business operations and staffing needs. In addition, COA continues to share information about a support group for health care providers and front-line staff offered through the HeartLight Center with PCMPs; promoted webinar/online meeting information tied to mental health support in the COVID-19 Provider Update; and has shared a seven-week, Project ECHO training course with PCMPs, titled Past the Pandemic: Mental Well-Being for You and Your Patients. This process will continue throughout the remainder of the pandemic, and as long as the provider community needs this support. Every contracted region 5 PCMP has an assigned practice facilitator who meets at least monthly with their assigned providers. As a part of their engagement with providers, the facilitators monitor attribution , closed panels, and capped attribution as they work to support providers in increasing their engagement with their attributed members—something which aligns with the primary care value-based payment utilization component. Because COA's practice facilitators, along with provider network managers (formally provider relations representatives), are so regularly engaged with providers, they quickly respond to any barriers providers could face which may impact access to care. Through this high touch interaction, staff are quickly able to see turnover in provider offices and help support onboarding of specific new hires with training focused on Medicaid rules and regulations, such as access to care standards.

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
To determine the providers who provide family planning services, COA pulled claims data from IBM source data. The family planning (FP) flag within the report for those providers has been added. For this reporting period, COA continues to have concerns that these data do not adequately represent network providers who provide family planning services, so COA is establishing an internal process to track these data. Family planning is, however, a standard part of all primary care providers' scope of work, so while the FP "flag" may not be indicated on all applicable providers currently, COA feels strongly members have more than adequate access to family planning services. Additionally, COA is directly working with several OBGYN providers in region 5 to develop a value-based payment model focused on family planning services which will be rolled out in 2022. COA believes this will support growth, provider satisfaction, and sustainability within the OBGYN network.   COA continues to educate providers on the new telehealth rules through webinars and provider resource groups hosted by its practice support team. COA is also promoting the use of telehealth in its provider newsletter, the Navigator, which helps educate providers on new telehealth policies or coding updates.   COA captures telehealth services as a datapoint from network providers and has begun listing this information in its provider directories to further increase access to care for members.   In Q2, the data showed terminations were related to life events, i.e., retirement, moved out of state, and roster clean-up.

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	136531	N/A	141600	N/A

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Total behavioral health practitioners (i.e., PROVCAT codes beginning with “BV” or “BG”)	6211	N/A	6983	N/A
Behavioral health practitioners accepting new members	3923	63.16%	4505	64.51%
Behavioral health practitioners offering after-hours appointments	1245	20.04%	1459	20.89%
New behavioral health practitioners contracted during the quarter	140	2.25%	162	2.31%
Behavioral health practitioners that closed or left the MCE’s network during the quarter	179	2.28%	88	1.26%

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	3	7
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	100	130
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	4	7
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	236	284
Total SUD treatment facilities offering ASAM Level 3.7 services	3	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	72	53
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	4	6
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	183	212
Total SUD treatment facilities offering ASAM Level 3.7 WM services	3	3

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	45	51

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
Both the size and scope of the behavioral health and substance use disorder (SUD) network ensures that all covered services continue to be accessible to members without unreasonable delay. COA continues to grow its network on a regular basis. Behavioral Health: During this quarter, COA increased its behavioral health network in all areas identified in the table above. This increase in the total behavioral health providers is partly due to the extensive work COA is performing to correct taxonomy codes in its source system. COA also saw a decrease in the number of behavioral health providers leaving the network or closing their practice. COA continues to encourage providers to render services via telehealth by promoting it in its provider newsletter, the Navigator. COA is also continuing to educate providers on the new and changing rules of telehealth through webinars and provider resources groups hosted by its practice support team and making its telehealth program team available for questions. Through these efforts, COA has seen a marked increase in telehealth utilization. Additionally, COA provides members with information on which providers in its network have telehealth availability through the customer service department and online provider directory. SUD: During this quarter, COA increased the number of facilities offering ASAM level 3.1 by four while also increasing the number of treatment beds for 3.1 by 30.

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

During this quarter, COA increased the number of facilities offering ASAM level 3.5 by three.

During this quarter, COA increased the number of beds offering ASAM level 3.5 by 28.

During this quarter, the number of SUD treatment beds offering ASAM level 3.7 decreased by 19. This decrease is directly related to the Valley Hope facility. Valley Hope has several locations. The Parker location is the only location to offer ASAM level 3.7 and was initially included in the count of facilities offering beds with ASAM 3.7 levels. COA was recently informed that they do not want to take Medicaid at the Parker location, so this caused the bed count for ASAM level 3.7 to decrease by 19.

During this quarter, COA increased the number of facilities offering ASAM level 3.2 WM by two while also increasing the number of treatment beds for level 3.2 WM by 29.

During this quarter, COA increased the number of beds with ASAM level 3.7 WM services by 6.

Currently, COA has 11 SUD providers in clinical review for additional ASAM levels.

COA continues to invite SUD providers into its network. There are currently 14 contracted providers who offer residential and detox levels of care to Colorado Access members. COA uses a Clinical Quality Review process that providers must pass in order to become contracted as a SUD provider. Nine providers have been requested to remediate clinical quality issues prior to contracting, and two providers submitted incomplete applications (and have been specifically directed to what documentation needs to be provided).

This quarter, COA deployed two behavioral health practice facilitators to offer application support for providers struggling to meet quality metrics. The practice facilitators are meeting individually with providers who have an application in progress to create or improve administrative practices and procedures, develop new workflows to improve authorization procedures and/or transitions of care, develop and organize training plans and requirements, and develop clinical oversight processes. At this time, COA continues to permit all SUD providers who are validated by the State to render SUD treatment and receive out-of-network rates.

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
In Q2, the data showed terminations were related to life events, i.e., retirement, moved out of state, and roster clean-up.

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

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 for region 5

3. Network Changes and Deficiencies

Network Changes

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

Table 4–Network Changes: Discussion

If the MCE experienced an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. Note: If the MCE experienced an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.
CHP+ MCO, Medicaid MCO, RAE
Colorado Access' quality, compliance and provider engagement departments monitor the network and tracks providers related to quality of care, competence and professional conduct. COA has not experienced a change in the network this quarter.

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?
N/A for RAE region 5

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 for RAE region 5

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 for RAE region 5

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 for RAE region 5

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
As documented in previous Network Adequacy reports, COA has relied on the Secret Shopper program to monitor its contracted provider's compliance with Access to Care standards. Over the past few quarters, COA has had the opportunity to evaluate the impact of the Secret Shopper program in order to further align this monitoring tool with additional network management efforts. During this review process, COA has also observed the unprecedented challenges faced by providers based on the current environment surrounding the global pandemic. Providers have been vocal about increased issues of staff shortages, high staff turnover, shortened office hours due to illnesses and provider burn out. Considering the pressures on providers, COA is expanding its ability to evaluate and monitor access to care standards. This evolved model is built upon data and outcomes obtained from the Secret Shopper program and, specifically, data trends in practices that were not passing the standards on which they were being tested. It was recognized that rotating or high staff turnover in the front office significantly contributed to challenges with adhering to access to care standards. As a result, this new model will consist of a highly engaged and collaborative training program with providers that is targeted around all aspects of access to care requirements, including a specific dedication to training front office staff members on Medicaid rules. COA believes that regular and consistent office training is the key to understanding and adhering to Medicaid requirements and will help practices be more successful with then completing a COA network monitoring program, such as Secret Shopper. COA's enhanced access to care training program, slated to begin in the first quarter of 2022, will target key areas of a practice to ensure all staff understand and adhere to the standards: for example, training on appointment scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. These trainings will preferably be conducted in person (virtually, if necessary) and will include leave-behind materials. Providers will participate in this COA led training at least annually and will receive training reminder "tips" quarterly via the Provider Portal and COA's Navigator newsletter. Any practice that experiences turnover in staff key to access to care compliance (front office, office manager etc.) will have training scheduled for all new staff within two

weeks of notification. All training will be available on COA's Learning Management System (LMS) and will be accessible to all providers at any time.

Once a practice has completed all access to care training, they will be referred to the Quality department who will enroll the trained practice in the Secret Shopper program. Those providers will then be targeted for a secret shopper call over the coming months. Any provider who does not successfully pass the secret shopper call will be referred to the Provider Network Services department and will receive an updated training on the missed standards as well as an overview of all access to care standards within two weeks of notification. These providers may be subject to additional secret shopper calls depending on the area of failure.

The HSAG information used during the review of this deliverable indicates that for "Gynecology, OB/GYN (PA)" no members (0%) met the time distance standard. This rate for R5, and significantly higher rates for the R3 counties seems to indicate that this is a data error. However, this is not a data error - it is a taxonomy code issue. Since PAs only have a general taxonomy code, we are still trying to add the secondary taxonomy code to drill down to actual specialty of the PA. You will see a significant difference in Q3's report.

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
As documented in previous Network Adequacy reports, COA has relied on the Secret Shopper program to monitor contracted provider's compliance with Access to Care standards. Over the past few quarters, COA has had the opportunity to evaluate the impact of the Secret Shopper program to further align this monitoring tool with additional network management efforts. During this review process, COA has also observed the unprecedented challenges faced by behavioral health providers based on the current environment surrounding the global pandemic. Providers have been vocal about increased issues of staff shortages, high staff turnover, shortened office hours due to illnesses and provider burn out. Considering the pressures on providers, the overwhelming need for behavioral health treatments for members and the State's Wildly Important Goal (WIG) of increasing the behavioral health networks across the state, COA is expanding its ability to evaluate and monitor access to care standards. This evolved model is built upon data and outcomes obtained from the Secret Shopper program and, specifically, data trends in practices that were not passing the standards on which they were being tested. It was recognized that rotating staff in the front office significantly contributed to challenges with adhering to the access to care standards. As a result, this new model will consist of highly engaged and collaborative training program with providers that is targeted around all aspects of access to care requirements, including a specific dedication to training front office staff members on

Medicaid rules. COA believes that regular and consistent office training is the key to understanding and adhering to Medicaid requirements and will help practices be more successful with then completing a COA network monitoring program, such as Secret Shopper.

COA's enhanced access to care training program, slated to begin in the first quarter of 2022, will target specific areas of a practice to ensure all staff understand and adhere to the standards: for example, training on appointment scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. These trainings will preferably be conducted in person (virtually, if necessary) and will include leave-behind materials. Providers will participate in this COA led training at least annually and will receive training reminder "tips" quarterly via the Provider Portal and COA's Navigator newsletter. Any practice that experiences turnover in staff key to access to care compliance (front office, office manager etc.) will have training scheduled for all new staff within two weeks of notification. All training will be available on COA's Learning Management System (LMS) and will be accessible to all providers at any time.

Once a practice has completed all access to care training, they will be referred to the Quality department who will enroll the trained practice in the Secret Shopper program. Any provider who does not successfully pass the secret shopper call will be referred to the Provider Network Services department and will receive an updated training on the missed standards as well as an overview of all access to care standards within two weeks of notification. These providers may be subject to additional secret shopper calls depending on the area of failure.

Regarding last quarter's secret shopper corrective action plans (CAPs), of the CAPs administered, all but four have been completed. Practices with outstanding CAPs will be enrolled into the new training model and will receive specific training on the identified deficits and then re-enrolled in Secret Shopper to test adherence.

All behavioral health CAPs resulting from a Secret Shopper call from the previous quarter have been successfully resolved except for the following:

These two providers are in the process of their second-level CAP and will complete this process with COA's Quality department:

Mental Health Partners
Mile High Behavioral Healthcare

For the following three providers, COA's quality department, in conjunction with the provider network services department, is working to transition these provider CAPs to training requirements per the updated process outlined above.

Integrated Pediatric Health Care
Idea Forum
Julie Duran

5. Time and Distance Standards

Health Care Network Time and Distance Standards

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

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

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

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

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

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific contracted urban counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
During this reporting quarter, for SUD, region 5 is at 100% in all categories except SUD ASAM levels 3.1 and above and currently has several SUD providers in the contracting process that will support the ASAM level 3.0. Colorado Access continually monitors its network adequacy, and the contracting and provider relations departments work closely with the care management team to address any areas of concern. When there is a need in the network, COA actively recruits providers in those areas. COA also continues to get requests from new providers wanting to join the network, and if eligible COA makes every effort to add them to its panel of providers. COA has a committee dedicated to the recruitment and retention of providers. Currently, the committee is determining the status of all the providers with particular focus on primary care and behavioral health. The Provider Network Services team continues to reach out to providers that have not submitted a claim in the last 18 months to ensure they are still in business, taking Medicaid members, and what their capacity is to increase their utilization. This information is shared with internal care management, customer service and utilization management departments to increase referrals to these identified providers. COA is continuing to contract with existing and new SUD providers at all ASAM levels for the network. COA continues to increase the number of both SUD facilities and beds at all ASAM levels. COA currently has nine SUD facilities in its clinical review process that evaluates the facility's clinical readiness to serve Medicaid members. As providers pass the process, they are added to the network. All Physical Health provider time and distance standards are met. For Behavioral Health, the following time and distance standards are "not met". The percentages listed show the percentage at which they do meet: SUD facilities with ASAM levels 3.1 = 62%, 3.3, 3.7, 3.7 WM = 0%. Psychiatric hospitals, or Psychiatric Units in Acute Care Hospitals = 99.9%

Table 12–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. List the specific contracted rural counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in its contracted rural Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
RAE region 5 does not have any rural areas.

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
RAE region 5 does not have any frontier areas.

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					
Detroit Behavioral Institute, LLC	9000163839	Out of State	BV100R	Residential Treatment Center	
Children's Hospital Colorado	9000164954	Adams	BF141	General Hospital with a Psych Unit	

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

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
When necessary, COA enters a SCA with a non-participating provider based on requests from its utilization management and/or care management department). Once a SCA is completed, COA reaches out to the provider to ask them if they are interested in joining the network or amending their contract to add the service. If interested, COA follows its usual policy and procedures with respect to the contracting process.

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

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Appendix C. Optional MCE Content

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