COLORADO
Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: *Colorado Access*

Line of Business: *RAE 5*

Contract Number: *19-107517A13*

Contact Name: *Jamie Lovitt-Nguyen*

Report Submitted by: *Brad Schrom*

Report Submitted on: *7/28/2023*

Report due by *07/31/2023* covering the MCE's network from *04/01/2023 – 06/31/2023*, FY*22-23* Q*4*

—Final Copy: June 2023 Release—

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Health Care Policy & Financing

Contents

COLORADO
Department of Health Care Policy & Financing

1. Instructions for Using the Network Adequacy Quarterly Report Template

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

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

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

Definitions

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

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

Report Instructions

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

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

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

Questions

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

2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2023, for the quarterly report due to the Department on July 31, 2023).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2023, for the quarterly report due to the Department on July 31, 2023).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	171,095	N/A	165,079	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	2,327	N/A	2,389	N/A
Primary care practitioners accepting new members	1,513	65.02%	2,315	96.90%
Primary care practitioners offering after-hours appointments	22	0.945%	24	1.00%
New primary care practitioners contracted during the quarter	23	0.988%	36	1.51%
Primary care practitioners that closed or left the MCE's network during the quarter	57	2.45%	30	1.26%

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 to ensure all covered services are accessible to members without unreasonable delay. COA's practice facilitators and the Provider Network Services (PNS) team regularly engage with providers and quickly respond to barriers providers could face which may impact access to care. Strong ongoing partnerships have led to COA and providers tackling problems together to ensure members have timely access to primary care. Between data, care management, quality improvement and resource support, COA ensures providers have what they need to support members in improving their health. COA strives to keep primary care at the hub of member healthcare by complementing and augmenting the work providers are already doing. 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, which aligns with the primary care value-based payment utilization component. In addition, practice support staff aid providers in maximizing funding potential in the value-based payment program. In the reporting period, COA's practice support team worked with Enhanced Care Providers (ECPs) to educate and inform about COA's Enhanced Care Provider Investment Payment, formerly the Vulnerable Populations Provider Support Payment, which rewards sites providing enhanced care services that aid in the delivery of whole-person care and address member needs outside the scope of what would be captured on a medical claim. Practice facilitators and network managers track member attribution rates at the practice level and gauge provider capacity leading to an increase or decrease in cap limits. In April, COA added a "Newly Attributed Member" column to the monthly member reports which offers an easy way for providers to identify individuals for engagement outreach. Decreases in cap limits are most commonly associated with staff turnover and the inability to fill vacancies with qualified individuals. COA has implemented new performance dashboards to help providers focus on priorities to help mitigate burnout and provide a more efficient way to review data and metrics. For some practices, this challenge has remained constant over the last three years. COA continues to support providers' business operations and staffing needs in a variety of ways. COA provides resources to reduce burnout professionally and operationally, and regularly promotes resources tied to physical and behavioral health support in COA's provider newsletters, the *Provider Update* and *Navigator*. COA has also positioned its practice supports and 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.

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
On a monthly basis, COA staff share a newly designed scorecard with providers that reflects their performance across all value-based payment measures. With this scorecard, providers are able to compare themselves against similar providers and quickly identify opportunities for improvement. In the reporting period, COA practice facilitators created personalized visual diagrams for practices to provide a "big picture" of measures across multiple quality improvement (QI) programs impacting Medicaid providers and members. These were then organized to illustrate alignment between different programs and measures they are participating in this year. 85% of COA's primary care practices have an active quality improvement plan in place where they work with their practice facilitator on rapid Plan-Do-Study-Act (PDSA) cycles. The practice support team provides coaching, data support and analysis to understand intervention effectiveness. In the reporting period, PCMPs began working on quality improvement projects tied to focus areas of interest to them. The practice support team has observed that some practice sites have used their QI project as a springboard to try different remote engagement platforms (e.g., patient portals, text, or email campaigns), and others have asked staff to make phone call outreaches to members tied to their QI focus area. The latter has been more challenging for practices that have competing demands on their front- and back-office staff or recent staff turnover. In the reporting period the practice support and quality teams continued to convene PCMP workgroups to focus on key performance indicators. Depression screening is the focus of the current group, which was convened in the fall of 2022 and concluded in June 2023. The workgroup included mid-performing providers and allowed for providers to share best practices, challenges and barriers impacting their work, and determine an improvement plan for the depression screen and follow-up measures using data to help inform their action steps. Additionally, the practice support team has implemented bi-monthly Provider Resource Groups within the COA Provider Network. The Provider Resource Groups allow providers to stay informed on different topics that can be applied to their day-to-day operations. During the reporting period, Provider Resource Groups focused on care planning, chronic disease management, behavioral health (BH) support, social determinant of health (SDOH) needs and vaccine engagement. COA partnered with the Behavioral Health and Wellness Program at the University of Colorado to deliver a skills-based training on improving vaccine engagement and uptake. Providers continue to experience barriers to specialty care referrals, specifically for Health First Colorado members in need of endocrinology, neurology, urology and orthopedic specialty care. PCMPs have voiced that many specialists are scheduling a year out on new appointments, presenting a large challenge for members who need care now.

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
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. Over the past year, COA has seen this model support growth and sustainability within the reproductive health network. During Q3 State Fiscal Year 2022-2023 (SFY 22-23), the average rate of family planning services for women ages 15-44, as reflected on a claim, across the Region 5 PCMP network during this time was 12.17%. In the reproductive health cohort, a higher rate of 23.82% was observed. Due to claims runout, data is reported on a three-month lag, which is why the previous quarter is included in this report. Family planning rates for all members aged 15-44 will be available beginning in the Q1 SFY 23-24 report. It is important to note that the network's ability to provide family planning services extends well beyond the number of contracted OB/GYN providers. 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 provide services to improve access. COA educates providers on new telehealth rules through webinars and provider resource groups hosted by its practice support team. COA also continues to promote the use of telehealth services in its provider newsletters which helps educate providers on new telehealth policies or coding updates. Lastly, COA's provider directory lists providers that offer telehealth services. Through its telehealth platform, COA's Virtual Care Collaboration and Integration (VCCI) Program continues to enhance access to health care within 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 member's home. The VCCI program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member's medical 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. In Q4, the VCCI Program supported 10 primary care practices in Region 5. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care. VCCI works with COA care management to coordinate connections to primary care and manage referrals to long-term care and other resources as needed. In Q4, the VCCI Program expanded to include referrals for COA members that are being discharged from bed-based behavioral health levels of care to be seen for time-limited medication management until they can be established with a long-term psychiatrist. The VCCI Program continues to expand and evolve its services to meet the increased need for behavioral health care.

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
The COA telehealth team is actively engaged in conversations with the community to understand community diversity, equity and inclusion (DE&I) needs and is working with the COA internal DE&I team to identify community partners that will help to increase access to behavioral health care services among marginalized communities and practices. TERMINATIONS: Potomac Family Medicine, a PCMP in Region 5, closed after being bought by a private equity firm. 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	171,095	N/A	165,079	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	7,754	N/A	8,302	N/A
Behavioral health practitioners accepting new members	1,269	16.37%	8,167	98.37%
Behavioral health practitioners offering after-hours appointments	108	1.39%	115	1.39%
New behavioral health practitioners contracted during the quarter	150	1.93%	257	3.10%
Behavioral health practitioners that closed or left the MCE's network during the quarter	70	0.903%	107	1.29%

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	10	14
Total SUD treatment facilities offering ASAM Level 3.3 services	0	1
Total SUD treatment facilities offering ASAM Level 3.5 services	11	21
Total SUD treatment facilities offering ASAM Level 3.7 services	4	9
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	9	11
Total SUD treatment facilities offering ASAM Level 3.7 WM services	4	7

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 recognizes the current capacity and workforce shortages experienced by behavioral health practices. COA continues to support providers' business operations and staffing needs in a variety of ways. COA provides resources to reduce burnout professionally and operationally, and regularly promotes resources tied to physical and behavioral health support in COA's provider newsletters, the *Provider Update* and *Navigator*. COA has also positioned its practice supports and 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.

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
Regarding telehealth, COA continues to provide services to improve access to behavioral health. COA educates providers on new telehealth rules through webinars and provider resource groups hosted by its practice support team. COA also continues to promote the use of telehealth services in its provider newsletters which helps educate providers on new telehealth policies or coding updates. Lastly, COA's provider directory lists providers that offer telehealth services. Through its telehealth platform, COA's Virtual Care Collaboration and Integration (VCCI) Program continues to enhance access to health care within 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 member's home. The VCCI program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member's medical 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. In Q4, the VCCI Program supported 10 primary care practices in Region 5. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care. VCCI works with COA care management to coordinate connections to primary care and manage referrals to long-term care and other resources as needed. In Q4, the VCCI Program expanded to include referrals for COA members that are being discharged from bed-based behavioral health levels of care to be seen for time-limited medication management until they can be established with a long-term psychiatrist. The VCCI Program continues to expand and evolve its services to meet the increased need for behavioral health care. The COA telehealth team is actively engaged in conversations with the community to understand community DE&I needs and is working with the COA internal DE&I team to identify community partners that will help to increase access to behavioral health care services among marginalized communities and practices. In Q4 SFY 22-23, there were 7,446 Behavioral Health providers in the Independent Provider Network (IPN). The "accepting new patients" number has increased greatly due to the new default setting of "yes" to accepting new patients unless COA is notified by the provider that they are not accepting new members. The default setting was not set to "yes" for all providers when COA switched to the new claims system.

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 levels

The reporting of the ASAM levels in Table 2B increased this quarter because it was discovered that all the locations under a contracted provider for the various levels were not being included in the count in the previous quarters. Only the contracted entity was being counted. COA continues to contract with existing and new substance use disorder (SUD) providers at all ASAM levels. Providers must pass a clinical quality review process in order to become contracted as a SUD provider. There are currently 27 contracted providers who offer residential and detox levels of care to COA members.

Mitigating barriers

COA continues to provide telehealth services to improve access. COA educates 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 newsletters which help educate providers on new telehealth policies or coding updates. COA's provider directory lists providers that offer telehealth services. At this time, COA does not capture telehealth service data.

Mitigating Barriers - Attestation Process for unlicensed/pre-licensed clinicians to render services

COA participates with the other RAEs to permit unlicensed/pre-licensed clinicians to render services to Health First Colorado members. The standards identified in the process are intended to safeguard the public while also maintaining the integrity of the health care profession. The greatest priority of the RAEs is maintaining a high clinical standard of care for members. The newly aligned standards will help ensure that unlicensed providers within mental health organizations and integrated care settings are receiving appropriate supervision and oversight, with the goal of quality member care that also supports expanding the workforce pipeline. A provider group will complete an initial attestation (with annual follow-up) that underscores adherence to established standards in conjunction with regular audit activities.

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

Other Support

COA provides pre-contracting and ongoing coaching support to its behavioral health network. COA continues 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, and not yet contracted with COA, to render SUD treatment and receive out-of-network rates.

As of December 2022, COA requires ASAM level 3.1 and higher providers to complete clinical reviews in order to contract. Prospective providers must meet a minimum of 18 Quality measures as a condition of participation. Providers that fall short of any of these measures are invited to attend a remediation meeting with behavioral health facilitators to enhance and, if necessary, create new policies, procedures and workflows that adhere to COA standards. When remediation is complete, providers may re-apply. COA recently completed the remediation process for an additional ASAM level 3.7 provider, and they are now in the contracting process. COA practice facilitators will continue to provide support to ASAM level 1 and 2.1 providers as needed or by request. Each ASAM level of care has unique requirements.

In the reporting period, COA in partnership with the other RAEs, provided funding to EDCare to open a new adult residential unit for Coloradans. This funding will also support the expansion of intensive outpatient and partial hospitalization programs.

COA has also funded and built strong partnerships with four intensive in-home providers who were previously contracted. This funding was dedicated to increase capacity, reduce waitlists and extend the COA geographic coverage area. This includes a provider who is offering intensive in-home services via telehealth to members living in rural areas. Providers will be submitting monthly reporting to COA's behavioral health team regarding capacity and waitlists which will assist in more timely and appropriate referrals to services for members.

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
Additionally, COA has developed the Behavioral Health Language Services Initiative pilot program to allocate funding to providers to address shortages in network capacity for services in non-English languages. Organizations that meet the provider eligibility requirements and service qualifications are eligible for an enhanced rate on qualified services. The pilot program went live on June 28th and 10 providers have completed the required training and attestation. TERMINATIONS: All terminations were roster clean-ups or life events.

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.

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
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.

COLORADO
Department of Health Care Policy & Financing

Inadequate Network Policies

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

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

Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area? **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 Access to Care (ATC) program to monitor its contracted providers' compliance with access to care standards. Over the past fiscal year, COA has had the opportunity to evaluate the impact of the Access to Care program in order to further align this monitoring tool with additional network management efforts. During this review process, COA observed the unprecedented challenges faced by providers based on the environment impacted by the pandemic. Providers have been vocal about increased issues of staff shortages, high staff turnover, shortened office hours due to illnesses and provider 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 Access to Care program and, specifically, data trends in practices that were not passing the standards for which they were being tested. It was recognized that rotating staff in the front office significantly contributed to challenges in adhering to the access to care standards. As a result, this new model will consist of a collaborative training program with providers that is targeted towards all aspects of access to care requirements, including a specific dedication to training front office staff on Health First Colorado rules. COA believes that regular and consistent office training is the key to understanding and adhering to program requirements and will help practices be more successful with completing COA network monitoring programs, such as Access to Care. In Q4, COA continued its enhanced training program for access to care standards targeting specific areas of practice 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. 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 asked to complete the training. Each staff member has three attempts to pass the training test. Once a practice has received the training, they will be referred to COA's quality department for the assessment portion of the program. COA conducts mock telephone calls or online inquiries to providers that mirror common member behavior to test consistency of provider behavior and availability of services. All test calls are based on validated scripts built internally by COA and describe specific scenarios tied to access to care standards outlined in the contract. COA has both adolescent and adult call scripts. For practices that are unable to be assessed via telephone calls or online

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
inquiries, the quality team will collaborate with the practice to complete a Third Next Available Appointment (TNAA) request, a Quality Management industry standard for monitoring access to care. Each provider receives a summary report of their performance and relevant findings. If practices fail the assessment portion of the program, indicating that they are unable to meet access to care timeliness standards and contractual agreements, the quality department may identify 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. COA 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 approval. 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 to participate in COA-led access to care training. The COA quality team will randomly select practices for inclusion in the training. The quality department uses a stratified process to select 50 behavioral health (or physical health (PH) providers and forwards them to the PNS team so the providers can train prior to being secretly shopped. The quality team is responsible for selecting the providers and the PNS team is responsible for training. During Q4, the PNS team administered training to 21 total PH providers that serve both Region 3 and Region 5 members. Eleven PH practices received Access to Care training as an effort to distribute trainings to large entities that see a high volume of members. These large entities have call centers and multiple clinic locations, so assessment included a TNAA request rather than mock calls to clinic facilities. These practices were asked to provide a TNAA measure for new and existing patients and were asked if their practice offers sick/urgent patient appointments. At the time of drafting this report, 5 TNAA requests had been received and passed with 1 practice requiring education around new patient appointment best practices. No quality improvement opportunities have been identified thus far. Additionally, 10 practices received training in Q4 as an effort to distribute ATC trainings to PCMP provider clinics and will be assessed for adherence to access to care standards in Q1 of SFY 23-24.

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 Access to Care 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 Access to Care program in order to further align this monitoring tool with additional network management efforts. During this review process, COA observed the unprecedented challenges faced by behavioral health providers based on the environment surrounding the pandemic. Providers have been vocal about increased issues of staff shortages, high staff turnover, shortened office hours due to illnesses and provider burnout.

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
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 Access to Care program and, specifically, data trends in practices that were not passing the standards for which they were being tested. It was recognized that rotating staff in the front office significantly contributed to challenges in adhering to the access to care standards. As a result, this new model will consist of a collaborative training program with providers that is targeted towards all aspects of access to care requirements, including a specific dedication to training front office staff on Health First Colorado rules. COA believes that regular and consistent office training is the key to understanding and adhering to program requirements and will help practices be more successful with completing COA network monitoring programs, such as Access to Care. COA has continued its enhanced training program for Access to Care standards targeting specific areas of practice 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. 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 complete the training. Once a practice has received the training, they will be referred to COA's quality department for the assessment portion of the program. COA conducts mock telephone calls or online inquiries to providers that mirror common member behavior to test consistency of provider behavior and availability of services. All test calls are based on validated scripts built internally by COA and describe specific scenarios tied to access to care standards outlined in the contract. COA has both adolescent and adult call scripts. For practices that are unable to be assessed via telephone calls or online inquiries, the quality team will collaborate with the practice to complete a Third Next Available Appointment (TNAA) request, a Quality Management industry standard for the monitoring of access to care. Each provider receives a summary report of their performance and relevant findings. If practices fail the assessment portion of the program, indicating that they are unable to meet access to care timeliness standards and contractual agreements, the quality department may identify 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. COA 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 approval. 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 to participate in COA-led access to care training. The COA quality team will randomly select practices for inclusion in the training. The Quality department uses a stratified process to select 50 behavioral health (BH) providers and forwards them to the PNS team so the

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

providers can train prior to being secret shopped. The quality team is responsible for selecting the providers and the PNS team is responsible for training.

During Q4, 2 practices received access to care training as an effort to distribute trainings to large entities that see a high volume of members. Assessment results correspond to the 2 BH practices most recently trained in Q4 & the 19 SUD practices trained in Q2. Four practices passed mock call assessments, 3 practices failed, and 12 practices are undergoing additional assessment or are in progress. Two practices were not assessed due to practice undergoing contract termination. All practices included serve both Region 3 and Region 5 members. At the time of this report, no quality improvement opportunities were identified due to failed practices having appropriate improvement initiatives in place. For example, practices appropriately referred members to additional resources or noted improvement initiatives being in progress such as additional hiring to improve member access.

In addition to the Access to Care program, COA's Contracting team provides additional funding to community mental health centers (CMHCs). This supports CMHCs in hiring additional staff to help with operations and clinical work, which results in greater access to services.

RAE 3/5 Access to Care Program Metrics Q4 2022-2023				
Quarter	**Practices Trained:**	**Training Results**	**Practices Secret Shopped / Assessed:**	**Secret Shopper / Assessment Results**
Q4 (April-June)	Behavioral Health/SUD: 2 practices received ATC training as an effort to distribute trainings to large entities that see a high volume of members.	Behavioral Health/SUD: Received training & did not complete/in progress: 2.	Behavioral Health/SUD: Results correspond to the 2 BH practices most recently trained in Q4 & the 19 SUD practices trained in Q2.	Behavioral Health/SUD: Passed: 4 Failed/ QI plan not needed: 3. Undergoing additional assessment/In progress: 12 Not assessed due to practice undergoing contract termination: 2 *At the time of writing this report, no QI plans are required from any practices. This could change after additional assessment.
	Physical Health: 11 practices received ATC training as an effort to distribute trainings to large entities that see a high volume of members. 10 practices received ATC training as an effort to distribute ATC trainings to PCMP provider clinics.	Physical Health: Passed: 5 Failed: 1 Received training & did not complete/in progress: 15	Physical Health: Results correspond to the 11 practices in Q4 as an effort to distribute trainings to large entities that see a high volume of members.	Physical Health (TNAA): Passed: 5 (with 1 practice receiving education around new patient appointments) In progress: 7 *At the time of writing this report, no QI plans are required from any practices. This could change after additional assessment.

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
COA continually monitors its network adequacy, and the Contracting and PNS teams work closely with the Care Management department 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 receive requests from new providers wanting to join the network; if eligible, COA makes every effort to add them to its panel of providers. COA's Provider Recruitment Program Manager continues to develop, implement, and direct a data driven strategy to recruit and maintain a provider network of culturally responsive providers based on the needs of COA members in their communities. Currently, through a data driven process, the provider recruitment program is determining the status of all providers and recruitment priorities. There is particular focus on recruiting primary care, behavioral health bilingual providers, residential mental and/or SUD treatment facilities for adolescents, eating disorder programs and SUD treatment facilities with ASAM levels 3.1 and higher. All physical health provider time and distance standards are met. COA has added ASAM level providers 3.3, 3.7 and 3.7 WM, however they are not showing up in the geocoding so they continue to show as unmet even though those categories should show as met. COA is actively working to address this and aims to have the geoaccess software issue resolved by the Q1 SFY 23-24 submission.

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 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.

COLORADO
Department of Health Care Policy & Financing

Appendix A. Single Case Agreements (SCAs)

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

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

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	[redacted]
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	[redacted]
CHP+ MCO, Medicaid MCO, RAE					
Avera McKennan Hospital	95000758	Weld	BF141	General Hospital with a Psych Unit	[redacted]
Benchmark Behavioral Health System, Inc.	9000175255	Arapahoe	BV100R	Residential Treatment Center	[redacted]
Britney Meiers, LCSW Counseling Services	9000167657	La Plata	BV130	Licensed Clinical Social Worker	[redacted]
UHS of Wyoming, Inc.	9000164152	Morgan	BV140	Mental Hospital	[redacted]

Table A-2–Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
CHP+ MCO, Medicaid MCO, RAE
When necessary, COA enters into a single case agreement (SCA) with a non-participating provider based on requests from its utilization management and/or care management departments. 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

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.