COLORADO
Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: Colorado Access

Line of Business: RAE5

Contract Number: 19-107517A7

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Report due by 7/30/2021, covering the MCE's network from 04/01/2021– *06/30/2021* FY*21* Q*4*

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1. Instructions for Using the Network Adequacy Quarterly Report Template

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

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

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

Definitions

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

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

Report Instructions

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

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

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

Questions

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

Establishing and Maintaining the MCE Network

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

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

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	127543	N/A	130987	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	3543	N/A	3866	N/A
Primary care practitioners accepting new members	2512	70.90%	2783	71.98%
Primary care practitioners offering after-hours appointments	1303	36.77%	1345	34.79%
New primary care practitioners contracted during the quarter	294	8.29%	86	2.22%
Primary care practitioners that closed or left the MCE's network during the quarter	254	7.16%	50	1.29%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
Colorado Access (COA) continues to grow its primary care provider network, on a regular basis, to ensure all covered services continue to be accessible to members without unreasonable delay. *COA is continuing to improve our new and termed provider data reporting to get the most accurate numbers. In light of, previously referenced, system challenges which we are currently addressing; this quarter, we manually validated all new and termed providers to ensure we had an accurate count. In the data file sent to HSAG, the category of new primary care practitioners contracted totals 125. This number reflects our current system challenges. After Manual validation, the correct number is 86, as shown in Table 1A. The number of providers newly contracted this quarter is down from last quarter. The higher number last quarter was due to the previously reported issue with providers who were termed because they weren't revalidated, Under the direction from HCPF, COA reinstated those providers in our systems.* *In the data file sent to HSAG, the category of primary care practitioners that closed or left the network totals 85. After manual validation, the correct number is 50 as reflected in Table 1A. Of the 50, only 1 provider had a contract that was termed. The PCMP is Federal Healthcare Inc. The contract was terminated due to the physician owner being unable to practice medicine due to his license being restricted by the Colorado Medical Board. The remaining 49 termed providers are from larger groups that have been cleaning up their rosters of providers who have left or retired or COA discovered a provider was no longer part of a group when they didn't respond to our re-credentialing requests. The number of providers terming this quarter is down from last quarter. The higher number from last quarter was due to the previously reported issue with providers who were not revalidated being termed.* *Telehealth continues to be a focus of COA and its provider networks. We are actively educating providers on the new rules and use of telehealth through webinars and provider resources groups hosted by our practice support team. We are also promoting the use of telehealth in our provider newsletter, the Navigator. COA saw a marked increase in telehealth utilization among primary care practitioners during the height of COVID but as restrictions have eased and vaccines have become available, we have seen a decrease in telehealth as office visits have increased. We still see a higher use of telehealth than pre COVID. COA monitors telehealth usage using a telehealth claims dashboard developed by our claims department. COA is now capturing telehealth services as a datapoint from our network providers and has begun listing this information in our provider directories to further increase access to care for members.*

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	127543	N/A	130987	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	6037	N/A	6206	N/A
Behavioral health practitioners accepting new members	3697	61.23%	4034	80.65%
Behavioral health practitioners offering after-hours appointments	1439	23.83%	1454	23.42%
New behavioral health practitioners contracted during the quarter	205	3.39%	180	2.90%
Behavioral health practitioners that closed or left the MCE's network during the quarter	242	4.00%	45	.072%

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	2	3
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	12	100
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	4	4
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	227	227
Total SUD treatment facilities offering ASAM Level 3.7 services	3	4
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	48	72

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	4	4
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	119	183
Total SUD treatment facilities offering ASAM Level 3.7 WM services	1	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	12	45

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 continues to grow its behavioral health provider network, on a regular basis, to ensure all covered services continue to be accessible to members without unreasonable delay. *COA is continuing to improve our new and termed provider data reporting to get the most accurate numbers. In light of system challenges which we are currently addressing, this quarter, we manually validated the new and termed providers to ensure we had an accurate count. In the data file sent to HSAG, the category of new behavioral health providers contracted totals 221. This number reflects our current system challenges. After manual validation, the correct number is 180, as shown in Table 2A. This quarter saw and increase of providers joining existing contracted groups.* *In the data file sent to HSAG, the category of behavioral health practitioners that closed or left the network totals 77. This number reflects our system challenges. After manual validation, the correct number is 45 as reflected in Table 2A. Of the 45, only 8 providers had contracts that were termed. The remaining 37 termed providers are from larger groups that have been cleaning up their rosters of providers who have left or retired or COA discovered a provider was no longer part of a group when they didn't respond to our re-credentialing requests. The number of providers terming this quarter is down from last quarter. The higher number from last quarter was due to the previously reported issue with providers who were not revalidated, being termed.*

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, as we automate our data reporting for ASAM levels within our systems, we discovered we undercounted ASAM level 3.2 WM in Q3. COA reported 119 beds in Q3. In Q4 we are now reporting the correct number of 183. *Telehealth continues to be a focus of COA and its provider networks. We are actively educating providers on the new rules and use of telehealth through webinars and provider resources groups hosted by our practice support team. We are also promoting the use of telehealth in our provider newsletter, the Navigator. Through these efforts, we have seen a marked increase in telehealth utilization.* *COA monitors telehealth usage using a telehealth claims dashboard developed by our claims department. We have seen a dramatic increase in the use of telehealth services across our behavioral health network since the beginning of the COVID-19 pandemic. Before COVID COA averaged under 500 behavioral health telehealth units billed and $75,000 in paid claims per month. Since the start of COVID, and the new telehealth rules being put in place, COA now averages around 25,000 units billed and $3,250,000 in claims paid per month in RAE region 5. This increase in the use of telehealth has made the availability of behavioral health services much more accessible to a larger number of members from across the region and allowed members to access much of our statewide behavioral health network. It has also helped break down transportation barriers for many members. COA is now capturing telehealth services as a datapoint from our network providers and has begun listing this information in our provider directories to further increase access to care for members.* *In addition to our existing behavioral health network, COA continues to expand access through its Access Care Services (ACS) subsidiary. ACS deploys telehealth services in a variety of settings, further augmenting the adequacy of the COA provider network. With a focus on integrating behavioral health support into primary care settings, and an emphasis on collaborative and team-based care, the ACS model utilizes an integrated approach to combine virtual mental health services within a physical health primary care setting. It provides licensed behavioral health clinicians, substance abuse counselors, and psychiatric providers with the ability to screen, diagnose, provide brief intervention, and recommend psychotropic medication regimens, all while collaborating and coordinating care with the member's primary care medical home. COA currently has 6 practices in region 5 utilizing this model. ACS also utilizes the Virtual Care Collaboration and Integration (VCCI) Direct Care program that allows the COA care management department to refer members to the ACS clinical team for behavioral telehealth services.* *Currently, helping some SUD providers understand authorizations, medical necessity, and clinical criteria has been the biggest barrier to incorporating the ASAM levels of care into our behavioral health network. Many providers have no experience with these healthcare processes. We have made our provider relations team*

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
available for trainings and our customer service department refers providers with questions on these processes to the PR team. Our utilization management team has also continued to meet 1:1 with each new provider to help them better understand our process. *COA continues to seek contracts with new and existing SUD providers for all implemented ASAM levels. We currently have 12 SUD facilities in our COA Clinical Review Process that evaluates their clinical readiness to serve Health First Colorado members. As these providers pass the Clinical Review process, they will go on to the COA contracting process to be added to the network. We continue to increase the number of both SUD facilities and beds.*

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

3. Network Changes and Deficiencies

Network Changes

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

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
For this quarter COA terminated one provider from the network. Federal Healthcare Inc. was terminated due to the sole physician being unable to practice medicine due to his license being restricted by the Colorado Medical Board. *Per the Colorado Medical Board "On April 16, 2021, the Panel reviewed materials relating to case number 2021-2247-A, and found that based upon the information reviewed, the Panel had reasonable grounds to believe that Respondent violated the Medical Practice Act and/or that the public health, safety or welfare imperatively required emergency action"* *COA sent termination notice letters to members within 15 days of sending the termination letter as required by our contract. Our Care Management department followed up with members for continuity of care.*

Table 5-CHP+ MCO Network Volume Changes and Notification: Discussion

If the MCE experienced at least a five percent (5%) increase or decrease in its network in a thirty (30) calendar day period, describe the change and answer the following questions: **Did the MCE notify the Department, in writing, within ten (10) business days of the change?** **Was the change due to a practitioner/practice site/entity's request to withdraw; was the change due to the MCE's activities to obtain or retain NCQA accreditation?** **Was the change due to a practitioner/practice site/entity's failure to receive credentialing or re-credentialing from the MCE?**
CHP+ MCO
N/A

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Inadequate Network Policies

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

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

Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area? If the MCE answered "yes", did the Department designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members?
CHP+ MCO
N/A

Table 7-CHP+ MCO Discontinue Services to an Entire County: Discussion

Did the MCE discontinue providing covered services to members within an entire county within the MCE's service area? If the MCE answered "yes", did the MCE provide no less than sixty (60) calendar days prior written notice to the Department of the MCE's intent to discontinue such services?
CHP+ MCO
N/A

Table 8-CHP+ MCO Provider Network Changes: Discussion

Did the MCE experience an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network? If the MCE answered "yes", did the MCE notify the Department, in writing, of the change?
CHP+ MCO
N/A

4. Appointment Timeliness Standards

Appointment Timeliness Standards

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

Table 9-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Colorado Access assesses the provider network for contract compliance annually through its provider assessment tool. Each Colorado Access Practice Support Facilitator works with their assigned practices to thoroughly review components of the contract annually and ensure provider compliance. Assessment of Access to Care Standards will be completed as part of the State Fiscal Year (SFY) 21-22 assessment module implemented in August 2021. Through this module, providers with appropriate electronic medical record (EMR) capabilities will report out the Third Next Available Report, and/or complete a self-reported survey on these standards. *Additionally, Colorado Access' Quality Department conducts an independent testing program to routinely monitor provider compliance with Access to Care standards, known as the Secret Shopper program. Colorado Access monitors providers on Access to Care standards quarterly by conducting calls to providers that mirror common member behavior to test the consistency of the provider behavior and availability of services offered to members through a series of calls. This activity checks for timeliness of appointment availability to validate compliance with standards as well as quality of calls. Provider selection for Secret Shopper calls is based primarily on random selection from quarterly claim volume stratification. However, the Quality Department may also select providers based on information received from other internal departments including but not limited to Care Management, Customer Service, and Compliance. Secret shopper data includes all lines of business, RAE3, RAE5 and CHP as many providers are contracted with multiple plans.* *All test calls are based on scripts built internally by Colorado Access and describe specific scenarios tied to access to care standards outlined in the contract validated by medical directors for accuracy. Colorado Access will also assess providers through email and provider website submission interactions when needed for follow-up to unsuccessful test calls. Colorado Access has both pediatric and adult call scripts to check a variety of populations. By utilizing an independent monitoring system that does not rely on self-reported performance by the provider, Colorado Access can more confidently validate provider behavior and the experience of its membership as well as support providers with actionable opportunities for improvement when gaps are*

identified. Colorado Access' robust experience in this space has highlighted variations that can occur across staff at provider practices, and specifically between practice leadership (who are knowledgeable on the practice's policies) and the frontline office staff (who are implementing the policies daily). The Secret Shopper Program allows Colorado Access to further connect with various staff across a clinic system and work alongside the practice to support opportunities for improvement.

Each provider receives a summary report of their performance and relevant findings. Providers that offer appointment availability outside Access to Care contractual standards during Secret Shopper calls are placed on a Correct Action Plan (CAP) from Colorado Access. To improve the quality of the Colorado Access Provider Network, beginning in SFY 20-21 Q4, Colorado Access also began issuing corrective action plans (CAPs) based on Secret Shopper interaction outcomes that break from community standards, other Colorado Access Policies & Procedures (i.e. provider contracts and responsibilities outlined in the Provider Manual), or that contribute to overall poor member experience (i.e. inability to speak with live representative during outbound calls, or long hold times). Prior to Q4, these Secret Shopper outcomes resulted in provider education letters and/or Requests for Additional Information (RFAI).

Outside of issuing CAPs for correction of network deficiencies and continuous quality improvement, Colorado Access may also issue a RFAI to the provider based on interaction results where potential process gaps/access to care issues exist or interactions were unable to assess Access to Care contractual standards. RFAI's can be in addition to or in the absence of CAPs. Beginning Q4, if successful contact was not made or administrative barriers such as providers requiring Medicaid ID to verify eligibility prior to appointment offering, Colorado Access began issuing RFAI's and requiring providers to submit current next appointment availability for standard assessed. In SFY 21-22, Colorado Access plans to formalize this process and will require providers to provide appointment availability using Third Next Available Report standards. This will be done in addition to and separate from the annual assessment conducted by Colorado Access Practice Support.

Providers must complete and return RFAI's and/or a CAP timeline back to Colorado Access within 15 calendar days of issuance. CAP timelines must outline an implementation plan to improve specific areas identified as deficient and plan must be completed by the end of the next SFY quarter, with Colorado Access then conducting follow up calls to ensure contractual compliance on previously identified deficiencies.

During Q3 of SFY20-21, Colorado Access successfully launched a contract with Signal Behavioral Health to roll out the Colorado Access substance use disorder (SUD) Secret Shopper Program to optimize call efficiency and collaborate with another contracting entity to ensure overall provider quality. The initial phase of the program was focused on residential and outpatient services, and in Q4, this pilot phase was expanded to also assess intensive out-patient (IOP) and withdrawal management services. At the time of this report writing, Colorado Access Quality Department is actively working with Signal Behavioral Health on clarification for the 49 SUD Secret Shopper calls completed in Q4 and therefore, is not included in the table below to ensure accuracy in reporting. This information will be provided to the Department upon clarification and resolution with Signal Behavioral Health. Additional program enhancements are being rolled out in SFY21-22 upon review of lessons learned during the pilot period.

LOB	Number of Interactions*	Population and Standard of Care Assessed	Number of Providers Assessed	Number of Providers placed on Corrective Action Plan (CAP)	Number of Providers where additional information was requested	Any Notable Trends Observed with Providers
RAE 3, RAE 5, and CHP+	22	Adult Behavioral Health: Non-urgent, symptomatic	7**	4**	3**	Faster contact response via email/online submission
RAE 3, RAE 5, and CHP+	19	Pediatric/Adolescent Behavioral Health: Non-urgent, symptomatic	7**	6**	6**	Providers aren't referring patients back to Colorado Access if don't have capacity for new members
CHP+ only	7	Pediatric/Adolescent Behavioral Health: Non-urgent, symptomatic	3	0	0	
Total	**48**	**-**	**15**	**8**	**7**	

**includes inbound and outbound calls, emails, and website submissions*

***Due to some providers being assessed using both pediatric/adolescent and adult call scripts during different calls, doesn't represent unique providers. Counts of unique providers is provided in the total row*

Interaction Outcome*	Number of Interactions*	Percentage of all Interactions
Appointment is offered and meets Access to Care Standard	10	20.83%
Violate Access to Care Standards	6	12.5%
Unable to assess if Access to Care Standards were met	28	58.33%
Violate other Colorado Access Policies & Procedures or community standards	8	16.67%
CAP Required	11	22.92%
Protocols/resources for appointment scheduling result in additional treatment barriers/overall poor member experience (i.e. inefficiencies in call system IT infrastructure)	16	33.33%
All other Requests for Additional Information	8	16.67%

*one interaction can be categorized in multiple categories

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
Colorado Access assesses the provider network for contract compliance annually through its provider assessment tool. Each Colorado Access Practice Support Facilitator works with their assigned practices to thoroughly review components of the contract annually and ensure provider compliance. Assessment of Access to Care Standards will be completed as part of the State Fiscal Year (SFY) 21-22 assessment module implemented in August 2021. Through this module, providers with appropriate electronic medical record (EMR) capabilities will report out the Third Next Available Report, and/or complete a self-reported survey on these standards. *Additionally, Colorado Access' Quality Department conducts an independent testing program to routinely monitor provider compliance with Access to Care standards, known as the Secret Shopper program. Colorado Access monitors providers on Access to Care standards quarterly by conducting calls to providers that mirror common member behavior to test the consistency of the provider behavior and availability of services offered to members through a series of calls. This activity checks for timeliness of appointment availability to validate compliance with standards as well as quality of calls. Provider selection for Secret Shopper calls is based primarily on random selection from quarterly claim volume stratification. However, the Quality Department may also select providers based on information received from other internal departments including but not limited to Care Management, Customer Service, and Compliance. Secret shopper data includes all lines of business, RAE3, RAE5 and CHP as many providers are contracted with multiple plans.* *All test calls are based on scripts built internally by Colorado Access and describe specific scenarios tied to access to care standards outlined in the contract validated by medical directors for accuracy. Colorado Access will also assess providers through email and provider website submission interactions when needed for follow-up to unsuccessful test calls. Colorado Access has both pediatric and adult call scripts to check a variety of populations. By utilizing an independent monitoring system that does not rely on self-reported performance by the provider, Colorado Access can more confidently validate provider behavior and the experience of its membership as well as support providers with actionable opportunities for improvement when gaps are identified. Colorado Access' robust experience in this space has highlighted variations that can occur across staff at provider practices, and specifically between practice leadership (who are knowledgeable on the practice's policies) and the frontline office staff (who are implementing the policies daily). The Secret Shopper Program allows Colorado Access to further connect with various staff across a clinic system and work alongside the practice to support opportunities for improvement.* *Each provider receives a summary report of their performance and relevant findings. Providers that offer appointment availability outside Access to Care contractual standards during Secret Shopper calls are placed on a Correct Action Plan (CAP) from Colorado Access. To improve the quality of the Colorado Access*

Provider Network, beginning in SFY 20-21 Q4, Colorado Access also began issuing corrective action plans (CAPs) based on Secret Shopper interaction outcomes that break from community standards, other Colorado Access Policies & Procedures (i.e. provider contracts and responsibilities outlined in the Provider Manual), or that contribute to overall poor member experience (i.e. inability to speak with live representative during outbound calls, or long hold times). Prior to Q4, these Secret Shopper outcomes resulted in provider education letters and/or Requests for Additional Information (RFAI).

Outside of issuing CAPs for correction of network deficiencies and continuous quality improvement, Colorado Access may also issue a RFAI to the provider based on interaction results where potential process gaps/access to care issues exist or interactions were unable to assess Access to Care contractual standards. RFAI's can be in addition to or in the absence of CAPs. Beginning Q4, if successful contact was not made or administrative barriers such as providers requiring Medicaid ID to verify eligibility prior to appointment offering, Colorado Access began issuing RFAI's and requiring providers to submit current next appointment availability for standard assessed. In SFY 21-22, Colorado Access plans to formalize this process and will require providers to provide appointment availability using Third Next Available Report standards. This will be done in addition to and separate from the annual assessment conducted by Colorado Access Practice Support.

Providers must complete and return RFAI's and/or a CAP timeline back to Colorado Access within 15 calendar days of issuance. CAP timelines must outline an implementation plan to improve specific areas identified as deficient and plan must be completed by the end of the next SFY quarter, with Colorado Access then conducting follow up calls to ensure contractual compliance on previously identified deficiencies.

During Q3 of SFY20-21, Colorado Access successfully launched a contract with Signal Behavioral Health to roll out the Colorado Access substance use disorder (SUD) Secret Shopper Program to optimize call efficiency and collaborate with another contracting entity to ensure overall provider quality. The initial phase of the program was focused on residential and outpatient services, and in Q4, this pilot phase was expanded to also assess intensive out-patient (IOP) and withdrawal management services. At the time of this report writing, Colorado Access Quality Department is actively working with Signal Behavioral Health on clarification for the 49 SUD Secret Shopper calls completed in Q4 and therefore, is not included in the table below to ensure accuracy in reporting. This information will be provided to the Department upon clarification and resolution with Signal Behavioral Health. Additional program enhancements are being rolled out in SFY21-22 upon review of lessons learned during the pilot period.

OB	Number of Interactions*	Population and Standard of Care Assessed	Number of Providers Assessed	Number of Providers placed on Corrective Action Plan (CAP)	Number of Providers where additional information was requested	Any Notable Trends Observed with Providers
RAE 3, RAE 5, and CHP+	22	Adult Behavioral Health: Non-urgent, symptomatic	7**	4**	3**	Faster contact response via email/online submission
RAE 3, RAE 5, and CHP+	19	Pediatric/Adolescent Behavioral Health: Non-urgent, symptomatic	7**	6**	6**	Providers aren't referring patients back to Colorado Access if don't have capacity for new members
CHP+ only	7	Pediatric/Adolescent Behavioral Health: Non-urgent, symptomatic	3	0	0	
Total	**48**	**-**	**15**	**8**	**7**	

**includes inbound and outbound calls, emails, and website submissions*

***Due to some providers being assessed using both pediatric/adolescent and adult call scripts during different calls, doesn't represent unique providers. Counts of unique providers is provided in the total row*

Interaction Outcome*	Number of Interactions*	Percentage of all Interactions
Appointment is offered and meets Access to Care Standard	10	20.83%
Violate Access to Care Standards	6	12.5%
Unable to assess if Access to Care Standards were met	28	58.33%
Violate other Colorado Access Policies & Procedures or community standards	8	16.67%
CAP Required	11	22.92%
Protocols/resources for appointment scheduling result in additional treatment barriers/overall poor member experience (i.e. inefficiencies in call system IT infrastructure)	16	33.33%
All other Requests for Additional Information	8	16.67%

*one interaction can be categorized in multiple categories

Health Care Network Time and Distance Standards

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

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

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

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

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

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
When there is a need in the network, we actively recruit providers in identified locations and/or specialties. Where we have not met time and distance standards of 100% we are consistently at 90% or higher. COA continually monitors our network adequacy. The contracting and provider relations departments work closely with our care management team to address any areas of concern. COA also continues to get requests from new providers wanting to join the network, and if eligible we make every effort to add them to our panel of providers. *To support the efforts of building a more effective network, COA has established the provider network maintenance and recruitment strategy workgroup to assess our current network. Along with assessing the overall makeup of our network, this group will work to gather specific information on DEI and the special populations our providers serve to inform our recruiting process. COA will identify areas of need in the provider network from a DEI and special populations lens and recruit providers where there are gaps. This information will be included in our provider directory to give members the option of finding a provider that fits their specific needs.* *In the area of SUD, COA is continuing to contract with existing and new SUD providers for the recently implemented ASAM levels. We are actively working to increase the number of SUD facilities and beds at all ASAM levels for the network* *COA is also working with HSAG to address any discrepancies in our GeoAccess reporting relative to theirs. COA has reached out to HSAG to understand how their time and distance calculations differ from ours and what software they are using. This will help us better understand and explain why there are these discrepancies and address them in future reporting. COA is committed to working with HSAG to make sure our data is meeting their needs for time and distance.*

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

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
N/A

Table 13–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
N/A

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					

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
COA enters into a Single Case Agreements (SCA) with non-participating providers (based on requests from our UM and/or Care Management department) to provide necessary services, outside our contracted network, to members when appropriate. Once an SCA is completed to provide the necessary services, our contracting and provider relations departments reach out to the provider to ask if they are interested in joining the network or amending their contract to add additional service. If interested, we follow our 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.