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 Submitted on: *7/29/2022*

Report due by *7/29/2022*, covering the MCE's network from *04/01/2022 – 06/30/2022* FY*21-22* Q*4*

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Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2022 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, or RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (September 2021 version).

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

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

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0622* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0622* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.

  MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:

  https://coruralhealth.org/resources/maps-resource

Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. The MCE should update the highlighted, italicized data fields on the cover page of this template to reflect their contact information, contact 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., June 30, 2022, for the quarterly report due to the Department on July 29, 2022).
- To count practitioners/practice sites:

  Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2022, for the quarterly report due to the Department on July 29, 2022).

  Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	148845	N/A	152277	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	4291	N/A	4682	N/A
Primary care practitioners accepting new members	3056	71.22%	3305	70.59%
Primary care practitioners offering after-hours appointments	1233	28.73%	1248	26.66%
New primary care practitioners contracted during the quarter	150	3.49%	123	2.62%
Primary care practitioners that closed or left the MCE's network during the quarter	46	1.07%	84	1.19%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
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. Colorado Access did not experience any barriers to primary care during this quarter that would negatively impact its ability to maintain a sufficient network. However, issues of workforce retention and burnout continue to be prominent among providers. COA recognizes the struggle and continues to support providers' business operations and staffing needs in a variety of ways. COA supports by providing resources to reduce burnout professionally and operationally. COA also has positioned its practice supports and provider network services (PNS) provider-facing teams to train, educate and leverage core COA programs to support providers. These programs include contracting support, access to care standards, telehealth support, data and value-based care programs and incentives Regarding resources to support burnout, COA continues to share information to help health care providers and front-line staff. COA promotes resources tied to behavioral health support in the *COVID-19 Provider Update* and COA's provider newsletter, the *Navigator*. From a program standpoint, COA contracted with the Office of Behavioral Health and Wellness at University of Colorado to address and redesign a program around youth vaccinations and vaccine hesitancy. The implementation of this program reduces the burden on providers and front-line staff as it equips them with tools to overcome barriers, they are facing with administering the COVID-19 vaccine. As a leader in this work, COA made this program available to the CCHA (Colorado Community Health Alliance) provider network. Every contracted Region 5 PCMP has an assigned practice facilitator from COA's practice support team. 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

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
component. COA has implemented new performance dashboards to help providers focus on priorities to help mitigate burnout and increase programmatic success for providers. Q4 was focused on rolling out new value-based payment programs to all primary care providers. These new models went live July 1, 2022. In addition, practice support staff aided providers by maximizing funding potential in the value-based payment program. On a monthly basis, COA staff share with providers the Provider Enhanced Payment Report (PEPR) to focus on engaged members and coordinate the services they need. As a result of sharing lists of engaged members monthly, providers' value-based payments increased, which has improved staff satisfaction in the practices. COA's practice facilitators and the PNS team (formally provider relations representatives), are regularly engaged with providers and quickly respond to barriers providers could face which may impact access to care. Through this high touch interaction, practice facilitators and network managers 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 the access to care standards. Regarding family planning services, COA has worked directly with reproductive health providers (OB/GYN), in Region 5 to develop a value-based payment model focused on family planning services. The newly developed Reproductive Health Model went live in July 2022. COA believes this will support growth, provider satisfaction, and sustainability within the reproductive health network. During March 2022, 100.0% of the Region 5 PCMP network reported data on family planning services and 100.0% of Region 5 members are attributed to these sites. The average rate of family planning services, as reflected on a claim, across the Region 5 network during March 2022 was 19.19% with a higher rate of 26.30% observed in the reproductive health provider cohort. Data are reported on a rolling 12-month timeframe and due to claims runout data is reported on a three (3) month lag.

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
It is important to note that the network's ability to provide family planning services goes well beyond the number of OB/GYN providers in our network. Family planning services are made available to all members, both women and men through their primary care providers as family planning is not limited to women's health services. Therefore, COA has a very robust network of providers who perform family planning services. Regarding telehealth, COA continues to educate providers on 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's provider directory lists providers that provide telehealth services. In addition, the Virtual Care Collaboration and Integration (VCCI) Program at COA continues to provide increased access to behavioral health care for its participating network providers. The VCCI program allows PCMPs to refer members to be seen for short-term/brief intervention treatment over telehealth by VCCI clinicians and psychiatrists either within the primary care setting or directly in the patient's home. The VCCI Program includes an eConsult component that allows its participating PCMPs to directly query a VCCI psychiatrist via asynchronous HIPAA-secure email for a rapid response to their psychiatric questions. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care and works with COA care management to coordinate referrals to long-term care and other resources. The VCCI Program continues to expand and evolve its services to meet the increased need for behavioral health care. During this review period, the VCCI Program incorporated updates to its on-line scheduling provider portal to increase efficiency for patient referrals and the sharing of clinical information through this HIPAA-secure web-based platform. Within this provider portal, scheduling, progress notes, consent forms, and demographic information can be shared to optimize the coordination of member care with VCCI's participating PCMPs. TERMINATIONS: Jesse O Sutherland Jr MD Inc terminated his contract with all lines of business, RAE and CHP HMO due to retirement. All other terminations were roster clean-ups or life events.

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	148845	N/A	152277	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	7021	N/A	6283	N/A
Behavioral health practitioners accepting new members	3043	43.34%	4093	65.14%
Behavioral health practitioners offering after-hours appointments	563	8.01%	1207	19.21%
New behavioral health practitioners contracted during the quarter	150	2.13%	164	2.61%
Behavioral health practitioners that closed or left the MCE's network during the quarter	112	1.59%	83	1.32%

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	8	9
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	10	10
Total SUD treatment facilities offering ASAM Level 3.7 services	4	4
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	7	7
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	3

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
COA did not experience any barriers to behavioral health during this quarter that would negatively impact its ability to maintain a sufficient network except for ASAM levels 3.2 WM, 3.3, 3.7 and 3.7 WM per the GeoAccess report. COA maintains a state-wide behavioral health network. Both the size and scope of this network ensures that all covered services continue to be accessible to members without unreasonable delay. COA continues to grow this network on a regular basis. In an effort to continually improve the behavioral health network, targeted recruitment efforts are underway that focus on identifying any licensed providers in the state who are not already contracted with COA. In addition to these recruitment efforts, thorough vetting processes are in place to ensure only high-quality providers are added to the network. In addition, COA reviews behavioral health provider claims utilization on a regular basis to ensure that all contracted providers are seeing Region 5 members. If there are providers who have zero claims or low claims volumes, COA staff reaches out to these providers to ensure they are still in business, still accepting Medicaid members and asks about their ability to take on new Medicaid patients. Data from previous reporting period (Q3) showed a decrease in the total behavioral health providers in the COA network; however, this was a result of a re-contracting effort and not a true decrease in providers. As of 4/1/2022, many of the behavioral health providers received rate increases and revised fee schedules. The old fee schedules were terminated in the source system for each provider on 3/31/22, which removed them from the Network Adequacy Report data. As a result, the providers that received the new rates did not show in Q3 but are showing again in the Q4 data. There are 1609 Behavioral Health providers that are part of the Independent Provider Network (IPN). COA continues to invite substance use disorder (SUD) providers into its network. There are currently 17 contracted providers who offer residential and detox levels of care to COA members. Providers must pass a clinical quality review process in order to become contracted as a SUD provider.

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
ASAM level 3.7 WM decreased by two providers from Q3 to Q4. This was due to the gap in time from when a provider is clinically approved to provide the level of care to when the contract is executed. While two providers were approved for ASAM level 3.7 WM in Q3, they have not signed the amendments to their contracts to add that level of care. From here forward, COA will only count the ASAM level in the quarter that the contract is executed. COA is continuing to contract with existing and new SUD providers at all ASAM levels for the network in order to increase the number of both SUD facilities and beds at all ASAM levels. This quarter, COA continued to utilize two behavioral health practice facilitators to offer application support for providers struggling to meet quality metrics. 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. In April 2022, COA implemented a new credentialing process for organizational providers (including integrated care clinics) wishing to utilize unlicensed clinicians to render clinical services. This was developed to respond to the behavioral health workforce shortage which ultimately impacts access. COA's highest priority is maintaining a high clinical standard of care for members. Updated policies will help ensure that unlicensed providers within mental health organizations and integrated care settings are receiving appropriate supervision and oversight, with the goal of excellent patient care that also supports expanding the workforce pipeline. TERMINATIONS: Center for Recovery termed its contract because they lost their OBH SUD certification as of 6/1/2022. This does not impact ASAM levels 3.1 and above. The remaining terminations were 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 to the Region 5 report.

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
Internal quality, compliance and provider engagement departments monitor the network and track 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?**
CHP+ MCO
N/A to the Region 5 report.

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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 to the Region 5 report.

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 to the Region 5 report.

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 to the Region 5 report.

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 providers' 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 physical health providers within the current environment. Providers have been vocal about increased issues of staff shortages, high staff turnover, and shortened office hours due to illnesses and burnout. 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 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 a highly engaged and collaborative training program with providers that is targeted at all aspects of access to care requirements, including a specific dedication to training front office staff 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 completing COA network monitoring programs, such as Secret Shopper. During the reporting period, COA continued to provide its enhanced training program for access to care standards to providers. Specific areas of practice were targeted to ensure all staff understand and adhere to the standards. Examples include training on appointment scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. This training is conducted in person preferably (virtual if necessary) and includes leave-behind materials. Providers are randomly selected to participate in this COA led training and will receive training reminder "tips" quarterly via the Provider Portal and the *Navigator*. 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.

Each practice staff member who sets patient appointments will be required to take the training. Each staff must successfully pass the training before the entire practice is deemed "complete" with the training regimen. Each staff has three attempts to pass the training test. Any staff within a practice who does not score a 100% on the training test by the third attempt will be referred back to their provider network manager for additional training and testing. Prior to the second round of training the practice facilitator assigned to the provider will be notified. The practice facilitator will discuss with the provider, practice owner or office manager that continued training failures will result in a deficient score in the Provider Metric Summary resulting in a corrective action.

Once a practice has successfully completed the training, they will be referred to the quality department who will enroll the previously trained practice in the Secret Shopper program. Practices who do not successfully pass the secret shopper call will be referred back to the PNS team and will receive updated training on the missed standards as well as an overview of all access to care standards within two weeks of notification.

If practices fail a second round of secret shopper calls, indicating that they are unable to meet access to care timeliness standards and contractual agreements, the quality department identifies an opportunity for quality improvement. The purpose of this opportunity is to offer support, education, and resources to practices for process improvement. This allows practices to develop and implement a practice-specific quality improvement plan that will improve access to care for members. An assigned practice facilitator assists practices with the creation of a quality improvement plan that is completed and approved within approximately 30 days after receiving results and implemented within 60 days after being approved. The intent is to better understand what barriers practices are experiencing and to assist practices in creating an individualized improvement plan with the knowledge of these existing barriers.

As mentioned above, practices are randomly selected across COA's regions to participate in COA led access to care training. The quality team will randomly select practices for inclusion in the access to care standards training. The quality department will use a stratified process to select 50 physical health, 15 SUD, 50 behavioral health, and 25 CHP HMO practices and forward to the PNS team so the providers can train prior to being secret shopped. CHP HMO providers are an exception, and the quality department will choose 25 providers from the counties that have the top 25 highest utilizing provider list. PH, BH, and SUD selections are representative of each line of business (Region 3, Region 5, and CHP HMO). The quality team will be responsible for selecting the providers to forward to the PNS team in accordance with the grid below:

Quarter	Practice Selections due to PNS	Practice Focus
1: Jan - March	April 1	Physical Health (R3 = MC/CHP) (R5 = MC/CHP) ***At a minimum, 15/50 practices will be trained, and secret shopped***

2: April - June	July 1	Behavioral Health (statewide) MC and CHP ***At a minimum, 15/50 practices will be trained, and secret shopped***
3: July - Sept	October 1	Substance Use Disorder Prov (R3 = MC) (R3 = MC) ***At a minimum, 15/15 practices will be trained, and secret shopped***
4: Oct - Dec	Jan 1	CHP HMO only counties ***At a minimum, 15/25 practices will be trained, and secret shopped***

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
BH Provider Access to Care Monitoring: As documented in previous Network Adequacy reports, COA has relied on the Secret Shopper program to monitor its contracted providers' 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 behavioral health providers within the current environment. Providers have been vocal about increased issues of staff shortages, high staff turnover, and shortened office hours due to illnesses and burnout. Considering the pressures on BH providers, the overwhelming need for behavioral health treatments for members and the State's Wildly Important Goal (WIG) of increasing behavioral health networks, 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 they were being tested on. 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 a highly engaged and collaborative training

program with providers that is targeted at 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 completing COA network monitoring programs, such as Secret Shopper.

During the reporting period, COA continued to provide its enhanced training program for access to care standards to providers. Specific areas of practice are targeted to ensure all staff understand and adhere to the standards. Examples include training on appointment scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. This training is conducted in person preferably (virtual if necessary) and includes leave-behind materials. Providers are randomly selected to participate in this COA led training and will receive training reminder "tips" quarterly via the Provider Portal and the *Navigator*. 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.

Each practice staff member who sets patient appointments will be required to take the training. Each staff must successfully pass the training before the entire practice is deemed "complete" with the training regimen. Each staff has three attempts to pass the training test. Any staff within a practice who does not score a 100% on the training test by the third attempt will be referred back to their provider network manager for additional training and testing. Prior to the second round of training the practice facilitator assigned to the provider will be notified. The practice facilitator will discuss with the provider, practice owner or office manager that continued training failures will result in a deficient score in the Provider Metric Summary resulting in a corrective action. Once a practice has successfully completed the training, they will be referred to the quality department who will enroll the previously trained practice in the Secret Shopper program. Practices who do not successfully pass the secret shopper call will be referred back to the PNS team 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.

If practices fail a second round of secret shopper calls, indicating that they are unable to meet access to care timeliness standards and contractual agreements, the quality department identifies an opportunity for quality improvement. The purpose of this opportunity is to offer support, education, and resources to practices for process improvement. This allows practices to develop and implement a practice-specific quality improvement plan that will improve access to care for members. An assigned practice facilitator assists practices with the creation of a quality improvement plan that is completed and approved within approximately 30 days after receiving results and implemented within 60 days after being approved. The intent is to better understand what barriers practices are experiencing and to assist practices in creating an individualized improvement plan with the knowledge of these existing barriers.

As mentioned above, practices are randomly selected across COA's regions to participate in COA led access to care training. The COA quality team will randomly select practices for inclusion in the

Access to Care standards training. The quality department will use a stratified process to select 50 physical health, 15 SUD, 50 behavioral health, and 25 CHP HMO practices and forward to the PNS team so the providers can train prior to being secret shopped. CHP HMO providers are an exception, and the quality department will choose 25 providers from the counties that have the top 25 highest utilizing provider list. Physical health, behavioral health, and SUD selections are representative of each line of business (Region 3, Region 5, and CHP HMO). The quality team will be responsible for selecting the providers to forward to our PNS team in accordance with the grid below:

Quarter	Practice Selections due to PNS	Practice Focus
1: Jan - March	April 1	Physical Health (R3 = MC/CHP) (R5 = MC/CHP) ***At a minimum, 15/50 practices will be trained, and secret shopped***
2: April - June	July 1	Behavioral Health (statewide) MC and CHP ***At a minimum, 15/50 practices will be trained, and secret shopped***
3: July - Sept	October 1	Substance Use Disorder Prov (R3 = MC) (R3 = MC) ***At a minimum, 15/15 practices will be trained, and secret shopped***
4: Oct - Dec	Jan 1	CHP HMO only counties ***At a minimum, 15/25 practices will be trained, and secret shopped***

From April - June, the PNS team conducted access to care training courses on 18/50 behavioral health practice sites in region 5. Overall, COA is consistently monitoring areas of failure to identify themes to enhance its training programs.

In addition to the Secret Shopper program, COA's contracting team provides additional incentives to community mental health centers (CMHCs). CMHCs are paid at increased rates to fund the hiring of staff to help with operations and clinical work, which results in more access to services.

In Q3 2022, COA increased the behavioral health fee schedule. This allowed behavioral health (BH) practices to keep their doors open to members needing all levels of care. Since the rate increase, COA continues to have an increase in providers wanting to contract. COA is using this increase in the behavioral health fee schedule to not only attract new behavioral health providers to the network, but to encourage providers to accept more Medicaid members, thus increasing access to behavioral health care 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 in its contracted counties, including region-specific contracted counties for RAEs' behavioral health networks. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care. For physical health time and distance requirements, MCEs are only required to report compliance with minimum time and distance requirements for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report compliance with minimum time and distance requirements for all members regardless of county residence.

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

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

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

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

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

Colorado Access continually monitors its network adequacy, and the contracting and PNS teams 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 Provider Recruit 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 PNS 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 to discuss 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.

All physical health provider time and distance standards are met. The following network categories are "not met." The percentages listed below actually show the percentage at which they do meet:

Network Category	% With Access
SUD Treatment Facilities-ASAM 3.3	0
SUD Treatment Facilities-ASAM 3.7	0
SUD Treatment Facilities-ASAM 3.2 WM	92.4
SUD Treatment Facilities-ASAM 3.7 WM	0

COA is continuing to contract with existing and new SUD providers at all ASAM levels for the network in order to increase the number of both SUD facilities and beds at all ASAM levels.

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
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
Region 5 does not have any frontier areas.

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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
CHP+ MCO, Medicaid MCO, RAE					

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 an SCA is complete, COA contacts the provider to ask 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

Free text

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Appendix C. Optional MCE Content

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