COLORADO

Department of Health Care Policy & Financing

FY 2024–2025

Network Adequacy Validation

June 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Overview

As required in Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a), states which contract with managed care organizations (MCOs) must have a qualified external quality review organization (EQRO) perform an annual external quality review (EQR) that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to beneficiaries across the continuum of services. The Department of Healthcare Policy & Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct network adequacy validation (NAV) analyses of the Medicaid and Child Health Plan *Plus* (CHP+) healthcare practitioner, practice group, and entity networks for all managed care entities (MCEs) during fiscal year (FY) 2024–2025. HSAG completed an Information Systems Capabilities Assessment (ISCA) for each of the MCEs contracted to provide Medicaid and CHP+ services in Colorado, and presented findings and an assessment of any concerns related to data sources used in the NAV. Following assessment of the MCE data systems and networks, HSAG produced both qualitative findings and quantitative compliance results for the Department. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for each of the MCEs assessed.

Aggregated ISCA Results

HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid and CHP+ services in Colorado, and presented findings and assessment of any concerns related to data sources used in the NAV. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems: each MCE's data collection procedures were acceptable. Fifty percent of the MCEs did not rely on an external delegated entity for network adequacy indicator reporting during the reporting period. For the MCEs that utilized external delegated entities to complete network adequacy indicator reporting, no issues were identified requiring correction within the last year. All MCEs received either *High Confidence* or *Moderate Confidence* ratings for all the network adequacy indicators.

Aggregated NAV Results

In alignment with the Department-approved methodology (Appendix A), HSAG validated each MCE's geoaccess compliance report submissions to the Department. HSAG developed and deployed the NAV dashboard tool reflecting NAV findings each quarter for the Department's use in network monitoring. Across provider type and urbanicity:

- The CHP+ MCOs met 66.4 percent of all applicable minimum network requirements.

- The Medicaid MCOs met 67.3 percent of all applicable minimum network requirements within contracted counties and 6.7 percent of all applicable minimum network requirements within non-contracted counties.
- The Regional Accountable Entities (RAEs) met 58.0 percent of all minimum network requirements within contracted counties and 50.1 percent of all applicable minimum network requirements within non-contracted counties.
- The Dental CHP+ prepaid ambulatory health plan (PAHP) met 67.6 percent of all minimum network requirements.

Discussion

Statewide Strengths and Opportunities for Improvement

Across each of the MCEs contracted to provide care in Colorado, HSAG noted the greatest level of alignment with the MCEs' self-reported time and distance standard results for frontier and rural counties. In urban counties, HSAG identified a broader range of variance between the MCEs' self-reported time and distance standard results and the HSAG-calculated compliance results. Based on the FY 2024–2025 ISCA findings and a detailed validation of each reporting indicator, HSAG notes that the MCEs generally demonstrate strong provider networks. Across all MCEs and all network adequacy indicators assessed, 94.0 percent received a *High Confidence* rating while 6.0 percent received a *Moderate Confidence* rating.

Statewide Recommendations

Quality data are integral to the accurate calculation of network adequacy metrics. To ensure the MCEs have the most up-to-date data on information such as provider status and locations served, HSAG recommends that the MCEs conduct regular provider directory audits, including the cross-validation of directories with utilization data.

During FY 2024–2025, the Department worked to identify and address opportunities to improve provider classification and reporting guidelines for the MCEs. Due to a transition in the methodology for categorizing substance use disorder (SUD) treatment facilities, HSAG observed and reported variations in performance for the SUD American Society of Addiction Medicine (ASAM) continuum of care across MCEs. HSAG recommends a standardized approach to assist the MCEs in accurately identifying and reporting SUD treatment facilities and ASAM level(s) of care.

2. Overview

As required in 42 CFR §438.350(a), states which contract with MCOs must have a qualified EQRO perform an EQR that includes validation of network adequacy. The purpose of NAV is to assess the accuracy of the state-defined network adequacy indicators reported by the MCEs and evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to evaluate, systems and processes used, and determine the overall validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by the Department. The Department contracted with HSAG as its EQRO to conduct NAV analyses of the Medicaid and CHP+ healthcare practitioner, practice group, and entity networks for all MCEs during FY 2024–2025.

HSAG conducted the FY 2024–2025 NAV activity in alignment with the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4),[1] validating the systems and processes, data sources, methods, and results for each MCE.

HSAG worked with the Department to identify applicable quantitative network adequacy standards by provider and plan type for validation. Information such as a description of network adequacy data and documentation, information flow from the MCEs to the Department, prior year NAV reports, and additional supporting information relevant to network adequacy monitoring and validation were obtained from the Department and incorporated into all planning phases of validation activities.

HSAG conducted the FY 2024–2025 validation of network adequacy indicators to confirm each MCE's ability to collect reliable and valid network adequacy monitoring data, to use sound methods to assess the adequacy of its managed care networks, and to produce accurate results to support the MCEs' and the Department's network adequacy monitoring efforts.

HSAG completed the following CMS EQR Protocol 4 activities to conduct the NAV:

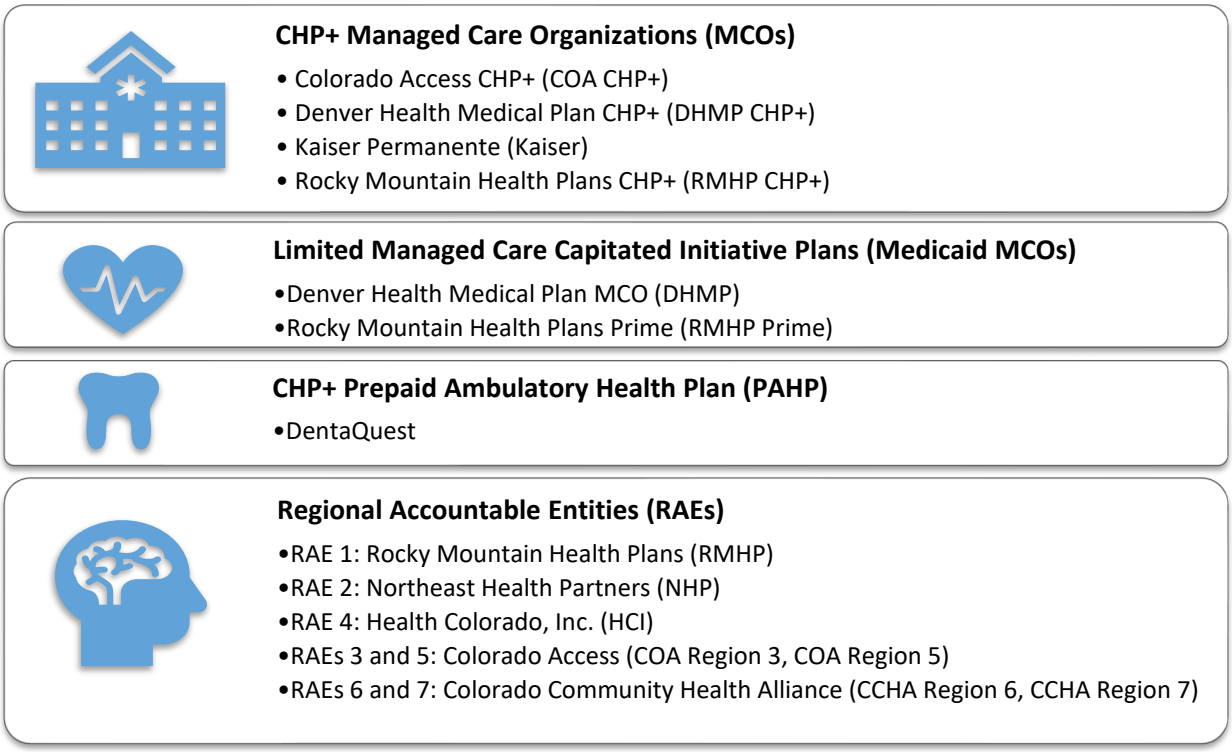
- **Defined the scope of the validation of quantitative network adequacy standards:** HSAG obtained information from the Department (i.e., network adequacy standards, descriptions, and samples of documentation the MCEs submit to the Department, a description of the network adequacy information flow, and any prior NAV reports), then worked with the Department to identify and define network adequacy indicators and provider types, and to establish the NAV activities and timeline.
- **Identified data sources for validation:** HSAG worked with the Department and MCEs to identify NAV-related data sources and to answer clarifying questions regarding the data sources.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: May 14, 2025.

- **Reviewed information systems underlying network adequacy monitoring:** HSAG reviewed any previously completed MCE ISCAs, then assessed processes for collecting network adequacy data that were not addressed in the ISCA, completed a comprehensive NAV ISCA by collecting an updated Information Systems Capabilities Assessment Tool (ISCAT) from each MCE, and interviewed MCE staff members or other personnel involved in production of network adequacy results.
- **Validated network adequacy assessment data, methods, and results:** HSAG used CMS EQR Protocol 4 Worksheet 4.6 in Appendix C to document each MCE's ability to collect reliable and valid network adequacy monitoring data, to use sound methods to assess the adequacy of its networks, and to produce accurate results that support the MCE and state network adequacy monitoring efforts. When evaluating the MCEs for this validation step, HSAG assessed data reliability, accuracy, timeliness, and completeness; the MCEs' methods to assess network adequacy; and the validity of the network adequacy results the MCEs submitted. HSAG used CMS EQR Protocol 4 Worksheet 4.7 to summarize its NAV findings, which are documented in the NAV Aggregate Report MCE-specific sections.
- **Communicated preliminary findings to each MCE:** HSAG communicated preliminary NAV findings to each MCE that provided findings, preliminary validation ratings, areas of potential concern, and recommendations for improvement. Each MCE was provided the opportunity to correct any preliminary report omissions and/or errors.
- **Submitted the NAV findings to the Department in the form of the NAV Aggregate Report:** HSAG used the Department-approved NAV Aggregate Report template to document the NAV findings and submitted the draft and final NAV Aggregate Report according to the state-approved timeline.

The MCEs submitted data to HSAG and the Department for geospatial analyses, including all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., healthcare facilities) contracted with the MCE to provide care to its Medicaid or CHP+ members. HSAG validated each MCE's annual network validation process, which includes a validation of the self-reported MCE compliance with minimum network requirements to support the Department's network monitoring. Additionally, data-related findings in this report align with HSAG's validation of the MCEs' FY 2024–2025 Quarter 2 (Q2) network adequacy reports, representing the most recently available measurement period reflecting the MCEs' networks from October 1, 2024, through December 31, 2024. These findings reflect the most recently available submission at the time of reporting. HSAG observed a small degree of variation between quarters for MCE minimum network requirement results; however, the trending findings quarter to quarter are highly consistent within the MCEs. Figure 2-1 lists the Health First Colorado[2] and CHP+ MCEs included in the FY 2024–2025 NAV.

Figure 2-1—MCEs Participating in the FY 2024–2025 NAV



To align with the Department's network terminology, the FY 2024–2025 NAV uses the following terms for different types of individuals and facilities offering healthcare services:

- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.

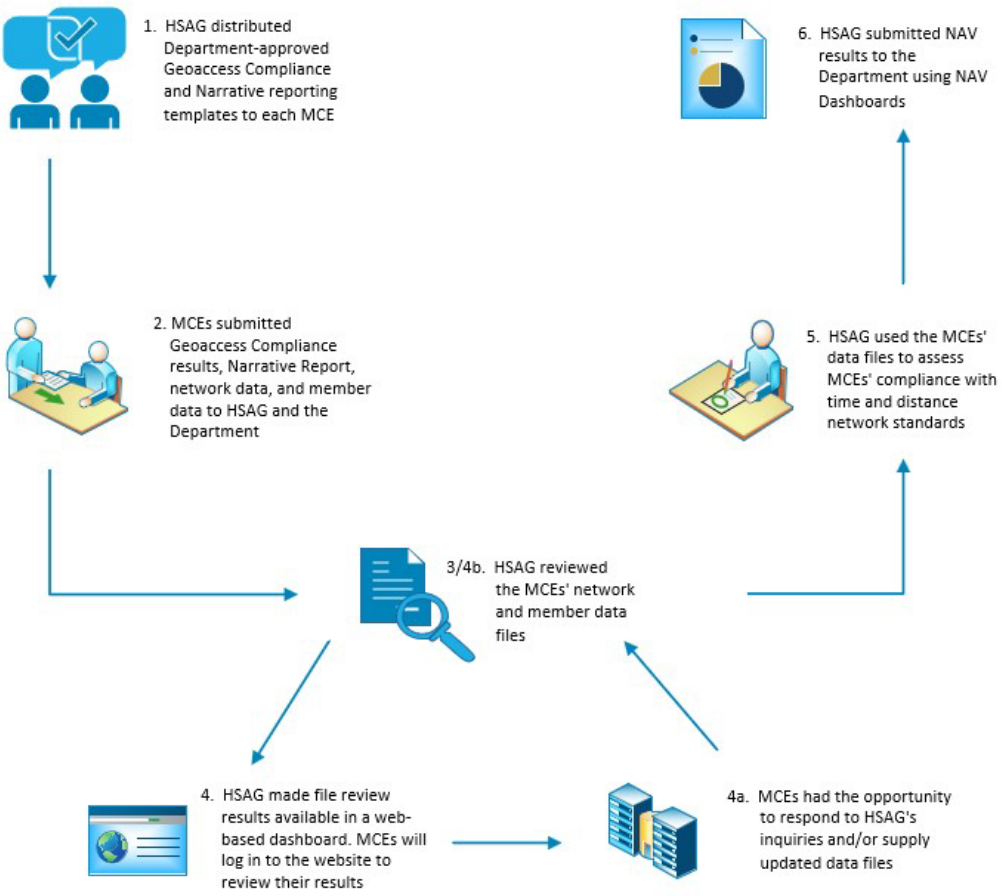
[2] Health First Colorado is the official name of Colorado's Medicaid program.

- A "practitioner" refers to an individual that personally performs the healthcare service.
- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

Throughout the report, the term "provider" is used to indicate both practice sites and practitioners, particularly in reference to analytic results.

Starting in the upper left corner of the diagram, Figure 2-2 summarizes HSAG's NAV process.

Figure 2-2—FY 2024–2025 NAV Data Processing and Validation Tasks[1]



[1] HSAG's NAV results reflect the MCEs' member and network data submissions, and the Department also supplied network and member data to HSAG for comparison with the MCEs' data.

HSAG drafted and submitted for the Department's review an ISCAT for use in collecting and evaluating the capabilities of each MCE's information systems infrastructure to monitor network standards in accordance with the requirements of CMS EQR Protocol 4. The last page of the ISCAT included a list of supplemental documentation requested, such as policies and procedures and provider mapping

documents. HSAG incorporated the Department's feedback into the final version of the document and submitted this document for the Department's reference.

HSAG supplied the ISCAT document request packets (DRPs) to the MCEs in December 2024 for the MCEs to submit alongside the FY 2024–2025 Q2 NAV data reporting submission. HSAG completed a desk review of each MCE's submitted ISCAT, followed by virtual interviews that included MCE network-related information systems demonstrations and discussion of data management processes described in the ISCAT submission. HSAG provided a summary of findings from the ISCAT review and virtual interviews in the annual network adequacy report. Please reference Section 3: Summary of Results.

HSAG validated the MCEs' networks during FY 2024–2025, including the review and validation of the MCEs' network adequacy data and Microsoft Excel (Excel) geoaccess compliance report submissions to verify that the MCEs' contracted networks met the Department's minimum time and distance network requirements listed in Appendix E.

As part of the validation process, HSAG utilized member and practitioner data provided by the MCEs and the Department and conducted an independent geospatial analysis of the travel time and distance between addresses of members and their nearest practitioner(s). HSAG's results were then compared with those submitted by each MCE. In addition, at the Department's request, HSAG examined each MCE's percentage of network results achieving 100 percent, 95.0 to 99.9 percent, 90.0 to 94.9 percent, and less than 90.0 percent of minimum network requirements for members by urbanicity.

During FY 2024–2025, HSAG and the Department collaborated to improve several NAV activity processes including the maintenance and periodic enhancement of the NAV dashboards, continued discussions on best practices, exploration of tool functionality, and targeted data investigations, as well as updates to reporting templates and materials.

3. Summary of Results

This section presents summary findings by health plan, including text describing the FY 2024–2025 ISCA and NAV activities.

Validation Team

The HSAG validation team was composed of lead reviewer(s) and several validation team members. HSAG assembled the team based on the skills required for NAV and requirements set forth by the Department. Some team members, including the lead reviewer, participated in the virtual review meetings; other validation team members participated in the desk review of submitted documentation only. A full list of validation team members, their roles, and their skills and expertise are provided in Appendix B.

Table 3-1 displays the health plans within the scope of review, review date, primary contact, and HSAG lead reviewer.

Table 3-1—List of Colorado Health Plans

Health Plan Name (Short Name)	Date	Primary Contact Name and Title	HSAG Lead Reviewer
Colorado Access (COA)	2/28/2025	Marcy Mullan, Compliance Director	Angela Farris
Colorado Community Health Alliance (CCHA)	2/18/2025	Cara Hebert, Region 6 Program Officer	Matthew Kelly
DentaQuest	2/26/2025	Logan Horn, Colorado CHP+ Program Manager	Alexis Earp
Denver Health Medical Plan (DHMP)	2/18/2025	Jeremy Sax, Manager of Government Products	AnnAlisa Cook
Health Colorado, Inc. (HCI)	2/19/2025	Lori Roberts, Chief Executive Officer/Program Officer	Sumayyah Hackett
Kaiser Permanente (Kaiser)	3/5/2025	Romilee Perdon, Compliance Consultant, MHPC Audit Management Team	Angela Farris
Northeast Health Partners (NHP)	2/24/2025	Brian Robertson, MPH, CSSBB, CMQ/OE Chief Operating Officer	Alexis Earp
Rocky Mountain Health Plans (RMHP)	2/27/2025	Meg Taylor, Program Officer, VP of Behavioral Health Dale Renzi, VP of Network Strategy and Operations	Matthew Kelly

Colorado Access (COA)

This section includes key findings and highlights from the ISCA results for COA: COA CHP+, RAE 3, and RAE 5.

ISCA Findings

HSAG completed an ISCA for COA and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that COA had in place to support network adequacy indicator reporting, which included the following findings:

- COA used HealthRules Payer (HRP) as the database management system to collect and maintain member enrollment and provider enrollment systems and data.
- COA used Morrisey Service Oriented Workflow (MSOW)/Apogee as the database management system for storing data related to provider credentialing.

HSAG evaluated the personnel that COA had in place to support network adequacy indicator reporting, which included the following:

- COA had two programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had about five years of experience in the field.

HSAG identified no concerns with COA's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by COA to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of COA's enrollment system included the following:

- Enrollment and eligibility data for Medicaid and CHP+ members were maintained within the member enrollment database management system, HRP.
- COA received daily and monthly 834 files and manual spreadsheet files from the Department's CHP+ enrollment vendor, known as the Colorado Medical Assistance Program (CMAP). COA collaborated with this vendor to address enrollment changes due to incorrect or missing information in the Department's enrollment files. This process pertained to the manual enrollment files for the CHP+ program which helped resolve issues related to incorrect or missing enrollments on the

Department's enrollment files. COA worked with CMAP to verify the eligibility of members facing these issues.

- COA received the 820 capitation file from the Department every week on Tuesday. The file was uploaded into the Enterprise Data Warehouse (EDW) to verify enrollment data in the HRP system. COA conducted weekly comparisons to ensure the accuracy of the enrollment data in HRP. Any discrepancies were flagged for a manual review by the member data integrity team and updates were made as needed.
- Newborns eligible with COA CHP+ were added to the system within the first 30 days under their mother's profile until the newborn obtained their own state-issued Medicaid identification (ID) and enrollment.
- COA performed monthly reconciliation between HRP and the 834 files received by the Department to ensure the completeness and accuracy of enrollment data by generating daily error and fall-out reports that were completed the same business day.
- COA conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - COA transmitted enrollment discrepancies, such as mismatches between capitation and enrollment, through a 270 file exchange process to the Department. A 271 file was then sent to COA, which verified the coverage.
  - COA collaborated with the Department's CHP+ enrollment vendor, CMAP, to help address enrollment changes caused by incorrect or missing information in the Department's enrollment files.
- COA's system captured and maintained both the state-issued Medicaid ID and a system-generated ID. If the Medicaid ID changed for any reason, COA used the system-generated ID to link enrollment history. Members who moved between Medicaid and the foster care system could be assigned different Medicaid ID numbers. If COA identified a member with multiple Medicaid IDs or the enrollment dates overlapped, COA worked directly with the Department to resolve and identify the correct ID to use.
- COA identified updates to member demographics based on the daily and monthly 834 files, which were considered the source of truth. If the member service department manually updated demographics in COA's system, those updates were overwritten by the 834 files received; however, members were advised to contact the Department to make demographic changes. Additionally, COA staff members assisted members with the Department's platform to update their demographics and explained to members that if updates are not made, it could overwrite their changes.
- COA used data from the 834 files to identify the member's most accurate available address, which included shelter addresses and commonly used Post Office (PO) Boxes. If an address could not be matched to a physical location on the map, COA monitored these members in the HRP system. Members needed a valid address, city, and ZIP Code within the state of Colorado to be geocoded. Records for addresses that could not be geocoded were excluded from COA's reporting.

HSAG identified no concerns with COA's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by COA to capture provider data and identified the following:

- COA ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- COA had adequate data collection processes in place to ensure completeness and consistency.
- COA collected data from providers to support the contracting and credentialing process in standardized formats directing providers to enter provider information through Council for Affordable Quality Healthcare (CAQH) to the extent feasible and appropriate.

HSAG's evaluation of COA's provider data system(s) included the following:

- Provider credentialing data were maintained in the MSOW/Apogee provider database management system.
- Provider network status data were maintained in the HRP database management system.
- Provider information for contracted providers was originally located in COA's former claims system (QNXT). COA migrated all contracted and non-contracted provider information that contained claims activity to the new HRP database management system. Inactive providers remained archived in QNXT where COA had read-only access to the historical QNXT data.
- COA received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.
- COA captured the Department-required provider types and specialties in the HRP database management system and demonstrated the logic for how COA identified provider types appropriately. COA used active taxonomy codes from the Department-provided crosswalk and from HRP to assign a provider to a provider category.
- COA's procedures for updating and maintaining provider data included the following:
  - COA maintained an online provider directory, which hosted a form that could be completed by members, providers, and internal staff when made aware of any changes to provider demographic information. COA's internal quality team tracked demographic changes and held monthly meetings with the provider data maintenance team to conduct research and outreach, where applicable, to confirm all changes. Once all provider demographic updates were confirmed, the downstream database management systems were updated. HRP was then used to track providers over time, across multiple office locations, and through changes in participation in COA's network.
  - COA had a dedicated full-time employee (FTE) who conducted provider data research and clean-up activities when notified of any provider demographic changes. In addition, COA indicated provider recredentialing activities take place every three years, which presented opportunities to validate provider demographic information. COA did not have specific time frames within which it required its provider network to update provider data outside of being notified of a change or through COA's recredentialing process every three years.

HSAG identified no concerns with COA's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of COA's delegated entity data and oversight included the following:

- COA subcontracted credentialing of behavioral health and physical health practitioners to Denver Health and Hospital Authority (DHHA), University of Colorado (UC) Medicine, Advent Health, Centura Common Spirit, UC Health, National Jewish Health, Northern Colorado Independent Practice Association (IPA), Boulder Valley IPA, Banner Health, Select Physical Therapy, Children's Hospital Colorado, LifeStance Health, and Intermountain Health. Each subcontracted entity submitted provider roster data, which was then integrated into the HRP and MSOW/Apogee. Sisters of Charity of Leavenworth (SCL) Health, previously a delegated entity, is no longer included in the scope of review of this year's activities, reflecting a change in COA's delegation structure for the current reporting period.
- COA maintained oversight of its delegated entities by:
  - Requiring regular submissions of provider additions and terminations from delegated entities.
  - Conducting annual audits to assess the compliance with credentialing and recredentialing requirements.
  - Communicating required data elements for provider rosters to ensure consistency and completeness.
  - Requiring monthly and annual performance reports, submitted either two weeks prior to the annual audit or upon request.
  - Reviewing submitted documentation, which included policies and procedures, monitoring practices, appeal processes, sub-delegation agreements, credentialing activity reports, and provider termination reports.
- COA did not identify any delegated entity network adequacy data-related items requiring corrective action within the last year.

Assessment of Network Adequacy Methods

HSAG evaluated COA's methodologies for assessing network adequacy and identified the following findings:

- COA used Quest Analytics Suite (QAS) to calculate and report time and distance indicators.
- COA calculated time and distance, and ratio standards as expected by the Department.
- The methods that COA selected to calculate all indicators were appropriate for the Colorado CHP+ MCO and Medicaid populations.

HSAG identified no concerns with COA's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed COA's network adequacy indicator reporting processes and identified the following findings:

- COA maintained data control procedures to ensure the accuracy and completeness of data merges from HRP, EDW, CAQH, and MSOW/Apogee provider database management system by performing monthly reconciliation of the enrollment data, conducting daily errors reports, and reviewing comparisons of membership data between the 834 enrollment data and HRP. Additionally, COA's internal quality team tracked demographic changes and held monthly meetings with the provider data maintenance team to confirm all provider demographic changes were accurate.
- To ensure continuity of network adequacy indicator report production, COA conducted data quality checks to review the accuracy of its network adequacy indicator reporting. COA created a validation report for each quarter comparing the previous quarter's network adequacy submission. A dedicated staff member used the validation report to track variation from month to month and validated the counts of providers attributed to a geographical area in comparison to the raw data file from QAS. Additionally, COA had a step-by-step guide on how to run the network adequacy reports.

HSAG identified no concerns with COA's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that COA used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that COA's **data collection procedures** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that COA's **network adequacy methods** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that COA's **network adequacy results** were:

☒ Acceptable

☐ Not acceptable

NAV Findings

This section presents the NAV findings for COA CHP+, RAE 3, and RAE 5.

COA CHP+

This section presents NAV findings for COA CHP+.

- In FY 2024–2025, HSAG assessed the compliance match rate for COA CHP+. Across both the physical health and behavioral health networks, 87.4 percent of COA CHP+ submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 1,665 physical health and behavioral health network standards for COA CHP+ during FY 2024–2025. Of the 1,665 aggregated results: 63.2 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes); 32.3 percent did not meet the minimum network requirements; and 4.5 percent of aggregate results had no CHP+ MCO members within the appropriate age range.
- COA CHP+ met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Acute Care Hospitals in frontier counties
  - Adult Primary Care Practitioner [Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), Certified Nurse Specialist (CNS), and Physician Assistant (PA)] in rural and urban counties
  - Family Practitioner (MD, DO, NP, CNS) in rural, urban, and frontier counties
  - Family Practitioner (PA) in rural and frontier counties
  - General Behavioral Health in rural and urban counties
  - General Cardiology in rural counties
  - General Orthopedics in rural counties
  - General Psychiatrists and other Psychiatric Prescribers in rural and urban counties
  - General SUD Treatment in rural counties
  - General Surgery in rural counties
  - Pediatric Behavioral Health in rural, urban, and frontier counties
  - Pediatric Cardiology in frontier counties
  - Pediatric Orthopedics in rural and frontier counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in rural, urban, and frontier counties
  - Pediatric Primary Care Practitioner (PA) in rural and frontier counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties
  - Pediatric SUD Treatment in rural and frontier counties
  - Pediatric Surgery in rural and frontier counties

  - Pharmacies in frontier counties
- COA CHP+ did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Pediatric Endocrinology in rural counties
  - Pediatric Gastroenterology in rural counties
  - Pediatric Ophthalmology in rural counties
  - Pediatric Otolaryngology/Ear, Nose and Throat (ENT) in rural counties
  - Pharmacies in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural, urban, and frontier counties

RAE 3

This section presents NAV findings for RAE 3.

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 3. Across both the physical health and behavioral health networks for contracted counties, 73.8 percent of RAE 3's submitted results were in agreement with HSAG's calculated results.
- Since RAE 3 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 92.4 percent of RAE 3's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 80 physical health and behavioral health network standards for RAE 3's contracted counties during FY 2024–2025. Of the 80 aggregated results: 22.5 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 77.5 percent did not meet the minimum network requirements.
- Since RAE 3 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 840 behavioral health network standards for RAE 3's non-contracted counties during FY 2024–2025. Of the 840 aggregated results: 44.2 percent met the minimum network requirements; 48.7 percent did not meet the minimum network requirements; and 7.1 percent of aggregate results had no members within the specified counties.
- RAE 3 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - General Behavioral Health in rural, urban, and frontier counties
  - General Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties
  - General SUD Treatment Practitioner in rural counties
  - Pediatric Behavioral Health in rural and urban counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in rural and urban counties
  - Pediatric SUD Treatment in rural counties

- RAE 3 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural and urban counties
  - SUD Treatment Facilities in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.1 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.2 Withdrawal Management (WM) in urban counties
  - SUD Treatment Facilities–ASAM 3.3 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.5 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural and urban counties

RAE 5

This section presents NAV findings for RAE 5.

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 5. Across both the physical health and behavioral health networks for contracted counties, 50.0 percent of RAE 5's submitted results were in agreement with HSAG's calculated results.
- Since RAE 5 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 95.0 percent of RAE 5's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 20 physical health and behavioral health network standards for RAE 5's contracted counties during FY 2024–2025. Of the 20 aggregated results: 40.0 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 60.0 percent did not meet the minimum network requirements.
- Since RAE 5 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 882 behavioral health network standards for RAE 5's non-contracted counties during FY 2024–2025. Of the 882 aggregated results: 42.5 percent met the minimum network requirements; 48.1 percent did not meet the minimum network requirements; and 9.4 percent of aggregate results had no members within the specified counties.
- RAE 5 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - General Behavioral Health in rural, urban, and frontier counties
  - General Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties

  - General and Pediatric SUD Treatment Practitioner in rural counties
  - Pediatric Behavioral Health in rural and urban counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in rural and urban counties
  - Pediatric SUD Treatment Practitioner in rural counties
- RAE 5 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Family Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural and urban counties
  - SUD Treatment Facilities in urban counties
  - SUD Treatment Facilities–ASAM 3.1 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.2 WM in urban counties
  - SUD Treatment Facilities–ASAM 3.3 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.5 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural and urban counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if COA's interpretation of data was accurate.

Table 3-2 summarizes HSAG's validation ratings for COA by indicator type.

Table 3-2—Summary of COA's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
COA CHP+	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%
RAE 3	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%
RAE 5	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, COA CHP+, RAE 3, and RAE 5 received *High Confidence* for both ratio and time and distance indicator types. However, there were identified areas for improvement; please refer to ISCA Findings or Strengths, Opportunities for Improvement, and Recommendations for more details.

Strengths, Opportunities for Improvement, and Recommendations

By assessing COA's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: COA enhanced the online provider directory to include a form for providers, members, and internal staff to report changes to provider demographic information. This expanded approach helped address gaps by allowing multiple sources to identify and report updated provider data.

Additionally, COA had a dedicated FTE to conduct provider data research and cleanup of provider data, ensuring that any reported discrepancies were thoroughly investigated. Once updates were submitted, they were reviewed and verified by the appropriate teams before being displayed in the database systems. This structured validation process ensured data accuracy and consistency, minimizing errors, and improved overall provider data integrity.

Strength #2: Across all frontier, rural, and urban counties, COA CHP+ met the minimum network requirements for Pediatric Behavioral Health and Pediatric Psychiatrists and other Psychiatric Prescribers. Across all frontier and rural counties, COA CHP+ met the minimum network requirements for Family Practitioner (MD, DO, NP, CNS, and PA) and Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA). Across all frontier counties, COA CHP+ met the minimum network requirements for Acute Care Hospitals, Pediatric Surgery, and Pharmacies. Additionally, across urban counties COA CHP+ met the minimum network requirements for General Behavioral Health and General Psychiatrists and other Psychiatric Prescribers.

Strength #3: RAE 3 met the minimum network requirements across all urban counties for General and Pediatric Behavioral Health and General and Pediatric Psychiatrists and other Psychiatric Prescribers.

Strength #4: While RAE 3 did not meet the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA), Family Practitioner (MD, DO, NP, CNS, and PA), and Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) across all contracted counties, for each of the three provider categories, RAE 3 demonstrated high rates of access. With the exception of Elbert County, all contracted counties displayed 99.9 percent or greater access. In Elbert County, access ranged from 92.7 percent to 95.6 percent across each of the three provider categories.

Strength #5: Across all rural and urban counties, RAE 5 met the minimum network requirements for General Behavioral Health and General Psychiatrists and other Psychiatric Prescribers. Additionally, across all urban counties, RAE 5 met the minimum network requirements for Pediatric Behavioral Health and Pediatric Psychiatrists and other Psychiatric Prescribers.

Strength #6: RAE 5 met the minimum network requirements for Adult Primary Care Practitioner. While RAE 5 did not meet the minimum network requirements for Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) or Family Practitioner (MD, DO, NP, CNS, and PA)

across all contracted counties, for each of the two provider categories, RAE 5 demonstrated high rates of access, with 99.9 or greater access.

Opportunity and Recommendations

Opportunity #1: COA noted HRP system capabilities limit COA from updating demographic information that differs from what is obtained through the 834 files. HRP has one dedicated field for demographic information that is populated through the receipt of the 834 files. If updated information is collected and entered in this field, it will be overridden by the information contained in the next 834 file.

Recommendation: Although COA redirected members and encouraged timely updates to the Department upon notification on any change in demographic information, HSAG recommends considering an alternative method for collecting updated demographic information to support more accurate and up-to-date demographic information used to inform network adequacy reporting.

Opportunity #2: COA CHP+ did not meet the minimum network requirements across all urbanicities for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals. In more than 78.0 percent of urban counties, COA CHP+ did not meet the minimum network requirements for Acute Care Hospitals and Pharmacies. Additionally, in rural and urban counties, COA CHP+ did not meet the minimum network requirements in more than 75.0 percent of the counties across multiple pediatric specialties, including Endocrinology, Gastroenterology, Neurology, Ophthalmology, and Otolaryngology/ENT.

Recommendation: To address these opportunities for improvement, HSAG recommends that COA CHP+ maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Opportunity #3: Across all urbanicities, RAE 3 did not meet the minimum network requirements for General and Pediatric SUD Treatment Practitioner and Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals.

Recommendation: To address these opportunities for improvement, HSAG recommends that RAE 3 maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Opportunity #4: RAE 5 did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in 93.3 percent of counties statewide where members were present.

Recommendation: To address these opportunities for improvement, HSAG recommends that RAE 5 maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Colorado Community Health Alliance (CCHA)

This section includes key findings and highlights from the ISCA results for CCHA: RAE 6 and RAE 7.

ISCA Findings

HSAG completed an ISCA for CCHA and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that CCHA had in place to support network adequacy indicator reporting, which included the following findings:

- CCHA used Core Systems Platform (CSP) Facets as the database management system to maintain comprehensive demographic and eligibility information.
- CCHA used Strategic Provider System (SPS) and CSP Facets as the database management systems to store provider data including, but not limited to, contract status, provider categories, and taxonomy.

HSAG evaluated the personnel that CCHA had in place to support network adequacy indicator reporting, which included the following:

- CCHA's physical health services were managed by Physician Health Partners, and CCHA's behavioral health services were managed by Elevance Health.
- For physical health, CCHA had four application-focused developers and three business intelligence-focused developers trained and capable of supporting network adequacy reporting activities for the physical health programs. On average, the programmers and business intelligence teams had approximately 16 years of experience in the field.
- For behavioral health, CCHA had 454 programmers who maintained and supported the applications used by CCHA for the behavioral health programs. The volume of programmers represented the total number of programmers within the application and support team, not necessarily the number assigned to specific programs. On average, the programmers Elevance Health used had approximately seven to 10 years of experience.

HSAG identified no concerns with CCHA's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by CCHA to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of CCHA's enrollment system included the following:

- Enrollment and eligibility data for Medicaid members were maintained within the member enrollment database management system, CSP Facets.
- CCHA received the full 834 file monthly and an 834 enrollment change file from the Department daily.
- CCHA performed monthly reconciliation between CSP Facets and the 834 file received by the Department to ensure the completeness and accuracy of enrollment data.
- CSP Facets maintained eligibility history by program and plan as well as date span to show a complete timeline of a member's participation.
- CCHA performed regularly scheduled transmissions of member data to subcontracted entities, which included pharmacy, vision, and transportation service vendors.
- CCHA conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - CCHA conducted a front-end review of records received in the 834 file and also used the Department's member portal to manually look up members if needed. If there were any discrepancies that CCHA could resolve, CCHA contacted the Department; however, CCHA indicated the volume of records requiring manual intervention and follow up with the Department or county is relatively low (i.e., three to four records a month).
  - If a member's information needed to be updated, CCHA directed them to contact the Department to make the changes, or to use the member portal program known as PEAK.
- CSP Facets captured the state-issued Medicaid ID as well as the member ID, which is assigned at the time of enrollment. The enrollment files occasionally contained instances in which the same member had more than one member ID number; however, the discrepancy was typically resolved through the Department's reconciliation process, and CCHA reported unresolved issues to the Department and/or the appropriate local county department for resolution.
- CCHA identified member demographic information and any demographic changes through the receipt of the monthly 834 file and daily 834 enrollment change file from the Department. Member demographic data were stored in CSP Facets by "address type." A member's physical address, mailing address, and contact address were also stored in CSP Facets and obtained from the 834 files. If a member's address was listed as a PO Box, this was also stored within CSP Facets by "address type."
- CSP Facets had an audit feature that tracked historical enrollment data.

HSAG identified no concerns with CCHA's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by CCHA to capture provider data and identified the following:

- CCHA ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- CCHA had adequate data collection processes in place to ensure completeness and consistency.
- CCHA collected data from providers to support the contracting and credentialing process in standardized formats by directing providers to enter provider information through the CAQH to the extent feasible and appropriate.

HSAG's evaluation of CCHA's provider data system(s) included the following:

- Provider credentialing data for behavioral health providers were maintained in the SPS provider database management system. Once the provider had been credentialed, the data were moved from the SPS provider database management system into CSP Facets. The Department provided credentialing data to CCHA for physical health providers, which were loaded into the Physician Health Partners provider master data system.
- Provider network status data were maintained in the SPS and CSP Facets provider database management systems.
- CCHA received the provider crosswalk quarterly.
- The Department's provider crosswalk was maintained and updated, where applicable, quarterly.
- CCHA captured the Department-required provider types and specialties in the CSP Facets database management system and demonstrated the logic for how CCHA identified provider types appropriately. CCHA used the Department's provider crosswalk.
- CCHA's procedures for updating and maintaining provider data included the following:
  - CCHA conducted ongoing validation of provider licensure using the National Plan and Provider Enumeration System (NPPES) and by cross-referencing the state license number with Department of Regulatory Agencies (DORA).
  - CCHA conducted monthly audits to validate provider network contract status and ensure the accuracy of demographic information.
  - CCHA conducted ongoing monitoring and updates to the provider online directory to ensure accuracy in panel capacity and demographic updates reflected the most recent changes.
  - CCHA physical health required its contracted provider network to update provider data at the point in time when a change is identified.

HSAG identified no concerns with CCHA's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of CCHA's delegated entity data and oversight included the following:

- CCHA did not rely on any external delegated entity data for the purpose of network adequacy indicator reporting during the reporting period in scope of review.

Assessment of Network Adequacy Methods

HSAG evaluated CCHA's methodologies for assessing network adequacy and identified the following findings:

- CCHA used Smarty Streets and Maptitude to calculate and report time and distance indicators for its physical health network. CCHA used QAS to calculate and report time and distance indicators for its behavioral health network.
- CCHA calculated time and distance, and ratio standards as expected by the Department.
- The methods that CCHA selected to calculate all indicators were appropriate for the Colorado Medicaid population.

HSAG identified no concerns with CCHA's methods for assessing network adequacy. However, HSAG recommends using all available address variables when geocoding for the most accurate results.

Network Adequacy Indicator Reporting

HSAG assessed CCHA's network adequacy indicator reporting processes and identified the following findings:

- CCHA maintained data control procedures to ensure the accuracy and completeness of data merges from Structured Query Language (SQL), CSP, SPS provider database management system, CSP Facets, Physician Health Partners master data system, Smarty Streets, Maptitude, and QAS. CCHA consumed the monthly 834 member file from the State directly into Maptitude for physical health and directly into QAS for behavioral health to calculate time and distance indicators. For provider data, CCHA conducted ongoing validation of provider licensure using the NPPES and the State license number using DORA. Additionally, CCHA conducted monthly audits to validate the provider network to ensure the accuracy of demographic information that goes into the network adequacy indicator reporting.
- To ensure continuity of network adequacy indicator report production, CCHA conducted data quality checks to review the accuracy of its network adequacy indicator reporting prior to the time and distance calculations. CCHA completed an internal review by reviewing file sizes, ensuring the number of records in each file were reviewed prior to and after data merges were complete, and confirming the number of records in each file were compared both to the control totals and totals obtained from the previous quarter. Additionally, CCHA conducted manual reviews to ensure the files were compiled according to the specifications from the State and HSAG each quarter, including completion of mandatory fields within each of the member, individual provider, and facility files.

After an extensive review process, CCHA verified the results accurately reflected members' access to CCHA providers.

HSAG identified no concerns with CCHA's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that CCHA used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that CCHA's **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that CCHA's **network adequacy methods** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that CCHA's **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

NAV Findings

This section presents the NAV findings for RAE 6 and RAE 7.

RAE 6

This section presents NAV findings for RAE 6.

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 6. Across both the physical health and behavioral health networks for contracted counties, 55.0 percent of RAE 6's submitted results were in agreement with HSAG's calculated results.
- Since RAE 6 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 87.7 percent of RAE 6's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 100 physical health and behavioral health network standards for RAE 6's contracted counties during FY 2024–2025. Of the 100 aggregated results: 31.0 percent met the minimum

network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 69.0 percent did not meet the minimum network requirements.

- Since RAE 6 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 826 behavioral health network standards for RAE 6's non-contracted counties during FY 2024–2025. Of the 826 aggregated results: 49.8 percent met the minimum network requirements; 43.3 percent did not meet the minimum network requirements; and 6.9 percent of aggregate results had no members within the specified counties.
- RAE 6 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - General Behavioral Health in rural, urban, and frontier counties
  - General Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties
  - General SUD Treatment Practitioner in rural and frontier counties
  - Pediatric Behavioral Health in rural and urban counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in rural and urban counties
  - Pediatric SUD Treatment in rural counties
- RAE 6 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.1 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.2 WM in urban counties
  - SUD Treatment Facilities–ASAM 3.3 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.5 in urban counties
  - SUD Treatment Facilities–ASAM 3.7 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural and urban counties

RAE 7

This section presents NAV findings for RAE 7.

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 7. Across both the physical health and behavioral health networks for contracted counties, 65.0 percent of RAE 7's submitted results were in agreement with HSAG's calculated results.
- Since RAE 7 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 92.4 percent of RAE 7's submitted results were in agreement with HSAG's calculated results.

- HSAG assessed 60 physical health and behavioral health network standards for RAE 7's contracted counties during FY 2024–2025. Of the 60 aggregated results: 30.0 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 70.0 percent did not meet the minimum network requirements.
- Since RAE 7 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 854 behavioral health network standards for RAE 7's non-contracted counties during FY 2024–2025. Of the 854 aggregated results: 51.2 percent met the minimum network requirements; 40.9 percent did not meet the minimum network requirements; and 8.0 percent of aggregate results had no members within the specified counties.
- RAE 7 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - General and Pediatric Behavioral health in rural, urban, and frontier counties
  - General and Pediatric Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties
  - General and Pediatric SUD Treatment Practitioner in rural and frontier counties
- RAE 7 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural and urban counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in rural and urban counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.3 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.7 in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural and urban counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if CCHA's interpretation of data was accurate.

Table 3-3 summarizes HSAG's validation ratings for CCHA by indicator type.

Table 3-3—Summary of CCHA's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
RAE 6	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%
RAE 7	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, RAE 6 and RAE 7 received *High Confidence* for both ratio and time and distance indicator types. However, there were identified areas for improvement; please refer to ISCA Findings or Strengths, Opportunities for Improvement, and Recommendations for more details.

Strengths, Opportunities for Improvement, and Recommendations

By assessing CCHA's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: CCHA continued to maintain a thoroughly documented deliverable validation process, which included a Responsible, Accountable, Consulted, and Informed (RACI) matrix that identified the responsible, accountable, consulted, and informed individuals for each phase of the deliverable. This documented process helped CCHA ensure business continuity in its network adequacy reports and its ability to maintain detailed steps to ensure the accuracy of these submissions.

Strength #2: While RAE 6 did not meet the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) or Family Practitioner (MD, DO, NP, CNS, and PA) across all contracted counties, for each of the three provider categories, RAE 6 demonstrated high rates of access, with all counties displaying 98.3 percent or greater access.

Strength #3: RAE 6 demonstrated a strong statewide behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health, and General and

Pediatric Psychiatrists and other Psychiatric Prescribers in all counties statewide where members were present.

Strength #4: While RAE 7 did not meet the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS) or Family Practitioner (MD, DO, NP, CNS, and PA) across all contracted counties, for each of the three provider categories, RAE 7 demonstrated high rates of access, with all but one county (Park) displaying 99.4 percent or greater access.

Strength #5: RAE 7 demonstrated a strong statewide behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all counties statewide where members were present.

Opportunity and Recommendations

Opportunity #1: Although CCHA verified provider data annually during the Office Systems Review (OSR) and required its providers to report demographic and service location changes, given CCHA was required to report results to the Department quarterly, the current frequency of updates could result in missing key provider changes that inform reporting.

Recommendation: HSAG recommends that CCHA establish more frequent time frames (e.g., monthly, quarterly) during which provider changes are required to be reported to ensure accurate data when submitting results.

Opportunity #2: CCHA utilized ZIP centroid-level geolocation for calculating physical health network adequacy indicators. While HSAG did not identify the use of ZIP centroid as a barrier to calculation or reporting, HSAG has marked this as a potential opportunity to improve the analysis.

Recommendation: HSAG recommends that CCHA use all address variables and not just the ZIP centroid for best geocoding results. Additionally, HSAG recommends that CCHA continue to monitor member access through quarterly network adequacy assessments based on the State's expectations.

Opportunity #3: RAE 6 did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in 95.1 percent of counties statewide where members were present. Across all counties statewide, 73.8 percent had access levels varying from 0 percent to 37.5 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends that RAE 6 continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Opportunity #4: RAE 7 did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in 95.0 percent of the counties statewide where

members were present. Across all counties statewide, 76.7 percent had access levels varying from 0 percent to 40.0 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 7 continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

DentaQuest

This section includes key findings and highlights from the ISCA results for DentaQuest.

ISCA Findings

HSAG completed an ISCA for DentaQuest and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that DentaQuest had in place to support network adequacy indicator reporting, which included the following findings:

- DentaQuest used Windward as the database management system to collect and maintain enrollment and provider data.
- DentaQuest used Symplr Credentialing as the database management system to collect and maintain provider contract and credentialing status. The Symplr Credentialing system was implemented in July 2024. All credentialing data were migrated from the previous system, Cactus Credentialing, to Symplr Credentialing.
- DentaQuest hosted an EDW that was used to reconcile multiple sources of data across member enrollment and provider, which contributed to network adequacy reporting.

HSAG evaluated the personnel that DentaQuest had in place to support network adequacy indicator reporting, which included the following:

- DentaQuest had eight programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately 10 years of experience in the field.

HSAG identified no concerns with DentaQuest's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by DentaQuest to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of DentaQuest's enrollment system included the following:

- Enrollment and eligibility data for CHP+ were maintained within the member enrollment database management system, Windward.

- DentaQuest received both daily and monthly enrollment files in the 834 file format from the Department. DentaQuest also received enrollment requests via email that resulted in 45 member records requiring manual adjustments within Windward after the information was verified.
- DentaQuest performed monthly reconciliation between Windward and the 834 file to ensure the completeness and accuracy of enrollment data.
- DentaQuest conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - DentaQuest performed business-level checks to ensure all data elements obtained through the 834 file were loaded into Windward. For electronic enrollment, DentaQuest reviewed initial enrollment transactions, update transactions, and termination or disenrollment transactions for accuracy through processing reports. Any errors that appeared on the reports were reviewed and corrected.
  - DentaQuest manually processed enrollment requests obtained via email into Windward. Employees that performed manual entry were required to validate that the group number was correct and had to correspond to the group name, even if Windward prefilled the group number. DentaQuest enforced required field edits to identify member duplicates and ensure data integrity for initial enrollment transactions, update transactions, and termination or disenrollment transactions.
  - If discrepancies were observed in the data load and integration process, an error report was generated for manual research and resolution of all identified discrepancies. Manual edits were made directly in Windward where research resulted in confirmed updates. Windward hosted the ability to track all edits made, which included date and time stamps, as well as tracking the user who made the direct change.
  - Missing or incomplete enrollment data were flagged in a report and sent directly to the Department for corrections.
- DentaQuest's system captured and maintained both the state-issued Medicaid ID and a system-generated, unique Global User ID (GUID) that linked different versions of a member and their associated coverage together under one unique ID. GUIDs were assigned during the load process of the 834 file.
- DentaQuest identified member demographic updates through the receipt of the daily and monthly 834 file submissions. While the 834 file is considered the source of truth, DentaQuest also received member demographic updates via email that were processed manually within Windward after the information was verified. The information entered manually was stored in the same tables as an 834 file, and DentaQuest enforced required field edits to ensure data integrity.

HSAG identified no concerns with DentaQuest's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by DentaQuest to capture provider data and identified the following:

- DentaQuest ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- DentaQuest had adequate data collection processes in place to ensure completeness and consistency.
- DentaQuest collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of DentaQuest's provider data system(s) included the following:

- Provider credentialing data were maintained in the Symplr Credentialing software system.
- Provider network status data were maintained in both the Symplr Credentialing software system and the Windward database management system.
- DentaQuest received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.
- DentaQuest captured the Department-required provider types and specialties in the Windward database management system and demonstrated logic for how DentaQuest identified dental provider types appropriately, using the Department's provider crosswalk, and captured them within the provider specialty data field.
- DentaQuest' s procedures for updating and maintaining provider data included the following:
  - DentaQuest network managers manually validated provider demographic information through routine on-site office visits. This included, but was not limited to, address, phone number, Taxpayer Identification Number (TIN), hours, providers affiliated, and acceptance of new patients. Network managers were contractually required to complete 20 office visits per month.
  - DentaQuest conducted primary source verification (PSV) of information asserted by providers as part of its credentialing process. At initial credentialing, DentaQuest verified the highest level of education of a provider from the appropriate educational institution or agency that provides primary source education verifications. At initial credentialing and recredentialing, DentaQuest verified completion of American Board Certification with the appropriate specialty board, if applicable. A portable document format (PDF) image of the verification was saved in the credentialing system, including the date and initials of the credentialing employee who reviewed and performed the verification.
  - During the initial credentialing process, reapplication credentialing process, and recredentialing process, all providers, any disclosing entity, its owners, and managing employees were screened against State and federal exclusion databases.
  - Information contained in the provider's record were securely stored electronically in DentaQuest's credentialing system and available for review by only duly authorized employees, clients, agents or third-party auditing agencies (e.g., the National Committee for Quality Assurance [NCQA]).
  - DentaQuest annually reached out to providers to ensure that accurate information was stored within the system. Providers could also contact DentaQuest anytime to update their information.

HSAG identified no concerns with DentaQuest's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of DentaQuest's delegated entity data and oversight included the following:

- DentaQuest did not rely on any external delegated entity data for the purpose of network adequacy indicator reporting during the reporting period in scope of review.

Assessment of Network Adequacy Methods

HSAG evaluated DentaQuest's methodologies for assessing network adequacy and identified the following findings:

- DentaQuest used QAS to calculate and report time and distance indicators as expected by the State.
- DentaQuest calculated time and distance, and ratio standards as expected by the Department.
- The methods that DentaQuest selected to calculate all indicators were appropriate for the Colorado CHP+ PAHP member population.

HSAG identified no concerns with DentaQuest's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed DentaQuest's network adequacy indicator reporting processes and identified the following findings:

- DentaQuest extracted network data in alignment with the Department's classification requirements for load into QAS to complete indicator-level calculations. DentaQuest maintained data quality and control procedures to ensure accuracy and completeness of data merges from Symplr Credentialing, Windward, and the DentaQuest EDW by comparing alignment against source data, maintaining internal protocols for data validation and refresh, and performing outreach to parties such as providers or the State to reconcile missing or unexpected discrepancies.
- DentaQuest conducted data reasonability checks by maintaining detailed data systems and regularly comparing network adequacy results against baseline metrics from prior extracts and reports. When DentaQuest encountered any unexpected findings, it followed an established process to investigate the source of data anomalies including a review of QAS scripts and file extract specifications.
- To ensure continuity of network adequacy indicator production, DentaQuest maintained records of prior reports, worked internally to maintain best practices for data extraction and preparation, and employed validation procedures to ensure the indicator-level calculations aligned with the Department's guidance.

HSAG identified no concerns with DentaQuest's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that DentaQuest used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that DentaQuest's **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that DentaQuest's **network adequacy methods** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that DentaQuest's **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

NAV Findings

This section presents the NAV findings for DentaQuest.

- In FY 2024–2025, HSAG assessed the compliance match rate for DentaQuest. For the PAHP network, 99.2 percent of DentaQuest's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 256 PAHP network standards for DentaQuest during FY 2024–2025. Of the 256 aggregated results: 67.6 percent met the minimum network requirements (i.e., 100 percent of PAHP members with access within the designated miles and minutes), and 32.4 percent did not meet the minimum network requirements.
- DentaQuest met the minimum network requirements (i.e., 100 percent of PAHP members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - General Dentists in rural and frontier counties
  - Oral Surgeons in urban counties
  - Orthodontists in rural and urban counties
- DentaQuest did not meet the minimum network requirements in more than 60.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Pediatric Dentists in frontier counties
  - Oral Surgeons in frontier counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if DentaQuest's interpretation of data was accurate.

Table 3-4 summarizes HSAG's validation ratings for DentaQuest by indicator type.

Table 3-4—Summary of DentaQuest's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
DentaQuest	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, DentaQuest received *High Confidence* for both ratio and time and distance indicator types. However, there were identified areas for improvement; please refer to ISCA Findings or Strengths, Opportunities for Improvement, and Recommendations for more details.

Strengths, Opportunities for Improvement, and Recommendations

By assessing DentaQuest's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: DentaQuest demonstrated the ability to maintain accurate and up-to-date member enrollment information via business-level checks to ensure all data were loaded into Windward, data integrity validation, review of processing reports for accuracy, edit and change tracking, review of error reports for missing or incomplete information, and correction of any identified errors.

Strength #2: DentaQuest met the minimum network requirements for General Dentists in 85.7 percent of all contracted counties. Additionally, access was 97.5 percent or greater in six of the eight counties where DentaQuest did not meet the minimum network requirement.

Strength #3: DentaQuest met the minimum network requirement for Oral Surgeons and Orthodontists in 92.9 percent of urban counties. In Weld County, where DentaQuest did not meet the minimum network requirements for these provider categories, access was 99.9 percent for both.

Strength #4: DentaQuest met the minimum network requirement for Orthodontists in 85.2 percent of rural counties.

Opportunity and Recommendations

Opportunity #1: Although updates were collected annually, the auditor observed potential missed opportunities when reporting quarterly network adequacy to capture provider updates that can occur throughout the year.

Recommendation: HSAG recommends that DentaQuest establish more frequent time frames (i.e., monthly, quarterly) during which provider changes are reported to ensure that processes are in place for ongoing management and collection of updated provider data.

Opportunity #2: DentaQuest did not meet the minimum network requirements in 78.3 percent of all frontier counties for Pediatric Dentists or 44.4 percent of rural counties for Oral Surgeons.

Recommendation: To address these opportunities for improvement, HSAG recommends that DentaQuest maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Denver Health Medical Plans (DHMP)

This section includes key findings and highlights from the ISCA results for DHMP: DHMP CHP+ and DHMP MCO.

ISCA Findings

HSAG completed an ISCA for DHMP and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that DHMP had in place to support network adequacy indicator reporting, which included the following findings:

- DHMP used QNXT to collect and maintain member enrollment data as well as provider data received from DHHA.
- On behalf of DHMP, COA used HRP to collect and maintain member enrollment data as well as provider contracting and roster information for all behavioral health services.
- DHMP maintained a data warehouse hosted on a SQL Server 2017 to ingest the active Medicaid and CHP+ provider list from the Department and compare it to provider contracts within QNXT to determine the active provider roster version.

HSAG evaluated the personnel that DHMP had in place to support network adequacy indicator reporting, which included the following:

- DHMP had seven programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had 13 years of experience in the field.

HSAG identified no concerns with DHMP's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by DHMP to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of DHMP's enrollment system included the following:

- Enrollment and eligibility data for physical health were maintained within the member enrollment database management system, QNXT.
- On behalf of DHMP, COA maintained member enrollment and eligibility data for behavioral health within the member enrollment database management system, HRP.
- DHMP and COA received daily and monthly 834 files from the Department.

- DHMP performed monthly reconciliation between QNXT and the Department's data to ensure the completeness and accuracy of enrollment data.
- DHMP conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - DHMP used QNXT system logic and fall-out reports that were worked manually within three business days by DHMP's member enrollment team. If the discrepancies of member data could not be resolved, they were sent to the Department for research.
- DHMP's system captured and maintained both the state-issued Medicaid ID and a system-generated ID. A member may have more than one carrier member ID if the member is enrolled in an alternative plan for DHMP. If the Medicaid ID changed for any reason, DHMP used the system-generated ID to link enrollment history.
- DHMP identified member demographic updates through the receipt of the daily and monthly 834 files.

HSAG identified no concerns with DHMP's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by DHMP to capture provider data and identified the following:

- DHMP ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- DHMP had adequate data collection processes in place to ensure completeness and consistency.
- DHMP collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of DHMP's provider data system(s) included the following:

- Provider credentialing data were maintained in the QNXT system.
- Provider network status data were maintained in the QNXT system.
- On behalf of DHMP, DHHA captured physical health Department-required provider types and specialties in MD staff and then provided monthly rosters to DHMP, who stored provider data in QNXT.
  - DHHA maintained most physical health providers. The remaining providers were directly contracted with DHMP. On average, 5 percent of the physical health providers were directly contracted with DHMP.
- DHMP received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.

- DHMP demonstrated the logic for how DHMP identified provider categories appropriately. DHMP used the active taxonomy codes from the Department-provided crosswalk to assign a provider to a provider category through the network adequacy crosswalk.
- On behalf of DHMP, COA captured all behavioral health Department-required provider categories and specialties in Apogee.
- DHMP's procedures for updating and maintaining provider data included the following:
  - DHMP used the MCO Provider File provided by the Department quarterly to update provider demographic information.
  - DHMP required its provider network to update provider data at least annually. Providers were made aware of this expectation via quarterly outreach by the Network Management Committee.
  - DHMP used an audit process requiring 100 percent of provider directory listings to verify the accuracy of the following data elements every 18 months:
    - Office location(s)
    - Phone number
    - Accepting new patients
    - Awareness of physician office staff of physician's participation in DHMP's network(s)

HSAG identified no concerns with DHMP's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of DHMP's delegated entity data and oversight included the following:

- DHMP subcontracted its behavioral health network to COA, including network adequacy reporting.
  - COA produced all behavioral health network adequacy results on behalf of DHMP.
- DHMP subcontracted 95.0 percent of its contracting and credentialing for physical health providers to DHHA.
- DHMP maintained oversight of its delegated entity by:
  - Collecting quarterly reports in a standardized format, inclusive of contractually required data elements.
  - Holding biweekly operational meetings with COA to address reporting.
  - Conducting quarterly audits to check for any variance from quarter to quarter.
- DHMP did not identify any delegated entity network adequacy data-related items requiring corrective action for the reporting period.

Assessment of Network Adequacy Methods

HSAG evaluated DHMP's methodologies for assessing network adequacy and identified the following findings:

- DHMP used ArcGIS to calculate and report physical health network adequacy indicators.
- DHMP subcontracted with COA for the calculation of Medicaid MCO behavioral health network adequacy indicators. On behalf of DHMP, COA used QAS to calculate behavioral health network adequacy indicators.
- DHMP calculated time and distance, and ratio standards as expected by the Department.
- The methods that DHMP selected to calculate all indicators were appropriate for the Colorado CHP+ MCO and Medicaid populations.

HSAG identified no concerns with DHMP's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed DHMP's network adequacy indicator reporting processes and identified the following findings:

- DHMP extracted physical health network data in alignment with the Department's classification requirements for load into ArcGIS to complete indicator-level calculations. DHMP maintained data quality and control procedures to ensure the accuracy and completeness of data merges from QNXT and HRP by comparing alignment against source data (DHHA and 834 file records), maintaining internal protocols for data validation and refresh, and performing outreach to parties such as providers or the State to reconcile missing or unexpected discrepancies.
- DHMP conducted data reasonability checks by maintaining detailed data systems and regularly comparing physical health network adequacy results against baseline metrics from prior extracts and reports. When DHMP encountered any unexpected findings, it followed an established process to investigate the source of data anomalies including a review of file extract specifications.
- DHMP subcontracted with COA for the quarterly calculation of Medicaid MCO behavioral health network adequacy indicators. COA submitted to DHMP individual and facility provider data and findings. DHMP compared the submitted results and data to in-house data to validate accuracy and completeness. DHMP compared behavioral health findings against prior reports to determine if any variance existed across quarters. During review, if DHMP identified any unexpected findings or concerns, it utilized established lines of communication with COA to discuss.

HSAG identified no concerns with DHMP's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that DHMP used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that DHMP's **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that DHMP's **network adequacy methods** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that DHMP's **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

NAV Findings

This section presents the NAV findings for DHMP CHP+ and DHMP MCO.

DHMP CHP+

This section presents NAV findings for DHMP CHP+.

- In FY 2024–2025, HSAG assessed the compliance match rate for DHMP CHP+. Across both the physical health and behavioral health networks, 68.9 percent of DHMP CHP+'s submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 148 physical health and behavioral health network standards for DHMP CHP+ during FY 2024–2025. Of the 148 aggregated results: 55.4 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes), and 44.6 percent did not meet the minimum network requirements.
- DHMP CHP+ met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes) in 75.0 percent or more of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS and PA) urban counties
  - Family Practitioner (MD, DO, NP, CNS) in urban counties
  - General and Pediatric Behavioral Health in urban counties
  - General Cardiology in urban counties

  - General Endocrinology in urban counties
  - General Gastroenterology in urban counties
  - General Neurology in urban counties
  - General Ophthalmology in urban counties
  - General Orthopedics in urban counties
  - General Otolaryngology/ENT in urban counties
  - General and Pediatric Psychiatrists and other Psychiatric Prescribers in urban counties
  - General Pulmonary Medicine in urban counties
  - General SUD Treatment in urban counties
  - General Surgery in urban counties
  - General Urology in urban counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in urban counties
- DHMP CHP+ did not meet the minimum network requirements in 75.0 percent or more of the counties assessed for the following provider categories and urbanicities:
  - Acute Care Hospitals in urban counties
  - Family Practitioner (PA) in urban counties
  - Gynecology, Obstetrics/Gynecology (OB/GYN) (PA) in urban counties
  - Pediatric Cardiology in urban counties
  - Pediatric Endocrinology in urban counties
  - Pediatric Gastroenterology in urban counties
  - Pediatric Neurology in urban counties
  - Pediatric Ophthalmology in urban counties
  - Pediatric Orthopedics in urban counties
  - Pediatric Otolaryngology/ENT in urban counties
  - Pediatric Primary Care Practitioner (PA) in urban counties
  - Pediatric Pulmonary Medicine in urban counties
  - Pediatric SUD Treatment in urban counties
  - Pediatric Surgery in urban counties
  - Pediatric Urology in urban counties
  - Pharmacies in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in urban counties

DHMP MCO

This section presents NAV findings for DHMP MCO.

- In FY 2024–2025, HSAG assessed the compliance match rate for DHMP MCO. Across both the physical health and behavioral health networks for contracted counties, 71.0 percent of DHMP MCO's submitted results were in agreement with HSAG's calculated results.
- Since DHMP MCO is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 39.6 percent of DHMP MCO's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 176 physical health and behavioral health network standards for DHMP MCO's contracted counties during FY 2024–2025. Of the 176 aggregated results: 34.1 percent met the minimum network requirements (i.e., 100 percent of MCO members with access within the designated miles and minutes), and 65.9 percent did not meet the minimum network requirements.
- Since DHMP MCO is contractually required to maintain a statewide behavioral health network, HSAG also assessed 840 behavioral health network standards for DHMP MCO's non-contracted counties during FY 2024–2025. Of the 840 aggregated results: 6.7 percent met the minimum network requirements; 2.9 percent did not meet the minimum network requirements; and 90.5 percent of aggregate results had no members within the specified counties.
- DHMP MCO met the minimum network requirements (i.e., 100 percent of MCO members with access within the designated miles and minutes) in 75.0 percent or more of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS) in urban counties
  - Family Practitioner (MD, DO, NP, CNS) in urban counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in urban counties
- DHMP MCO did not meet the minimum network requirements in 75.0 percent or more of the counties assessed for the following provider categories and urbanicities:
  - Acute Care Hospitals in urban counties
  - Adult Primary Care Practitioner (PA) in urban counties
  - Family Practitioner (PA) in urban counties
  - General Cardiology in urban counties
  - General and Pediatric Endocrinology in urban counties
  - General and Pediatric Gastroenterology in urban counties
  - General Neurology in urban counties
  - General and Pediatric Ophthalmology in urban counties
  - General Orthopedics in urban counties
  - General and Pediatric Otolaryngology/ENT in urban counties
  - General Pulmonary Medicine in urban counties

- General Surgery in urban counties
- General Urology in urban counties
- Gynecology, OB/GYN (MD, DO, NP, CNS, and PA) in urban counties
- Pharmacies in urban counties

Additionally, DHMP did not meet the minimum network requirements for SUD Treatment Facilities—ASAM 3.3 and ASAM 3.7 in 64.3 percent of counties statewide, where members were present.

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if DHMP's interpretation of data was accurate.

Table 3-5 summarizes HSAG's validation ratings for DHMP by indicator type.

Table 3-5—Summary of DHMP's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
DHMP CHP+	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	18.9%	81.1%	0%	0%
DHMP MCO	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	56.5%	43.5%	0%	0%

Of the network adequacy indicators assessed, DHMP CHP+ and DHMP MCO received *High Confidence* for ratio behavioral health time and distance indicators and received *Moderate Confidence* in physical health time and distance indicators. However, there were identified areas for improvement; please refer to ISCA Findings or Strengths, Opportunities for Improvement, and Recommendations for more details.

Strengths, Opportunities for Improvement, and Recommendations

By assessing DHMP's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: DHMP efficiently maintained the accuracy and completeness of provider information through its quarterly directory audit process.

Strength #2: DHMP CHP+ demonstrated a strong physical health network. The plan met the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) across all contracted counties. While DHMP CHP+ did not meet 100 percent of all members within the minimum network requirements for the Primary Care Practitioner (PA) provider category, all contracted counties had access of 97.0 percent or greater. Additionally, 97.0 percent of members or greater had access to all specialty provider categories.

Strength #3: DHMP CHP+ demonstrated a strong behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties. While DHMP CHP+ did not meet the minimum network requirements for General or Pediatric SUD Treatment Facilities in 50.0 percent of contracted counties, where DHMP CHP+ failed to meet, access to these provider categories was 97.0 percent to > 99.9 percent.

Strength #4: While DHMP MCO did not meet the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS and PA) or Family Practitioner (MD, DO, NP, CNS, and PA) across all contracted counties, for each of the three provider categories, DHMP MCO demonstrated high rates of access, with all counties displaying 99.5 percent or greater access.

Strength #5: DHMP MCO met the minimum network requirements for General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties, and statewide in counties where members were present. While DHMP did not meet the minimum network requirements for General and Pediatric SUD Treatment Practitioners in every contracted county, percent access ranged from 99.8 percent to 100 percent. Additionally, while DHMP MCO did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in every contracted county, percent access ranged from 98.4 percent to 100 percent.

Opportunity and Recommendations

Opportunity #1: DHMP was not able to fully describe or submit oversight procedures and indicated that the MCE conducted minor oversight of COA's reported results.

Recommendation: HSAG recommends that DHMP increase oversight and validation activities to ensure accuracy across all network adequacy results produced by COA on behalf of DHMP. Validation activities could include queries to confirm counts/measurement period as well as validating a sample of provider demographic information (e.g., provider address) to ensure the accuracy of the data.

Opportunity #2: HSAG identified an opportunity for DHMP to improve the analysis to calculate physical health time and distance indicators. DHMP did not calculate driving distance or time in ArcGIS. DHMP calculated straight-line distance, no time metrics.

Recommendation: HSAG recommends that DHMP follow State guidance and use driving distance to calculate time and distance indicators. Additionally, HSAG recommends that DHMP continue to

monitor member access through annual network adequacy assessments based on the State's expectations.

Opportunity #3: DHMP CHP+ did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in each of the contracted counties. However, for this provider category, rates of access ranged from 94.8 percent to 99.9 percent. Similarly, DHMP did not met the minimum network requirements in 75.0 percent of contracted counties for Pediatric Cardiology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Neurology, Pediatric Ophthalmology, Pediatric Orthopedics, Pediatric Otolaryngology/ENT, Pediatric Pulmonary Medicine, Pediatric Surgery, or Pediatric Urology. However, access to these provider categories overall ranged from 99.1 percent to 100 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends that DHMP CHP+ maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Health Colorado, Inc. (HCI)

This section includes key findings and highlights from the ISCA results for HCI.

ISCA Findings

HSAG completed an ISCA for HCI and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that HCI had in place to support network adequacy indicator reporting, which included the following findings:

- HCI used Carelon's proprietary and confidential database management system, CONNECTS, to collect and maintain member enrollment and provide data management. CONNECTS is comprised of three major systems (i.e., managed healthcare, finance, and security), each of which include several subsystems and modules.

HSAG evaluated the personnel that HCI had in place to support network adequacy indicator reporting, which included the following:

- HCI had six programmers. On average, the programmers had over 11 years of experience in the field.

HSAG identified no concerns with HCI's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by HCI to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of HCI's enrollment system included the following:

- Enrollment and eligibility data for HCI were maintained within CONNECTS.
- HCI received daily and monthly enrollment files in the 834 file format from the Department.
- HCI performed monthly reconciliation between CONNECTS and the Department's enrollment data to ensure the completeness and accuracy of enrollment data.
- HCI conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - HCI used a series of edit checks that identified missing, incomplete, or inaccurate member data. As each eligibility file was run, error reports were generated which captured any critical data

elements that were missing. Another report was generated which was analyzed by a business analyst.

- Data integrity was controlled at four levels:
  - Extract, Transform, Load (ETL) Process Log Parsing—This error prevention method was used to verify the successful completion of the ETL process within the system by searching for known error messages and alerting the staff if an error message existed in the log.
  - Record Count Checking—This error check type ensured that no data were lost during the ETL process and alerted the staff if any discrepancies were found.
  - Parity Checking—This type of error checking searched inside the data files to determine if any data corruption occurred during the ETL process.
  - Oracle Alert Log Parsing—This pattern-matching algorithm was used to search through the Oracle Alert Log for predetermined keywords that indicated an error condition within the database server.
- HCI's system captured and maintained both the state-issued Medicaid ID and added a two-byte suffix as a system-generated ID. If the Medicaid ID changed for any reason, HCI used the system-generated ID to link enrollment history.
- HCI identified member demographic updates based on the 834 file.

HSAG identified no concerns with HCI's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by HCI to capture provider data and identified the following:

- HCI ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- HCI had adequate data collection processes in place to ensure completeness and consistency.
- HCI collected data from providers to support the contracting and credentialing process in standardized formats by directing providers to enter provider information through the CAQH to the extent feasible and appropriate.

HSAG's evaluation of HCI's provider data system(s) included the following:

- Provider credentialing data were maintained in CONNECTS.
- Provider network status data were maintained in CONNECTS.
- HCI received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.

- HCI captured the Department-required provider types and specialties in CONNECTS and demonstrated the logic for how HCI identified provider types appropriately using the Department's provider crosswalk.
- HCI's procedures for updating and maintaining provider data included the following:
  - HCI used the initial credentialing process and recredentialing process to track providers over time, across multiple office locations, and through changes in participation in HCI's network.
  - HCI monitored several sources (e.g., Office of Inspector General [OIG], Office of Foreign Assets Control [OFAC], System for Award Management [SAM]) monthly to identify providers or organizations excluded from the Medicaid and CHP+ programs each month to validate provider network contract status and ensure the accuracy of demographic information.
  - HCI required its provider network to review and update all provider data included in the provider directory at least annually. Providers were made aware of this expectation via quarterly email reminders and in-person outreach by the provider relations team.

HSAG identified no concerns with HCI's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of HCI's delegated entity data and oversight included the following:

- HCI subcontracted administrative services, including network adequacy reporting, to Carelon, the Administrative Service Organization (ASO). Carelon was delegated to create, maintain, and oversee the network. This includes all aspects of the network adequacy reporting including but not limited to provider recruitment, contracting, and credentialing, in addition to calculating network adequacy indicators.
- HCI maintained oversight of its delegated entities by:
  - Conducting both periodic and annual audits of delegated functions, including eligibility determinations, network adequacy indicators, and provider data accuracy.
  - HCI performed weekly eligibility audits by submitting member manual load reports to Carelon's Quality Team, who conducted a 100 percent audit of randomized samples to ensure accuracy. Carelon also conducted daily and weekly audit reviews across CONNECTS inquiries, file loads, projects, and implementation and termination actions, with audit results tracked internally in a centralized spreadsheet to support ongoing monitoring and follow-up of delegated functions.
  - Quarterly monitoring, including the collection and analysis of standardized reports containing contractually required data elements.
  - Monthly Joint Operations Committee meetings to review key performance metrics and results of ongoing monitoring of delegated entity data.
  - HCI reviewed the Quality Control Checklist to validate the technical accuracy of network adequacy reports. These reviews were conducted at least quarterly and served to confirm that Carelon's reporting process aligned with CMS network adequacy requirements and contractually defined data standards.

HCI did not identify any delegated entity network adequacy data-related items requiring corrective action for the reporting period.

Assessment of Network Adequacy Methods

HSAG evaluated HCI's methodologies for assessing network adequacy and identified the following findings:

- HCI used QAS to calculate and report time and distance indicators.
- HCI calculated time and distance, and ratio standards as expected by the Department.
- The methods that HCI selected to calculate all indicators were appropriate for the Colorado Medicaid population.

HSAG identified no concerns with HCI's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed HCI's network adequacy indicator reporting processes and identified the following findings:

- HCI did not merge data together to create network adequacy indicator reporting. HCI used five files in the QAS tools to calculate time and distance indicators. The five files were extracted from CONNECTS and Provider Connects in Excel format and were loaded directly into QAS. HCI maintained data control procedures to ensure the accuracy and completeness of data within CONNECTS by using the Connects Administrative System (CAS) to identify missing, incomplete, or inaccurate member data. Each eligibility file produced an error report that captured any critical data elements that were missing. Additionally, HCI used an automated error detection and notification process that validated the accuracy and monitored the timeliness of the loading of the member files. Provider demographic data were updated directly from individual providers through CONNECTS. HCI conducted preliminary reviews of the provider data for missing data in key elements, misspelled names, or potential duplication and then conducted a provider data clean-up based on the quality control findings.
- To ensure continuity of network adequacy indicator report production, HCI conducted standardized quality assurance checks to monitor the reasonableness and accuracy of the network adequacy indicators. HCI had a documented QC Checklist with over 80 checks that were completed and reviewed by the analysts each quarter. Additionally, each quarter HCI completed a review of the current data submission in comparison to the previous quarter's data submission to ensure that the information that was reported was consistent and aligned with the previous quarter's results.

HSAG identified no concerns with HCI's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that HCI used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that HCI's **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that HCI's **network adequacy methods** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that HCI's **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

NAV Findings

This section presents the NAV findings for HCI (assessed in network adequacy analysis as RAE 4).

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 4. Across both the physical health and behavioral health networks for contracted counties, 96.1 percent of RAE 4's submitted results were in agreement with HSAG's calculated results.
- Since RAE 4 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 96.2 percent of RAE 4's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 380 physical health and behavioral health network standards for RAE 4's contracted counties during FY 2024–2025. Of the 380 aggregated results: 71.8 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 28.2 percent did not meet the minimum network requirements.
- Since RAE 4 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 630 behavioral health network standards for RAE 4's non-contracted counties during FY 2024–2025. Of the 630 aggregated results: 57.5 percent met the minimum network requirements; 37.5 percent did not meet the minimum network requirements; and 5.1 percent of aggregate results had no members within the specified counties.

- RAE 4 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS) in rural, urban, and frontier counties
  - Adult Primary Care Practitioner (PA) in rural counties
  - Family Practitioner (MD, DO, NP, CNS) in rural, urban, and frontier counties
  - Family Practitioner (PA) in rural counties
  - General and Pediatric Behavioral Health in rural, urban, and frontier counties
  - General Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties
  - General and Pediatric SUD Treatment Practitioner in rural and frontier counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in rural, urban, and frontier counties
  - Pediatric Primary Care Practitioner (PA) in rural counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in urban and frontier counties
  - SUD Treatment Facilities in frontier counties
- RAE 4 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (PA) in urban counties
  - Family Practitioner (PA) in urban counties
  - Pediatric Primary Care Practitioner (PA) in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.3 in urban and frontier counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural and frontier counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if HCI's interpretation of data was accurate.

Table 3-6 summarizes HSAG's validation ratings for HCI by indicator type.

Table 3-6—Summary of HCI's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
HCI	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, HCI received *High Confidence* for both ratio and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

By assessing HCI's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: HCI supported the needs of behavioral health programs and improved care coordination through CONNECTS, a fully integrated, proprietary management information system. CONNECTS streamlined operations by enabling real-time access to comprehensive member and provider data, which reduced administrative burden on care managers and providers. Its integrated platform supported functions like eligibility, credentialing, and care management, all which allowed providers to focus more on direct member care, rather than navigating multiple systems or duplicative processes.

Strength #2: HCI demonstrated a strong physical health network. The plan met the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) across all contracted counties. Additionally, HCI met the minimum network requirements for the Primary Care Practitioner (PA) provider category across 84.2 percent of all contracted counties. In the three counties where HCI did not meet the minimum network requirements for the Adult, Pediatric, and Family Primary Care Practitioner (PA) provider categories access ranged from 84.2 percent to 99.9 percent of members.

Strength #3: HCI demonstrated a strong statewide behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health in all counties statewide where members were present. HCI met the minimum network requirements for General SUD Treatment Practitioners in 93.7 percent of counties statewide where members were present, and Pediatric SUD Treatment Practitioners in 93.0 percent of all counties statewide where members were present.

Opportunity and Recommendations

Opportunity #1: HCI did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in 95.2 percent of counties statewide where members were present. Across all counties statewide, 79.4 percent had access levels varying from 0 percent to 27.3 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends that HCI maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Kaiser Permanente Colorado (Kaiser)

This section includes key findings and highlights from the ISCA results for Kaiser.

ISCA Findings

HSAG completed an ISCA for Kaiser and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that Kaiser had in place to support network adequacy indicator reporting, which included the following findings:

- Kaiser used Common Membership (CM) as the database management system to collect and maintain member enrollment data.
- Kaiser used MSOW as the database management system for collecting and maintaining provider data.
- Kaiser used QAS to calculate and report provider network adequacy indicators.

HSAG evaluated the personnel that Kaiser had in place to support network adequacy indicator reporting, which included the following:

- Kaiser had five programmers with 10 years of experience trained and capable of supporting network adequacy activities.

HSAG identified no concerns with Kaiser's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by Kaiser to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of Kaiser's enrollment system included the following:

- Enrollment and eligibility data for Kaiser members were maintained within the member enrollment database management system, CM. The electronic file integration (EFI) team was responsible for receiving and integrating the 834 files into the CM system.
- Kaiser received daily and monthly enrollment files in the 834 file format from the Department.
- Kaiser performed monthly reconciliation between the CM system and the MSOW system and the 834 enrollment data to ensure the completeness and accuracy of enrollment data.

- Kaiser conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - Kaiser had an automated process in place that matched data elements received on the 834 file to existing data in the CM database, which included first name, last name, date of birth (DOB), and sex code. These data elements were used to match to the health record numbers (HRNs) for existing members. In instances where a match could not be found, account administrative representatives (AARs) performed a search within CM to determine if the member had an existing HRN; if a match was not found, the member obtained a new HRN.
    - Kaiser generated and provided automated reports to staff where it identified potential missing or incomplete data. Staff reviewed these reports and conducted research across various source data and systems to resolve any errors or discrepancies in the enrollment data. Kaiser indicated that it typically saw discrepancies such as incorrect Medicaid ID, typos on files, and reversed DOB.
  - Kaiser ensured data transferred were accurate by comparing data files from the previous quarter to determine if there were any large discrepancies or changes in data.
- Kaiser captured and maintained both the state-issued Medicaid ID and a system-generated ID. If the Medicaid ID changed for any reason, Kaiser used the system-generated ID to link enrollment history. Kaiser assigned a unique HRN that was generated by CM upon assignment in the system, and the HRN stayed with the member for life. HRNs were numeric and assigned sequentially. If a member left Kaiser and returned as a member later, the member retained their HRN when re-enrolled.
- Kaiser identified member demographic updates based on the completion of a health record match and research process. Member addresses had a dedicated table structure that tracked the history of a variety of data sources that informed demographic information.
- Kaiser used the 834 file as the source of truth for member demographic data. If a member called to update demographics, a notation was made in the system, however, the address was not updated. This was due to the address field linked to the demographic information obtained through the 834 file, which would override any direct updates to this field upon receipt of a new 834 file. Member services referred the members to the Department for all demographic updates. Only when a member called the Department to make these updates will the changes be reflected in the 834 file and in downstream reporting.

HSAG identified no concerns with Kaiser's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by Kaiser to capture provider data and identified the following:

- Kaiser ensured that data received from providers were accurate and complete by validating data report outputs to ensure the accuracy and timeliness of reported data.

- Kaiser had adequate data collection processes in place to ensure completeness and consistency.
- Kaiser collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of Kaiser's provider data system(s) included the following:

- Provider credentialing data were maintained in the MSOW provider database management system.
- Provider network status data were maintained in the MSOW provider database management system.
- Kaiser received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.
- Kaiser captured the Department-required provider types in the MSOW provider database management system and demonstrated logic for how Kaiser identified provider types appropriately. The provider types within MSOW were mapped to the Department's provider crosswalk.
- Kaiser's procedures for updating and maintaining provider data included the following:
  - The initial credentialing process and recredentialing process were used to track providers over time, across multiple office locations, and through changes in participation in Kaiser's network.
  - Providers that require credentialing were recredentialed on a three-year cycle. Provider data (including specialty, licensure, degree, location, etc.) were loaded into MSOW.
  - In January 2025, Kaiser implemented an attestation portal using Microsoft Dynamics that allowed providers to self-report and update their data more efficiently.
  - Quarterly, MSOW sent "attestation reports" to all network providers that included all their pertinent demographic and location information. Providers were expected to attest to the accuracy of their data or provide updates which the provider data management team made in MSOW. Any non-responders were contacted separately. Providers were made aware of this expectation through the attestation process.
  - Provider data were submitted to the LexisNexis data verification vendor, which issued alerts for potential data discrepancies. Kaiser reviewed these alerts and took action to validate and update provider records as needed.

HSAG identified no concerns with Kaiser's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of Kaiser's delegated entity data and oversight included the following:

- Kaiser did not rely on any external delegated entity data for the purpose of network adequacy indicator reporting during the reporting period in scope of review.

Assessment of Network Adequacy Methods

HSAG evaluated Kaiser's methodologies for assessing network adequacy and identified the following findings:

- Kaiser used QAS to calculate and report time and distance indicators.
- Kaiser calculated time and distance, and ratio standards as expected by the Department.
- The methods that Kaiser selected to calculate all indicators were appropriate for the Colorado CHP+ MCO population.

HSAG identified no concerns with Kaiser's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed Kaiser's network adequacy indicator reporting processes and identified the following findings:

- Kaiser maintained data control procedures to ensure the accuracy and completeness of data merges from CM and MSOW by performing monthly reconciliation of the data from the 834 files and the CM database and MSOW. Additionally, Kaiser generated automated reports which identified potential missing and incomplete data and assigned designated staff members to review the reports and resolve any errors within the enrollment data.
- To ensure continuity of network adequacy indicator production, Kaiser conducted reviews of the current quarter's data in comparison to the prior quarter's data to ensure the providers are being categorized consistently. Additionally, the comparison of quarter to quarter helped identify significant changes in the data. If a significant change was identified, it was investigated to ensure if the change was accurate.

HSAG identified no concerns with Kaiser's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that Kaiser used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that Kaiser's **data collection procedures** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Kaiser's **network adequacy methods** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that Kaiser's **network adequacy results** were:

☒ Acceptable

☐ Not acceptable

NAV Findings

This section presents the NAV findings for Kaiser.

- In FY 2024–2025, HSAG assessed the compliance match rate for Kaiser. Across both the physical health and behavioral health networks, 86.5 percent of Kaiser's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 926 physical health and behavioral health network standards for Kaiser during FY 2024–2025. Of the 1,665 aggregated results: 58.7 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes), and 41.3 percent did not meet the minimum network requirements.
- Kaiser met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - General and Pediatric Behavioral Health in urban counties
  - General and Pediatric Psychiatrists and other Psychiatric Prescribers in urban counties
- Kaiser did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Family Practitioner (PA) in urban counties
  - Pediatric Primary Care Practitioner (PA) in urban counties
  - Pharmacies in urban counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Kaiser's interpretation of data was accurate.

Table 3-7 summarizes HSAG's validation ratings for Kaiser by indicator type.

Table 3-7—Summary of Kaiser's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Kaiser	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, Kaiser received *High Confidence* for both ratio and time and distance indicator types. However, there were identified areas for improvement; please refer to ISCA Findings or Strengths, Opportunities for Improvement, and Recommendations for more details.

Strengths, Opportunities for Improvement, and Recommendations

By assessing Kaiser's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: In January 2025, Kaiser implemented an attestation portal using Microsoft Dynamics. The attestation portal allowed providers to self-report and update their demographic information, streamlining the process for collecting updates to provider data.

Strength #2: Kaiser established processes to improve validity and network adequacy for conducting quarterly validation of CHP+ network adequacy gaps along with determining whether gaps were due to a lack of available providers or of an inability to contract with providers in the specific geographic areas.

Strength #3: While Kaiser did not meet the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS) or Family Practitioner (MD, DO, NP, CNS) across all contracted counties, the plan demonstrated high rates of access to these primary care provider categories. Across all counties for each of these three provider categories, 98.1 percent of members or greater had access.

Strength #4: While Kaiser did not meet the minimum network requirements for an array of specialty care providers across the plan's contracted counties, Kaiser consistently demonstrated high

rates of access to specialty provider categories. Among all General and Pediatric specialty provider categories, member access ranged from 92.9 to 100 percent. The only exception to this range was General Endocrinology in Douglas County, for which HSAG identified the rate of member access as 85.7 percent.

Strength #5: Kaiser demonstrated a strong behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties. Among General and Pediatric SUD Treatment practitioners, member access ranged from 92.9 percent to 100 percent.

Opportunity and Recommendations

Opportunity #1: Kaiser indicated that it is still unable to establish a clear process for how it captures updated demographic information outside of the 834 file. However, Kaiser indicated that a notation of an updated address is made in the system but confirmed the use of the 834 files as the source of truth for all member demographic information.

Recommendation: Although Kaiser redirected members and encouraged timely updates to the Department upon notification on any change in demographic information, HSAG recommends considering an alternative method for collecting updated demographic information to support more accurate and up-to-date demographic information used to inform network adequacy reporting.

Northeast Health Partners (NHP)

This section includes key findings and highlights from the ISCA results for NHP.

ISCA Findings

HSAG completed an ISCA for NHP and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that NHP had in place to support network adequacy indicator reporting, which included the following findings:

- NHP used Carelon's proprietary and confidential database management system, CONNECTS, to collect and maintain member enrollment and provide data management. CONNECTS is comprised of three major systems (i.e., managed healthcare, finance, and security), each of which include several subsystems and modules.

HSAG evaluated the personnel that NHP had in place to support network adequacy indicator reporting, which included the following:

- NHP had a total of six programmers, four SQL developers, and two analysts trained and capable of supporting network adequacy reporting activities. On average, the programmers had over 11 years of experience in the field.
- Carelon's information technology (IT) team was responsible for all system enhancements, data security, data quality, and general oversight of the information systems infrastructure.
- Carelon's Colorado data analytics and reporting (DAR) team was responsible for all programming of network adequacy-related reporting.

HSAG identified no concerns with NHP's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by NHP to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of NHP's enrollment system included the following:

- Enrollment and eligibility data for the Medicaid population were maintained within the CONNECTS database management system.
- NHP received daily and monthly enrollment files in the 834 file format from the Department.

- On behalf of NHP, Carelon performed monthly reconciliation between CONNECTS and the 834 file submissions from the Department to ensure the completeness and accuracy of enrollment data.
- On behalf of NHP, Carelon conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - On behalf of NHP, Carelon conducted a series of edit checks that identified missing, incomplete, or inaccurate member data. As each eligibility file was run, NHP generated error reports, which captured any critical data elements that were determined to be missing. NHP generated another report that was analyzed by NHP's business analyst. Data integrity was controlled at four levels:
    - ETL Process Log Parsing—This error prevention method was used to verify the successful completion of the ETL process within the system by searching for known error messages and alerting the staff if an error message exists in the log.
    - Record Count Checking—This error check type ensured that no data rows were lost during the ETL process and alerted the staff if any discrepancies were found.
    - Parity Checking—This type of error checking searched inside the data files to determine if any data corruption occurred during the ETL process.
    - Oracle Alert Log Parsing—This is a pattern-matching algorithm used to search through the Oracle Alert Log for predetermined keywords that indicate an error condition within the database server.
- On behalf of NHP, Carelon's system captured and maintained both the state-issued Medicaid ID and added a two-byte suffix as a system-generated ID. If the Medicaid ID changed for any reason, NHP used the system-generated, unique assigned ID to link enrollment history.
- On behalf of NHP, Carelon identified member demographic updates through the receipt of the daily and monthly 834 file.

HSAG identified no concerns with NHP's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by NHP to capture provider data and identified the following:

- On behalf of NHP, Carelon ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- On behalf of NHP, Carelon had adequate data collection processes in place to ensure completeness and consistency.
- On behalf of NHP, Carelon collected data from providers to support the contracting and credentialing process in standardized formats by directing providers to enter provider information through CAQH to the extent feasible and appropriate.

HSAG's evaluation of NHP's provider data system(s) included the following:

- Provider credentialing data and network status were maintained in the CONNECTS database management system.
- On behalf of NHP, Carelon received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.
- On behalf of NHP, Carelon captured Department-required provider types and specialties in the CONNECTS database management system and demonstrated the logic for how NHP identified provider types appropriately.
- On behalf of NHP, Carelon's procedures for updating and maintaining provider data included the following:
  - The initial credentialing process and recredentialing process were used to track providers over time, across multiple office locations, and through changes in participation in NHP's network.
  - On behalf of NHP, Carelon had its provider network update provider data every three years as part of the recredentialing process.
  - On behalf of NHP, Carelon required its provider network to review and update all provider data included in the provider directory at least annually. Providers were made aware of this expectation via quarterly outreach by the provider relations team. If the provider did not update or attest to their provider demographic information at least once within a rolling calendar year, these providers would not be removed from the network, but they would be suppressed from the directory until they could review and ensure that their contact information and acceptance of new members were validated. Approximately 2.4 percent were suppressed during the reporting period.

HSAG identified no concerns with NHP's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of NHP's delegated entity data and oversight included the following:

- NHP subcontracted administrative services, including network adequacy reporting, to Carelon, which used CONNECTS to capture all related data.
- NHP maintained oversight of its delegated entities by:
  - Conducting annual audit reviews of delegated functions through a third party.
  - Collecting monthly reports in a standardized format, inclusive of contractually required data elements.
  - Holding quarterly Joint Operations Committee meetings to review key performance metrics and results of ongoing monitoring of delegated entity data.

NHP did not identify any delegated entity network adequacy data-related items requiring corrective action for the reporting period.

Assessment of Network Adequacy Methods

HSAG evaluated NHP's methodologies for assessing network adequacy and identified the following findings:

- NHP used QAS to calculate and report time and distance indicators.
- NHP calculated time and distance, and ratio standards as expected by the Department.
- The methods that NHP selected to calculate all indicators were appropriate for the Colorado Medicaid population.

HSAG identified no concerns with NHP's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed NHP's network adequacy indicator reporting processes and identified the following findings:

- NHP did not merge data together to create network adequacy indicator reporting. NHP used five files in the QAS tools to calculate time and distance indicators. The five files were extracted from CONNECTS and Provider Connects in Excel format and were loaded directly into QAS. NHP maintained data control procedures to ensure accuracy and completeness of data within CONNECTS by using the CAS system to identify missing, incomplete, or inaccurate member data. Each eligibility file produced an error report which captured any critical data elements that were missing. Additionally, there is an automated error detection and notification process that validated the accuracy and monitored the timeliness of the loading of the member files. Provider demographic data were updated directly from individual providers through Provider Connects. NHP conducted preliminary reviews of the provider data for missing data in key elements, misspelled names, or potential duplication and then conducted a provider data clean-up based on the quality control findings.
- To ensure continuity of network adequacy indicator report production, NHP conducted standardized quality assurance checks to monitor the reasonableness and accuracy of the network adequacy indicators. NHP has a documented QC Checklist with over 80 checks that are completed and reviewed by the analysts each quarter. Additionally, each quarter NHP completed a review of the current data submission in comparison to the previous quarter's data submission to ensure that the information that was reported was consistent and aligned with the previous quarter's results.

HSAG identified no concerns with NHP's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that NHP used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that NHP's **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that NHP's **network adequacy methods** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that NHP's **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

NAV Findings

This section presents the NAV findings for NHP (assessed in network adequacy analysis as RAE 2).

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 2. Across both the physical health and behavioral health networks for contracted counties, 95.5 percent of RAE 2's submitted results were in agreement with HSAG's calculated results.
- Since RAE 2 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 95.6 percent of RAE 2's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 200 physical health and behavioral health network standards for RAE 2's contracted counties during FY 2024–2025. Of the 200 aggregated results: 59.0 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 41.0 percent did not meet the minimum network requirements.
- Since RAE 2 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 756 behavioral health network standards for RAE 2's non-contracted counties during FY 2024–2025. Of the 756 aggregated results: 57.0 percent met the minimum network requirements; 31.0 percent did not meet the minimum network requirements; and 12.0 percent of aggregate results had no members within the specified counties.

- RAE 2 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS) in rural and frontier counties
  - Family Practitioner (MD, DO, NP, CNS) in rural and frontier counties
  - General and Pediatric Behavioral Health in rural and urban counties
  - General Psychiatrists and other Psychiatric Prescribers in rural and urban counties
  - General and Pediatric SUD Treatment Practitioner in rural counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in rural and frontier counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in urban counties
- RAE 2 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in urban counties
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural and urban counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if NHP's interpretation of data was accurate.

Table 3-8 summarizes HSAG's validation ratings for NHP by indicator type.

Table 3-8—Summary of NHP's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
NHP	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, NHP received *High Confidence* for both ratio and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

By assessing NHP's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: NHP had an automated error detection and notification process in place and generated turnaround reports to ensure its member data were accurate. NHP had business-level checks including ETL process log parsing, record count checking, parity checking, and Oracle Alert Log parsing to ensure member data were valid, member data were complete, no discrepancies existed, no data corruption occurred during the ETL process, and timeliness of loading the data. NHP generated turnaround reports that identified errors were updated within one day of being detected.

Strength #2: NHP met the minimum network requirements for Adult or Pediatric Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) in 88.9 percent of all contracted counties. In the single county where NHP did not meet the minimum network requirement for these three primary care provider categories, access was 99.7 percent for each.

Strength #3: NHP demonstrated a strong behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health in all contracted counties. NHP met the minimum network requirements for General Psychiatrists and Pediatric Psychiatrists in more than 88.0 percent of all counties statewide were members were present. Additionally, NHP met the minimum network requirements for both General and Pediatric SUD Treatment Practitioners in 88.9 percent of contracted counties. In the single county where NHP did not meet the minimum network requirements for General and Pediatric SUD Treatment Practitioners, access was 99.7 percent for each.

Opportunity and Recommendations

Opportunity #1: NHP did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in 91.5 percent of counties statewide where members were present. Across all counties statewide, 78.0 percent had access levels varying from 0 percent to 50.0 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends that RAE 2 maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Rocky Mountain Health Plans (RMHP)

This section includes key findings and highlights from the ISCA results for RMHP: RMHP CHP+, RMHP Prime, and RAE 1.

ISCA Findings

HSAG completed an ISCA for RMHP and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that RMHP had in place to support network adequacy indicator reporting, which included the following findings:

- RMHP used the CSP Facets application as the management system to collect and maintain member enrollment and provider data.

HSAG evaluated the personnel that RMHP had in place to support network adequacy indicator reporting, which included the following:

- RMHP had approximately 70 programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately four years of experience in the field.

HSAG identified no concerns with RMHP's information systems data processing procedures and personnel.

Enrollment System

HSAG evaluated the information systems and processes used by RMHP to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the Department. HSAG's evaluation of RMHP's enrollment system included the following:

- Enrollment and eligibility data for Medicaid and CHP+ were maintained within the CSP Facets application.
- RMHP received daily and monthly enrollment files in the 834 file format from the Department.
- RMHP performed monthly reconciliation between CSP Facets and the 834 enrollment data from the Department to ensure the completeness and accuracy of enrollment data.
- RMHP conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - After the 834 file(s) were loaded into CSP Facets, missing or incomplete member data dropped to a fall-out report. Enrollment processors manually reviewed and worked fall-out reports daily.

Manual review included verification of member information (i.e., first name, last name, and social security number [SSN]) on the Department's eligibility website and reconciliation with the 834 file(s).

– RMHP had processors who validated the information with the Department's electronic verification system before making updates in CSP Facets. Quality assessments were completed monthly for all processors on a sampling of no less than 10 transactions that included a verification of first name, last name, SSN, Medicaid ID, and DOB. Additional eligibility verification was completed via the 820 reconciliation process by enrollment processors.

- RMHP's system captured and maintained both the state-issued Medicaid ID and a system-generated ID. If the Department sent different member ID elements via the 834 files, CSP Facets may have created a duplicate entry. RMHP's system ran a weekly report to identify enrollees with more than one active record. If an enrollee was found to have more than one active record, the additional active record was voided, and a note was added to the voided record noting the correct CSP Facets Subscriber ID.
- RMHP identified member demographic updates through receipt of the daily and monthly 834 files. For member provided updates, members were directed to contact the Department using the PEAK system.

HSAG identified no concerns with RMHP's enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by RMHP to capture provider data and identified the following:

- RMHP ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- RMHP had adequate data collection processes in place to ensure completeness and consistency.
- RMHP collected data from providers to support the contracting and credentialing process in standardized formats by directing providers to enter information through the cloud-based digital platform My Practice Profile (MPP) and through CAQH to the extent feasible and appropriate.

HSAG's evaluation of RMHP's provider data system(s) included the following:

- Provider credentialing data were maintained in the Network Database (NBD).
- Provider network status as well as contracting data were maintained in the CSP Facets application.
- NHP received the provider crosswalk quarterly. The Department's provider crosswalk was maintained and updated, where applicable, quarterly.
- RMHP captured Department-required provider types and specialties in the CSP Facets system and demonstrated the logic for how RMHP identified provider types appropriately using the Department's provider crosswalk.

- RMHP's procedures for updating and maintaining provider data included the following:
  - RMHP required its provider network to review and update all provider data included in the provider directory at least annually. Providers were made aware of this expectation via quarterly outreach by the provider relations team.
  - RMHP used multiple intake channels with the intent to allow practitioners to validate, or attest to, the demographic data on file every 90 days, including a cloud-based digital platform for practitioners to access; roster processing; an Inbound Demographic Change Line in which providers can call with updates; and Provider Verification Outreach (PVO), which leverages email or telephonic outreach.
  - RMHP utilized the PhyCon web-based tool, provider Medicaid enrollment data, and NDB to track providers over time, across multiple office locations, and through changes in participation in RMHP's network.

HSAG identified no concerns with RMHP's provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of RMHP's delegated entity data and oversight included the following:

- RMHP did not rely on any external delegated entity data for the purpose of network adequacy indicator reporting during the reporting period in scope of review.

Assessment of Network Adequacy Methods

HSAG evaluated RMHP's methodologies for assessing network adequacy and identified the following findings:

- RMHP used QAS to calculate and report time and distance indicators as expected by the State.
- RMHP calculated time and distance, and ratio standards as expected by the Department.
- The methods that RMHP selected to calculate all indicators were appropriate for the Colorado CHP+ MCO and Medicaid populations.

HSAG identified no concerns with RMHP's methods for assessing network adequacy.

Network Adequacy Indicator Reporting

HSAG assessed RMHP's network adequacy indicator reporting processes and identified the following findings:

- RMHP extracted network data in alignment with the Department's classification requirements for load into QAS to complete indicator-level calculations. RMHP maintained data quality and control procedures to ensure the accuracy and completeness of data merges from CSP Facets and the NDB by comparing alignment against source data, maintaining internal protocols for data validation and refresh, and performing outreach to parties such as providers or the State to reconcile missing or unexpected discrepancies.
- RMHP conducted data reasonability checks by maintaining detailed data systems and regularly comparing network adequacy results against baseline metrics from prior extracts and reports. When RMHP encountered any unexpected findings, it followed an established process to investigate the source of data anomalies including a review of QAS scripts and file extract specifications.
- To ensure continuity of network adequacy indicator production, RMHP maintained records of prior reports, worked internally to maintain best practices for data extraction and preparation, and employed validation procedures to ensure the indicator-level calculations aligned with the Department's guidance.

HSAG identified no concerns with RMHP's network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that RMHP used to collect and store data for each network adequacy indicator in the scope of NAV.

Overall, HSAG determined that RMHP's **data collection procedures** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that RMHP's **network adequacy methods** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that RMHP's **network adequacy results** were:

☒ Acceptable

☐ Not acceptable

NAV Findings

This section presents the NAV findings for RMHP CHP+, RMHP Prime, and RAE 1.

RMHP CHP+

This section presents NAV findings for RMHP CHP+.

- In FY 2024–2025, HSAG assessed the compliance match rate for RMHP CHP+. Across both the physical health and behavioral health networks, 93.2 percent of RMHP CHP+'s submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 814 physical health and behavioral health network standards for RMHP CHP+ during FY 2024–2025. Of the 814 aggregated results: 77.4 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes); 13.4 percent did not meet the minimum network requirements; and 9.2 percent of aggregate results had no CHP+ MCO members within the appropriate age range.
- RMHP CHP+ met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Acute Care Hospitals in frontier counties
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - General Behavioral Health in rural counties
  - General Cardiology in rural counties
  - General Ophthalmology in rural counties
  - General Orthopedics in rural counties
  - General Psychiatrists and other Psychiatric Prescribers in rural counties
  - General Pulmonary Medicine in rural counties
  - General SUD Treatment in rural counties
  - General Surgery in rural counties
  - General Urology in rural counties
  - Gynecology, OB/GYN (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - Pediatric Behavioral Health in rural and frontier counties
  - Pediatric Cardiology in frontier counties
  - Pediatric Gastroenterology in frontier counties
  - Pediatric Neurology in frontier counties
  - Pediatric Ophthalmology in frontier counties
  - Pediatric Orthopedics in frontier counties
  - Pediatric Otolaryngology/ENT in frontier counties

  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - Pediatric Psychiatrists and other Psychiatric Prescribers in rural and frontier counties
  - Pediatric Pulmonary Medicine in frontier counties
  - Pediatric SUD Treatment in rural and frontier counties
  - Pediatric Surgery in rural and frontier counties
  - Pediatric Urology in frontier counties
  - Pharmacies in frontier counties
- RMHP CHP+ did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural and frontier counties

RMHP Prime

This section presents NAV findings for RMHP Prime.

- In FY 2024–2025, HSAG assessed the compliance match rate for RMHP Prime. Across both the physical health and behavioral health networks, 100 percent of RMHP Prime's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 270 physical health and behavioral health network standards for RMHP Prime during FY 2024–2025. Of the 270 aggregated results: 88.9 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 11.1 percent did not meet the minimum network requirements.
- RMHP Prime met the minimum network requirements (i.e., 100 percent of MCO members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Acute Care Hospitals in frontier counties
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - General and Pediatric Cardiology in rural and frontier counties
  - General and Pediatric Endocrinology in frontier counties
  - General and Pediatric Gastroenterology in frontier counties
  - General and Pediatric Neurology in rural and frontier counties
  - General and Pediatric Ophthalmology in rural and frontier counties
  - General and Pediatric Orthopedics in rural and frontier counties
  - General and Pediatric Otolaryngology/ENT in rural and frontier counties
  - General and Pediatric Pulmonary Medicine in rural and frontier counties
  - General and Pediatric Surgery in rural and frontier counties
  - General and Pediatric Urology in rural and frontier counties
  - Gynecology, OB/GYN (MD, DP, NP, CNS) in rural counties

  - Gynecology, OB/GYN (PA) in rural and frontier counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - Pharmacies in frontier counties
- RMHP Prime did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Acute Care Hospitals in rural counties

RAE 1

This section presents NAV findings for RAE 1.

- In FY 2024–2025, HSAG assessed the compliance match rate for RAE 1. Across both the physical health and behavioral health networks for contracted counties, 98.9 percent of RAE 1's submitted results were in agreement with HSAG's calculated results.
- Since RAE 1 is contractually required to maintain a statewide behavioral health network, HSAG also assessed the compliance match rate for the MCE's non-contracted counties. Across the behavioral health network for non-contracted counties, 99.3 percent of RAE 1's submitted results were in agreement with HSAG's calculated results.
- HSAG assessed 440 physical health and behavioral health network standards for RAE 1's contracted counties during FY 2024–2025. Of the 440 aggregated results: 63.0 percent met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes), and 37.0 percent did not meet the minimum network requirements.
- Since RAE 1 is contractually required to maintain a statewide behavioral health network, HSAG also assessed 588 behavioral health network standards for RAE 1's non-contracted counties during FY 2024–2025. Of the 588 aggregated results: 52.6 percent met the minimum network requirements; 45.9 percent did not meet the minimum network requirements; and 1.5 percent of aggregate results had no members within the specified counties.
- RAE 1 met the minimum network requirements (i.e., 100 percent of RAE members with access within the designated miles and minutes) in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - Family Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties
  - General and Pediatric Behavioral Health in rural, urban, and frontier counties
  - General and Pediatric Psychiatrists and other Psychiatric Prescribers in rural, urban, and frontier counties
  - General and Pediatric SUD Treatment Practitioner in rural, urban, and frontier counties
  - Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) in rural and frontier counties

- RAE 1 did not meet the minimum network requirements in more than 80.0 percent of the counties assessed for the following provider categories and urbanicities:
  - Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.1 in rural and frontier counties
  - SUD Treatment Facilities–ASAM 3.3 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.5 in rural counties
  - SUD Treatment Facilities–ASAM 3.7 in rural, urban, and frontier counties
  - SUD Treatment Facilities–ASAM 3.7 WM in rural and frontier counties

Network Adequacy Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if RMHP's interpretation of data was accurate.

Table 3-9 summarizes HSAG's validation ratings for RMHP by indicator type.

Table 3-9—Summary of RMHP's Validation Findings

MCE	Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
RMHP CHP+	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%
RMHP Prime	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%
RAE 1	Ratio Indicators	100%	0%	0%	0%
	Time/Distance Indicators	100%	0%	0%	0%

Of the network adequacy indicators assessed, RMHP CHP+, RMHP Prime, and RAE 1 received *High Confidence* for both ratio and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

By assessing RMHP's performance, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: Similar to the previous review period, RMHP continued to demonstrate robust processes to research daily and monthly missing or incomplete data from the 834 file, which included its capture of the data on the daily fall-out reports, and manual validation and oversight by the RMHP processors for reconciliation. RMHP verified the accuracy of all data received through validation checkpoints.

Strength #2: Similar to the previous review period, RMHP continued to offer providers multiple options to capture provider updates through several intake channels that allowed providers the opportunity to attest to data via MPP, Inbound Demographic Change Line, Roster Processing, and CAQH ProView.

Strength #3: RMHP met the minimum network requirements for Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) across all contracted counties. Additionally, RMHP met the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA) and Family Practitioner (MD, DO, NP, CNS, and PA) in all but one contracted frontier county. In Moffat County, RMHP was very close to meeting the minimum network requirements for Adult and Family Primary Care Practitioners, with member access at 99.9 percent for each category.

Strength #4: RMHP demonstrated a strong statewide behavioral health network, meeting the minimum network requirements for both General and Pediatric Behavioral Health, and General and Pediatric Psychiatrists and other Psychiatric Prescribers in all counties statewide where members were present.

Strength #4: RMHP CHP+ met the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA), Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Family Practitioner (MD, DO, NP, CNS, and PA) in all contracted counties where members were present. Additionally, RMHP CHP+ met the minimum network requirements for Gynecology, OB/GYN (MD, DO, NP, CNS, and PA) in 93.2 percent of all contracted counties.

Strength #5: RMHP CHP+ met the minimum network requirements for General and Pediatric Behavioral Health, General and Pediatric Psychiatrists and other Psychiatric Prescribers, and General and Pediatric SUD Treatment Practitioners in all contracted counties where members were present.

Strength #6: RMHP Prime met the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA), Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Family Practitioner (MD, DO, NP, CNS, and PA) in all contracted counties.

Strength #7: RMHP Prime met the minimum network requirements for Pediatric Cardiology, Pediatric Neurology, Pediatric Ophthalmology, Pediatric Orthopedics, Pediatric Otolaryngology/ENT, Pediatric Pulmonary Medicine, Pediatric Surgery, and Pediatric Urology in all contracted counties. Additionally, RMHP Prime performed well across General specialty provider categories, meeting the minimum network requirements in 88.9 percent of contracted counties for

General Cardiology, General Neurology, General Ophthalmology, General Orthopedics, General Otolaryngology/ENT, General Surgery, and General Urology. For these provider categories, in the counties where the MCE did not meet the minimum network requirement, access was > 99.9 percent.

Opportunity and Recommendations

Opportunity #1: RMHP did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in any frontier or rural counties statewide, or 85.7 percent of urban counties statewide.

Recommendation: To address these opportunities for improvement, HSAG recommends that RMHP maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Opportunity #2: RMHP CHP+ did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals in any contracted frontier or rural counties, or for Pediatric Endocrinology in 64.3 percent of contracted rural counties.

Recommendation: To address these opportunities for improvement, HSAG recommends that RMHP CHP+ maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Opportunity #3: RMHP Prime did not meet the minimum network requirement for Acute Care Hospitals in 55.6 percent of contracted counties.

Recommendation: To address these opportunities for improvement, HSAG recommends that RMHP Prime maintain current compliance and continue to conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

4. Aggregate NAV Results by Line of Business

During FY 2024–2025, HSAG collaborated with the Department to update the MCEs' quarterly network adequacy reporting materials and to develop and implement NAV dashboards in Tableau using the methodology summarized in Appendix A. HSAG validated the MCEs' self-reported compliance with minimum network requirements and provided the Department with the validation results in NAV dashboards that feature MCE-specific results. Data-related findings in this report align with HSAG's validation of the MCEs' FY 2024–2025 Q2 network adequacy reports, representing the most recently available measurement period reflecting the MCEs' networks from October 1, 2024, through December 31, 2024.

For an MCE to meet the FY 2024–2025 minimum network requirements outlined in its contract with the Department, the MCE must ensure that its network is such that 100 percent of its enrolled members have access to providers within the minimum network requirements (i.e., 100 percent access level, unless otherwise specified). For example, the MCEs in urban counties (e.g., Denver County) must ensure that at least two family practitioners are within 30 miles or 30 minutes of 100 percent of each MCE's applicable members. An MCE's failure to meet a minimum network requirement does not necessarily reflect a network concern, since the MCE may use alternative methods of ensuring members' access to care (e.g., the use of telehealth, where applicable).

Table 4-1 presents the network categories applicable to each MCE type; within each network category, network categories included in the FY 2024–2025 NAV correspond to the MCEs' network contract standards. Appendix E contains a listing of detailed network categories and contract standards applicable to each MCE type, and the applicable member population for each contract standard.

Table 4-1—FY 2024–2025 NAV Network Categories by MCE Type

Network Category	CHP+ MCOs	Medicaid MCOs	PAHP	RAE
Primary Care, Prenatal Care, and Women's Health Services[1]	X	X		X
Physical Health Specialists	X	X		
Behavioral Health	X	X[2]		X
Facilities (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X		X[3]
Dental Services (*Primary Care and Specialty Services*)			X	

[1] Throughout the report, these categories are referred to as "physical health primary care." Please refer to Appendix E for full network categories and contract standards.

[2] Of the two Medicaid MCOs, only DHMP includes the behavioral health categories. RMHP Prime does not have a minimum network requirement for behavioral health practitioners.

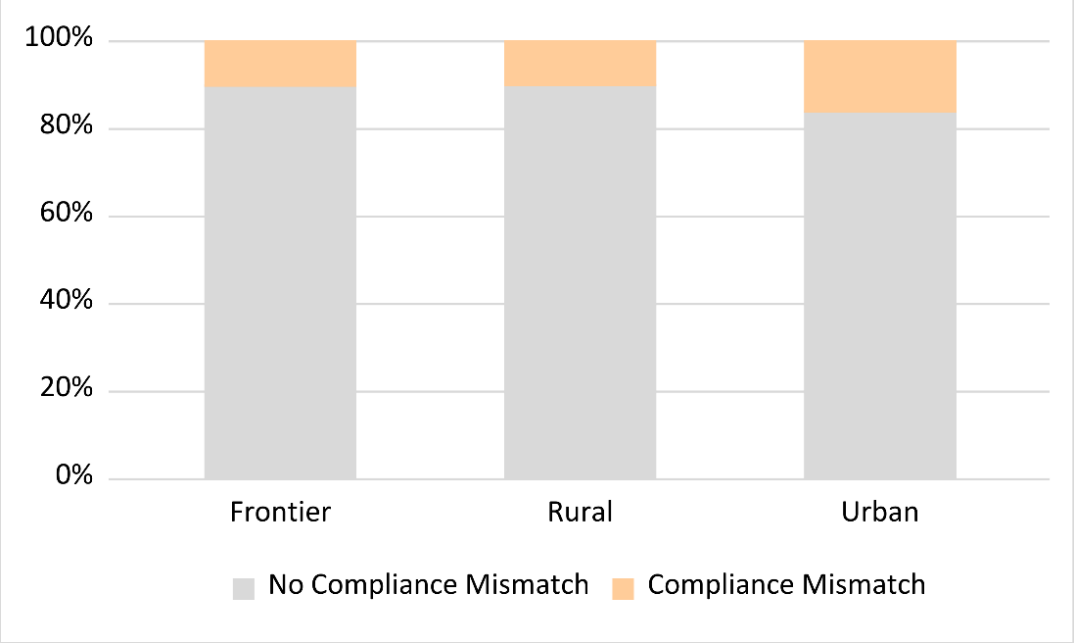
[3] Facilities for RAEs include hospitals and exclude pharmacies, imaging services, and laboratories.

This section presents FY 2024–2025 Q2 NAV MCE results for compliance with network standards as well as results from HSAG's validation of the MCEs' self-reported compliance with time and distance network contract standards.

CHP+ MCOs

Figure 4-1 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) among all CHP+ MCOs by urbanicity.

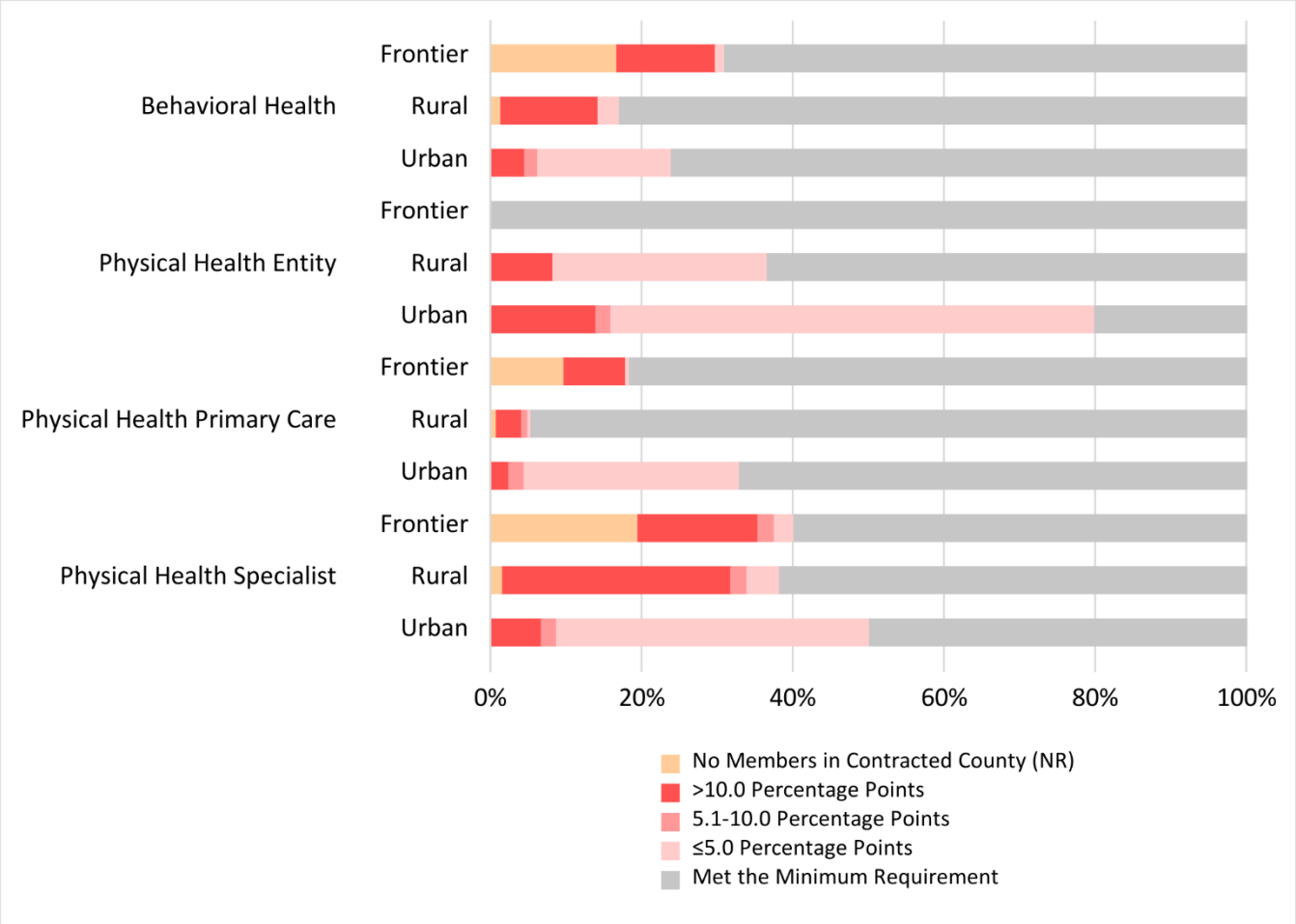
Figure 4-1—Aggregate CHP+ MCO Geoaccess Compliance Results for FY 2024–2025 by Urbanicity



HSAG agreed with 89.9 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 90.0 percent of reported results for rural counties, and 84.0 percent of reported results for urban counties.

Figure 4-2 displays the percentage of behavioral health and physical health primary care network results achieving 100 percent, 95.0 to 99.9 percent, 90.0 to 94.9 percent, and less than 90.0 percent of minimum network requirements for CHP+ MCO members by urbanicity for FY 2024–2025. 'NR' indicates there were no applicable CHP+ MCO members meeting the criteria for the minimum time and distance behavioral health and physical health primary care network requirements for the selected counties.[3]

Figure 4-2—Percentage of Aggregate CHP+ MCO Behavioral Health and Physical Health Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2024



Since the CHP+ MCOs are contracted to cover different Colorado counties (Appendix D), each combination of a minimum time and distance requirement and county is measured separately. Not all members may reside within the CHP+ MCOs' contractual minimum network requirements for two or more practitioners in a given network category. As such, Figure 4-2 summarizes the number of

[3] Due to the limited number of adult CHP+ MCO members, 'NR' is unique to the CHP+ MCO NAV results; see Appendix E for a complete list of network categories selected by the Department for inclusion in the FY 2024–2025 NAV analyses.

behavioral health and physical health entity, primary care, and specialist results (i.e., minimum network requirement and county combinations) in which all members had access within the minimum network requirement, or a lower percentage of members had access within the minimum network requirement for the county.

- Minimum time and distance behavioral health requirements include Pediatric and Adult Psychiatrists and other Psychiatric Prescribers and SUD Treatment Practitioners and entities, as well as Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals. CHP+ MCOs are required to ensure that all members have two behavioral health practitioners or practice sites from each specified network type available within the specified time and distance requirement.
- Minimum time and distance physical health entity requirements include Acute Care Hospitals and Pharmacies. CHP+ MCOs are required to ensure that all members have two physical health entities from each specified network type available within the specified time and distance requirement.
- Minimum time and distance physical health primary care requirements include Pediatric, Adult, and Family Primary Care Practitioners, as well as practitioners specializing in OB/GYN. CHP+ MCOs are required to ensure that all members have two physical health primary care practitioners from each specified network type available within the specified network requirements.
- Minimum time and distance physical health specialist requirements include practitioners such as cardiologists, endocrinologists, and gastroenterologists, etc. CHP+ MCOs are required to ensure that all members have two physical health specialist practitioners from each specified network type available within the specified minimum network requirement.

Table 4-2 through Table 4-5 display the aggregated percentages and total counts reflected in Figure 4-2.

Behavioral Health

Table 4-2—Aggregated CHP+ MCO Behavioral Health Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	68.9%	82.9%	76.0%
≤ 5.0 Percentage Points	1.2%	2.9%	17.7%
5.1–10.0 Percentage Points	0%	0%	1.7%
> 10.0 Percentage Points	13.0%	12.9%	4.6%
No Members (NR)	16.8%	1.4%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 546 behavioral health results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county behavioral health results: 68.9 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes), 1.2 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 13.0 percent of the results were greater than 10.0 percentage points away from the minimum network requirements. An additional 16.8 percent of aggregate results had no CHP+MCO members within the appropriate age range for behavioral health requirements.
- Of the aggregated rural county behavioral health results: 82.9 percent met the minimum network requirements, 2.9 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 12.9 percent were greater than 10.0 percentage points away from the minimum network requirements. An additional 1.4 percent of aggregated results had no CHP+ MCO members within the appropriate age range for the behavioral health requirements.
- Of the aggregated urban county behavioral health results: 76.0 percent met the minimum network requirements, 17.7 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.7 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 4.6 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Entities

Table 4-3—Aggregated CHP+ MCO Physical Health Entity Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	100%	63.3%	20.0%
≤ 5.0 Percentage Points	0%	28.3%	64.0%
5.1–10.0 Percentage Points	0%	0%	2.0%
> 10.0 Percentage Points	0%	8.3%	14.0%
No Members (NR)	0%	0%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 156 physical health entity results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county physical health entity results: 100 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members had access to physical health entities within the minimum network requirements).
- Of the aggregated rural county physical health entity results: 63.3 percent met the minimum network requirements. An additional 28.3 percent were less than or equal to 5.0 percentage points away from the minimum network requirements and 8.3 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health entity results: 20.0 percent met minimum network requirements, 64.0 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.0 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 14.0 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

Table 4-4—Aggregated CHP+ MCO Physical Health Primary Care Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	81.5%	94.6%	67.0%
≤ 5.0 Percentage Points	0.5%	0.4%	28.5%
5.1–10.0 Percentage Points	0%	0.8%	2.0%
> 10.0 Percentage Points	8.2%	3.3%	2.5%
No Members (NR)	9.8%	0.8%	0.0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 624 physical health primary care results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

- Of the aggregated frontier county physical health primary care results: 81.5 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members had access to physical health primary care within the minimum network requirements). An additional 0.5 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 8.2 percent were greater than 10.0 percentage points away from the minimum network requirements, and

9.8 percent of aggregated results had no CHP+ MCO members within the appropriate age range for the physical health primary care requirements.

- Of the aggregated rural county physical health primary care results: 94.6 percent met the minimum network requirements, 0.4 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.8 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 3.3 percent were greater than 10.0 percentage points away from the minimum network requirements. An additional 0.8 percent of aggregated results had no CHP+ MCO members within the appropriate age range for the physical health primary care requirements.
- Of the aggregated urban county physical health primary care results: 67.0 percent met the minimum network requirements, 28.5 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.0 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 2.5 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Specialist

Table 4-5—Aggregated CHP+ MCO Physical Health Specialist Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	59.8%	61.7%	49.8%
≤ 5.0 Percentage Points	2.6%	4.3%	41.4%
5.1–10.0 Percentage Points	2.2%	2.2%	2.0%
> 10.0 Percentage Points	15.9%	30.2%	6.8%
No Members (NR)	19.6%	1.7%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 1,560 physical health specialist results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined CHP+ MCOs are contracted to serve.

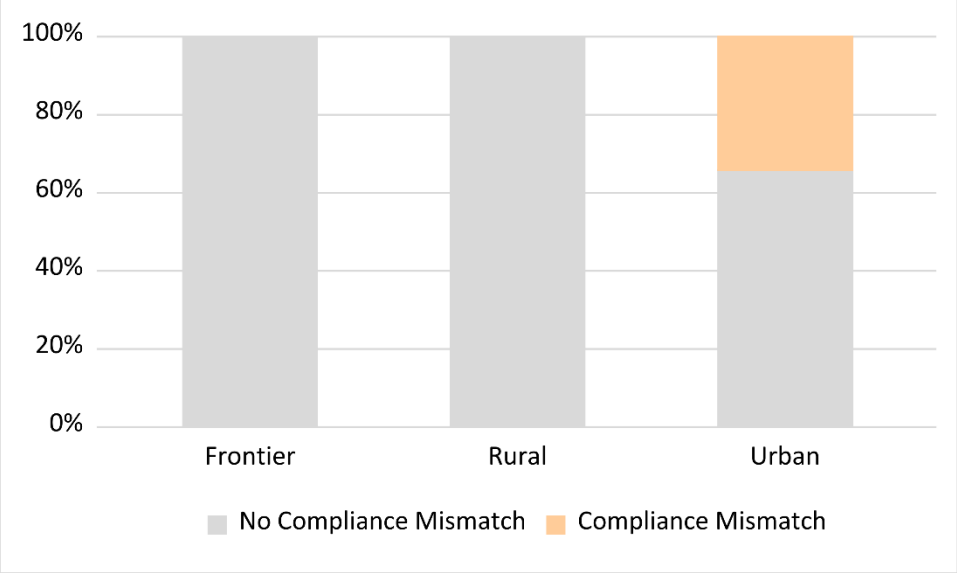
- Of the aggregated frontier county physical health specialist results: 59.8 percent met the minimum network requirements, 2.6 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.2 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, 15.9 percent were greater than 10.0 percentage points away from the minimum network requirements, and 19.6 percent of aggregate results had no CHP+ MCO members within the appropriate age range for the physical health specialist requirements.

- Of the aggregated rural county physical health specialist results: 61.7 percent met the minimum network requirements, 4.3 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.2 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 30.2 percent were greater than 10.0 percentage points away from the minimum network requirements. An additional 1.7 percent of aggregate results had no CHP+ MCO members within the appropriate age range for the physical health specialist requirements.
- Of the aggregated urban county physical health specialist results: 49.8 percent met the minimum network requirements, 41.4 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.0 percent were within 5.1 to 10.0 percentage points of the minimum network requirement, and 6.8 percent were greater than 10.0 percentage points away from the minimum network requirements.

Medicaid MCOs

Figure 4-3 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) among all Medicaid MCOs by urbanicity.

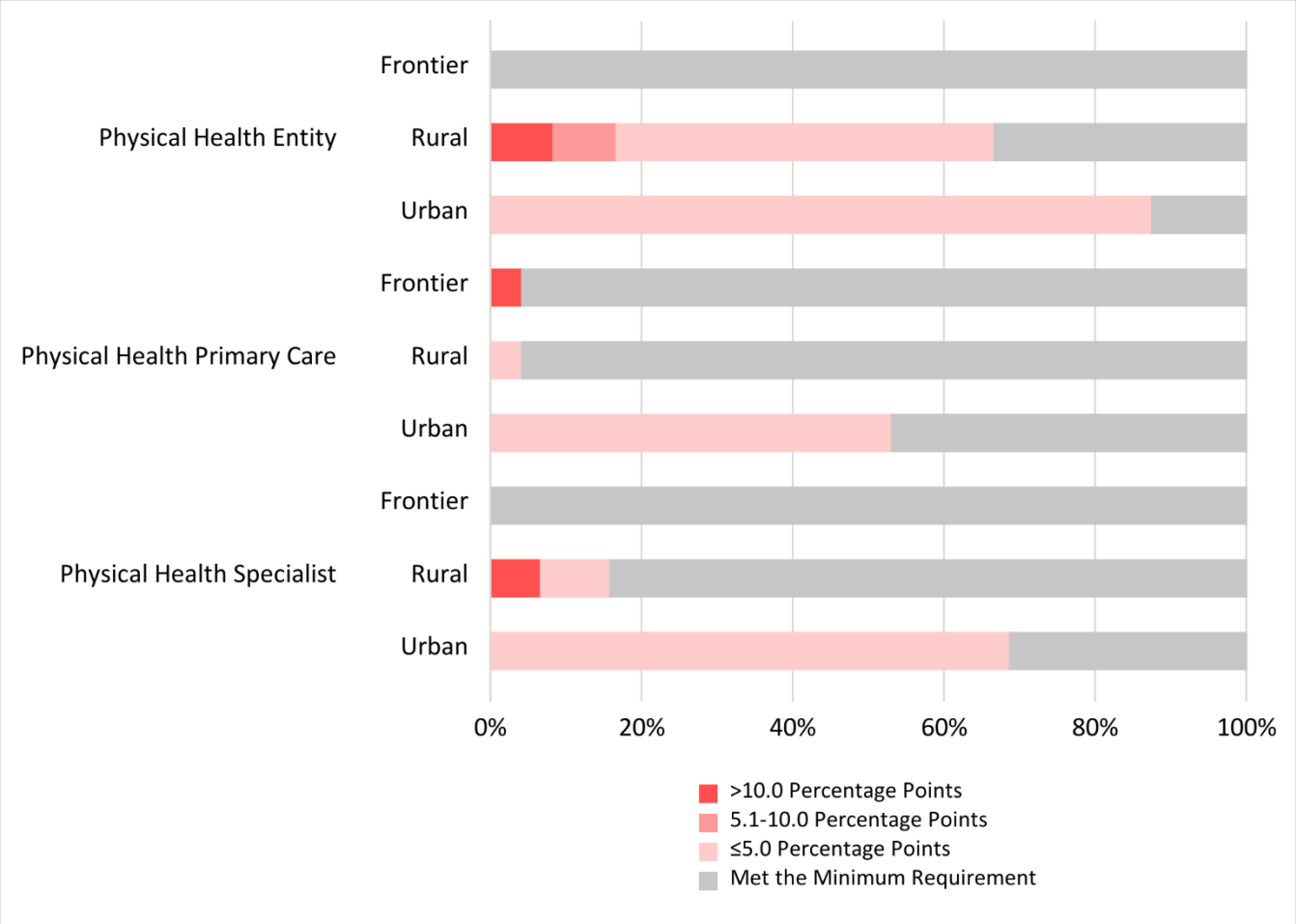
Figure 4-3—Aggregate Medicaid MCO Geoaccess Compliance Results for FY 2024–2025 by Urbanicity



HSAG agreed with 100 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 100 percent of reported results for rural counties, and 65.8 percent of reported results for urban counties.

Figure 4-4 displays the percentage of physical health primary care network results achieving 100 percent, 95.0 to 99.9 percent, 90.0 to 94.9 percent, and less than 90.0 percent of minimum network requirements for Medicaid MCO members by urbanicity for FY 2024–2025.

Figure 4-4—Percentage of Aggregate Medicaid MCO Physical Health Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity



Since the Medicaid MCOs are contracted to cover different Colorado counties (Appendix D), each combination of a network time and distance network requirement and county is measured separately. Not all members may reside within the Medicaid MCOs' contractual minimum network requirements for one practitioner in a given network category. As such, Figure 4-4 summarizes the number of physical health entity, primary care, and specialist results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- Minimum time and distance physical health entity requirements include Acute Care Hospitals and Pharmacies. Medicaid MCOs are required to ensure that all members have one physical health entity

from each specified network type available within the specified time and distance network requirement.

- Minimum time and distance physical health primary care requirements include Pediatric, Adult, and Family Primary Care Practitioners, as well as OB/GYN practitioners. Medicaid MCOs are required to ensure that all members have two physical health primary care practitioners from each specified network type available within the specified time and distance requirement.
- Minimum time and distance physical health specialist requirements refer to practitioners such as cardiologists, endocrinologists, and gastroenterologists. Medicaid MCOs are required to ensure that all members have one physical health specialist practitioner from each specified network type available within the minimum network requirement.

Table 4-6 through Table 4-8 display the aggregated percentages and total counts reflected in Figure 4-4.

Physical Health Entities

Table 4-6—Aggregated Medicaid MCO Physical Health Entity Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	100%	33.3%	12.5%
≤ 5.0 Percentage Points	0%	50.0%	87.5%
5.1–10.0 Percentage Points	0%	8.3%	0%
> 10.0 Percentage Points	0%	8.3%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 26 physical health entity results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined MCOs are contracted to serve.

- Of the aggregated frontier county physical health entity results: 100 percent met the minimum network requirements (i.e., 100 percent of MCO members had access to physical health entities within the minimum network requirements).
- Of the aggregated rural county physical health entity results: 33.3 percent met the minimum network requirements. An additional 50.0 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 8.3 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 8.3 percent were greater than 10.0 percentage points away from the minimum network requirements.

- Of the aggregated urban county physical health entity results: 12.5 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, and 87.5 percent were less than or equal to 5.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

Table 4-7—Aggregated Medicaid MCO Physical Health Primary Care Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	95.8%	95.8%	46.9%
≤ 5.0 Percentage Points	0%	4.2%	53.1%
5.1–10.0 Percentage Points	0%	0%	0%
> 10.0 Percentage Points	4.2%	0%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 104 physical health primary care results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined MCOs are contracted to serve.

- Of the aggregated frontier county physical health primary care results: 95.8 percent met the minimum network requirements and 4.2 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county physical health primary care results: 95.8 percent met the minimum network requirements and 4.2 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health primary care results: 46.9 percent met the minimum network requirements, and 53.1 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements.

Physical Health Specialist

Table 4-8—Aggregated Medicaid MCO Physical Health Specialist Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	100%	84.2%	31.3%
≤ 5.0 Percentage Points	0%	9.2%	68.8%
5.1–10.0 Percentage Points	0%	0%	0%
> 10.0 Percentage Points	0%	6.7%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

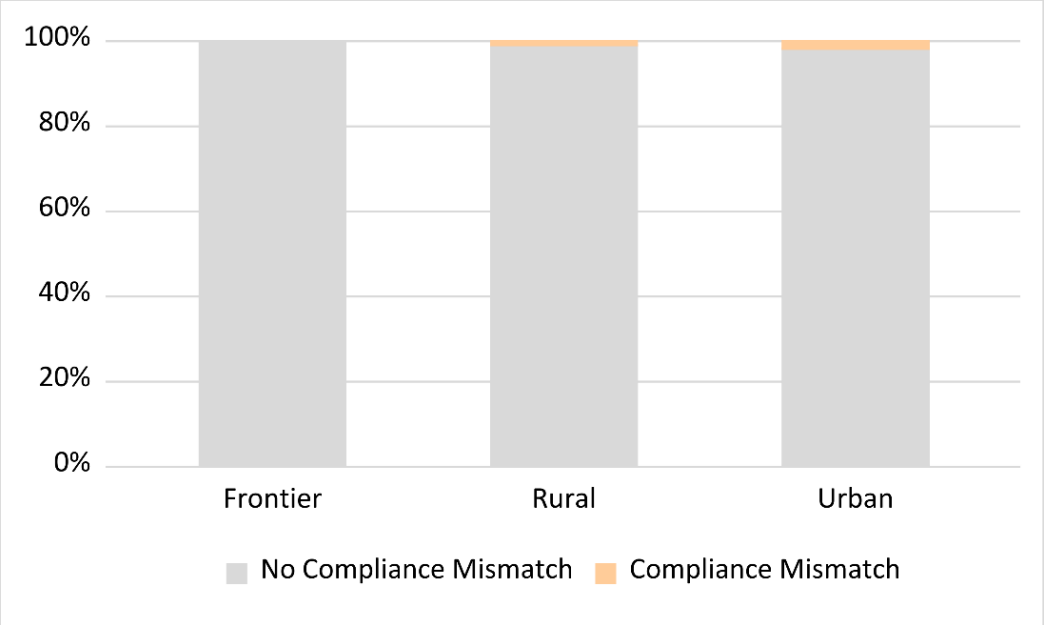
HSAG assessed a total of 286 physical health specialist results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined MCOs are contracted to serve.

- Of the aggregated frontier county physical health specialist results: 100 percent met the minimum network requirements (i.e., 100 percent of MCO members had access to physical health specialists within the minimum network requirements).
- Of the aggregated rural county physical health specialist results: 84.2 percent met the minimum network requirements, 9.2 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 6.7 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health specialist results: 31.3 percent met the minimum network requirements, and 68.8 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements.

Dental PAHP

Figure 4-5 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCE's quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCE's quarterly geoaccess compliance results) for the PAHP by urbanicity.

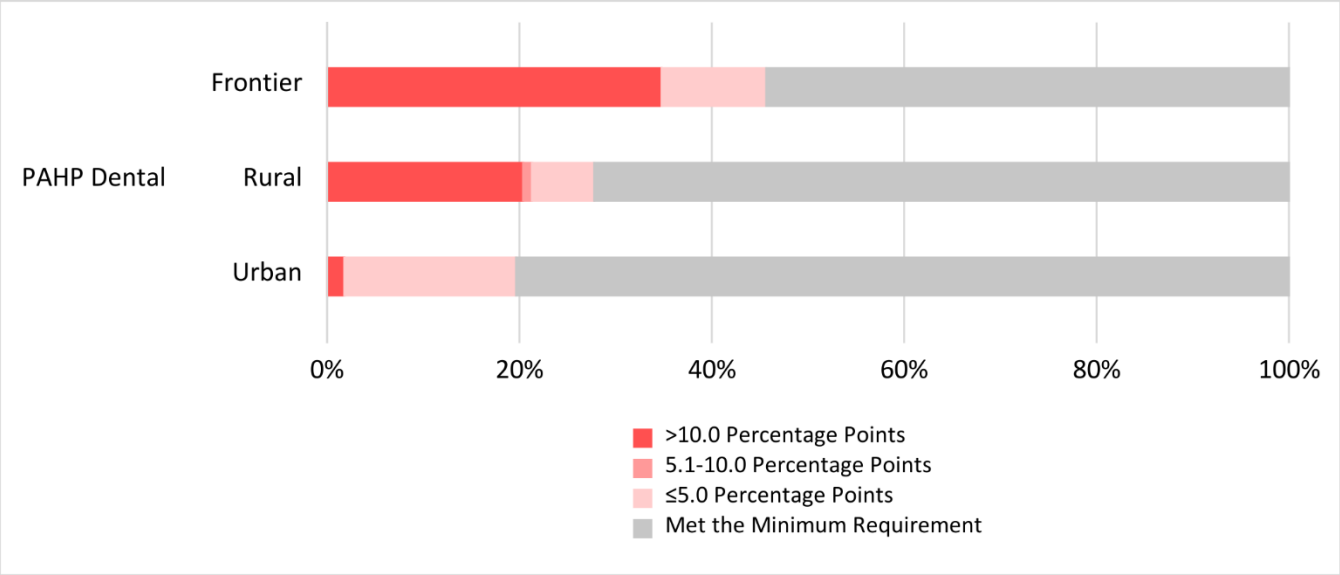
Figure 4-5—Aggregate PAHP Geoaccess Compliance Results for FY 2024–2025 by Urbanicity



HSAG agreed with 100 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 99.1 percent of reported results for rural counties, and 98.2 percent of reported results for urban counties.

Figure 4-6 displays the percentage of dental network results having 100 percent, 95.0 to 99.9 percent, 90.0 to 94.9 percent, and less than 90.0 percent of PAHP members with access in the network requirement by urbanicity for FY 2024–2025.

Figure 4-6—Percentage of Aggregate PAHP Dental Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity



Since contract requirements vary by urbanicity, and the PAHP is contracted to cover all Colorado counties (Appendix D), each combination of a time and distance network requirement and county is measured separately. Not all members may reside within the PAHP's contractual minimum network requirements for one practitioner in a given network category. As such, Figure 4-6 summarizes the number of dental results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- Minimum time and distance dental requirements pertain to general and pediatric dentists, as well as practitioners specializing as oral surgeons or orthodontists (Appendix E). The PAHP is required to ensure that all members have one dental practitioner from each specified network type available within the specified time and distance requirement.

Table 4-9 displays the aggregated percentages and total counts reflected in Figure 4-6.

Dental Services

Table 4-9—Aggregated PAHP Dental Service Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	54.3%	72.2%	80.4%
≤ 5.0 Percentage Points	10.9%	6.5%	17.9%
5.1–10.0 Percentage Points	0%	0.9%	0%
> 10.0 Percentage Points	34.8%	20.4%	1.8%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

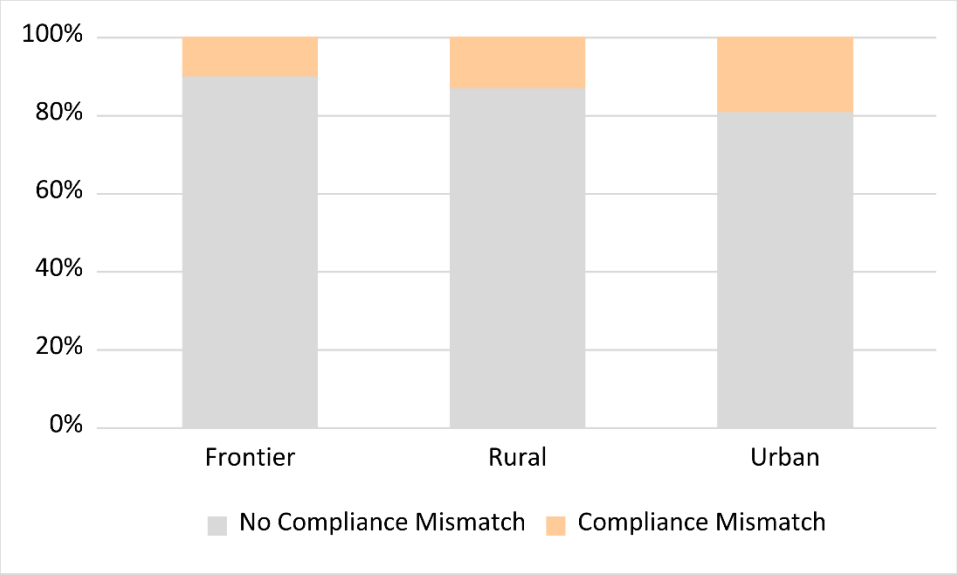
HSAG assessed a total of 256 dental service results, summarizing the percentage of members within each minimum network requirement and Colorado county the PAHP is contracted to serve.

- Of the aggregated frontier county dental service results: 54.3 percent met the minimum network requirements. An additional 10.9 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 34.8 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county dental service results: 72.2 percent met the minimum network requirements. An additional 6.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.9 percent of the results were within 5.0 and 10.0 percentage points away from the minimum network requirements, and 20.4 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county dental service results: 80.4 percent met the minimum network requirements. An additional 17.9 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 1.8 percent were greater than 10.0 percentage points away from the minimum network requirements.

RAEs

Figure 4-7 displays the rate of compliance mismatch (i.e., HSAG did not agree with the MCEs' quarterly geoaccess compliance results) and no compliance mismatch (i.e., HSAG agreed with the MCEs' quarterly geoaccess compliance results) among all RAEs by urbanicity.

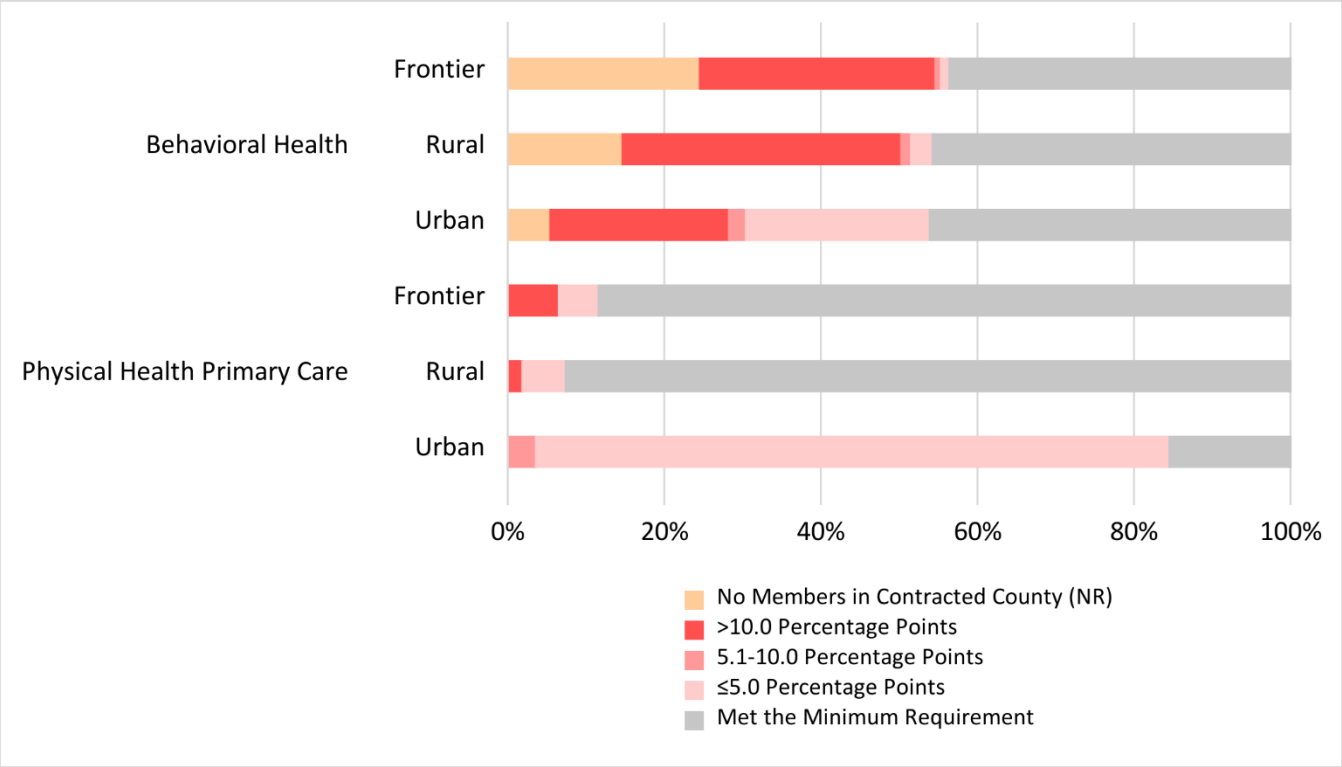
Figure 4-7—Aggregate RAE Geoaccess Compliance Results for FY 2024–2025 by Urbanicity



HSAG agreed with 90.3 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 87.3 percent of reported results for rural counties, and 81.2 percent of reported results for urban counties.

Figure 4-8 displays the percentage of behavioral health results for the RAEs and DHMP, and physical health primary care results for the RAEs having 100 percent, 95.0 to 99.9 percent, 90.0 to 94.9 percent, and less than 90.0 percent of members with access in the network requirement by urbanicity for FY 2024–2025.

Figure 4-8—Percentage of Aggregate RAE and DHMP Behavioral Health and RAE Physical Health Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity



Since the RAEs and DHMP are contracted to cover different Colorado counties (Appendix D), each combination of a minimum network requirement and county is measured separately. Not all members may reside within the RAEs' contractual minimum network requirements for two or more practitioners in a given network category. As such, Figure 4-8 summarizes the number of behavioral health and physical health primary care results (i.e., minimum network requirement and county combinations) in which all members had access within the network requirement, or a lower percentage of members had access within the network requirement for the county.

- Minimum time and distance behavioral health requirements include Pediatric and Adult Psychiatrists and other Psychiatric Prescribers and SUD Treatment Practitioners and entities, as well as Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals. The RAEs and DHMP are required to ensure that all members have two behavioral health practitioners or practice sites from each specified network type available within the specified time and distance requirement.

- Minimum time and distance physical health primary care requirements include Pediatric, Adult, and Family Primary Care Practitioners. The RAEs are required to ensure that all members have two primary care practitioners from each specified network type available within the specified time and distance network requirement.

Table 4-10 and Table 4-11 display the aggregated percentages and total counts reflected in Figure 4-8.

Behavioral Health

Table 4-10—Aggregated RAE and DHMP Behavioral Health Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	43.6%	45.7%	46.1%
≤ 5.0 Percentage Points	1.1%	2.7%	23.5%
5.1–10.0 Percentage Points	0.7%	1.3%	2.2%
> 10.0 Percentage Points	30.1%	35.6%	22.8%
No Members (NR)	24.5%	14.6%	5.4%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 6,272 behavioral health results, summarizing the percentage of members within each minimum network requirement and Colorado county the combined RAEs and DHMP are contracted to serve.

- Of the aggregated frontier county behavioral health results: 43.6 percent met the minimum network requirements, 1.1 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.7 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 30.1 percent of the results were greater than 10.0 percentage points away from the minimum network requirements. An additional 24.5 percent of aggregate results had no members within the specified counties for the behavioral health requirements.
- Of the aggregated rural county behavioral health results: 45.7 percent met the minimum network requirements, 2.7 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.3 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 35.6 percent of the results were greater than 10.0 percentage points away from the minimum network requirements. An additional 14.6 percent of aggregate results had no members within the specified counties for the behavioral health requirements.

- Of the aggregated urban county behavioral health results: 46.1 percent met the minimum network requirements, 23.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 2.2 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 22.8 percent were greater than 10.0 percentage points away from the minimum network requirements. An additional 5.4 percent of aggregate results had no members within the specified counties for the behavioral health requirements.

Physical Health Primary Care

Table 4-11—Aggregated RAE Physical Health Primary Care Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity[1]

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	88.4%	92.6%	15.5%
≤ 5.0 Percentage Points	5.1%	5.6%	81.0%
5.1–10.0 Percentage Points	0%	0%	3.6%
> 10.0 Percentage Points	6.5%	1.9%	0%

[1] Due to rounding, total percentages by urbanicity may not sum to 100 percent.

HSAG assessed a total of 384 physical health primary care results, summarizing the percentage of members within each minimum network requirement and Colorado county the RAEs are contracted to serve.

- Of the aggregated frontier county physical health primary care results: 88.4 percent met the minimum network requirements (i.e., 100 percent of RAE members had access to physical health primary care within the minimum network requirements). An additional 5.1 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 6.5 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county physical health primary care results: 92.6 percent met the minimum network requirements. An additional 5.6 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 1.9 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health primary care results: 15.5 percent met the minimum network requirements. An additional 81.0 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 3.6 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements.

Network Changes and Deficiencies

The Department requested that HSAG, incorporate an overview of network changes and deficiencies reported in FY 2024–2025 into the annual report. As a part of the quarterly NAV data collection process, the MCEs are responsible for reporting all changes or deficiencies in their networks related to access to care within five business days of the change in writing to the Department.

During FY 2024–2025, the MCEs did not report deficiencies in the networks related to access to care.

5. Discussion

Conclusions

The Department requested that HSAG conduct NAV activities for the Health First Colorado and CHP+ practitioner/practice/entity networks for all MCEs during FY 2024–2025 under the EQR contract. The FY 2024–2025 NAV activity built upon the FY 2023–2024 NAV activity, designed to be a robust validation of Colorado's network adequacy and executed in alignment with federal regulations.

ISCA

HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid and CHP+ services in Colorado, and presented findings and assessment of any concerns related to data sources used in the NAV. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the assessed MCEs. Based on the findings from the ISCA activity, HSAG determined that all MCEs adhered to acceptable data collection procedures. Half of the MCEs did not rely on an external delegated entity for network adequacy indicator reporting during the reporting period. For the MCEs that did utilize external delegated entities as part of the network adequacy indicator reporting during the reporting period, HSAG did not identify issues requiring correction.

NAV

HSAG assessed the rates of the compliance with the minimum network requirements across all MCEs and urbanicities. HSAG observed that an aggregate of 71.5 percent of rural counties, 69.5 percent of frontier counties, and 49.4 percent of urban counties met all applicable minimum network requirements in contracted counties. Additionally, since the RAEs and DHMP MCO are contractually required to maintain a statewide behavioral health network, HSAG assessed the rate of compliance with the minimum network requirements for non-contracted counties. HSAG observed that an aggregate 48.5 percent of urban counties, 44.8 percent of rural counties, and 41.2 percent of frontier counties met all applicable minimum network requirements in non-contracted counties.

The CHP+ MCOs, Medicaid MCOs, and RAEs each exhibited strength within their behavioral health networks, particularly for General and Pediatric Behavioral Health. For these provider categories, 100 percent of contracted counties and/or counties statewide where members were present met the minimum network requirements.

The CHP+ MCOs demonstrated strength in the General and Pediatric Behavioral Health and Pediatric Psychiatrists and other Psychiatric Prescribers categories, with 100 percent of contracted counties where members were present meeting the minimum network requirements. Additionally, CHP+ MCO showed strength in their physical health network, particularly in Adult and Pediatric Primary Care (MD, DO, NP, CNS) and Family Practitioner (MS, DO, NP, CNS) provider categories with over 93.0 percent of all contracted counties where members were present meeting the minimum network requirements.

However, across all CHP+ MCO-contracted counties, 93.6 percent did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals.

DHMP MCO exhibited strength in both the General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers categories, with both MCEs meeting minimum network requirements for these provider categories across all contracted counties and/or counties statewide where members were present. However, DHMP MCO did not meet the minimum network requirements for Acute Care Hospitals or General Endocrinology in 100 percent of contracted counties.

RMHP Prime demonstrated strength in Adult and Pediatric Primary Care Practitioners (MD, DO, NP, CNS and PA), Family Care Practitioners (MD, DO, NP, CNS, and PA) and pediatric specialties including Cardiology, Neurology, Ophthalmology, Orthopedics, Otolaryngology/ENT, Pulmonary Medicine, Surgery and Urology. For these provider categories, 100 percent of contracted counties met the minimum network requirements. However, RMHP Prime did not meet the minimum network requirements for Acute Care Hospitals in 55.6 percent of the contracted counties.

The PAHP demonstrated a strong network of General Dentists, meeting all minimum network requirements in 87.5 percent of contracted counties. However, the PAHP was not able to meet the minimum network requirements for Pediatric Dentists in 56.3 percent of the contracted counties.

The RAEs met all minimum network requirements for both General and Pediatric Behavioral Health, in 100 percent of contracted counties and/or counties statewide where members were present. Additionally, the RAEs met the minimum network requirements in more than 85.0 percent of the contracted counties and/or counties statewide for General and Pediatric Psychiatrists and other Psychiatric Prescribers. However, over 89.0 percent of all contracted counties and/or counties statewide with the RAEs' did not meet the minimum network requirements for Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals and SUD Treatment Facilities–ASAM 3.3.

Network Adequacy Validation Ratings

Based on the results of the ISCAs combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the MCEs' interpretation of data was accurate. Table 5-1 presents the HSAG calculated validation ratings for each of the MCEs.

Table 5-1—Validation Ratings by MCE[1]

MCE	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
COA CHP+	100%	0%	0%	0%
COA RAE Region 3	100%	0%	0%	0%
COA RAE Region 5	100%	0%	0%	0%
CCHA RAE Region 6	100%	0%	0%	0%
CCHA RAE Region 7	100%	0%	0%	0%
DentaQuest	100%	0%	0%	0%
DHMP CHP+	18.9%	81.1%	0%	0%
DHMP MCO	56.5%	43.5%	0%	0%
HCI RAE Region 4	100%	0%	0%	0%
Kaiser	100%	0%	0%	0%
NHP RAE Region 2	100%	0%	0%	0%
RMHP CHP+	100%	0%	0%	0%
RMHP RAE Region 1	100%	0%	0%	0%
RMHP Prime	100%	0%	0%	0%

[1] The percentages presented in the tables are based on the total number of indicators assessed and what percentage of the indicators scored *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence/Significant Bias* overall. The sum of the percentages of validation ratings per MCE may not equal 100 percent due to rounding.

Analytic Considerations

Various factors associated with the FY 2024–2025 NAV may affect the validity or interpretation of the results presented in this report, including, but not limited to, the following analytic considerations and data-related caveats:

- HSAG validated the MCEs' self-reported time and distance geoaccess compliance results, reflecting the network categories and corresponding practitioner, practice site, or entity attributions listed in Appendix E. Each MCE's network may include practitioners, practice sites, and entities that support additional healthcare services covered by Colorado's Health First Colorado or CHP+ programs.
  - For many network categories, the MCEs must demonstrate that 100 percent of their members reside within the minimum network requirements to be found in compliance with the network contract requirements. As a result, an MCE's failure to demonstrate that 100 percent of members

have access to the minimum network requirements may not necessarily equate to a network concern, and the MCE may have alternative methods of ensuring members' access to care (e.g., the use of telehealth or mail-order pharmacy services).

  - NAV findings are associated with the MCEs' network data files for all practitioners, practice sites, and entities active with each MCE as of December 31, 2024, and are contingent on the quality of member and network data supplied by the MCEs. Any substantial and systematic errors in the MCEs' member data, network data, and/or geoaccess compliance reporting submissions may compromise the validity and reliability of the FY 2024–2025 NAV results, including the following detailed considerations:
  - HSAG and the Department directed the MCEs to use the Department-approved Network Crosswalk from December 2024 when preparing network data. A lack of compliance identified during the NAV analyses may reflect either a lack of contracted practitioners, practice sites, or entities for the specified MCE, or an MCE's challenges in aligning internal network data with the Department-approved Network Crosswalk categories.
  - For the MCE network data reflected as of December 31, 2024, a change was made with how SUD treatment facilities and the ASAM levels of care were identified and reported. It is possible that the change may yield network adequacy results and reported provider counts that were not consistent with prior analyses.
  - For alignment with the MCEs' geoaccess compliance reports, HSAG primarily used the member county attributions noted in the MCEs' data for the NAV analyses. If an MCE's data were missing the member's county, HSAG used the QAS to identify the member's county of residence for records with an exact address match to the geocoding resource (i.e., the address could be matched to a specific latitude and longitude).
  - HSAG's NAV analyses used members' residential addresses and network service addresses as supplied in the MCEs' data, and addresses may not reflect members' actual place of residence or service locations available to offer on-site services.

- The time and distance calculations reflected in the FY 2024–2025 NAV represent a high-level measurement of the similarity of the geographic distribution of network locations relative to members. These raw, comparative statistics do not account for the individual status of a practitioner's panel (i.e., accepting or not accepting new patients) at a specific location or how active the network location is in the Health First Colorado or CHP+ programs.
  - It is likely that network locations are contracted to provide services for more than one MCE. As such, time and distance results highlight the geographic distribution of a network for all available network locations noted in the MCEs' network data files, without considering potential barriers to new patient acceptance or appointment availability at individual service locations.
  - Prior to calculating time and distance results, HSAG geocoded the MCEs' network and member data to assign latitude and longitude values to each record. A limited percentage of records could not be geocoded and were subsequently excluded from NAV analyses.
  - The MCEs' address data may not always reflect a member's place of residence (e.g., use of PO Boxes), or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). For a small percentage of members, the geographic

coordinates assigned to the members may not align with the member's exact residential location for records that do not use a standard street address.

Promising Practices and Opportunities for Improvement

Based on the FY 2024–2025 NAV process and analytic results, HSAG offers the following promising practices and opportunities to support the Department's ongoing efforts to provide consistent oversight of the MCEs' compliance with network adequacy contract requirements and the provision of high-quality network data:

- Enhance Network Data Quality: As an ongoing refinement to the quarterly network adequacy reporting process, the Department has directed its EQRO to incorporate additional data verification processes into the quarterly NAV. In FY 2021–2022, HSAG introduced the Network Adequacy Data Initial Validation (NADIV) process and data display dashboard to enhance the thoroughness of quarterly data quality review. HSAG provided initial data quality results quarterly to the MCEs and the Department in the NADIV dashboards beginning in FY 2021–2022 and maintained this process during the FY 2024–2025 NAV activity, working closely with the Department and the MCEs to ensure access and support continued use of the interactive tool. The NADIV dashboards reflect HSAG's review of the MCEs' most recent quarterly network adequacy data submissions, including any potential findings warranting an MCE's data resubmission or clarification, and make results available to the Department and Colorado MCEs through a Web portal.
  - The MCEs' network data quality could be further enhanced by cross-referencing against the Department's interChange data to confirm MCE practitioner network National Provider Identifiers (NPIs), practitioner identification values, practitioner addresses, and taxonomy codes to determine the extent to which each MCE's network aligns with the practitioner/practice site/entities enrolled in interChange.
  - The Department may consider providing guidance to the MCEs regarding members identified without a physical address and whether those members should be included or excluded from the NAV analysis to ensure consistency across the MCEs. Additionally, the Department and the MCEs should collaborate to ensure that an appropriate address is available to all members who have a residential address. If an MCE has a large population of unhoused or unsheltered members, the Department may consider requesting the MCE discuss ways it ensures those members have access to care.
  - Enhance Network Oversight Processes: The Department has maintained significant growth in its oversight of the MCEs' networks through standardized quarterly network adequacy reporting materials, developed and implemented in the previous fiscal year. The Department may consider continuing to address network adequacy concerns in circumstances in which the MCEs are persistently unable to meet applicable Colorado NAV time and distance standards. Future enhancements may include, but are not limited to, the following:
  - The Department may consider the extent to which the MCEs offer alternative service delivery mechanisms to ensure members' access to care when minimum network requirements may not be the most appropriate method of measuring access for certain geographic areas and/or network

categories. For example, the Department may consider the extent to which an MCE offers and ensures that members are able to use telehealth modalities to obtain services when practitioners are not available in rural or frontier counties.

  - While generally the MCEs are doing quite well, there were minor inconsistencies in the methodology used across the MCEs for calculating the NAV indicators. The Department may consider providing further guidance around expectations for methodology on calculating time or distance and ratio standards (e.g., provider ratios should be calculated at the individual provider level, not for provider locations, and time distance should be calculated using driving distance instead of straight line distance) to ensure consistency across the MCEs.
  - HSAG understands that the Department plans to add an exception request process starting in FY 2025–2026 that will allow the MCEs to request an exception for provider categories and counties where the MCE is unable to meet the minimum network requirement due to a lack of providers or other barriers to access.

- Expand Network Adequacy Assessment: To further assess network adequacy, the Department may integrate specified data review topics into network adequacy analysis and an expansion of the NAV dashboard to reflect specific initiatives and goals. Future expansions may include, but are not limited to, the following:
  - In addition to the number of practitioners accepting Medicaid members, the Department may consider asking the MCEs to submit practitioner panel capacity data indicating the number of Medicaid members they are able or willing to accept for treatment to better assess the adequacy of the network in meeting healthcare needs for enrolled Medicaid members. While the geographic distribution of practitioners is assessed through time and distance standards, the analysis does not account for whether those practitioners have the capacity to serve the number of Medicaid members in the respective catchment areas. Further consideration of practitioner panel capacity would allow for a better understanding of network adequacy in terms of capacity to serve members.
  - When analyzing network adequacy, it is important to consider that the list of network practitioners' physical locations may not accurately or completely represent an enrolled member's access to services. The Department may consider conducting additional analyses such as using claims and encounter data to identify which of the MCEs' network of practitioners are actively providing services to members during the measurement period. To the extent that contracted practitioners are not actively serving Medicaid members, the time and distance analyses based on the list of contracted practitioners may not be an accurate reflection of the network as experienced by Medicaid members. Future access to care evaluations may incorporate the MCEs' claims and encounter data to assess members' utilization of services and potential gaps in access to care associated with inactive practitioners in the network.
  - The Department may consider the incorporation and utilization of claims and encounter data to assess network adequacy based on population need. To the extent that current network standards take into account the population need for different practitioner types, the standards may not capture the full picture of network adequacy to meet the needs of the population. The use of historical claims and encounter data to identify population needs and utilization, and application of that knowledge to the development of standards that more closely align with population needs

would provide the Department, the MCEs, and Medicaid members with networks better structured to provide appropriate and adequate care. Additionally, the Department may establish alternative metrics for measuring population need and determining network adequacy based on need that may be applied to future assessment and adjustment of network adequacy standards.

Appendix A. Methodology

ISCA Methodology

Validation of network adequacy consists of several activities that fall into three phases of activities: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the MCEs, HSAG obtained all Department-defined network adequacy standards and indicators that the Department requires for validation.

HSAG prepared a DRP that was submitted to each MCE outlining the activities conducted during the validation process. The DRP included a request for documentation to support HSAG's ability to assess the MCEs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. Data and documentation from the MCEs such as, but not limited to, network data files or directories and member enrollment files, were obtained through a single documentation request packet provided to each MCE.

HSAG hosted an MCE-wide webinar focused on providing technical assistance to the MCEs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

Validation activities were conducted via interactive virtual review and are referred to as "virtual review," as the activities are the same in a virtual format as in an on-site format.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring:** HSAG conducted an ISCA by using each MCE's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCE tracks providers over time, across multiple office locations, and through changes in participation in the MCE's network. The ISCAT was used to assess the ability of the MCE's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCE's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

- **Validate network adequacy logic for calculation of network adequacy indicators:** HSAG required each MCE that calculated the Department-defined indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG completed a line-by-line review of the logic provided to ensure compliance with the Department-defined performance indicator specifications. HSAG identified whether the required variables were in alignment with the Department-defined indicators used to produce the MCE's indicator calculations. HSAG required each MCE that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCE took for indicator calculation.
- **Validate network adequacy data and methods:** HSAG assessed data and documentation from MCEs that included, but was not limited to, network data files or directories, member enrollment data files, claims and encounter data files (if applicable), member experience survey results, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results:** HSAG assessed the MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and Department network adequacy monitoring results. HSAG validated network adequacy reporting against Department-defined indicators and against the most recent network adequacy reports to assess trending patterns and reasonability of reported indicator-level results, if available. HSAG assessed whether the results were valid, accurate, and reliable, and if the MCE's interpretation of the data was accurate.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

HSAG conducted a virtual review with the MCEs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities are described below:

- Opening meeting
- Review of ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted several interviews with key MCE staff members who were involved with the calculation and reporting of network adequacy indicators. Appendix B lists the MCE interviewees.

Opening meeting: The opening meeting included an introduction of the validation team and key MCE staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.

Review of the ISCAT and supporting documentation: This session was designed to be interactive with key MCE staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and understand systems and processes for maintaining and updating provider data and assessing the MCE's information systems required for network adequacy validation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

Evaluation of underlying systems and processes: HSAG evaluated the MCE's information systems, focusing on the MCE's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCE oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.

Overview of data collection, integration, methods, and control procedures: The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator for FY 2024–2025. HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network adequacy source data PSV and results: HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level. PSV is a review technique used to confirm that the information from the primary source information systems matches the analytic output files used for reporting. Using this technique, HSAG assessed the methods, logic, and processes used to confirm accuracy of the data and detect errors. HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by the MCE or obtained through external entities matched. For example, the PSV review may detect programming logic errors resulting in further root cause analysis and corrections. HSAG reviewed indicator-level results and assessed alignment with state-defined requirements.

Closing conference: The closing conference included a summation of preliminary findings based on the review of the underlying systems and processes, data collection, integration, and methods used. In

addition, it included findings from the virtual review and documentation requirements for any post-virtual review activities.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and Department network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCE used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-1.

Table A-1—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have Significant Bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-2, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-2—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has Significant Bias on the results	*No Confidence*

Table A-3 and Table A-4 present sample validation rating determinations. Table A-3 presents an example of a validation rating determination that is based solely on the validation score, as there were no *Not Met* elements that were determined to have Significant Bias on the results, whereas Table A-4 presents an example of a validation rating determination that includes a *Not Met* element that had Significant Bias on the results.

Table A-3—Example Validation Rating Determination—No Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	16	*Moderate Confidence*
B. Total number of *Not Met* elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of *Not Met* elements determined to have Significant Bias on the results	0	

Table A-4—Example Validation Rating Determination—Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	15	*No Confidence*
B. Total number of *Not Met* elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of *Not Met* elements determined to have Significant Bias on the results	1	

Significant Bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had Significant Bias on the results by:

- Requesting that the MCE provide a root cause analysis of the finding.
- Working with the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for Significant Bias.

NAV Methodology

This section summarizes the FY 2024–2025 NAV methodology, including HSAG's NAV analyses and collaborative activities with the Department to update quarterly network adequacy reporting materials used by each MCE to submit contractually required network adequacy reports to the Department. HSAG conducted NAV analyses of the Medicaid and CHP+ healthcare practitioner, practice group, and entity networks for all MCEs during FY 2024–2025, validating the systems and processes, data sources, methods, and results according to the CMS EQR Protocol 4. Please recall that the results described in Section 4: Network Adequacy Validation Results represent the most recent measurement period reflecting the MCEs' networks from October 1, 2024, through December 31, 2024.

Data Collection

Network data are collected and maintained using varying data fields, formats, and levels of specificity across the MCEs and the Department, resulting in ongoing collaborative efforts to support consistent, comparable network information. To support the MCEs' quarterly requirement to submit network adequacy reports to the Department, HSAG collaborated with the Department to update and distribute standardized quarterly network adequacy reporting materials for each MCE type.[4]

[4] Quarterly network adequacy reporting materials include the network crosswalk; a Microsoft Word (Word) document describing the network categories and the criteria for uniform identification of practitioners, practice groups, and/or entities within each network category; Word and Excel reporting template files used by the MCEs to submit quarterly network adequacy reports to the Department; and an MCE data submission requirements document describing the data elements and submission requirements for quarterly network adequacy data files.

Network Adequacy Data and Documentation Request

This section describes HSAG's process for requesting data and documentation from plans and the Department for the FY 2024–2025 NAV analysis.

Request for the MCEs' Network and Member Data

HSAG has collaborated with the Department to develop network crosswalk definitions and standardized network adequacy reporting materials, with the goal of standardizing the MCEs' quarterly network adequacy reports and network data collection to facilitate the EQRO's validation of the MCEs' NAV results. On December 13, 2024, HSAG sent each MCE a reminder notice regarding the January 31, 2025, deadline to submit the FY 2024–2025 Q2 network adequacy report and data files. Each MCE's reminder notice included an MCE-specific network adequacy quarterly geoaccess results report template containing the MCE's applicable network requirements and contracted counties.

To conduct the FY 2024–2025 NAV, HSAG collaborated with the Department to develop and update detailed network and member data requirements documents, supplied to the MCEs as a component of their quarterly network adequacy reporting to the Department. To allow consistent network definitions across the MCEs and over time, HSAG supplied the MCEs with the Department-approved December 2024 version of the Network Crosswalk for use in assigning practitioners, practice sites, and entities to uniform network categories.

Request for the Department's Member Data

Concurrent with requesting the MCEs' network and member data, HSAG requested Medicaid and CHP+ member files from the Department using a detailed member data requirements document for members actively enrolled with an MCE as of December 31, 2024. During the FY 2024–2025 NAV, HSAG used the Department's member data to assess the completeness of the MCEs' member data submissions (e.g., comparing the number of members by county between the two data sources). During the FY 2024–2025 NAV, HSAG used the Department's member data to verify that the MCEs' member data were complete and accurate.

Geoaccess Analyses

HSAG used the MCEs' network and member data to conduct NAV analyses to evaluate the geographic distribution of an MCE's network location relative to the MCE's Health First Colorado or CHP+ populations. For each MCE, HSAG calculated the following spatially derived metric, for the network categories applicable to the MCE type:

- Percentage of members within predefined minimum access requirements: A higher percentage of members within the contractually required time and distance to the practitioner, practice, or entity indicates better geographic distribution of an MCE's network locations in relation to its Health First Colorado or CHP+ members. This metric was calculated for the network categories for which the Department identified a minimum time and distance access requirement prior to initiation of the analysis.

Prior to analysis, HSAG assessed the completeness and validity of selected data fields critical to the NAV analyses from the MCEs' member and network data files. Within the MCEs' network and member data files, HSAG conducted a variety of validation checks for fields pertinent to the time and distance calculations, including the following:

- Evaluating the extent of missing and invalid data values.
- Compiling the frequencies of data values.
- Comparing the current data to the MCEs' prior quarterly data submissions.

Key member data fields included, but were not limited to, Medicaid ID, gender, DOB, and residential address. Key network data fields included, but were not limited to, Medicaid ID; NPI; service address; network category code; and practitioner type, specialties, taxonomy code(s), and degree(s)/credential(s), as applicable to the network category. HSAG also used the Department's member data to assess the completeness and reasonability of the MCEs' member data files (e.g., assessing the proportion of members residing outside of an MCE's assigned counties and comparing the results to prior quarters' data). Through the NADIV dashboards, HSAG supplied each MCE with feedback on initial file review findings and stated whether clarifications and/or data file resubmissions were required.

Following the initial data review and HSAG's receipt of the MCEs' data resubmissions and/or clarifications, HSAG reviewed the member and network addresses to ensure they could be geocoded (i.e., latitude and longitude could be assigned to each record). Geocoded member and network data were assembled and used to conduct plan type specific (PAHP, Medicaid MCO, RAE, and CHP+) analysis using the QAS Version 2024.4 software.

HSAG used QAS to calculate the duration of travel time or physical (driving) distance between the members' addresses and the addresses of the nearest practitioner(s) for the selected network categories. Drive times were estimated by QAS based on the following driving speeds: urban areas are estimated at a driving speed of 30 miles per hour, suburban areas are estimated at a driving speed of 45 miles per hour, and rural areas are estimated at a driving speed of 55 miles per hour.

Consistent with the Department's instructions to the MCEs, HSAG used the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier.[5] Urban counties with rural areas (i.e., Larimer, Mesa, and Park counties) were reported with the rural counties and use the rural minimum network requirements (Appendix E). HSAG used the counties listed in the MCEs' member data files to attribute each member to a Colorado county for the county-level time and distance calculations (i.e., the number and percentage of members residing in the specified county with a residential address within the minimum time and distance requirement for the specific network requirement among all applicable practitioners, regardless of the practitioners' county). For MCE member records missing the county information, HSAG used the county identified by QAS if the

[5] Colorado Rural Health Center, State Office of Rural Health. Colorado: County Designations, 2022. Available at: https://coruralhealth.org/wp-content/uploads/2013/10/2022-county-designations.pdf. Accessed on: May 19, 2025.

address was an exact match during the geocoding process. Members who could not be attributed to a Colorado county were excluded from NAV analyses.

NAV Dashboard and NADIV Dashboard

Following an analytic review of submitted quarterly data files from the MCEs, HSAG provided the Department with the initial data quality assessment results in the NADIV dashboard tool. The NADIV dashboards reflect HSAG's review of the MCEs' most recent quarterly network adequacy data submissions, including any potential findings warranting an MCE's data resubmission or clarification.

- The *Metric Results Overview* dashboard reflects the MCEs' member and practitioner data quality metric results for the data files each MCE submitted for quarterly NAV analysis. The dashboard displays file details of submitted data and any actions that may be required from the MCEs, as well as individual metric results.
- The *Network Category and Taxonomy Distribution* dashboard details the network category and taxonomy distributions of the practitioner and entity data submitted to HSAG by the MCEs for quarterly NAV analysis.
- The *Data Download—Metric Results* dashboard includes metric results for all submitted data and allows each MCE and the Department to filter and download specific metric result datasets.

Upon completing the quarterly time and distance calculations and comparing the compliance results to the MCEs' self-reported geoaccess compliance results, HSAG provided the Department with the results in the NAV dashboards. The NAV dashboards, described below, included a comparison of the MCEs' self-reported NAV results and HSAG's calculated NAV results.

- The *Network Adequacy Assessment Comparison—Time and Distance* dashboard assessed the differences between the time and distance results submitted by the MCEs and the time and distance results calculated by HSAG. Each dashboard included a table and a map. The table for this dashboard could be filtered by MCE type, MCE name, urbanicity, county, network category, and compliance mismatch; the map for this dashboard could be filtered by MCE type, MCE name, and network category.
- The *Time and Distance Network Standards Assessment* dashboard assessed MCE compliance with the minimum network requirements by MCE, county, urbanicity, and network category, based on the time and distance results calculated by HSAG. The table for this dashboard could be filtered by MCE type, MCE name, urbanicity, county, network category, and compliance result; the map could be filtered by MCE type, MCE name, and network category.
- The *Time and Distance Standards Assessment—Trending* dashboard assessed MCE compliance with minimum network requirements compared to the previous quarter by MCE, county, urbanicity, and network category.
- The *Time and Distance Standards Assessment—Results Brief Download* dashboard replaced the MCE-specific Results Briefs provided to the Department with a downloadable dataset detailing a list of the instances in which each MCE reported in its Excel geoaccess spreadsheet that it failed to meet

a network requirement or HSAG calculated a failure to meet a network requirement based on the MCE's submitted data.

Updating the MCEs' Reporting Documentation

HSAG collaborated with the Department to update the quarterly network adequacy reporting templates, network crosswalk, and data requirements used by each MCE to submit contractually required network adequacy information to the Department.

HSAG validated the MCEs' self-reported time and distance results using the minimum network requirements listed in Appendix E. HSAG provided the Department with the validation results in the NAV dashboards. HSAG provided initial data quality results to the MCEs and the Department in the NADIV dashboards.

Appendix B. HSAG Validation Team and List of Interviewees

This section contains a list of the MCE interviewees who attended the virtual review sessions as well as HSAG interviewing staff.

Table B-1 lists the COA staff members interviewed by the HSAG validation team.

Table B-1—List of COA Interviewees

Interviewee Name	Title
Marcy Mullan	Director, Compliance Programs
Danae Wardrup	Business Intelligence Analyst III
Gabriel Bigger	Senior Security Engineer
Stacy Garza	Manager, Member Data Integrity
Travis Roth	Manager, Credentialing and Provider Data
Mike Grimberg	Supervisor of Provider Data Integrity
Jeni Sargent	Director, Member and Provider Data Integrity
David Simpson	Supervisor, Production Control
Isela Lozano	Compliance Policy and Privacy Specialist
Rachel Williamson	Manager, Compliance & Privacy
Anne Taylor	Manager, Provider Recruitment

Table B-2 lists the CCHA staff members interviewed by the HSAG validation team.

Table B-2—List of CCHA Interviewees

Interviewee Name	Title
Cara Hebert	Director, Account Management and External Partnerships and Program Officer
Thomas Johnson	Director, Application Development
Laketa Hicks	Data Integrity Specialist
Chad Jeffers	Manager, Informatics
Josie Dostie	Senior CCHA Network Manager
Andrea Skubal	Contract Manager
Terri Piechocki	IT Market Manager
Marianne Lynn	Compliance Manager
Franchesca Radcliffe	Compliance Manager, Medicaid External Audit Management (EAM)

Interviewee Name	Title
Abigail Roa	Director II, Compliance
Brandi Montoya	Senior Provider Data Analyst
Abhilash Reddy Pilla	Engineer Lead
Eddie Duckworth	Manager II, Engineering

Table B-3 lists the DentaQuest staff members interviewed by the HSAG validation team.

Table B-3—List of DentaQuest Interviewees

Interviewee Name	Title
Logan Horn	CHP+ Program Manager
Jennifer Labishak	Senior Manager, Provider Partner
Liza Morris	Associate Director, Provider Operations
Sarah Cook	Associate Director, Client Partner
Lisa Reynolds	Medicaid Program Manager
Nicole Mantanye	Director, Provider Network Intelligence
Michael Duhamel	Director, Member Enrollment and Benefits

Table B-4 lists the DHMP staff members interviewed by the HSAG validation team.

Table B-4—List of DHMP Interviewees

Interviewee Name	Title
Katie Gaffney	Lead Health Plan Compliance Analyst, Government Products
Jeremy Sax	Government Products Manager
Dr. Christine Seals-Messersmith	Chief Medical Officer
Katie Egan	Manager, Health Plan Quality Improvement
Jessica Stockmyer	Manager of Medical Economics, Denver Health Medical Plan

Table B-5 lists the HCI staff members interviewed by the HSAG validation team.

Table B-5—List of HCI Interviewees

Interviewee Name	Title
Lori Roberts	Chief Executive Officer/Program Officer
Jamie Coahran	Senior Account Service Manager
Alicia Williams	Chief Operations Officer/Director of Operations
Stacey Bassett	Eligibility Business Consultant
Chris Klaric	Manager of Credentialing Operations
Stephen Puzio	Business Analyst III
Hunter Mullins	Business Information Solutions Engineer Senior Advisor BI Architecture
Dario Russo	Business Information Developer
Madeline Dunn	Director, Network Management
Nikoli Streeter	Manager I, Network Data

Table B-6 lists the Kaiser staff members interviewed by the HSAG validation team.

Table B-6—List of Kaiser Interviewees

Interviewee Name	Title
Casey Snow	Accreditation Regulatory and Licensing Specialist
Christina Mickle	Clinical Consultant, Performance Improvement
Dorothy Chan	IT Risk Management Client Accounting and Advisory Services Professional, Privacy, Security, and Technology Compliance
Elizabeth Chapman	Medicaid CHP+ Contract Program Manager
Judy Owiti	Data Analyst, National Provider Contracting
Kirsten Swart	Colorado Medicaid Compliance Manager, Medicaid Health Plan Compliance
Lillian Hans	Data Reporting and Analytics Consultant, Compliance and Regulatory
Marty J. Schultz	Senior Director, Managerial Consulting
Mikala Gibbs	Project Manager, Network Operations
Michele O'Neal	Business Consultant Member Service, Quality and Risk
Ranae Pemberton	Executive Director, Network Development and Provider Contracting
Rhonda R. Meili	Senior Manager, Provider Experience

Interviewee Name	Title
Trey Parks	Compliance Consultant, Medicaid Health Plan Compliance
Irene Hui	Senior Counsel, Government Programs Practice Group, Legal Department
Douglas B. Carter	Business Consultant Member Service, Quality and Risk
Tori Gill	Senior Manager, Medicaid Health Plan Compliance
Romilee Perdon	Audit Coordinator, Medicaid Health Plan Compliance
Sandhya Rghava	Director Information Risk Management Client Accounting and Advisory Services, Compliance, Privacy, and Security Compliance

Table B-7 lists the NHP staff members interviewed by the HSAG validation team.

Table B-7—List of NHP Interviewees

Interviewee Name	Title
Kari Snelson	Chief Executive Officer
Brian Robertson	Chief Operations Officer
Wayne Watkins	Chief Information Officer
Chantel Hawkins	Quality Manager
Jennefer Rolf	Project Manager
Jamie Coahran	Senior Account Service Manager
Alicia Williams	Director of Operations
Stacey Bassett	Eligibility Business Consultant
Chris Klaric	Manager of Credentialing Operations
Dario Russo	Business Information Developer
Madeline Dunn	Director, Network Management
Nikoli Streeter	Manager I, Network Data

Table B-8 lists the RMHP staff members interviewed by the HSAG validation team.

Table B-8—List of RMHP Interviewees

Interviewee Name	Title
Jeremiah Fluke	Director of Contract Administration
Kendra Peters	CHP+ Contract Manager
Dale Renzi	Vice President, Provider Network
Glen McDaniel	Regional Chief Information Officer
Susan Hanna	Senior Analyst, Program Analytics, Data Systems & Strategy
Micky Follansbee	Supervisor, Enrollment/Eligibility—Client Experience & Operations
Daynon Gardner	Enrollment Quality Analyst—Issue Resolution Team
Nicole Nemec	Operational Readiness Lead
Nicole Miller	Community and State Eligibility Maintenance System (CEMS) Product Owner—834 Eligibility Advocacy Team
Elizabeth Lytle	Director of Program Analytics—Data Systems & Strategy
Braden Neptune	Director of Business Operations
Stephanie Oeverndiek	Manager, Medicaid Network Adequacy
Luann Paulson	Program Pillar Business Analytics Sciences Insights & Strategies (BASIS) Data Diggers Program Strategist
Claudia Stein	United Healthcare Regulatory Adherence
Jeremy Parks	Director, Provider Data—Provider Data Operations
Jennifer Farrar	Executive Director, Behavioral Health Operations
Elizabeth Mullin	Network Program Manager
Brian Atkins	Associate Director, Provider Quality Assurance
Wendy Filek	Supervisor—Behavioral Health Provider Data Management Senior Install Specialist
Donna Luna	Director, Provider Data Operations, Regulatory Response
Daneen Barnett	Regulatory Adherence Manager—Provider Directories
Linda Hickman	Supervisor—Credentialing Regulatory Team
Sonovia Kearse	Manager, Provider Data Analytics and Delivery Team

Interviewee Name	Title
Shannon Zellner	Associate Director of Compliance, Behavioral Health
John Murkin	Associate Director, Network Adequacy
Estrella France	Senior Provider Data Analyst—Provider Data Operations
Jessica Boni	Behavioral Health Provider Data Management Senior Install Specialist
Nancy Lautenbach	Data Analyst—Provider Data Operations
Tim Harrington	Business Analysis Consultant— United Health Care Business Operations & Experience
James Hart	Compliance Consultant, Audit Management
Vanessa Beaulieau	Associate Regulatory Adherence Analyst, Claims Solutions & Implementations
Robin Gillie	Regulatory Adherence Analyst, Claims Solutions & Implementations
Tivvany James	Provider Data Analyst, Provider Data Operations
Natalie Ortloff	Provider Data Consultant, Provider Data Operations
Kevin Prouty	Regulatory Adherence Analyst
Leisa Wright	Senior Enrollment Eligibility Representative, Client Experience & Operations

Table B-9 lists the HSAG validation team members, their roles, and their skills and expertise.

Table B-9—HSAG Validation Team

Name and Title	Role
Elisabeth Hunt, MHA, CHCA *Executive Director, Data Science & Advanced Analytics (DSAA)*	Certified Healthcare Effectiveness Data and Information Set (HEDIS®)[6] Compliance Auditor (CHCA); multiple years of auditing experience with expertise in data integration, information systems, provider data, NAV, and performance measure development and reporting.
Rachael French, CHCA *Director, Audits/Practice Leader, DSAA*	CHCA; subject matter expertise in managed care, quality measure reporting, quality improvement (QI), performance measure knowledge, data integration, systems review and analysis, provider data, and NAV.

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Name and Title	Role
Matthew Kelly, MBA *Analytics Manager III, DSAA*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Sumayyah Hackett *Auditor, DSAA* *Task Lead*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
AnnAlisa Cook *Auditor, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Alexis Earp *Auditor, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Angela Farris *Auditor, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Deborah Swain, MBA *Analytics Coordinator III, DSAA*	Audit support team; assists with coordination of audit-related projects, project management, and administrative support.
Leslie Arendell, MS *Director, Analytics, DSAA*	Subject matter expertise in network adequacy, data analysis, Medicaid managed care, provider network data and validation, QI, and member eligibility/enrollment data.
Ashling Whelan *Analytics Manager, Associate, DSAA* *NAV Auditor*	Subject matter expertise in network adequacy data, analysis, and reporting. Analytics auditor for CY 2025 ISCA virtual review.
Adrianna Ancillo *Analytics Coordinator, Senior, DSAA* *NAV Auditor*	Subject matter expertise in network adequacy data, analysis, and reporting. Analytics auditor for CY 2025 ISCA virtual review.

Appendix C. Network Adequacy Validation Worksheets

Full CMS EQR Protocol 4 Worksheets were provided to the Department and to the MCEs as part of the CMS EQR Protocol 4 activity.

Appendix D. Contracted Counties by MCE

Appendix D details the counties for which each MCE was contracted by the Department to provide services for Medicaid and/or CHP+ members. HSAG evaluated the travel time (in minutes) or driving distance (in miles) between members' place of residence and the physical location of the practitioners, practice sites, and entities contracted with the MCE by contracted county.

The Code of Colorado Regulations (CCR), Section 10 CCR 2505-10 8.013,[7] indicates that practitioners, practice sites, and entities in neighboring locales are subject to the same network requirements in situations in which it is general practice for Colorado Medicaid recipients in a locality to seek medical care in another state. As confirmed by the Department, HSAG's CHP+ MCO, Medicaid MCO, and RAE NAV analyses included practitioners, practice sites, and entities with service addresses in selected neighboring counties adjacent to Colorado's state borders listed in Table D-1, to the extent that records with such service addresses were included in the MCEs' network data. HSAG's PAHP NAV analyses excluded practitioners, practice sites, and entities with service addresses in counties outside of Colorado.

Table D-1—Neighboring Counties to be Included in NAV Analyses

State	Counties
Arizona	Apache, Navajo
Kansas	Cheyenne, Greeley, Hamilton, Morton, Sherman, Stanton, Wallace
Nebraska	Chase, Cheyenne, Deuel, Dundy, Keith, Kimball, Perkins
New Mexico	Colfax, Rio Arriba, San Juan, Taos, Union
Oklahoma	Beaver, Cimarron, Texas
Texas	Dallam, Hansford, Hartley, Lipscomb, Ochiltree, Sherman
Utah	Daggett, Grand, San Juan, Uintah
Wyoming	Albany, Carbon, Laramie, Sweetwater

[7] Out-Of-State Medical Care. Code of Colorado Regulations Section 2505-10 8.013; 2017. Available at: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7282&fileName=10 CCR 2505-10 8.000. Accessed on: May 19, 2025.

CHP+ MCO and PAHP Contracted Counties

CHP+ MCOs were responsible for providing physical health and behavioral health services in the contracted counties presented in Table D-2. DentaQuest was responsible for providing contracted PAHP services statewide.

CHP+ MCO and PAHP contracted county reference: https://hcpf.colorado.gov/sites/hcpf/files/CHP-Comparison-Chart_Dec%202022.pdf

Table D-2—CHP+ MCO and PAHP Contracted Counties

CO County	COA CHP+ MCO	DHMP CHP+	Kaiser	RMHP CHP+	DentaQuest
Urban					
Adams	X	X	X		X
Arapahoe	X	X	X		X
Boulder	X		X		X
Broomfield	X		X		X
Clear Creek	X				X
Denver	X	X	X		X
Douglas	X		X		X
El Paso	X				X
Elbert	X				X
Gilpin	X				X
Jefferson	X	X	X		X
Pueblo	X				X
Teller	X				X
Weld	X				X
Rural					
Alamosa	X				X
Archuleta				X	X
Chaffee	X				X
Conejos	X				X
Crowley	X				X
Delta	X			X	X
Eagle	X			X	X
Fremont	X				X
Garfield				X	X
Grand				X	X
La Plata				X	X
Lake				X	X
Larimer	X				X
Logan	X				X
Mesa				X	X

CO County	COA CHP+ MCO	DHMP CHP+	Kaiser	RMHP CHP+	DentaQuest
Montezuma				X	X
Montrose				X	X
Morgan	X				X
Otero	X				X
Ouray				X	X
Park	X				X
Phillips	X				X
Pitkin				X	X
Prowers	X				X
Rio Grande	X				X
Routt				X	X
Summit	X			X	X
Frontier					
Baca	X				X
Bent	X				X
Cheyenne	X				X
Costilla	X				X
Custer	X				X
Dolores				X	X
Gunnison				X	X
Hinsdale				X	X
Huerfano	X				X
Jackson				X	X
Kiowa	X				X
Kit Carson	X				X
Las Animas	X				X
Lincoln	X				X
Mineral	X				X
Moffat				X	X
Rio Blanco				X	X
Saguache	X				X
San Juan				X	X
San Miguel				X	X
Sedgwick	X				X
Washington	X				X
Yuma	X				X

Medicaid MCO and RAE Contracted Counties

RMHP Prime was responsible for providing physical health services in contracted counties. The RAEs and the DHMP Medicaid MCO were responsible for providing physical health services in contracted counties and behavioral health services statewide. While the RAEs and DHMP were responsible for behavioral health services regardless of a member's Colorado county of residence, NAV analyses for behavioral health minimum network requirements were limited to contracted counties.

Medicaid MCO contracted county reference: https://www.healthfirstcolorado.com/wp-content/uploads/2018/07/Health-First-Colorado-Managed-Care-Plans-Comparison-Chart.pdf

RAE contracted county reference: https://www.healthfirstcolorado.com/health-first-colorado-regional-organizations/

Table D-3—Medicaid MCO and RAE Contracted Counties

CO County	DHMP	RMHP Prime	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7
Urban									
Adams	X				X				
Arapahoe	X				X				
Boulder								X	
Broomfield								X	
Clear Creek								X	
Denver	X						X		
Douglas					X				
El Paso									X
Elbert					X				
Gilpin								X	
Jefferson	X							X	
Pueblo						X			
Teller									X
Weld				X					
Rural									
Alamosa						X			
Archuleta			X						
Chaffee						X			
Conejos						X			
Crowley						X			
Delta		X	X						
Eagle			X						
Fremont						X			
Garfield		X	X						
Grand			X						
La Plata			X						

CO County	DHMP	RMHP Prime	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7
Lake						X			
Larimer			X						
Logan				X					
Mesa		X	X						
Montezuma			X						
Montrose		X	X						
Morgan				X					
Otero						X			
Ouray		X	X						
Park									X
Phillips				X					
Pitkin		X	X						
Prowers						X			
Rio Grande						X			
Routt			X						
Summit			X						
Frontier									
Baca						X			
Bent						X			
Cheyenne				X					
Costilla						X			
Custer						X			
Dolores			X						
Gunnison		X	X						
Hinsdale			X						
Huerfano						X			
Jackson			X						
Kiowa						X			
Kit Carson				X					
Las Animas						X			
Lincoln				X					
Mineral						X			
Moffat			X						
Rio Blanco		X	X						
Saguache						X			
San Juan			X						
San Miguel		X	X						
Sedgwick				X					
Washington				X					
Yuma				X					

Appendix E. Detailed Listing of Network Categories by MCE Type

Appendix E presents tables detailing the network categories selected for each MCE type by the Department for inclusion in the FY 2024–2025 NAV analyses, similar to the tables presented in the Department-approved FY 2024–2025 NAV Protocol. The tables presented in this section detail the network categories selected for each MCE type by the Department for inclusion in the FY 2024–2025 NAV analysis.

CHP+ MCO

Unless otherwise noted below, all standards listed in Table E-1 require that 100 percent of members reside within the time and distance limits identified.

Table E-1—CHP+ MCO Minimum Network Requirements, as of December 31, 2024

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Physical Health—Primary Care						
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	PV062, PV065, PV068, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	PV070, PV071	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	Not Applicable (NA)
Adult Primary Care Practitioner (MD, DO, NP, CNS)[2]	PV060, PV063, PV066, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult Primary Care Practitioner (PA)[2]	PV069, PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Family Practitioner (MD, DO, NP, CNS)	PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner (PA)	PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Gynecology, OB/GYN (MD, DO, NP, CNS)[3]	PV020, PV021, PV024	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Gynecology, OB/GYN (PA)[3]	PV022	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Physical Health—Specialists						
Pediatric Cardiology[1]	SV203, SV202	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Endocrinology[1]	SV207, SV206	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Gastroenterology[1]	SV209, SV208	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Surgery[1]	SV229, SV228	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Neurology[1]	SV217, SV216	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Ophthalmology[1]	SV221, SV220	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Orthopedics[1]	SV219, SV218	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Otolaryngology/ ENT[1]	SV223, SV222	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Pulmonary Medicine[1]	SV227, SV226	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Urology[1]	SV231, SV230	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
General Cardiology[2]	SV202	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Endocrinology[2]	SV206	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Gastroenterology[2]	SV208	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Surgery[2]	SV228	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Neurology[2]	SV216	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Ophthalmology[2]	SV220	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Orthopedics[2]	SV218	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
General Otolaryngology/ ENT[2]	SV222	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Pulmonary Medicine[2]	SV226	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Urology[2]	SV230	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Physical Health—Entities						
Pharmacies	PF160	1 Facility	10 minutes or 10 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Acute Care Hospitals	PF150	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Behavioral Health—Specialists						
Pediatric Behavioral Health[1]	BV104, BV103, BV102, BV121, BV120, BV130, BV131, BG126, BG127, BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
Pediatric Psychiatrists and other Psychiatric Prescribers[1]	BV101, BV100, BG110, BG111, BG112, BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
Pediatric SUD Treatment[1]	BV080, BF085, BG113	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Behavioral Health[2]	BV102, BV103, BV120, BV130, BV131, BV132, BG126, BG127, BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
General Psychiatrists and other Psychiatric Prescribers[2]	BV100, BG110, BG111, BG112, BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
General SUD Treatment[2]	BV080, BF085, BG113	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Behavioral Health—Entities						
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	BF140, BF141	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA

[1] Pediatric practitioners serving members from birth through the end of the month of the 19th birthday. General and family practitioners serve both pediatric and adult members.

[2] Adult practitioners serving members from 19 years and older, beginning at the month after the month of the 19th birthday. General and family practitioners serve both pediatric and adult members.

[3] Practitioners only serving female members 13 years and older.

DHMP Medicaid MCO

Unless otherwise noted below, all standards listed in Table E-2 require that 100 percent of members reside within the time and distance limits identified.

Table E-2—DHMP Medicaid MCO Minimum Network Requirements, as of December 31, 2024

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Physical Health—Primary Care						
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	PV062, PV065, PV068, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	PV070, PV071	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Adult Primary Care Practitioner (MD, DO, NP, CNS)[2]	PV060, PV063, PV066, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult Primary Care Practitioner (PA)[2]	PV069, PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Family Practitioner (MD, DO, NP, CNS)	PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner (PA)	PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Gynecology, OB/GYN (MD, DO, NP, CNS)[3]	PV020, PV021, PV024	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Gynecology, OB/GYN (PA)[3]	PV022	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Physical Health—Specialists						
Pediatric Cardiology[1]	SV203, SV202	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Endocrinology[1]	SV207, SV206	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Pediatric Gastroenterology[1]	SV209, SV208	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Surgery[1]	SV229, SV228	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Neurology[1]	SV217, SV216	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Ophthalmology[1]	SV221, SV220	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Orthopedics[1]	SV219, SV218	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Otolaryngology/ ENT[1]	SV223, SV222	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Pulmonary Medicine[1]	SV227, SV226	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Urology[1]	SV231, SV230	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Cardiology[2]	SV202	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Endocrinology[2]	SV206	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Gastroenterology[2]	SV208	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Surgery[2]	SV228	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Neurology[2]	SV216	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Ophthalmology[2]	SV220	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Orthopedics[2]	SV218	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Otolaryngology/ ENT[2]	SV222	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Pulmonary Medicine[2]	SV226	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Urology[2]	SV230	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Physical Health—Entities						
Pharmacies	PF160	1 Facility	10 minutes or 10 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Acute Care Hospitals	PF150	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Behavioral Health—Specialists[4]						
Pediatric Behavioral Health[1]	BV104, BV103, BV102, BV121, BV120, BV130, BV131, BG126, BG127 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
Pediatric Psychiatrists and other Psychiatric Prescribers[1]	BV101, BV100, BG110, BG111, BG112 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
Pediatric SUD Treatment Practitioner[1]	BV080	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Behavioral Health[2]	BV102, BV103, BV120, BV130, BV131, BV132, BG126, BG127 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
General Psychiatrists and other Psychiatric Prescribers[2]	BV100, BG110, BG111, BG112 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
General SUD Treatment Practitioner[2]	BV080	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Behavioral Health—Entities[4]						
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	BF140, BF141	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
SUD Treatment Facilities	BF085 BG113	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
SUD Treatment Facilities-ASAM 3.1	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 871	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.3	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 872	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.5	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 873	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 874	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.2 WM	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 875	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7 WM	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 876	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA

[1] Pediatric practitioners serving members younger than 21 years. General and family practitioners serve both pediatric and adult members.

[2] Adult practitioners serving members 21 years and older. General and family practitioners serve both pediatric and adult members.

[3] Practitioners only serving female members 13 years and older.

[4] Although DHMP is a Medicaid MCO, DHMP is responsible for its own behavioral health network.

RMHP Prime Medicaid MCO

All standards listed in Table E-3 require that 100 percent of members reside within the time and distance limits identified.

Table E-3—RMHP Prime Medicaid MCO Minimum Network Requirements, as of December 31, 2024

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Physical Health—Primary Care						
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	PV062, PV065, PV068, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	PV070, PV071	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Adult-Only Primary Care Practitioner (MD, DO, NP, CNS)[2]	PV060, PV063, PV066, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult-Only Primary Care Practitioner (PA)[2]	PV069, PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Family Practitioner (MD, DO, NP, CNS)	PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner (PA)	PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Gynecology, OB/GYN (MD, DO, NP, CNS)[3]	PV020, PV021, PV024	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Gynecology, OB/GYN (PA)[3]	PV022	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Physical Health—Specialists						
Pediatric Cardiology[1]	SV203, SV202	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Endocrinology[1]	SV207, SV206	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Gastroenterology[1]	SV209, SV208	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Surgery[1]	SV229, SV228	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Neurology[1]	SV217, SV216	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Ophthalmology[1]	SV221, SV220	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Orthopedics[1]	SV219, SV218	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Otolaryngology/ENT[1]	SV223, SV222	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Pulmonary Medicine[1]	SV227, SV226	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Urology[1]	SV231, SV230	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Cardiology[2]	SV202	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Endocrinology[2]	SV206	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Gastroenterology[2]	SV208	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Surgery[2]	SV228	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Neurology[2]	SV216	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Ophthalmology[2]	SV220	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Orthopedics[2]	SV218	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Otolaryngology/ENT[2]	SV222	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Pulmonary Medicine[2]	SV226	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Urology[2]	SV230	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Physical Health—Entities						
Pharmacies	PF160	1 Facility	10 minutes or 10 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Acute Care Hospitals	PF150	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA

[1] Pediatric practitioners serving members younger than 21 years. General and family practitioners serve both pediatric and adult members.

[2] Adult practitioners serving members 21 years and older. General and family practitioners serve both pediatric and adult members.

[3] Practitioners only serving female members 13 years and older.

PAHP

All standards listed in Table E-4 require that 100 percent of members reside within the time and distance limits identified.

Table E-4—PAHP Minimum Network Requirements, as of December 31, 2024

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
Dental Services						
General Dentists	DV001	1 Practitioner	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Pediatric Dentists[1]	DV002	1 Practitioner	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Oral Surgeons	DV007	1 Practitioner	60 minutes or 60 miles	75 minutes or 75 miles	90 minutes or 90 miles	NA
Orthodontists	DV008	1 Practitioner	60 minutes or 60 miles	75 minutes or 75 miles	90 minutes or 90 miles	NA

[1] Pediatric practitioners serving members from birth through the end of the month of the 19th birthday.

RAE

Unless otherwise noted below, all standards listed in Table E-5 require that 100 percent of members reside within the time and distance limits identified.

Table E-5—RAE Minimum Network Requirements, as of December 31, 2024

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Requirement	Rural Time/Distance Requirement	Frontier Time/Distance Requirement	Ratio
Physical Health—Primary Care						
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	PV062, PV065, PV068, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	PV070, PV071	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Adult Primary Care Practitioner (MD, DO, NP, CNS)[2]	PV060, PV063, PV066, PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult Primary Care Practitioner (PA)[2]	PV069, PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Family Practitioner (MD, DO, NP, CNS)	PV061, PV064, PV067	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner (PA)	PV070	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Behavioral Health—Specialists[4]						
Pediatric Behavioral Health[1]	BV104, BV103, BV102, BV121, BV120, BV130, BV131, BG126, BG127 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Requirement	Rural Time/Distance Requirement	Frontier Time/Distance Requirement	Ratio
Pediatric Psychiatrists and other Psychiatric Prescribers[1]	BV101, BV100, BG110, BG111, BG112 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
Pediatric SUD Treatment Practitioner[1]	BV080	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Behavioral Health[2]	BV102, BV103, BV120, BV130, BV131, BV132, BG126, BG127 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
General Psychiatrists and other Psychiatric Prescribers[2]	BV100, BG110, BG111, BG112 BG113	2 Practitioners	90% of members within 30 minutes or 30 miles	90% of members within 60 minutes or 60 miles	90% of members within 90 minutes or 90 miles	1:1,800
General SUD Treatment Practitioner[2]	BV080	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Behavioral Health—Entities						
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	BF140, BF141	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
SUD Treatment Facilities	BF085 BG113	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
SUD Treatment Facilities-ASAM 3.1	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 871	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.3	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 872	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Requirement	Rural Time/Distance Requirement	Frontier Time/Distance Requirement	Ratio
SUD Treatment Facilities-ASAM 3.5	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 873	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 874	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.2 WM	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 875	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7 WM	BF085 with MCID_Prov Type 64 and MCID_Prov Spec 876	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA

[1] Pediatric practitioners serving members younger than 21 years. General and family practitioners serve both pediatric and adult members.

[2] Adult practitioners serving members 21 years and older. General and family practitioners serve both pediatric and adult members.

[3] Practitioners only serving female members 13 years and older.