COLORADO

Department of Health Care Policy & Financing

FY 2023–2024 Network Adequacy Validation

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HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary 1-1
Overview 1-1
Discussion 1-1

2. Background 2-1

3. Information Systems Capabilities Assessment Results 3-1
Validation Team 3-1
ISCA Validation of Network Adequacy Results 3-2
Colorado Community Health Alliance (CCHA) 3-2
Colorado Access (COA) 3-7
DentaQuest 3-12
Denver Health Medical Plans (DHMP) 3-17
Kaiser Permanente (Kaiser) 3-21
Northeast Health Partners (NHP) 3-26
Health Colorado, Inc. (HCI) 3-31
Rocky Mountain Health Plans (RMHP) 3-36

4. Network Adequacy Validation Results 4-1
CHP+ Managed Care Organizations (MCOs) 4-2
COA CHP+ 4-8
DHMP CHP+ 4-10
RMHP CHP+ 4-12
Kaiser 4-14
Medicaid Managed Care Organizations (MCOs) 4-16
DHMP MCO 4-21
RMHP Prime 4-23
Dental Prepaid Ambulatory Health Plan (PAHP) 4-25
DentaQuest 4-25
Regional Accountable Entities (RAEs) 4-30
RAE 1 4-34
RAE 2 4-36
RAE 3 4-38
RAE 4 4-40
RAE 5 4-42
RAE 6 4-44
RAE 7 4-46
Network Changes and Deficiencies 4-48

5. Discussion 5-1
Conclusions 5-1
Analytic Considerations 5-3
Promising Practices and Opportunities for Improvement 5-4

Appendix A. Methodology A-1
ISCA Methodology A-1
Technical Methods of Data Collection and Analysis A-1
Virtual Review Validation Activities A-2
Network Adequacy Indicator Validation Rating Determinations A-4
NAV Methodology A-6
Data Collection A-6
Geoaccess Analyses A-7
NAV Dashboards A-9
Updating the MCEs' Reporting Documentation A-10

Appendix B. List of Interviewees and HSAG Validation Team B-1

Appendix C. Network Adequacy Validation Worksheets C-1
CCHA – RAE 6 ..... C-1
CCHA – RAE 7 ..... C-6
COA CHP+ C-13
COA – RAE 3 ..... C-33
COA – RAE 5 ..... C-38
DentaQuest C-43
DHMP CHP+ C-45
DHMP MCO C-53
Kaiser C-62
NHP – RAE 2 ..... C-71
HCI – RAE 4 ..... C-81
RMHP CHP+ C-91
RMHP Prime C-104
RMHP – RAE 1 ..... C-115

Appendix D. Contracted Counties by MCE D-1
CHP+ MCO and PAHP Contracted Counties D-2
Medicaid MCO and RAE Contracted Counties D-4

Appendix E. Detailed Listing of Network Categories by MCE Type E-1
CHP+ MCO E-1
DHMP Medicaid MCO E-5
RMHP Prime Medicaid MCO E-9
PAHP E-11
RAE E-12

1. Executive Summary

Overview

Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires that 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. The purpose of network adequacy validation (NAV) is to assess the accuracy of the State-defined network adequacy indicators reported by the managed care entities (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 of Health Care Policy & Financing (the Department).

Health Services Advisory Group, Inc. (HSAG) completed an Information Systems Capabilities Assessment (ISCA) for each of the MCEs contracted to provide Medicaid 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 each of the MCEs assessed. Additionally, HSAG determined that 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 used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified requiring correction within the last year.

HSAG used the methodology approved by the Department (Appendix A) to validate each MCE's geoaccess compliance report submissions to the Department. HSAG developed and deployed the NAV dashboards each quarter. Across provider type and urbanicity: the Child Health Plan *Plus* (CHP+) MCOs met 70.2 percent of all applicable minimum network requirements, the Medicaid MCOs met 57.9 percent of all applicable minimum network requirements, the Regional Accountable Entities (RAEs) met 57.3 percent of all minimum network requirements, and the dental prepaid ambulatory health plan (PAHP) met 66.0 percent of all minimum network requirements.

Discussion

Generally, across all MCEs, the frontier and rural counties' compliance results matched the HSAG calculated results, while the urban counties' results had greater variation to the HSAG calculated results. Based on the results of the ISCA combined with the detailed validation of each indicator, generally, the MCEs are doing well, with most MCEs receiving Moderate to High Confidence in their validation rating of the network adequacy indicators with one MCE receiving Significant Bias for 49.3 percent of the network adequacy indicators.

HSAG recommends that the MCEs continue to monitor member access through quarterly network adequacy assessments based on the State's expectations and to inquire with the Department regarding whether there are any specific guidelines for calculating provider-to-enrollee ratios and geocoding members without a physical address.

2. Background

As required in 42 CFR §438.350(a), states which contract with MCOs must have a qualified EQRO perform an annual 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 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 fiscal year (FY) 2023–2024.

HSAG conducted NAV, validating the systems and processes, data sources, methods, and results, according to 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).[2-1]

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

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 acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by the State. If states elect to conduct network adequacy for each MCE, the EQRO will validate the indicators produced by the state as if they were calculated by the MCEs and validate the MCEs' systems and processes, and source data provided to the state, to inform network adequacy analysis activities.

As the EQRO for the Department, HSAG conducted the FY 2023–2024 validation of network adequacy indicators, confirming 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 MCE and the Department 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

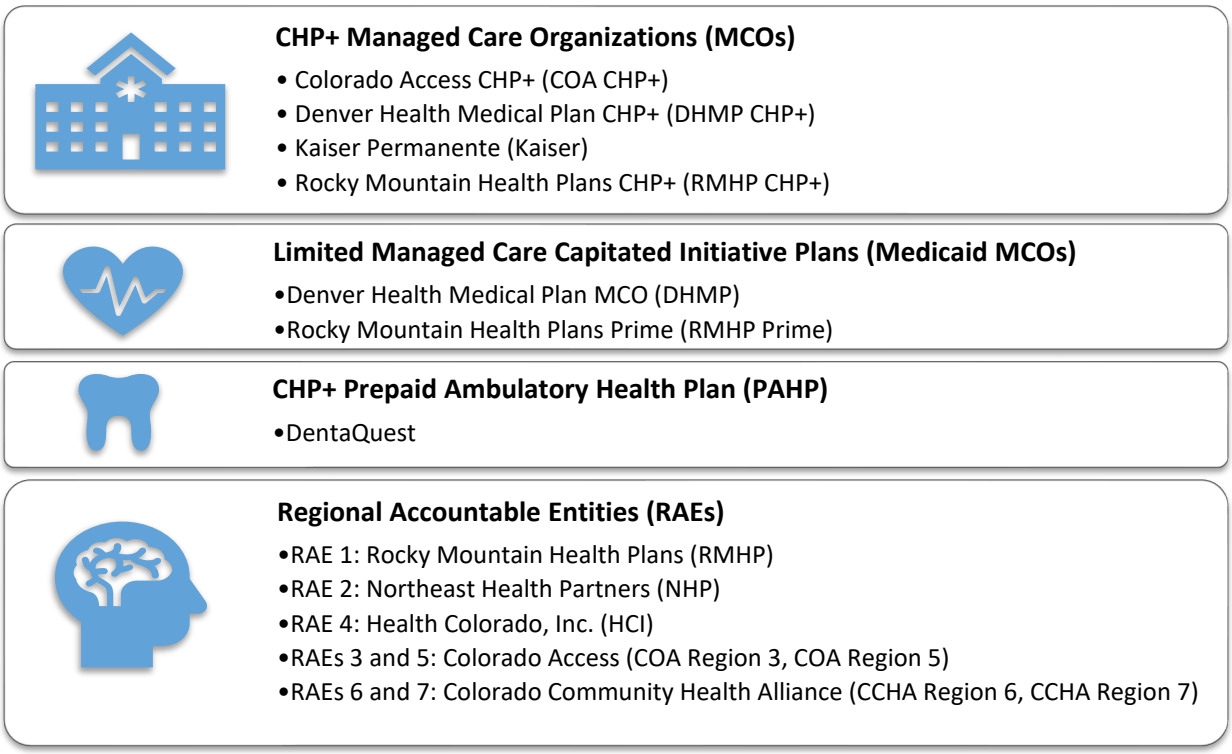
[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf . Accessed on: May 29, 2024.

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.
- **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 the FY 2023–2024 Quarter 2 (Q2) NAV 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 as of December 31, 2023. Figure 2-1 lists the Health First Colorado[2-2] and CHP+ MCEs included in the FY 2023–2024 NAV.

Figure 2-1—MCEs Participating in the FY 2023–2024 NAV



To align with the Department's network terminology, the FY 2023–2024 NAV uses the following terms for different types of individuals and facilities offering healthcare services:

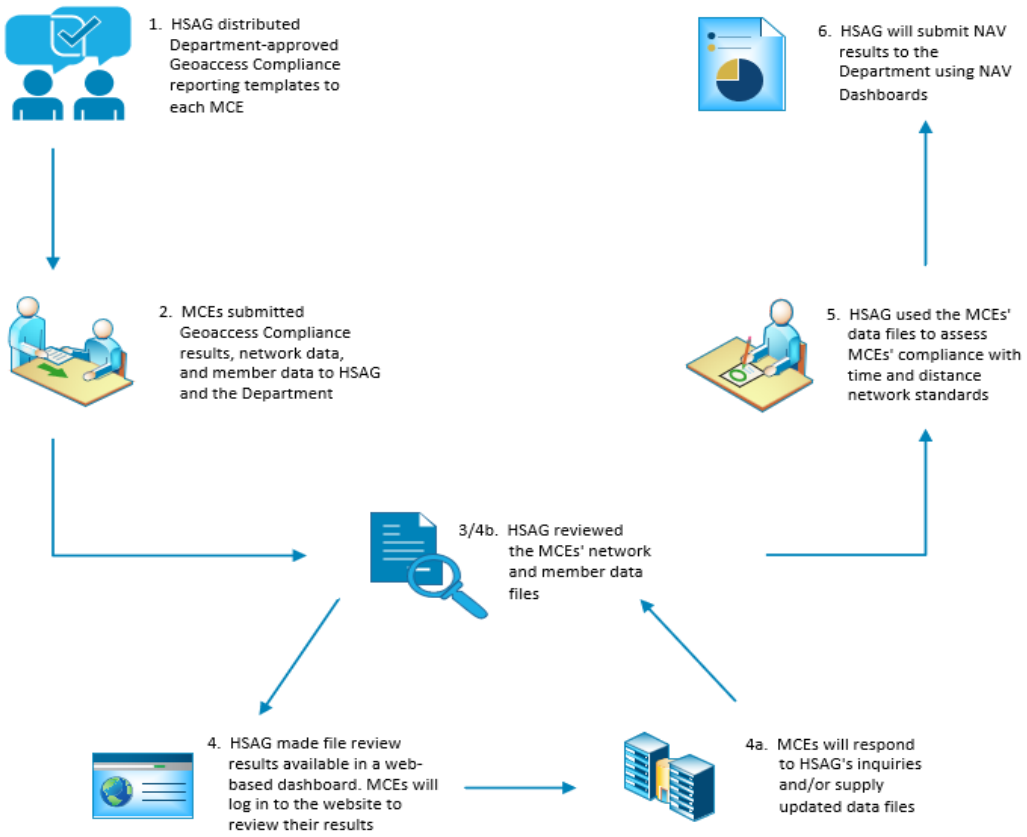
- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service.
- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, 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.

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

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

Figure 2-2—FY 2023–2024 Quarterly NA Data Processing and Validation Tasks



* 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 the purpose of 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 2023 to be submitted alongside the FY 2023–2024 Q2 NAV data 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 NA report. Please reference Section 3: Information Systems Capabilities Assessment Results.

HSAG validated the MCEs' networks quarterly during FY 2023–2024, including the review and validation of the MCEs' NA data and Microsoft (MS) 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.

Each quarter, 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 average level of access across all of its members, considering whether the MCE met standards for the required 100 percent of members, or for one of three alternative access levels (95 to 99.9 percent, 90 to 94.9 percent, or less than 90 percent). Please reference Section 4: Network Adequacy Validation Results for full findings.

During FY 2023–2024, 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 quarterly reporting templates and materials.

3. Information Systems Capabilities Assessment Results

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 State. Some validation 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 is provided Appendix B.

Table 3-1 presents the MCEs within the scope of review, review date, primary MCE contact, and HSAG lead reviewer.

Table 3-1—Colorado Health Plans

MCE Name (Plan Type)	Date	Primary MCE Contact Name and Title	HSAG Lead Reviewer
Colorado Community Health Alliance (RAE 6, RAE 7)	04/05/24	Aris Coney: Supervisor, Project Management	Elisabeth Hunt
Colorado Access (COA CHP+, RAE 3, RAE 5)	04/02/24	Brad Schrom: Program Coordinator	Elisabeth Hunt
DentaQuest (PAHP)	04/12/24	Logan Horn: CHP+ Project Manager	Rachael French
Denver Health Medical Plans (DHMP MCO, DHMP CHP+)	04/02/24	Katie Gaffney: Lead Health Plan Compliance Analyst	Cynthia Anderson
Kaiser Permanente (CHP+)	04/09/24 and 04/11/24	Elizabeth Chapman: Contract Manager, Medicaid and Charitable Programs	Rachael French
Northeast Health Partners (NHP/RAE 2)	03/11/24	Brian Robertson: Chief Operating Officer	Emily Redman
Health Colorado, Inc. (HCI/RAE 4)	03/07/24	Lori Roberts: Chief Executive Officer/Program Officer	Emily Redman
Rocky Mountain Health Plans (RMHP MCO, RMHP CHP+, RAE 1)	04/08/24	Jeremiah Fluke: Director, Contract Administration	Cynthia Anderson

ISCA Validation of Network Adequacy Results

Colorado Community Health Alliance (CCHA)

ISCA Findings and Data Validity

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 and data processing procedures that CCHA had in place to support network adequacy indicator reporting, which included the following:

- CCHA used Core Services Platform (CSP) as the database management system to maintain comprehensive demographic and eligibility information.
- CCHA used SPS and Facets as the database management system to store provider data including, but not limited to, contract status, provider type, 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.
- 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 16.5 years of experience in the field.
- 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 State. 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.
- CCHA received the full 834 file monthly and an 834 enrollment change file from the Department daily.
- CCHA performed monthly reconciliation between the Core Systems Platform and the 834 enrollment data received by the Department to ensure the completeness and accuracy of enrollment data.
- The CSP 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 State's provider portal to manually look up members if needed. If there were any discrepancies that CCHA could resolve, CCHA contacted the State; however, CCHA indicated the volume of records requiring manual intervention and follow up with the State or county is relatively low (i.e., three to four records a month).
- CCHA's system captured the state-issued Medicaid identification (ID), which is assigned at the time of enrollment. The enrollment files occasionally contained instances in which the same member had more than one 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 count department for resolution.
- CCHA identified member demographic information and any demographic changes through the receipt of the daily and monthly 834 files. Member demographic data were stored in the CSP by "address type." A member's physical address, mailing address, and contact address were also stored in the CSP and obtained from the 834 files.
- The CSP 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 Council for Affordable Quality Healthcare (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 Facets. The Department provided credentialing data to CCHA for physical health providers, which were loaded into the Physician Health Partners master data system.
- Provider network status data were maintained in the SPS and Facets provider database management systems.
- CCHA captured all state-required provider types and specialties in the Facets database management system and demonstrated the logic for how CCHA identified provider types appropriately.
- 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 Affairs (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.

Network Adequacy Indicator Reporting

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

- CCHA used Quest Analytics Suite (Quest) to calculate and report behavioral health network adequacy indicators, and Smarty Streets and Maptitude for physical health network adequacy indicators.
- CCHA integrated member and provider for network adequacy indicator reporting.
- CCHA conducted data quality checks to review the accuracy of its network adequacy indicator reporting programs by having outside reviewers examine provider and member data files prior to time and distance calculations. CCHA has detailed documentation outlining the processes and steps for calculating time and distance. Additionally, CCHA completes an internal review and comparison of the current and most recent prior time periods to evaluate potential errors. After an extensive review process, CCHA verifies the results accurately reflect members access to CCHA providers.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at CCHA were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at CCHA were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on CCHA's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends CCHA continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.
- HSAG recommends CCHA inquire with the Department regarding whether there are any specific guidelines for calculating behavioral health provider-to-enrollee ratios.

Strengths, Opportunities for Improvement, and Recommendations

By assessing CCHA's performance and NAV reporting process, 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 maintained 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.

Opportunities for Improvement and Recommendations

Opportunity #1: CCHA indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when CCHA is informed of a change in member demographic information.

Recommendation: HSAG recommends CCHA explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Colorado Access (COA)

ISCA Findings and Data Validity

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 and data processing procedures that COA had in place to support network adequacy indicator reporting, which included the following:

- COA used Health Rules Payor (HRP) as the database management system to collect and maintain member enrollment and provider data.
- In November 2022, COA transitioned from using QNXT to HRP as the database management system used to host enrollment data. Historical data in QNXT remained accessible with read-only access.
- 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 the 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 approximately four 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 State. HSAG's evaluation of COA's enrollment system included the following:

- Enrollment and eligibility data for Medicaid and CHP+ members were maintained within the HRP member enrollment database management system.
- The Department's CHP+ enrollment vendor, Colorado Medical Assistance Program (CMAP), sent daily spreadsheet files with any manual enrollment updates.
- COA received 820 capitation files from the Department every Tuesday. Files were loaded into COA's Enterprise Data Warehouse (EDW) and used to verify enrollment data in HRP.
- COA received daily and monthly enrollment files in the 834 file format from the Department.

- COA performed monthly reconciliation between HRP and the 834 enrollment data received by the Department to ensure completeness and accuracy of enrollment data.
- COA conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - COA generated daily error reports, which identified 834 files received, but were not imported correctly into HRP. The member data integrity (MDI) team reviewed all errors identified daily and conducted a manual review and resolution process.
  - The MDI team completed a weekly comparison between membership data in HRP and the 820 capitation files received weekly from the Department. Discrepancies in the member data identified through the comparison process were worked with the member's county office directly or with the Department's contacts to resolve.
  - COA sent any enrollment discrepancies, such as capitation to enrollment mismatches, through a 270 file exchange process to the Department. A 271 file was then sent back to COA, which verified coverage.
- 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 member demographic updates through the receipt of the daily and monthly 834 file submissions.

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 by directing providers to enter provider information through 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 information for all contracted and non-contracted providers who had 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 captured all state-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 MCO list and from HRP to assign a provider to a provider category through the network adequacy crosswalk.
- 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 took place every three years, which presented another opportunity 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 Hospital Authority, University of Colorado Medicine, Advent Health, Centura Common Spirit, UC Health, National Jewish Health, Northern Colorado IPA, Boulder Valley IPA, Banner Health, Select Physical Therapy, Children's Hospital Colorado, LifeStance Health, and SCL Health. Each subcontracted entity submitted provider roster data, which was then integrated into the HRP and MSOW/Apogee.
- COA maintained and extracted all delegated entity provider data in the same manner in which it maintained and extracted its own provider data.
- COA maintained oversight of its delegated entities by:
  - Conducting annual audits.

  - Collecting monthly and annual reports, either two weeks prior to the annual audit or as requested. Documentation included, but was not limited to, policies and procedures related to credentialing and recredentialing, ongoing monitoring, notification to authorities, and practitioner appeal rights; status of sub-delegation agreements; a list of participating providers; a credentialing activity report; and a provider termination report.
  - Holding quarterly Joint Operations Committee meetings to review key performance metrics and results of ongoing monitoring of delegated entity data.
- COA did not identify any delegated entity network adequacy data-related items requiring corrective action within the last year.

Network Adequacy Indicator Reporting

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

- COA used Quest to calculate and report network adequacy indicators. However, COA used all provider locations in calculating the provider-to-enrollee ratios, which could result in systematic overcounting of the number of providers available to enrollees.
- COA integrated member and provider data for network adequacy indicator reporting.
- COA conducted data quality checks to review the accuracy of its network adequacy indicator reporting programs. COA creates a validation report that a dedicated staff member uses to validate the data for the current submission. This validation report compares the previous quarter's network adequacy submission with the current quarter's network adequacy submission, tracking any variation from quarter-to-quarter for further investigation.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at COA were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at COA were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on COA's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends COA continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.
- HSAG recommends COA inquire with the Department regarding whether there are any specific guidelines for calculating provider-to-enrollee ratios.

Strengths, Opportunities for Improvement, and Recommendations

By assessing COA's performance and NAV reporting process, 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 has improved upon its provider specialty matching since converting to the use of HRP, as it now relies solely upon the use of taxonomy codes for specialty matching instead of its previous process that included the use of multiple values (i.e., specialty description and provider types) to identify provider specialty.

Strength #2: COA maintains detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.

Opportunities for Improvement and Recommendations

Opportunity #1: COA indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when COA is informed of a change in member demographic information.

Recommendation: HSAG recommends COA explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

DentaQuest

ISCA Findings and Data Validity

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 and data processing procedures that DentaQuest had in place to support network adequacy indicator reporting, which included the following:

- DentaQuest used Windward as the database management system to collect and maintain enrollment and provider data.
- DentaQuest used Cactus Credentialing as the database management system to collect and maintain provider contract and credentialing status.
- DentaQuest hosted an EDW used to reconcile multiple sources of data across member enrollment and provider, which contributed to network adequacy reporting.

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

- DentaQuest had eight internal 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 State. 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 performed monthly reconciliation between Windward and the 834 enrollment data 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. 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 unique Global User ID (GUID) that linked different versions of a member and their associated coverage together under one unique ID. Unique IDs 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. DentaQuest did not have a system or process in place to capture updated demographic information reported through alternative methods.

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 Cactus Credentialing software system.
- Provider network status data were maintained in both the Cactus Credentialing software system and the Windward database management system.
- DentaQuest captured all state-required provider types and specialties in the Windward database management system and demonstrated logic for how DentaQuest identified provider types appropriately and captured them within the Provider Primary Specialty data field.
- DentaQuest's procedures for updating and maintaining provider data included the following:
  - DentaQuest network managers manually validated provider demographic information through on-site office visits. This included, but was not limited to, address, phone number, hours, providers affiliated, and patient panel capacity.

- DentaQuest obtained demographic updates through the provider online portal. Staff members obtained notification of a requested update, and changes were directly entered into the Cactus Credentialing software system. Updates made through the Cactus Credentialing software system were then integrated into the Windward database management system, which was used to track provider information and changes over time, across multiple office locations, and through changes in participation in DentaQuest's network.
- DentaQuest conducted monthly monitoring activities to identify providers or organizations excluded from the Medicaid program and Children's Health Insurance Program (CHIP).
- DentaQuest required its provider network to update provider data every three years as part of the recredentialing process.

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.

Network Adequacy Indicator Reporting

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

- DentaQuest used Quest to calculate and report network adequacy indicators.
- DentaQuest integrated member and provider data for network adequacy indicator reporting.
- DentaQuest conducted the following data quality checks to review the accuracy of its network adequacy indicator reporting programs:
    - Programming code was sent through quality assurance, and was reviewed for data consistency and accuracy. Results were reviewed by the business analyst and subject matter experts.
    - Data files were validated against current data structure specifications.
    - Results were compared against prior quarters to check for significant change.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at DentaQuest were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at DentaQuest were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on DentaQuest's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends DentaQuest continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.
- DentaQuest indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when DentaQuest is informed of a change in member demographic information. HSAG recommends DentaQuest explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Strengths, Opportunities for Improvement, and Recommendations

By assessing DentaQuest's performance and NAV reporting process, 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: Through DentaQuest's use of change logs and the internal audit process in its provider data storage, DentaQuest demonstrated capabilities of effective internal data validation.

Strength #2: DentaQuest demonstrated the ability to maintain accurate and complete provider information through its quarterly directory validation process.

Opportunities for Improvement and Recommendations

Opportunity #1: DentaQuest indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when DentaQuest is informed of a change in member demographic information.

Recommendation: HSAG recommends DentaQuest explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Denver Health Medical Plans (DHMP)

ISCA Findings and Data Validity

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 and data processing procedures that DHMP had in place to support network adequacy indicator reporting, which included the following:

- DHMP used QNXT to collect and maintain member enrollment data as well as provider contracting and roster information.
- DHMP maintained a data warehouse hosted on a SQL server 2017 to ingest the provider list for Medicaid and CHP+ from the State and compare it to provider contracts in QNXT to determine the active provider roster version.

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

- DHMP had five 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 State. HSAG's evaluation of DHMP's enrollment system included the following:

- Enrollment and eligibility data for DHMP were maintained within the member enrollment database management system, QNXT.
- DHMP received daily and monthly 834 files from the Department.
- DHMP performed monthly reconciliation between QNXT and the Department's data to ensure completeness and accuracy of enrollment data.
- DHMP conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - DHMP utilized QNXT system logic and fall-out reports that were worked manually within 48 hours. If the missing member data could not be resolved, it was 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.
- DHMP captured all state-required provider types and specialties in QNXT and demonstrated the logic for how DHMP identified provider types appropriately. DHMP used the active taxonomy codes from the Department-provided MCO list to assign a provider to a provider category through the network adequacy crosswalk.
- 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 a quarterly audit of 20 percent of provider directory listings to verify the accuracy of the following data elements:
    - 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.
- 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 2023 reporting period.

Network Adequacy Indicator Reporting

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

- DHMP used ArcGIS to calculate and report network adequacy indicators.
- DHMP integrated member and provider data for network adequacy indicator reporting.
- DHMP conducted data quality checks on their data warehouse through the IS team, a third party contractor. Additional checks were performed by the Government Products team during the initial data pull of member files. Before the network adequacy reports was submitted, a final review for inconsistencies is performed by the Government Products Lead. DHMP also compared previous quarter's network adequacy reports to check for variance from quarter-to-quarter.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at DHMP were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at DHMP were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on DHMP's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends DHMP to inquire with the Department regarding whether there are any specific guidelines for geocoding members without a physical address.
- HSAG recommends DHMP use driving distance to calculate distance standards in accordance with the State's expectations.
- HSAG recommends DHMP continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.

Strengths, Opportunities for Improvement, and Recommendations

By assessing DHMP's performance and NAV reporting process, 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. During each quarter, it evaluated a 20 percent sample of the provider directory. By year-end, it had thoroughly reviewed the entire directory.

Opportunities for Improvement and Recommendations

Opportunity #1: DHMP indicated that the member demographic information that comes through the 834 file is considered the source of truth regardless of when DHMP is informed of a change in member demographic information.

Recommendation: HSAG recommends DHMP explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Kaiser Permanente (Kaiser)

ISCA Findings and Data Validity

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 and data processing procedures that Kaiser had in place to support network adequacy indicator reporting, which included the following:

- Kaiser used Common Membership (CM) as the database management system to collect and maintain member enrollment data.
- Kaiser used Morrisey Service Oriented Workflow (MSOW) as the database management system for collecting and maintaining provider data.

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

- Kaiser had three programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had over five years of experience in the field.

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 State. 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 both daily and monthly enrollment files in the 834 file format from the Department.
- Kaiser performed monthly reconciliation between the MSOW system and the 834 enrollment data received by the Department to ensure completeness and accuracy.
- 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.
- The Kaiser system 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 was given their old 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 fed the address information. The 834 file was used as the source of truth for member demographic data.

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 verifying 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 captured all state-required provider types and specialties in the MSOW provider database management system and demonstrated logic for how Kaiser identified provider types appropriately.
- 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.

  - Kaiser required its provider network to update provider data quarterly. Providers were made aware of this expectation through an attestation process.

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.

Network Adequacy Indicator Reporting

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

- Kaiser used Quest to calculate and report network adequacy indicators. Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No Confidence" validation rating.
- Kaiser integrated member and provider data for network adequacy indicator reporting.
- Kaiser conducted manual reviews of any indicators that did not meet the access requirements. Additionally, two reviewers confirmed the results entered into the network adequacy template submitted to the State quarterly.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at Kaiser were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at Kaiser were:

☐ Acceptable

☒ Not acceptable

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

☐ Acceptable

☒ Not acceptable

Analysis and Conclusions

Based on Kaiser's ISCA results, HSAG's conclusions are as follows:

- For all indicators (to improve data collection procedure): Kaiser indicated that the 834 file that comes from the Department contains a pseudo address of "General Delivery" in the address field where a member's address is unknown. Although the impact identified was not determined to be significant, Kaiser was unable to provide HSAG with a clear process for how it captures updated demographic information and the system's capability to capture updated demographic information. Kaiser confirmed the use the 834 file as the source of truth for all member eligibility and demographic information.
- HSAG recommends Kaiser develop a provider portal to allow providers to self-report and update their provider data in order to ensure accuracy and integrity in the provider data collected and maintained.
- HSAG recommends Kaiser develop a documented process and/or workflow outlining its oversight and validation for tracking turnaround times for the resolution of DOB discrepancies that are sent to the State.
- To improve analysis, HSAG recommends Kaiser explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.
- HSAG recommends Kaiser take a look at Quest and have deeper understanding of it. Although driving distance was used, Kaiser was unaware.
- To improve analysis, HSAG recommends Kaiser use unique providers for ratio calculations.

Strengths, Opportunities for Improvement, and Recommendations

By assessing Kaiser's performance and NAV reporting process, 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: Kaiser had established a robust process to maintain the accuracy and completeness of provider information through its quarterly attestation reminders, which were sent to providers from its MSOW system and quarterly provider directory attestation requirement, three-year cycle for credentialing and recredentialing process, and several web crawls that were run by MSOW regularly, ensuring business continuity of the process.

Opportunities for Improvement and Recommendations

Opportunity #1: Kaiser indicated that the 834 file that comes from the Department contains a pseudo address of "General Delivery" in the address field where a member's address is unknown. Although the impact identified was not determined to be significant, Kaiser was unable to provide HSAG with a clear process for how it captures updated demographic information and the system's capability to capture updated demographic information. Kaiser confirmed the use of the 834 files as the source of truth for all member eligibility and demographic information.

Recommendation: HSAG recommends Kaiser explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file.

Northeast Health Partners (NHP)

ISCA Findings and Data Validity

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 and data processing procedures that NHP had in place to support network adequacy indicator reporting, which included the following:

- 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 health care, 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 approximately 10 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 State. 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.
- NHP performed monthly reconciliation between CONNECTS and the 834 file submissions from the Department to ensure completeness and accuracy of enrollment data.

- NHP conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - NHP 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 is an error prevention method 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 ensures that no data rows are lost during the ETL process and alerts the staff if any discrepancies are found.
  - Parity Checking—This is a type of error checking that searches inside the data files to determine if any data corruption has 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.
- NHP'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 ID to link enrollment history.
- NHP 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:

- NHP ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- NHP had adequate data collection processes in place to ensure completeness and consistency.
- NHP 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.

- NHP captured all state-required provider types and specialties in the CONNECTS database management system and demonstrated the logic for how NHP identified provider types appropriately.
- NHP'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.
  - NHP 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.

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 audits.
  - 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 2023 reporting period.

Network Adequacy Indicator Reporting

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

- NHP used Quest to calculate and report network adequacy indicators.
- NHP integrated member and provider data for network adequacy indicator reporting. However, NHP did not deduplicate behavioral health providers who had multiple licenses or credentials when calculating time and distance indicators. HCI may have used all provider locations in calculating its provider-to-enrollee ratios. Either of these practices could lead to over-counting of the number of providers available to enrollees within the standards.
- NHP conducted standardized quality assurance checks to monitor the reasonableness and accuracy of its network adequacy indicator results and reports.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at NHP were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at NHP were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on NHP's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends NHP continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.
- HSAG recommends NHP inquire with the Department regarding whether there are any specific guidelines for geocoding members without a physical address.
- HSAG recommends NHP inquire with the Department regarding specific guidelines for calculating provider-to-enrollee ratios.

Strengths, Opportunities for Improvement, and Recommendations

By assessing NHP's performance and NAV reporting process, 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 established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and annual provider directory attestation requirement, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists.

Strength #2: NHP had established a robust process to maintain data accuracy by frequently performing internal audits of a representative sample of updated member and provider records, wherein audits were conducted at a 100 percent rate for new employees and reduced as accuracy goals were met.

Opportunities for Improvement and Recommendations

Opportunity #1: NHP used the daily and monthly 834 files for member demographic data, but up to 5 percent of members on the enrollment files did not have a physical address on the file.

Recommendation: HSAG recommends NHP inquire with the Department regarding whether it should pursue other sources of address information for its members to ensure completeness of its member data used for network adequacy reporting.

Health Colorado, Inc. (HCI)

ISCA Findings and Data Validity

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 and data processing procedures that HCI had in place to support network adequacy indicator reporting, which included the following:

- HCI used CONNECTS as the database management system to collect and maintain member enrollment and provider data.

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

- HCI had six total 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 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 State. HSAG's evaluation of HCI's enrollment system included the following:

- Enrollment and eligibility data for Medicaid 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 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, HCI generated error reports, which captured any critical data elements that were missing. HCI generated another report which was analyzed by a business analyst.

- Data integrity was controlled at four levels:
  - ETL Process Log Parsing—This is an error prevention method 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 ensures that no data rows are lost during the ETL process and alerts the staff if any discrepancies are found.
  - Parity Checking—This is a type of error checking that searches inside the data files to determine if any data corruption has 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.
- 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 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 captured all state-required provider types and specialties in CONNECTS.
- 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 program and CHIP each month.
  - 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, which used CONNECTS to capture all related data.
- HCI maintained oversight of its delegated entities by:
  - Conducting annual audits.
  - Collecting quarterly 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.
- HCI did not identify any delegated entity network adequacy data-related items requiring corrective action for the 2023 reporting period.

Network Adequacy Indicator Reporting

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

- HCI used Quest to calculate and report network adequacy indicators.
- HCI integrated member and provider data for network adequacy indicator reporting. However, HCI did not deduplicate behavioral health providers who had multiple licenses or credentials when calculating time and distance indicators. HCI may have used all provider locations in calculating its provider-to-enrollee ratios. Either of these practices could lead to over-counting of the number of providers available to enrollees within the standards.
- HCI conducted standardized quality assurance checks to monitor the reasonableness and accuracy of its network adequacy indicator results and reports.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at HCI were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at HCI were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on HCI's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends HCI continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.
- HSAG recommends HCI inquire with the Department regarding whether there are any specific guidelines for geocoding members without a physical address.
- HSAG recommends HCI inquire with the Department regarding specific guidelines for calculating provider-to-enrollee ratios.

Strengths, Opportunities for Improvement, and Recommendations

By assessing RAE 4's performance and NAV reporting process, 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 had established robust processes to keep provider data up to date and accurate through its quarterly attestation reminders to providers and annual provider directory attestation requirement, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists.

Strength #2: HCI had established robust processes to maintain data accuracy by frequently performing internal audits of a representative sample of updated member and provider records, wherein audits were conducted at a 100 percent rate for new employees and reduced as accuracy goals were met.

Opportunities for Improvement and Recommendations

Opportunity #1: HCI used the daily and monthly 834 files for member demographic data, but up to 8 percent of members on the enrollment files did not have a physical address on the file.

Recommendation: HSAG recommends HCI inquire with the Department regarding whether it should pursue other sources of address information for its members to ensure completeness of its member data used for network adequacy reporting.

Rocky Mountain Health Plans (RMHP)

ISCA Findings and Data Validity

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 and data processing procedures that RMHP had in place to support network adequacy indicator reporting, which included the following:

- RMHP used the Core Services Platform (CSP) Facets application as the management system to collect and maintain member enrollment and provider data.

HSAG evaluated the personnel that the 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 State. 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 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 on the state eligibility website and reconciliation with the 834 file(s).

  - RMHP had processors who validated the information with the state 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. Additional eligibility verification was completed via the 820 reconciliation process.
- RMHP's system captured and maintained both the state-issued Medicaid ID and a system-generated ID. If the State sent different member identification 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.

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 CSP Facets application.
- Provider network status data were maintained in the CSP Facets application.
- RMHP captured all state-required provider types and specialties in the CSP Facets system and demonstrated the logic for how RMHP identified provider types appropriately.
- 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 Network Database (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.

Network Adequacy Indicator Reporting

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

- RMHP used Quest to calculate and report network adequacy indicators.
- RMHP integrated member and provider data for network adequacy indicator reporting.
- RMHP conducted data quality checks by creating several checkpoints that are performed for each network adequacy run. The checkpoints are automatically run for every report. An analysts on the Network Adequacy team also reviewed the results to determine if the results are reasonable and expected based on prior reports.

Assessment of Data Validity

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

Overall, HSAG determined that the **data collection procedures** in place at RMHP were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at RMHP were:

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Analysis and Conclusions

Based on RMHP's ISCA results, HSAG's conclusions are as follows:

- HSAG recommends RMHP inquire with the Department regarding whether there are any specific guidelines for geocoding members without a physical address.
- HSAG recommends RMHP continue monitoring member access through quarterly network adequacy assessments based on the State's expectations.

Strengths, Opportunities for Improvement, and Recommendations

By assessing RMHP's performance and NAV reporting process, 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: RMHP had established 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. RMHP had strong data security, and annual testing was completed.

Strength #2: RMHP offered providers multiple options for provider data updates through multiple intake channels that allowed providers the opportunity to attest to data via MPP, Inbound Demographic Change Line, Roster Processing, and CAQH ProView.

Opportunities for Improvement and Recommendations

Opportunity #1: No ISCA-specific opportunities were identified.

Recommendation: NA

4. Network Adequacy Validation Results

During FY 2023–2024, 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. Each quarter, 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 2023–2024 Q2 network adequacy reports, representing the measurement period reflecting the MCEs' networks from October 1, 2023, through December 31, 2023.

For an MCE to meet the FY 2023–2024 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 2023–2024 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 2023–2024 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 2023–2024 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.

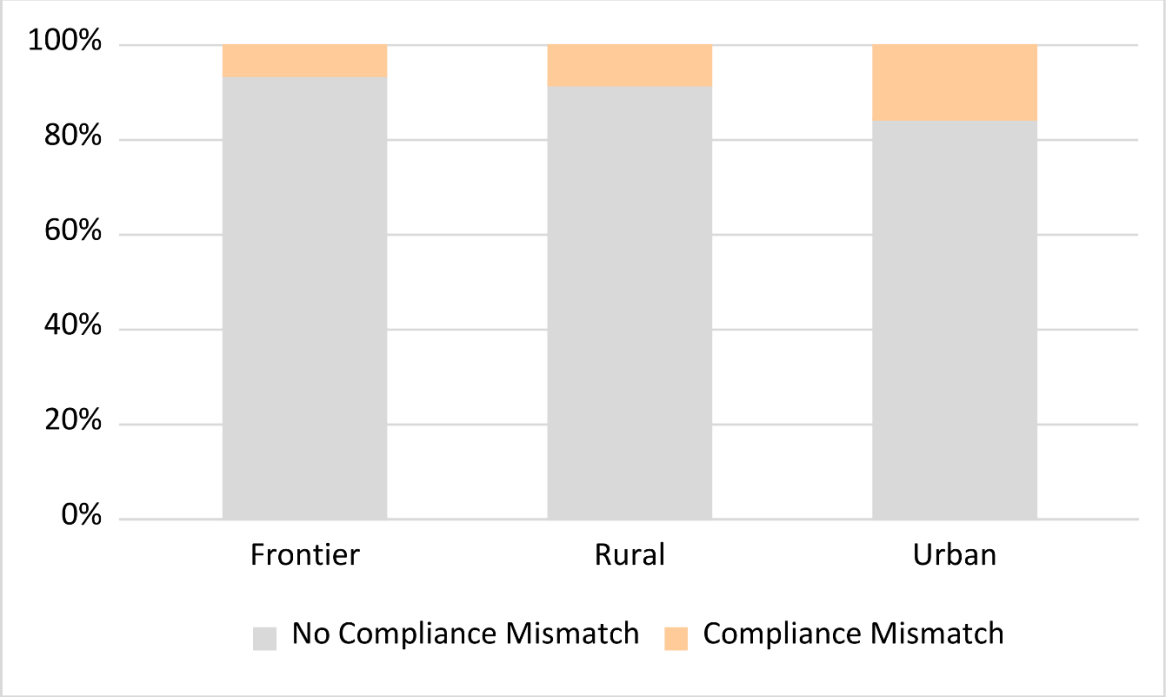
MCE-specific results are grouped by line of business and are presented in subsections:

- **Network Adequacy Indicator-Specific Validation Results:** HSAG evaluated the MCEs' 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 state network adequacy monitoring efforts.
- **NAV Results:** HSAG evaluated the MCEs' compliance with network standards and provided a summary of each MCE's strengths as well as opportunities for improvement based on the evaluation. Additionally, HSAG has made recommendations for each MCE based on the opportunities identified.

CHP+ Managed Care Organizations (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.

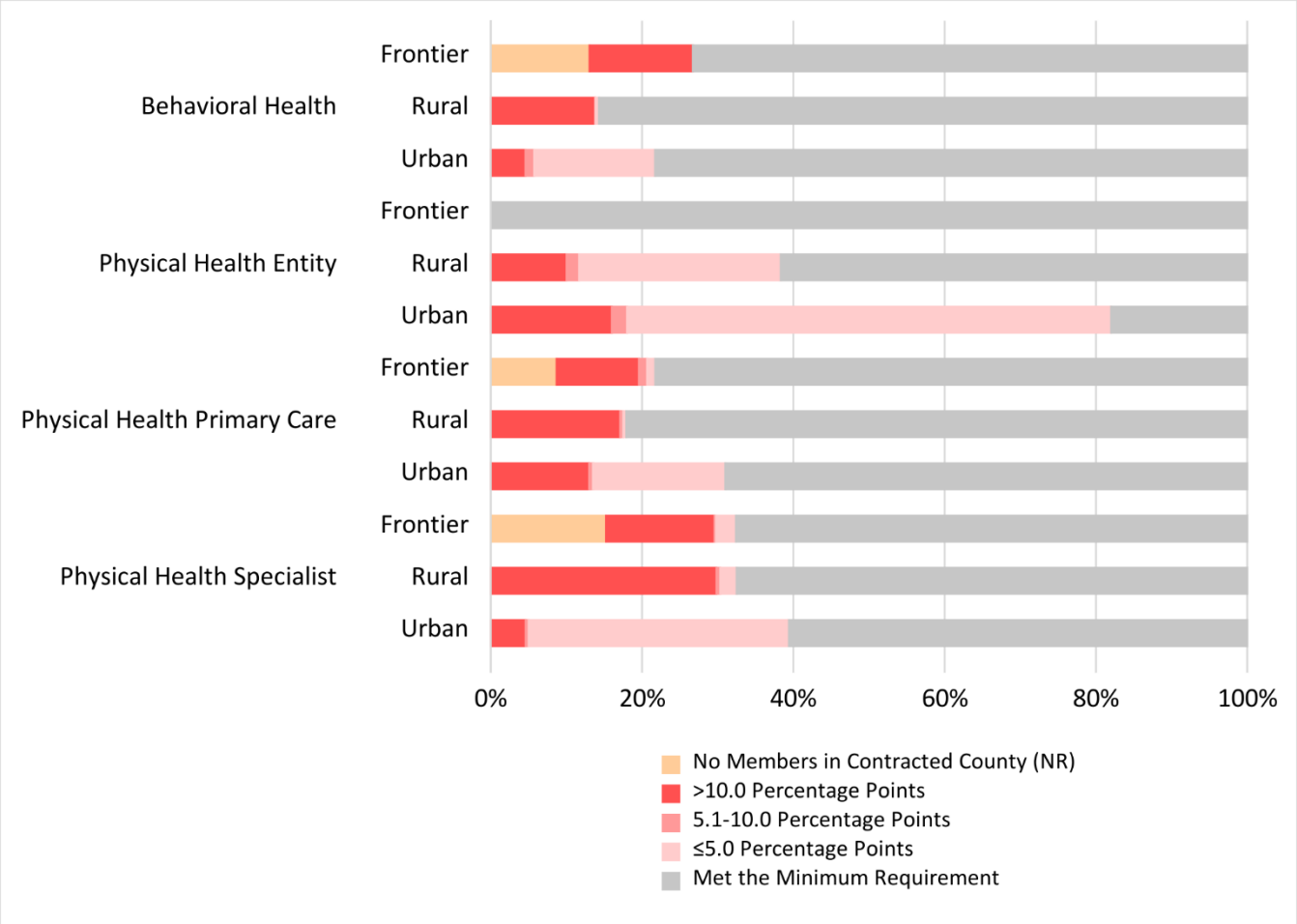
Figure 4-1—Aggregate CHP+ MCO Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 93.5 percent of the CHP+ MCOs' reported quarterly geoaccess compliance results for frontier counties, 91.5 percent of reported results for rural counties, and 84.3 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 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for CHP+ MCO members by urbanicity for FY 2023–2024 Q2. '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.[4-1]

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, 2023



[4-1] 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 2023–2024 NAV analyses.

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 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 substance use disorder (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 obstetrics and/or gynecology (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 Behavioral Health Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	73.3%	85.7%	78.3%
≤ 5.0 Percentage Points	0%	0.5%	16.0%
5.1-10.0 Percentage Points	0%	0%	1.1%
> 10.0 Percentage Points	13.7%	13.8%	4.6%

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
No Members (NR)	13.0%	0%	0%

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: 73.3 percent met the minimum network requirements (i.e., 100 percent of CHP+ MCO members with access within the designated miles and minutes). An additional 13.7 percent of the results were greater than 10.0 percentage points away from the minimum network requirements, and 13.0 percent of aggregated results had no CHP+ MCO members within the appropriate age range for the behavioral health requirements.
- Of the aggregated rural county behavioral health results: 85.7 percent met the minimum network requirements, 0.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 13.8 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county behavioral health results: 78.3 percent met the minimum network requirements, 16.0 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 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 Physical Health Entity Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	100%	61.7%	18.0%
≤ 5.0 Percentage Points	0%	26.7%	64.0%
5.1-10.0 Percentage Points	0%	1.7%	2.0%
> 10.0 Percentage Points	0%	10.0%	16.0%
No Members (NR)	0%	0%	0%

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: 61.7 percent met the minimum network requirements. An additional 26.7 percent 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 10.0 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health entity results: 18.0 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 16.0 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

Table 4-4—Aggregated Physical Health Primary Care Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	78.3%	82.1%	69.0%
≤ 5.0 Percentage Points	1.1%	0.4%	17.5%
5.1-10.0 Percentage Points	1.1%	0.4%	0.5%
> 10.0 Percentage Points	10.9%	17.1%	13.0%
No Members (NR)	8.7%	0%	0%

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: 78.3 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 1.1 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, 10.9 percent were greater than 10.0 percentage points away from the minimum network requirements, and 8.7 percent

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: 82.1 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, 0.4 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 17.1 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health primary care results: 69.0 percent met the minimum network requirements, 17.5 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.5 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 13.0 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Specialist

Table 4-5—Aggregated Physical Health Specialist Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	67.6%	67.5%	60.6%
≤ 5.0 Percentage Points	2.6%	2.2%	34.4%
5.1-10.0 Percentage Points	0.2%	0.5%	0.4%
> 10.0 Percentage Points	14.3%	29.8%	4.6%
No Members (NR)	15.2%	0%	0%

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: 67.6 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, 0.2 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, 14.3 percent were greater than 10.0 percentage points away from the minimum network requirements, and 15.2 percent 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: 67.5 percent met the minimum network requirements, 2.2 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.5 percent were within 5.1 to 10.0 percentage points of the

minimum network requirements, and 29.8 percent were greater than 10.0 percentage points away from the minimum network requirements.

- Of the aggregated urban county physical health specialist results: 60.6 percent met the minimum network requirements, 34.4 percent were less than or equal to 5.0 percentage points away from the minimum network requirements, 0.4 percent were within 5.1 to 10.0 percentage points of the minimum network requirement, and 4.6 percent were greater than 10.0 percentage points away from the minimum network requirements.

COA CHP+

Network Adequacy Indicator-Specific Validation Rating

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 CHP+'s interpretation of data was accurate.

Table 4-6 summarizes HSAG's validation ratings for COA CHP+, by indicator type.

Table 4-6—Summary of COA CHP+ Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 141 indicators for COA CHP+. Of these indicators, 78.7 percent received ratings of High Confidence, and 21.3 percent received ratings of Moderate Confidence. For the indicators for which COA CHP+ did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios, and the MCE stated that Quest may have used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Validation Results

By assessing COA CHP+'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 CHP+ met the minimum network requirements for Pediatric Behavioral Health and for Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.

Strength #2: COA CHP+ met the minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS, and PA), General Behavioral Health, and General Psychiatrists and other Psychiatric Prescribers across all rural and urban counties.

Strength #3: Across all frontier and rural counties, COA CHP+ met the minimum network requirements for Family Practitioner (MD, DO, NP, CNS, and PA), Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Pediatric SUD Treatment.

Strength #4: COA CHP+ met the minimum network requirements in frontier counties for Acute Care Hospitals, Pediatric Surgery, and Pharmacies, as well as met the minimum network requirements for General SUD Treatment and General Surgery across all rural counties.

Opportunities for Improvement and Recommendations

Opportunity #1: COA CHP+ did not meet the minimum network requirements for the Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for 100 percent of rural counties, 93.3 percent of frontier counties, and 85.7 percent of urban counties.

Opportunity #2: COA did not meet the minimum network requirements for more than 50 percent of the contracted counties for the following pediatric specialists: Endocrinology, Gastroenterology, Otolaryngology/ENT, Ophthalmology, Neurology, and Pulmonary Medicine.

Recommendation: To address these opportunities for improvement, HSAG recommends COA CHP+ 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.

DHMP CHP+

Network Adequacy Indicator-Specific Validation Rating

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 CHP+'s interpretation of data was accurate.

Table 4-7 summarizes HSAG's validation ratings for DHMP CHP+, by indicator type.

Table 4-7—Summary of DHMP CHP+ Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	X			
Time/Distance Indicators		X		

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 67 indicators for DHMP CHP+. Of these indicators, 44.8 percent received ratings of High Confidence, and 55.2 percent received ratings of Moderate Confidence. For the indicators for which DHMP CHP+ did not receive a rating of High Confidence, HSAG noted that although the methodology for calculating this indicator was sound, DHMP CHP+ used straight line distance, which does not align with the State's expectations.

Network Adequacy Validation Results

By assessing DHMP CHP+'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 CHP+ met minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS), Pediatric Primary Care Practitioner (MD, DO, NP, CNS), and Family Practitioner (MD, DO, NP, CNS) in all contracted counties. Additionally, DHMP CHP+ met the minimum network requirements for Adult Primary Care Practitioner (PA) in 75 percent of contracted counties.

Strength #2: DHMP CHP+ met minimum network requirements for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.

Strength #3: DHMP CHP+ met minimum network requirements for General Urology in all contracted counties. While DHMP CHP+ did not meet the minimum network requirements for a

number of general and pediatric specialty provider categories across contracted counties, the level of access for these provider categories was consistently 99 percent or greater.

Opportunities for Improvement and Recommendations

Opportunity #1: DHMP CHP+ did not meet the minimum network requirements for Acute Care Hospitals; Gynecology, OB/GYN (PA); Pediatric SUD Treatment; or Pharmacy and Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals for any of the contracted counties.

Opportunity #2: DHMP CHP+ did not meet the minimum network requirement for any of the contracted counties for the following pediatric specialists: Cardiology, Endocrinology, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Otolaryngology/ENT, and Pulmonary Medicine.

Recommendation: To address these opportunities for improvement, HSAG recommends DHMP CHP+ 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.

RMHP CHP+

Network Adequacy Indicator-Specific Validation Rating

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 CHP+'s interpretation of data was accurate.

Table 4-8 summarizes HSAG's validation ratings for RMHP CHP+, by indicator type.

Table 4-8—Summary of RMHP CHP+ Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	X			
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 104 indicators for RMHP CHP+. Of these indicators, 100 percent received ratings of High Confidence.

Network Adequacy Validation Results

By assessing RMHP CHP+'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: RMHP CHP+ performed well within the behavioral health network category, meeting all minimum network requirements for Pediatric Behavioral Health, Pediatric Psychiatrists and other Psychiatric Prescribers, and Pediatric SUD Treatment in all contracted counties. Additionally, for General Behavioral Health, General Psychiatrists and other Psychiatric Prescribers, and General SUD Treatment, RMHP CHP+ met the minimum requirements in greater than 90 percent of all contracted counties.

Strength #2: RMHP CHP+ met the minimum network requirements for Family Practitioner (MD, DO, NP, CNS) and Pediatric Primary Care Practitioner (MD, DO, NP, CNS) across all contracted counties. Additionally, RMHP CHP+ met the minimum network requirement for Adult Primary Care Practitioner (MD, DO, NP, CNS) in greater than 90 percent of all contracted counties.

Strength #3: RMHP CHP+ met the minimum network requirements for the following specialty provider categories in 90 percent or more of all contracted counties: General Behavioral Health, General and Pediatric Cardiology, General and Pediatric Ophthalmology, General and Pediatric

Orthopedics, General Otolaryngology/ENT, General Pulmonary Medicine, General Surgery and General Urology.

Opportunities for Improvement and Recommendations

Opportunity #1: RMHP CHP+ did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals for any contracted counties.

Opportunity #2: RMHP CHP+ did not meet the minimum network requirements for Gynecology, OB/GYN (PA) in greater than 95 percent of all contracted counties.

Opportunity #3: RMHP CHP+ did not meet minimum network requirements for a number of specialty provider categories across contracted counties. For example, RMHP CHP+ did not meet minimum network requirements for Pediatric Endocrinology in 59.1 percent of all contracted counties, nor for General Endocrinology in 31.8 percent of all contracted counties.

Recommendation: To address these opportunities for improvement, HSAG recommends RMHP CHP+ 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

Network Adequacy Indicator-Specific Validation Rating

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 4-9 summarizes HSAG's validation ratings for Kaiser, by indicator type.

Table 4-9—Summary of Kaiser Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X[1]			X[1]

[1] Kaiser received a validation score of High Confidence for the four Behavioral Health Time/Distance indicators with 90 percent standards, and No Confidence/Significant bias for the remainder of the Time/Distance indicators.

HSAG assessed a total of 67 indicators for Kaiser. Of these indicators, 6.0 percent received ratings of High Confidence, 44.8 percent received ratings of Moderate Confidence, and 49.3 percent received ratings of No Confidence/Significant Bias[4-2].

Kaiser was the only MCE to receive a validation rating of No Confidence during the FY 2023–2024 NAV ISCA assessment. HSAG observed that Kaiser is using a standard different that those set forth by the Department as listed in Appendix E. Since the MCE has used standards divergent from the Department's requirements, there are elements determined to have "Significant Bias," which result in a validation rating of No Confidence.

Network Adequacy Validation Results

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: Kaiser met all minimum network requirements across all contracted counties for Adult, Family, and Pediatric Primary Care Practitioner (MD, DO, NP, CNS); both General and Pediatric Behavioral Health; General and Pediatric Psychiatrists and other Psychiatric Prescribers and General SUD Treatment.

[4-2] The sum of the percentages of validation ratings per MCE may not equal 100 percent due to rounding.

Strength #2: Kaiser demonstrated strength in general specialty provider types, meeting the minimum network requirements for General Cardiology, General Gastroenterology, General Neurology, General Ophthalmology, General Orthopedics, General Otolaryngology/ENT, General Pulmonary Medicine, General Surgery and General Urology across all contracted counties.

Strength #3: While Kaiser did not meet the minimum network requirements for all pediatric specialty provider types, the plan demonstrated greater than 98 percent access for each provider type where the plan failed to meet the standard, across all contracted counties.

Opportunities for Improvement and Recommendations

Opportunity #1: Kaiser did not meet the minimum network requirements for Adult, Family, and Pediatric Primary Care Practitioner (PA) in any contracted county.

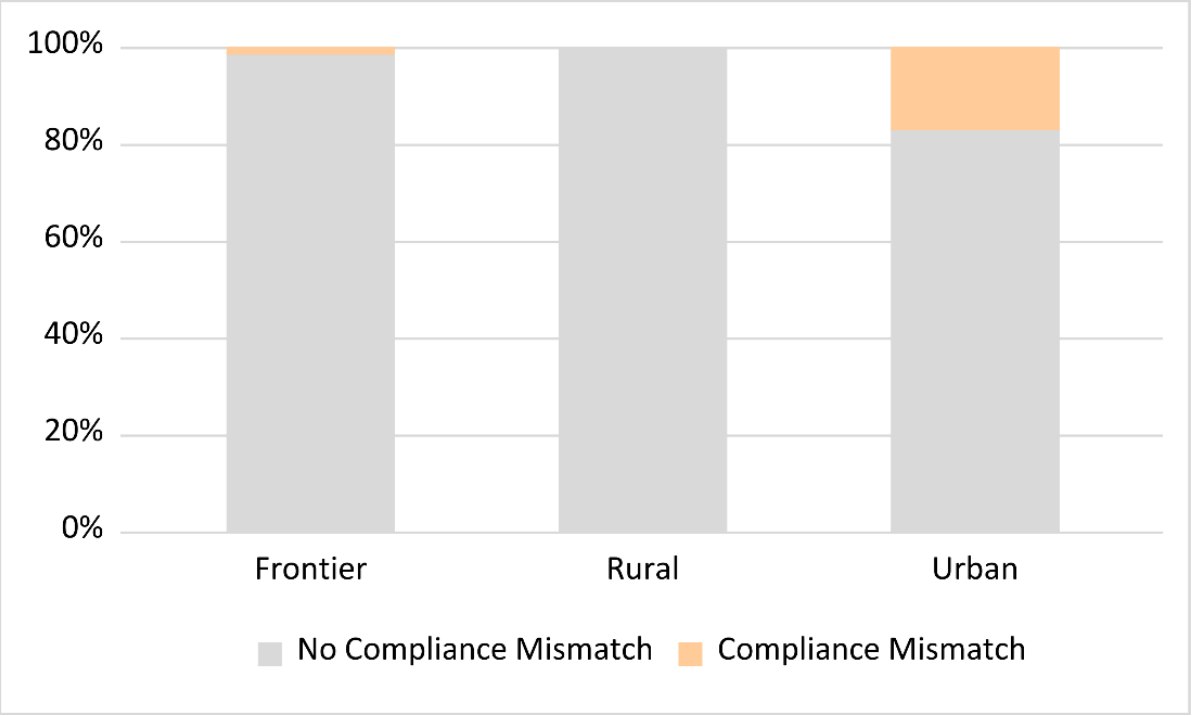
Opportunity #2: Kaiser did not meet the minimum network requirement for Pharmacies and Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in 85.7 percent of contracted counties.

Recommendation: To address these opportunities for improvement, HSAG recommends Kaiser 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.

Medicaid Managed Care Organizations (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.

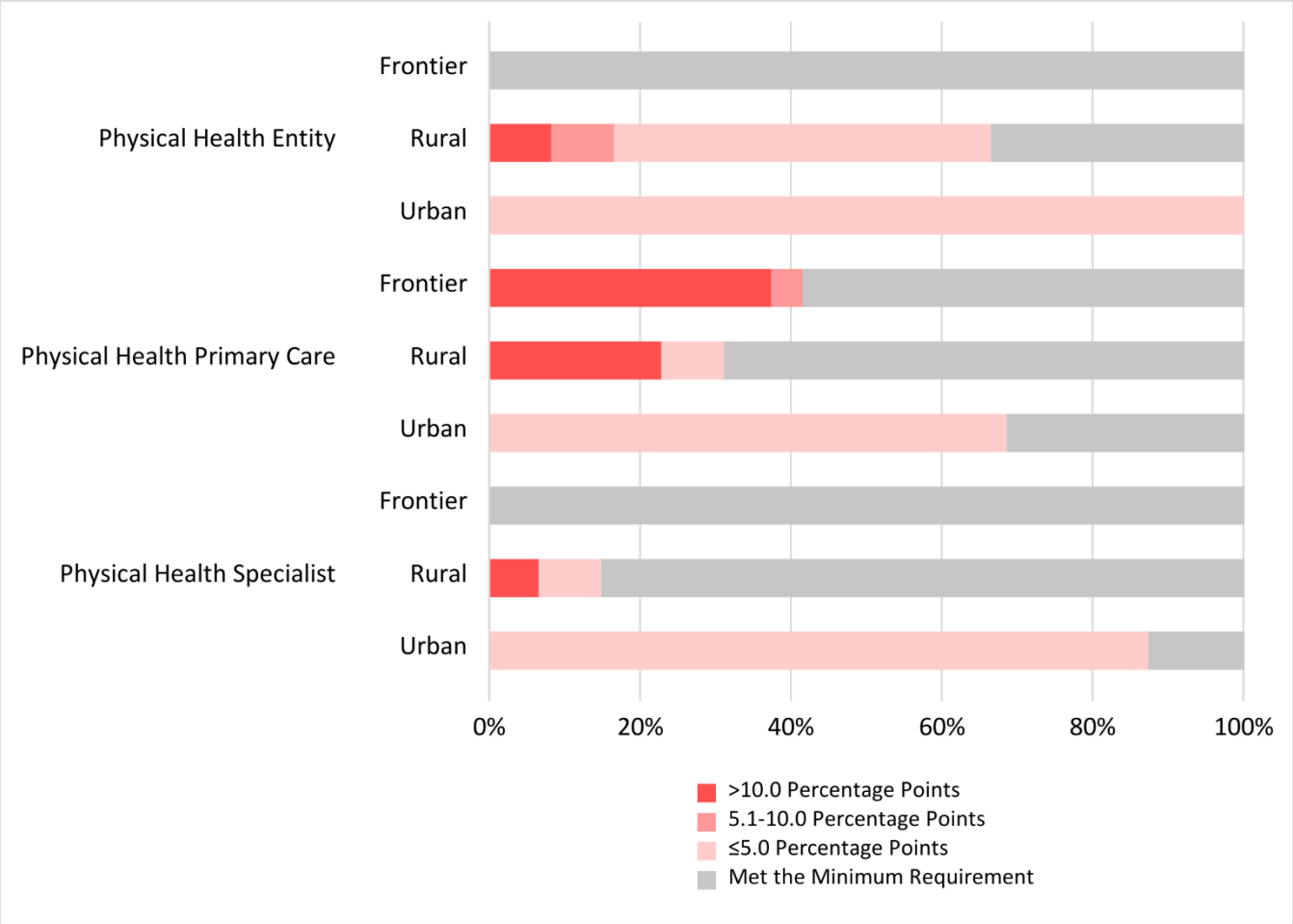
Figure 4-3—Aggregate Medicaid MCO Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 98.9 percent of the Medicaid MCOs' reported quarterly geoaccess compliance results for frontier counties, 100 percent of reported results for rural counties, and 83.3 percent of reported results for urban counties.

Figure 4-4 displays the percentage of physical health primary care network results achieving 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of minimum network requirements for Medicaid MCO members by urbanicity for FY 2023–2024 Q2.

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, as of December 31, 2023



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 gynecology and 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 4-10 through Table 4-12 display the aggregated percentages and total counts reflected in Figure 4-4.

Physical Health Entities

Table 4-10—Aggregated Physical Health Entity Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

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

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: 100 percent were less than or equal to 5.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

Table 4-11—Aggregated Physical Health Primary Care Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	58.3%	68.8%	31.3%
≤ 5.0 Percentage Points	0%	8.3%	68.8%
5.1-10.0 Percentage Points	4.2%	0%	0%
> 10.0 Percentage Points	37.5%	22.9%	0%

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: 58.3 percent met the minimum network requirements. An additional 4.2 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 37.5 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county physical health primary care results: 68.8 percent met the minimum network requirements. An additional 8.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 22.9 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health primary care results: 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.

Physical Health Specialist

Table 4-12—Aggregated Physical Health Specialist Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	100%	85.5%	12.5%
≤ 5.0 Percentage Points	0%	8.3%	87.5%
5.1-10.0 Percentage Points	0%	0%	0%
> 10.0 Percentage Points	0%	6.7%	0%

HSAG assessed a total of 260 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: 85.5 percent met the minimum network requirements, 8.3 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: 12.5 percent met the minimum network requirements, and 87.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements.

DHMP MCO

Network Adequacy Indicator-Specific Validation Rating

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 MCO's interpretation of data was accurate.

Table 4-13 summarizes HSAG's validation ratings for DHMP MCO, by indicator type.

Table 4-13—Summary of DHMP MCO Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 77 indicators for DHMP MCO. Of these indicators, 44.2 percent received ratings of High Confidence, and 55.8 percent received ratings of Moderate Confidence. For the indicators for which DHMP MCO did not receive a rating of High Confidence, HSAG noted that although the methodology for calculating this indicator was sound, DHMP used straight line distance, which does not align with the State's expectations.

Network Adequacy Validation Results

By assessing DHMP MCO'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 MCO performed well in the behavioral health network category, meeting all minimum network requirements for General Behavioral Health, Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.

Strength #2: DHMP MCO met minimum network requirements for Adult Primary Care Practitioner (MD, DO, NP, CNS), Pediatric Primary Care Practitioner (MD, DO, NP, CNS), and Family Practitioner (MD, DO, NP, CNS) in 75 percent of contracted counties. Where DHMP did not meet the minimum network requirement for the specified provider categories, access was greater than 99.9 percent.

Strength #3: While DHMP MCO did not meet the minimum network requirements for a number of standards across all contracted counties, the rate of access for provider types including Adult, Pediatric, and Family Primary Care Practitioner (MD, DO, NP, CNS, and PA), Acute Care Hospitals, and an array of general and pediatric specialty providers was consistently 99 percent or greater.

Opportunities for Improvement and Recommendations

Opportunity #1:DHMP MCO did not meet the minimum network requirements for SUD Treatment Facilities across all American Society of Addiction Medicine (ASAM) levels of care in all contracted counties. DHMP struggled particularly with ASAM 3.2 withdrawal management (WM), 3.3, and 3.7, with rates of access ranging from 0 percent to 0.2 percent in all contracted counties.

Recommendation: To address these opportunities for improvement, HSAG recommends DHMP MCO 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.

RMHP Prime

Network Adequacy Indicator-Specific Validation Rating

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 Prime's interpretation of data was accurate.

Table 4-14 summarizes HSAG's validation ratings for RMHP Prime, by indicator type.

Table 4-14—Summary of RMHP Prime Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	X			
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 88 indicators for RMHP Prime. Of these indicators, 100 percent received ratings of High Confidence.

Network Adequacy Validation Results

By assessing RMHP Prime'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: RMHP Prime met minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in all contracted counties. RMHP Prime met minimum network requirements for Family Practitioner (MD, DO, NP, CNS) in all but one county, where access was greater than 99.9 percent.

Strength #2: RMHP Prime performed strongly in the specialty provider network category, meeting minimum network requirements for General Pulmonary Medicine, Pediatric Cardiology, Pediatric Neurology, Pediatric Ophthalmology, Pediatric Orthopedics, Pediatric Otolaryngology, Pediatric Pulmonary Medicine, Pediatric Urology, General Surgery, and Pediatric Surgery across all contracted counties.

Strength #3: RMHP Prime met the minimum network requirements for Pharmacies in 66.6 percent of all contracted counties. In the counties where RMHP Prime did not meet the minimum network requirement, access was 99.3 percent or greater.

Opportunities for Improvement and Recommendations

Opportunity #1: While RMHP Prime met minimum network requirements for Gynecology, OB/GYN (MD, DO, NP, CNS) in greater than 77.7 percent of contracted counties, the plan did not meet the minimum network requirement for Gynecology, OB/GYN (PA) in any contracted counties.

Opportunity #2: RMHP Prime did not meet the minimum network requirements for Acute Care Hospitals or Family Practitioner (PA) in more than half (55.6 percent) of all contracted counties.

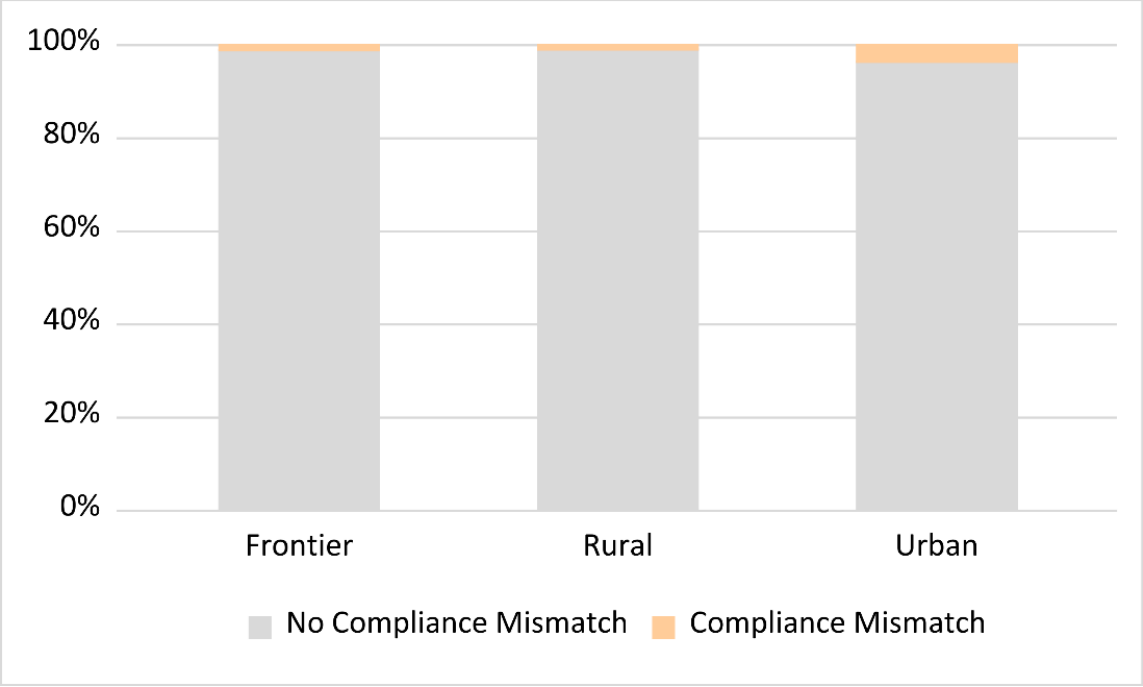
Recommendation: To address these opportunities for improvement, HSAG recommends RMHP Prime conduct an in-depth review of provider categories for which the plan did not meet the time and distance contract standards, with the goal of determining whether the failure to meet the contract standards was the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

Dental Prepaid Ambulatory Health Plan (PAHP)

DentaQuest

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.

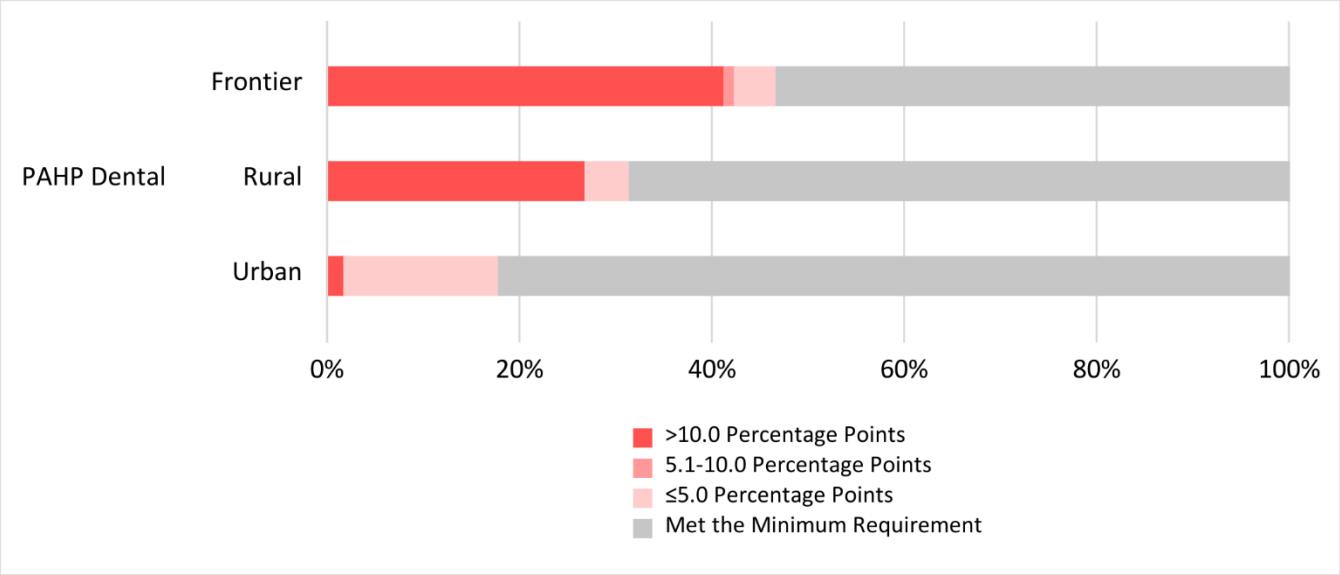
Figure 4-5—Aggregate PAHP Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 98.9 percent of the PAHP's reported quarterly geoaccess compliance results for frontier counties, 99.1 percent of reported results for rural counties, and 96.4 percent of reported results for urban counties.

Figure 4-6 displays the percentage of dental network results having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of PAHP members with access in the network requirement by urbanicity for FY 2023–2024 Q2.

Figure 4-6—Percentage of Aggregate PAHP Dental Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023



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 B). 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 4-15 displays the aggregated percentages and total counts reflected in Figure 4-6.

Dental Services

Table 4-15—Aggregated Dental Service Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	53.3%	68.5%	82.1%
≤ 5.0 Percentage Points	4.3%	4.6%	16.1%
5.1-10.0 Percentage Points	1.1%	0%	0%
> 10.0 Percentage Points	41.3%	26.9%	1.8%

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: 53.3 percent met the minimum network requirements. An additional 4.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 41.3 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county dental service results: 68.5 percent met the minimum network requirements. An additional 4.6 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 26.9 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county dental service results: 82.1 percent met the minimum network requirements. An additional 16.1 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.

Network Adequacy Indicator-Specific Validation Rating

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 4-16 summarizes HSAG's validation ratings for DentaQuest, by indicator type.

Table 4-16—Summary of DentaQuest Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 12 indicators for DentaQuest. Of these indicators, 100 percent received ratings of High Confidence.

Network Adequacy Validation Results

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 met the minimum network requirements for General Dentists in 89.1 percent of all contracted counties. In urban counties, where DentaQuest did not meet the minimum network requirements for General Dentists, access was 99.9 percent. In rural counties, in the single county where DentaQuest did not meet the minimum network requirements for General Dentists, access was 97.7 percent.

Strength #2: DentaQuest met the minimum network requirements for Orthodontists in 81.3 percent of all contracted counties.

Strength #3: While DentaQuest did not meet the minimum network requirements for Oral Surgeons across all contracted counties, in all urban counties, access to oral surgeons was greater than 99.9 percent.

Strength #4: While DentaQuest met the minimum network requirements for Pediatric Dentists in only 48.4 percent of all contracted counties across urbanicity, in urban counties, access to Pediatric Dentists was consistently greater than 99 percent except for one county for which access was 88.8 percent.

Opportunities for Improvement and Recommendations

Opportunity #1: DentaQuest did not meet the minimum network requirements for Oral Surgeons in 54.7 percent of all contracted counties. In rural counties, DentaQuest met the minimum network requirements for Oral Surgeons in only nine counties, achieving 99.4 percent access in one additional county. Rural counties otherwise demonstrated rates of access ranging from 0 percent to 30.6 percent. DentaQuest performed similarly in frontier counties, meeting the minimum network

requirements for Oral Surgeons in seven counties, and demonstrating rates of access from 0 percent to 86.4 percent in all other contracted frontier counties.

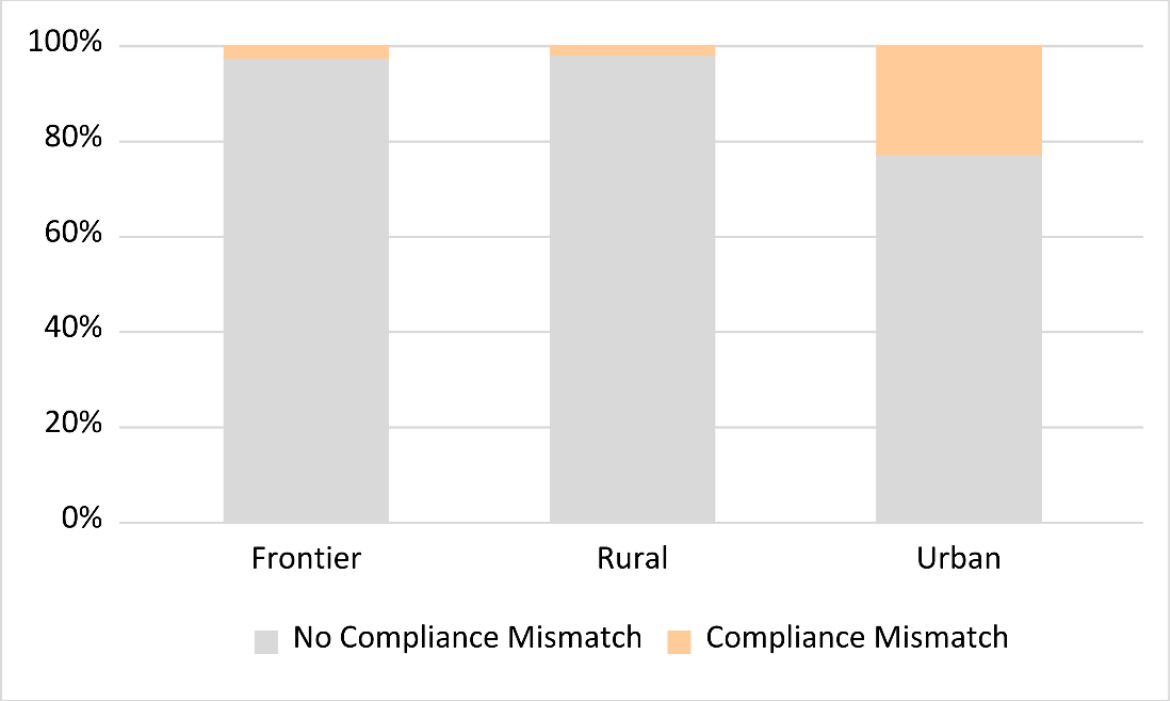
Opportunity #2: As described in Strength #4, DentaQuest did not meet the minimum network requirements for Pediatric Dentists in 51.6 percent of all contracted counties. Particularly impacted were rural and frontier counties, where among counties not meeting the standard access ranged from 0 percent to 99.9 percent of all members

Recommendation: To address these opportunities for improvement, HSAG recommends DentaQuest 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.

Regional Accountable Entities (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.

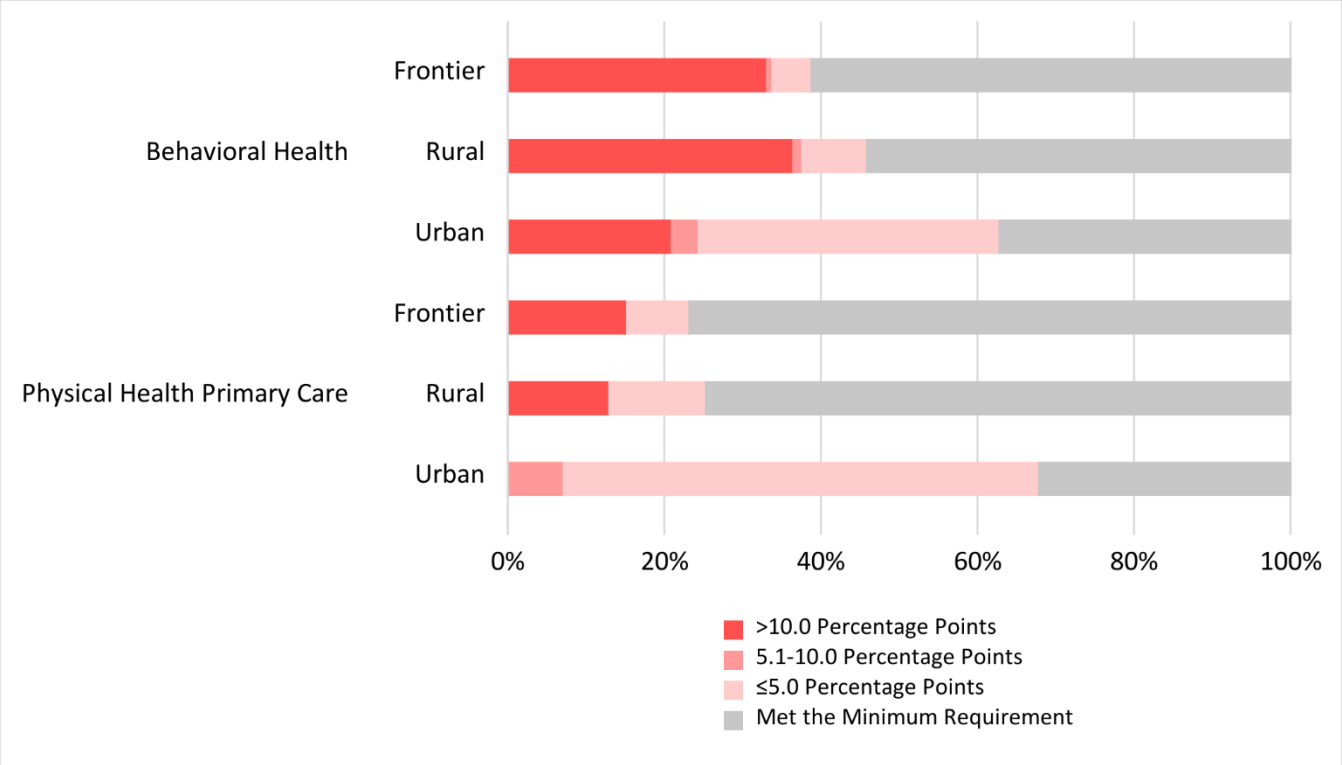
Figure 4-7—Aggregate RAE Geoaccess Compliance Results for FY 2023–2024 Q2 by Urbanicity



HSAG agreed with 97.7 percent of the RAEs' reported quarterly geoaccess compliance results for frontier counties, 98.2 percent of reported results for rural counties, and 77.4 percent of reported results for urban counties.

Figure 4-8 displays the percentage of behavioral health and physical health primary care results having 100 percent, 95 to 99 percent, 90 to 94 percent, and less than 90 percent of RAE members with access in the network requirement by urbanicity for FY 2023–2024 Q2.

Figure 4-8—Percentage of Aggregate RAE Behavioral Health and Physical Health Primary Care Results Within the Time and Distance Network Requirement for Varying Levels of Access, by Urbanicity, as of December 31, 2023



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. 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, as well as gynecology and OB/GYN practitioners. 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 4-17 and Table 4-18 display the aggregated percentages and total counts reflected in Figure 4-8.

Behavioral Health

Table 4-17—Aggregated Behavioral Health Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	61.2%	54.1%	37.2%
≤ 5.0 Percentage Points	5.0%	8.3%	38.5%
5.1-10.0 Percentage Points	0.7%	1.1%	3.4%
> 10.0 Percentage Points	33.1%	36.5%	20.9%

HSAG assessed a total of 884 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: 61.2 percent met the minimum network requirements. An additional 5.0 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 33.1 percent of the results were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county behavioral health results: 54.1 percent met the minimum network requirements. An additional 8.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 1.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements, and 36.5 percent of the results were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county behavioral health results: 37.2 percent met the minimum network requirements. An additional 38.5 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, 3.4 percent were within 5.1 to 10.0 percentage points of the minimum network requirements, and 20.9 percent were greater than 10.0 percentage points away from the minimum network requirements.

Physical Health Primary Care

Table 4-18—Aggregated Physical Health Primary Care Results Within Time and Distance Network Requirements for Varying Levels of Access, by Urbanicity, as of December 31, 2023

Level of Access (Percentage Points From 100 Percent)	Frontier Counties	Rural Counties	Urban Counties
Met the Minimum Requirement	76.8%	74.7%	32.1%
≤ 5.0 Percentage Points	8.0%	12.3%	60.7%
5.1-10.0 Percentage Points	0%	0%	7.1%
> 10.0 Percentage Points	15.2%	13.0%	0%

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 combined RAEs and DHMP are contracted to serve.

- Of the aggregated frontier county physical health primary care results: 76.8 percent met the minimum network requirements (i.e., 100 percent of RAE and DHMP members had access to physical health primary care within the minimum network requirements). An additional 8.0 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 15.2 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated rural county physical health primary care results: 74.7 percent met the minimum network requirements. An additional 12.3 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 13.0 percent were greater than 10.0 percentage points away from the minimum network requirements.
- Of the aggregated urban county physical health primary care results: 32.1 percent met the minimum network requirements. An additional 60.7 percent of the results were less than or equal to 5.0 percentage points away from the minimum network requirements, and 7.1 percent of the results were within 5.1 to 10.0 percentage points of the minimum network requirements.

RAE 1

Network Adequacy Indicator-Specific Validation Rating

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 RAE 1's interpretation of data was accurate.

Table 4-19 summarizes HSAG's validation ratings for RAE 1, by indicator type.

Table 4-19—Summary of RAE 1 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	X			
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 50 indicators for RAE 1. Of these indicators, 100 percent received ratings of High Confidence.

Network Adequacy Validation Results

By assessing RAE 1'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: RAE 1 met the minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) across all contracted counties.

Strength #2: RAE 1 performed strongly in the behavioral health network category, meeting the minimum requirements for both General and Pediatric Behavioral Health, General and Pediatric Psychiatrists and other Psychiatric Prescribers, and General and Pediatric SUD Treatment Practitioner across all contracted counties.

Strength #3: While RAE 1 did not consistently meet the minimum time and distance requirements for the various SUD Treatment Facilities–ASAM level of care standards across counties, for ASAM level of care 3.2 WM, RAE 1 met the minimum network requirement in 63.3 percent of all contracted counties. For this ASAM level, rates of access were consistently 99 percent or greater, with the exception of four counties.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 1 did not meet the minimum time requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in any contracted counties.

Opportunity #2: RAE 1 consistently did not meet the minimum network requirements for any SUD Treatment Facilities–ASAM levels of care across all contracted counties. For SUD Treatment Facilities–ASAM level of care 3.7 WM, RAE 1 did not meet minimum network requirements in 95.5 percent of all counties. Likewise, for SUD Treatment Facilities–ASAM levels of care 3.1, 3.3., 3.5, and 3.7, RAE 1 did not meet the minimum network requirements in greater than 80 percent of all contracted counties.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 1 conduct an in-depth review of provider categories for which RAE 1 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.

RAE 2

Network Adequacy Indicator-Specific Validation Rating

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 RAE 2's interpretation of data was accurate.

Table 4-20 summarizes HSAG's validation ratings for RAE 2, by indicator type.

Table 4-20—Summary of RAE 2 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 69 indicators for RAE 2. Of these indicators, 65.2 percent received ratings of High Confidence, and 34.8 percent received ratings of Moderate Confidence. For the indicators for which RAE 2 did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Validation Results

By assessing RAE 2'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: RAE 2 met all minimum network requirements for both General and Pediatric Behavioral Health, as well as both General and Pediatric Psychiatrists and other Psychiatric Prescribers across all contracted counties.

Strength #2: RAE 2 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in 90 percent of contracted counties. In the two counties where the plan did not meet the minimum network requirements for both General and Pediatric SUD Treatment Practitioner, access was 99.7 percent.

Strength #3: RAE 2 met the minimum network requirements for Pediatric Primary Care Practitioner (MD, DO, NP, CNS) in 90 percent of contracted counties, and for Adult Primary Care Practitioner (MD, DO, NP, CNS) and Family Practitioner (MD, DO, NP, CNS) in 80 percent of all contracted

counties. For these provider types, where RAE 2 did not meet the standard, access was 98 percent or greater.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 2 did not meet the minimum network requirements for SUD Treatment Facilities–ASAM levels of care 3.1, 3.2 WM, and 3.3 in any contracted counties, nor did RAE 2 meet the minimum network requirements for SUD Treatment Facilities–ASAM levels of care 3.7 and 3.7 WM in 90 percent of contracted counties.

Opportunity #2: RAE 2 did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in 80 percent of contracted counties.

Opportunity #3: While RAE 2 performed fairly well for the Adult, Pediatric, and Family Primary Care Practitioners (MD, DO, NP, CNS) provider categories, the plan did not consistently meet minimum network requirements for each Adult, Pediatric, and Family Primary Care Practitioners (PA) across contracted counties. Results varied by urbanicity, with urban and rural counties collectively demonstrating 98 percent or greater access to these provider types. RAE 2 struggled particularly in frontier counties, with access in counties where the plan did not meet the minimum network standards for Adult, Pediatric, and Family Primary Care Practitioners (PA) ranging from 32.2 percent to 44.2 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 2 conduct an in-depth review of provider categories for which RAE 2 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.

RAE 3

Network Adequacy Indicator-Specific Validation Rating

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 RAE 3's interpretation of data was accurate.

Table 4-21 summarizes HSAG's validation ratings for RAE 3, by indicator type.

Table 4-21—Summary of RAE 3 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 31 indicators for RAE 3. Of these indicators, 61.3 percent received ratings of High Confidence, and 38.7 percent received ratings of Moderate Confidence. For the indicators for which RAE 3 did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios, and the MCE stated that Quest may have used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Validation Results

By assessing RAE 3'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.

Strength

Strength #1: RAE 3 met the minimum network requirements for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.

Strength #2: RAE 3 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 50 percent of all contracted counties. In the counties where RAE 3 did not meet the minimum requirements for these provider categories, access was greater than 90 percent.

Strength #3: While RAE 3 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in only 25 percent of all contracted counties, the level of access for these provider types in all contracted counties was greater than 91.1 percent.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 3 did not consistently meet the minimum network requirements for any SUD Treatment Facilities–ASAM level of care across any of the contracted counties. Within these provider types, compliance with minimum network requirements varied greatly. SUD Treatment Facilities–ASAM levels of care 3.2 WM, 3.3, and 3.7 reflected rates of 0 percent access across all contracted counties. However, SUD Treatment Facilities–ASAM levels of care 3.1, 3.5, and 3.7 WM demonstrated rates of 98 percent or greater access in 75 percent of contracted counties, with the exception of Elbert County, where access ranged from 11.5 percent to 76.6 percent.

Opportunity #2: RAE 3 did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals in any of the contracted counties.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 3 conduct an in-depth review of provider categories for which RAE 3 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.

RAE 4

Network Adequacy Indicator-Specific Validation Rating

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 RAE 4's interpretation of data was accurate.

Table 4-22 summarizes HSAG's validation ratings for RAE 4, by indicator type.

Table 4-22—Summary of RAE 4 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 69 indicators for RAE 4. Of these indicators, 65.2 percent received ratings of High Confidence, and 34.8 percent received ratings of Moderate Confidence. For the indicators for which RAE 4 did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Validation Results

By assessing RAE 4'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: RAE 4 met the minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP,CNS), and Family Practitioner (MD, DO, NP, CNS). in all contracted counties.

Strength #2 RAE 4 performed well in the behavioral health network category, meeting all minimum network requirements for both General and Pediatric Behavioral Health, and General and Psychiatrists and other Psychiatric Prescribers in all contracted counties.

Strength #3: RAE 4 met the minimum network requirements for General and Pediatric SUD Treatment Practitioner in 94.7 percent of the contracted counties.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 4 did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted counties.

Opportunity #2: RAE 4 did not meet the minimum network requirements SUD Treatment Facilities–ASAM level of care 3.3 in all contracted counties, and 89 percent or more of the contracted counties did not meet the minimum network requirements for SUD Treatment Facilities–ASAM levels of care 3.7 and 3.7 WM.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 4 conduct an in-depth review of provider categories for which RAE 4 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.

RAE 5

Network Adequacy Indicator-Specific Validation Rating

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 RAE 5's interpretation of data was accurate.

Table 4-23 summarizes HSAG's validation ratings for RAE 5, by indicator type.

Table 4-23—Summary of RAE 5 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators		X		
Time/Distance Indicators	X			

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 31 indicators for RAE 5. Of these indicators, 61.3 percent received ratings of High Confidence, and 38.7 percent received ratings of Moderate Confidence. For the indicators for which RAE 5 did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios, and the MCE stated that Quest may have used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Validation Results

By assessing RAE 5'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: RAE 5 demonstrated strength in the physical health primary care network category, meeting all minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA), and Family Practitioner (MD, DO, NP, CNS, and PA).

Strength #2: RAE 5 demonstrated strength in the behavioral health network category, meeting all minimum network requirements for both General and Pediatric Behavioral Health, both General and Pediatric Psychiatrists and other Psychiatric Prescribers, both General and Pediatric SUD Treatment Practitioner, and Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals.

Strength #3 RAE 5 met all minimum network requirements for SUD Treatment Facilities–ASAM levels of care 3.1, 3.5, and 3.7WM in the contracted county.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 5 did not meet the minimum network requirements for SUD Treatment Facilities–ASAM levels of care 3.2WM, 3.3 and 3.7 WM in the contracted county.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 5 conduct an in-depth review of provider categories for which RAE 5 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.

RAE 6

Network Adequacy Indicator-Specific Validation Rating

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 RAE 6's interpretation of data was accurate.

Table 4-24 summarizes HSAG's validation ratings for RAE 6, by indicator type.

Table 4-24—Summary of RAE 6 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	X[1]	X[1]		
Time/Distance Indicators	X			

[1] RAE 6 received Moderate Confidence for six of the ratio indicators and High Confidence for six of the ratio indicators. Since RAE 6 relied on Quest to calculate the behavioral health ratio indicators, which potentially included all provider locations in calculating the provider-to-enrollee ratios, the behavioral health ratio indicators received a Moderate Confidence rating, while the physical health ratio indicators were calculated outside of Quest and therefore received a High Confidence rating.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 31 indicators for RAE 6. Of these indicators, 80.6 percent received ratings of High Confidence, and 19.4 percent received ratings of Moderate Confidence. For the indicators for which RAE 6 did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios for the behavioral health providers, and the MCE stated that Quest may have used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Validation Results

By assessing RAE 6'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: RAE 6 performed strongly in the behavioral health network category, 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. Additionally, while RAE 6 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in 20 percent and 40 percent of contracted counties, respectively, the rate of access for these provider types was 99 percent or greater in all contracted counties.

Strength #2: While RAE 6 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 types, RAE 6 demonstrated high rates of access, with all counties displaying 99.7 percent or greater access.

Strength #3: While RAE 6 did not meet the minimum network requirements for SUD Treatment Facilities–ASAM levels of care 3.5 and 3.7 across all contracted counties, the rate of access for these provider types in counties where the plan failed to meet the minimum network requirements ranged from 93.2 percent to greater than 99.9 percent.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 6 did not meet the minimum network requirement for SUD Treatment Facilities–ASAM levels of care 3.1, 3.2 WM, 3.3, 3.5 and 3.7 WM in all contracted counties.

Opportunity #2: RAE 6 did not meet the minimum network requirement for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted counties. In 60 percent of the contracted counties, access for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals ranged from 98.9 percent to greater than 99.9 percent, and in the remaining 40 percent of counties, access ranged from 4.1 percent to 35.1 percent.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 6 conduct an in-depth review of provider categories for which RAE 6 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.

RAE 7

Network Adequacy Indicator-Specific Validation Rating

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 RAE 7's interpretation of data was accurate.

Network Adequacy Validation Results

By assessing RAE 7'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.

Table 4-25 summarizes HSAG's validation ratings for RAE 7, by indicator type.

Table 4-25—Summary of RAE 7 Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	X[1]	X[1]		
Time/Distance Indicators	X			

[1] RAE 7 received Moderate Confidence for six of the ratio indicators and High Confidence for six of the ratio indicators. Since RAE 7 relied on Quest to calculate the behavioral health ratio indicators, which potentially included all provider locations in calculating the provider-to-enrollee ratios, the behavioral health ratio indicators received a Moderate Confidence rating, while the physical health ratio indicators were calculated outside of Quest and therefore received a High Confidence rating.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 50 indicators for RAE 7. Of these indicators, 88.0 percent received ratings of High Confidence, and 12.0 percent received ratings of Moderate Confidence. For the indicators for which RAE 7 did not receive a rating of High Confidence, HSAG noted that the MCE relied on Quest to calculate ratios for the behavioral health providers, and the MCE stated that Quest may have used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Strengths

Strength #1: RAE 7 met the minimum network requirements for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrists and other Psychiatric Prescribers in all contracted counties.

Strength #2: RAE 7 met the minimum network requirements for both General and Pediatric SUD Treatment Practitioner in 66.6 percent of contracted counties. In the counties where RAE 7 failed to

meet the minimum network requirements, access for both General and Pediatric SUD Treatment Practitioner was greater than 99.9 percent.

Strength #3: In the contracted counties where RAE 7 did not meet minimum network requirements for both Adult and Pediatric Primary Care Practitioner (MD, DO, NP, CNS, and PA) and Family Practitioner (MD, DO, NP, CNS, and PA), access ranged from 99 percent to greater than 99.9 percent of the minimum network requirement for all listed categories.

Opportunities for Improvement and Recommendations

Opportunity #1: RAE 7 did not meet the minimum network requirement for SUD Treatment Facilities across all ASAM levels of care in all contracted counties.

Opportunity #2: RAE 7 did not meet the minimum network requirement for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals across all contracted counties, with access ranging from 39.8 percent to 97.9 percent in urban counties and 22.5 percent access in rural counties.

Recommendation: To address these opportunities for improvement, HSAG recommends RAE 7 conduct an in-depth review of provider categories for which RAE 7 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.

Network Changes and Deficiencies

The Department requested that its EQRO, HSAG, incorporate an overview of network changes and deficiencies reported in FY 2023–2024 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 2023–2024, two of the seven RAEs reported that they had experienced a network change or deficiency. Both RAE 2 and RAE 4 reported a termination of contract with the Chanda Center for Health and the Nuleaf Counseling Center in July 2023, impacting the Medicaid population seeking behavioral health services. Both RAEs reported minimum impact on access to care, citing no current utilization history requiring members to be transitioned from services.

On July 27, 2023, RAE 2 reported the termination of contract with GEO Reentry Services LLC, as well as issued a correction for reporting on Turning Point, a provider previously reported as having left the RAE 2 Medicaid network. Both the termination and correction affected RAE 2's population seeking behavioral health services. Additionally, on November 7, 2023, RAE 2 reported a change in hours of operation for the Centennial Mental Health Center's Journey Point Respite Program from 24 hours per day to 12 hours per day, which reduced the availability of 24-hour behavioral health services for the RAE's population.

On June 12, 2023, RAE 4 reported the termination of contract with primary care medical provider (PCMP) Affordable Health Clinic as ownership transitioned to Omnicare Health Solutions. RAE 4 reported that while Omnicare Health Solutions has retained the same providers and continues to serve existing members, it is not prepared to contract as a PCMP with RAE 4. On December 19, 2023, RAE 4 reported the termination of one PCMP provider in Pueblo County and one PCMP provider in Conejos County, impacting RAE 4 members seeking primary care services. RAE 4 does not anticipate disruption of services to members and will continue to monitor and assist with transition of care.

Table 4-26 presents a brief chronological overview of the MCE network change and deficiency materials, submitted to the Department per contractual requirements. Full materials detail the extent to which the MCE's network has been impacted by the closure or termination, as well as any and all steps the RAEs have taken to ensure access to care for the affected populations under Medicaid.

Table 4-26—Network Changes and Deficiencies Reported in FY 2023–2024

MCE	Submission Date	Network Change or Deficiency Identified
RAE 2	07/25/23	Termination of contract with the Chanda Center for Health, affecting NHP RAE 2's population seeking behavioral health services. Termination of contract with Nuleaf Counseling Center, affecting NHP RAE 2's population seeking behavioral health services.
	07/27/23	Termination of contract with GEO Reentry Services LLC, affecting NHP RAE 2's population seeking behavioral health services. Correction for reporting on Turning Point, previously reported as having left the network, affecting NHP RAE 2's population seeking behavioral health services.
	11/07/23	Change in hours of operation for Centennial Mental Health Center's Journey Point Respite Program, affecting members seeking behavioral health and respite care services.
RAE 4	06/12/23	Termination of PCMP provider, impacting members seeking access to primary care services.
	07/26/23	Termination of contract with the Chanda Center for Health, affecting HCI RAE 4's population seeking behavioral health services. Termination of contract with Nuleaf Counseling Center, affecting HCI RAE 4's population seeking behavioral health services.
	12/19/23	Termination of two PCMP providers in Pueblo and Conejos counties, impacting members seeing primary care services.

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 2023–2024 under the EQR contract. The FY 2023–2024 NAV activity built upon the FY 2022–2023 NAV activity, designed to be a robust validation of Colorado's network adequacy and executed in alignment with the federal regulations in place at the time of the activity, while incorporating additional elements to achieve compliance with CMS EQR Protocol 4.

Overall frontier and urban counties performed well across all MCEs, with 70.5 percent and 70.3 percent of the results meeting all applicable minimum network requirements, respectively, while only 54.1 percent of urban counties met all applicable minimum network requirements.

The CHP+ MCOs, MCOs, and RAEs all exhibited strength across the behavioral health network category, particularly for both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrist and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements. The CHP+ MCOs demonstrated strength in Pediatric Behavioral Health and Pediatric Psychiatrists and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements. However, across all CHP+ MCOs' contracted counties, 94.8 percent did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals.

The MCOs exhibited strength in both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrist and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements. However, all MCOs' contracted counties did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals; Gynecology, OB/GYN (PA); and SUD Treatment Facilities–ASAM levels of care 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM.

The PAHP performed well across the contracted counties for General Dentists with 89 percent of the contracted counties meeting all minimum network requirements. However, the PAHP was not able to meet the minimum network requirements for Oral Surgeons in 54.7 percent of the contracted counties.

The RAEs displayed strength in both General and Pediatric Behavioral Health, and both General and Pediatric Psychiatrist and other Psychiatric Prescribers, with all contracted counties meeting the minimum network requirements. However, over 95 percent of the RAEs' contracted counties did not meet the minimum network requirements for Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals and SUD Treatment Facilities ASAM 3.3.

HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid 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. Additionally, HSAG determined that all MCEs had acceptable data collection procedures. Half of the MCEs did not rely on an external delegated entity for NA indicator reporting during the reporting period. For the MCEs which did utilize external delegated entities to complete NA indicator reporting during the reporting period, no issues were identified requiring correction within the last year.

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 eight MCEs.

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

MCE[2]	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
CCHA	85.2%	14.8%	0%	0%
COA	73.4%	26.6%	0%	0%
DentaQuest	100%	0%	0%	0%
DHMP	44.4%	55.6%	0%	0%
Kaiser	6.0%	44.8%	0%	49.3%
NHP	65.2%	34.8%	0%	0%
HCI	65.2%	34.8%	0%	0%
RMHP	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, Moderate, Low, or No Confidence/Significant Bias overall. The sum of the percentages of validation ratings per MCE may not equal 100 percent due to rounding.

[2] MCEs with multiple lines of business (e.g., COA is COA CHP+, RAE 3 and RAE 5) were evaluated together and received the same validation rating.

Generally, the MCEs received a validation rating of Moderate to High Confidence for the NA indicators, with the exception of one MCE, which received a Significant Bias for 49.3 percent of the NA indicators. The most common issues identified were the calculation of ratios utilizing provider locations instead of unique providers and the method of calculating time distance based on straight line distance versus driving distance.

Additional MCE-specific information on validation ratings can be found in Appendix C.

Analytic Considerations

This section describes any analytic considerations or data-related caveats for NAV.

Various factors associated with the FY 2023–2024 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 C.
  - 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 meet a time and distance network requirement does 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, 2023, 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 2023–2024 NAV results, including the following detailed considerations:
  - NAV results do not reflect the MCEs' network changes implemented since January 2024.
  - HSAG and the Department directed the MCEs to use the Department-approved Network Crosswalk from September 2023 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 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 Quest 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). Consistent with the Department's instructions to the MCEs, HSAG's NAV analyses applied the rural minimum network requirements to the urban counties with rural areas (i.e., Larimer, Mesa, and Park counties).
  - 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 2023–2024 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 post office boxes), or be identifiable with mapping software (e.g., addresses reflecting local place designations, rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates 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 2023–2024 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 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 2023–2024 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[5-1] 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.
- **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

[5-1] interChange is the Department's Medicaid Management Information System (MMIS). All practitioners, practice sites, and entities serving Health First Colorado or CHP+ members are required to enroll in this data system, in addition to contracting with individual MCEs. While interChange offers a direct alignment with the Network Crosswalk for selected network categories, not all network categories are directly identified from the interChange data fields.

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

Appendix A summarizes the FY 2023–2024 CMS EQR Protocol 4 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.

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 document request packet that was submitted to each MCE outlining the activities conducted during the validation process. The document request packet 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, primary source verification (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. 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

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

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 the HSAG 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 2023–2024 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 2023–2024, 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 measurement period reflecting the MCEs' networks from October 1, 2023, through December 31, 2023.

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.[A-1]

[A-1] Quarterly network adequacy reporting materials include the network crosswalk; an MS Word document describing the network categories and the criteria for uniform identification of practitioners, practice groups, and/or entities within each network category; MS Word and MS 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.

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 15, 2023, HSAG sent each MCE a reminder notice regarding the January 31, 2024, deadline to submit the FY 2023–2024 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 2023–2024 Q2 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 September 2023 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, 2023. During the FY 2023–2024 Q2 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 2023–2024 Q2 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, date of birth, 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 Network Adequacy Data Initial Validation (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 Quest Version 2023.3 software.

HSAG used Quest 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 Quest 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.[A-2] 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 Quest if the

[A-2] 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 29, 2024.

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 Dashboards

Following an analytic review of submitted quarterly data files from the health plans, 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 MS 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.

In September 2023, HSAG collaborated with the Department to align the quarterly reporting materials for use in the quarterly FY 2023–2024 NAV analyses. In the Network Crosswalk Definitions document, HSAG updated the OB/GYN description to reflect the changes in RAE reporting requirements which took effect in FY 2022–2023 Q1. HSAG updated the NA Quarterly Geoaccess Compliance Report template with references to FY 2023–2024 Q2 deadlines, and reviewed the data requirements document with the Department to ensure requirements aligned with expectations. No notable changes to the quarterly reporting material templates or instructions were implemented during FY 2023–2024.

HSAG validated the MCEs' self-reported time and distance results using the minimum network requirements listed in Appendix C. Each quarter, 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. List of Interviewees and HSAG Validation Team

Appendix B contains a list of the health plan interviewees who attended each MCE's virtual review session, as well as the HSAG validation team who facilitated each call.

Table B-1 lists the Colorado Community Health Alliance (CCHA) staff members interviewed by the HSAG validation team.

Table B-1—List of CCHA Interviewees

Interviewee Name	Title
Colleen Daywalt	Vice President, Government Programs
Cara Hebert	Director, Account Management and External Partnerships
Thomas Johnson	Director, Application Development
Chad Jeffers	Manager, Informatics
Terri Piechocki	IT Market Manager
Laketa Hicks	Data Integrity Specialist
Abhilash Reddy Pilla	Engineer Lead, Elevance Health
Rosa Moran	Business Analyst III, Elevance Health
Zida Ash	Systems Analyst Advisor, Elevance Health
Nandhini Baradwaj	Business Architect Senior, Elevance Health
Kathi Decker	Compliance Manager, Elevance Health
Josie Dostie	Senior CCHA Network Manager, Physician Health Partners
Eddie Duckworth	Manager II Engineering, Elevance Health
Todd Hong	Manager, Medicaid State Operations, Elevance Health
Karla Lawson	Director Program Management, Elevance Health
Marianne Lynn	Compliance Manager, Elevance Health
Kristen Mader	Provider Data Analyst Senior, Elevance Health
Abigail Roa	Director II Compliance, Elevance Health
Lisa Shevenell	Director I Compliance, Elevance Health
Andrea Skubal	ACN Program Manager, Physician Health Partners
Cindi Terra	Director, Practice Transformation, Physician Health Partners
Latoya Vaughn	Business Information Consultant Senior, Elevance Health
Renata Wilcox	Business Information Analyst II, Elevance Health
Cynthia Wylie	Business Change Director, Elevance Health
Aris Coney	Supervisor, Project Management

Table B-2 lists the Colorado Access (COA) staff members interviewed by the HSAG validation team.

Table B-2—List of COA Interviewees

Interviewee Name	Title
Anne Taylor	Provider Recruitment Program Manager
David Simpson	Supervisor of Production Control
Dustin Vallier	Product Owner
Erika Gonzalez	Program Support Analyst
Jim Beam	Manager of Application Development
Justin Masyga	Senior (Sr.) Business Analyst
Keri Kugler	Director of Data and Analytics
Marcy Mullan	Director of Compliance Programs
Stacy Garza	Manager of Member Data Integrity
Travis Roth	Manager of Credentialing and Provider Data
Mike Grimberg	Supervisor of Provider Data Integrity
Danae Wardrup	Business Intel Analyst III
Jeni Sarget	Director of Member and Provider Data Integrity
Siva Adusumilli	Developer
Sandeep Tella	Technical Lead

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

Table B-3—List of DentaQuest Interviewees

Interviewee Name	Title
Tim Gorter	Business Systems Analyst
Liza Morris	Associate Director, Provider Operations
Deseray Backman	Credentialing Delegation Auditor Consultant
Jennifer Labishak	Sr. Manager, Provider Partner
Sai Krishna Seethala	Director, Business Intelligence
Nicole Mantanye	Director, Provider Network Intelligence
Talia Rodgers	Sr. Manager Business Analytics
Logan Horn	Colorado CHP+ Program Manager

Table B-4 lists the Denver Health Medical Plans (DHMP) staff members interviewed by the HSAG validation team.

Table B-4—List of DHMP Interviewees

Interviewee Name	Title
Joshua Koslosky	Cognizant Sr. Associate Compliance Assurance
Melissa Belles	Cognizant Associate Compliance Assurance
Sarah Fox	Cognizant Enrollment Process Specialist
Cynthia Blair	Cognizant Provider Delivery Manager
Chetan Machare	Cognizant Provider Team Manager
John Aulgur	Cognizant Manager: Compliance Assurance
Michael Wagner	Chief Operating Officer
Natalie Score	Director of Insurance Products
Jeremy Sax	Government Products Manager
Katie Gaffney	Lead Health Plan Compliance Analyst
Lucas Wilson	Associate Chief Operating Office
Bryant Wiltrout	Director of Information Systems
Ujwala Vallampatla	Manager, Applications Management
Robb Novak	Manager of Information Systems
Barbara Camps-Sierra	Interim Director of Claims (Contractor)
Chris White	Manager of Enrollment Services
Christie Mettenbrink	Lead Epidemiologist
Joseph Caldwell	Chief Financial Officer
Rebecca Stob	Director of Actuarial Services
Tye Rubin	Medical Economics Analyst
Jessica Stockmeyer	Manager of Medical Economics
William Holder	Medical Economics Analyst
Landon Palmer	Chief Compliance and Audit Officer
Stacy Grein	Compliance Specialist
Elaina Holland	Director of Health Plan Services
Alicia Persich	Marketing and Engagement Manager
Murielle Romine	Provider Relations and Contracting Analyst
Pam Briscoe	Paralegal
Pam Roth	Managed Care Credentialing Coordinator
Deb Harris	Managed Care Credentialing Coordinator

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

Table B-5—List of Kaiser Interviewees

Interviewee Name	Title
Chris Laidley	Sr. Manager, Process Improvement, Medicaid and Charitable Coverage (Membership Team)
Michele O Neal	Consultant II, Medicaid and Charitable Coverage (Membership Team)
Liz Chapman	Contract Manager, Medicaid and Charitable Programs (Administrative Support for CHP+ and Medicaid in KPCO)
Kirsten Swart	Compliance Consultant IV, Regional Compliance (Compliance)
Janelle Castanares	Consultant II, Medicaid and Charitable Coverage (Membership Team)
Tracy Copeland	Project Manager, Medicaid and Charitable Programs (Administrative Support for CHP+ and Medicaid in KPCO)
Marty Schultz	Director Network Operations, Group Relations (Provider Data)
Mikala Gibbs	Project Manager V, Group Relations (Provider Data)
Jetaime Esquibel	Data Reporting and Analytics Consultant III, Compliance and Regulatory, Group Relations (Provider Data)
Lillian Hans	Data Reporting and Analytics Consultant III, Compliance and Regulatory, Group Relations (Provider Data)
Vanessa McDonald	Compliance Consultant III, Compliance Health Plan (Compliance)
Tori Gill	Manager, Compliance, Compliance Health Plan (Compliance)
Casey Snow	Accreditation, Regulatory, and Licensing Specialist IV, Clinical (Legal)
Rhonda Meili	Manager Network Provider Relations, Group Relations (Provider Experience and Contracting Team)
Christina Mickle	Clinical Consultant III, Performance Improvement (Provider Panels)
Ahmed Al-dulaimi	Sr. Director, Data Reporting and Analytics, National Provider Contracting (KP Physician Observer)

Table B-6 lists the Northeast Health Partners (NHP) staff members interviewed by the HSAG validation team.

Table B-6—List of NHP Interviewees

Interviewee Name	Title
Kari Snelson	Chief Executive Officer, NHP
Brian Robertson	Chief Operating Officer, NHP
Wayne Watkins	Chief Information Officer, NHP
Chantel Hawkins	Quality Manager, NHP
Jennefer Rolf	Project Manager, NHP
Jamie Coahran	Sr. Account Service—CO, Carelon
Alicia Williams	COO/Director of Operations, Carelon
Stacey Bassett	Eligibility Business Consultant, Carelon
Chris Klaric	Manager of Credentialing Operations, Carelon
Nikoli Streeter	Network Data Manager, Carelon
Hunter Mullins	Business Intelligence (BI) Solutions Engineer Sr. Advisor, BI Architecture, Carelon
Dario Russo	Business Information Developer, Carelon
Ryan Sorrell	RVP Provider Solutions, Carelon
Sharon Forney	Business Analyst III, Carelon
Gretchen Hudson	Director II of Technology, Carelon

Table B-7 lists the Health Colorado, Inc. (HCI) staff members interviewed by the HSAG validation team.

Table B-7—List of HCI Interviewees

Interviewee Name	Title
Lori Roberts	Chief Executive Officer/Program Officer, HCI
Sarah Nelson	Director of Operations, HCI
Jamie Coahran	Senior Account Service—CO, Carelon
Alicia Williams	Chief Operating Officer/Director of Operations, Carelon
Stacey Bassett	Eligibility Business Consultant, Carelon
Chris Klaric	Manager of Credentialing Operations, Carelon
Stephen Puzio	Business Analyst III, Carelon
Hunter Mullins	BI Solutions Engineer Sr. Advisor, BI Architecture, Carelon
Dario Russo	Business Information Developer, Carelon
Ryan Sorrell	Regional Vice President Provider Solutions, Carelon
Sharon Forney	Business Analyst III, Carelon
Nick Thomas	Director, Carelon Provider Configuration, Carelon

Table B-8 lists the Rocky Mountain Health Plans (RMHP) staff members interviewed by the HSAG validation team.

Table B-8—List of RMHP Interviewees

Interviewee Name	Title
James Hart	Compliance Consultant—UHC Audit Management
Karyn Afari	Senior Business Process Analyst—Claims Solution & Implementation
Coshaun Allan	Senior Capability Manager—Provider Shared Services Support
Jeri Applegate	Regulatory Manager—National Credentialing
Brian Atkins	Associate Director of General Management—Provider Data Operations
Daneen Barnett-Johnson	Regulatory Adherence Manager—Provider Directory Data Depiction
Vanessa Beaulieu	Associate Regulatory Adherence Analyst—Claims Solution & Implementation
Michelle Burgess	Regulatory Adherence Consultant—Claims Solution & Implementation
Rhonda Butenhoff	Provider Data Consultant—Provider Data Operations
Todd Carlon	Interim Colorado Compliance Officer
Danielle Cayemberg	Compliance Consultant—Optum
Keli Deemer	Network Program Specialist—Provider Data Operations
Jeremiah Fluke	RMHP Director of Contract Administration
Patrick Gordon	RMHP CEO
Susan Hanna	RMHP Senior Analyst, Program Analytics, Data Systems & Strategy
Sonovia Kearse	Data Analytics and Delivery Manager—Provider Data Operations
Steve Klinga	Enrollment Manager—Issue Resolution Team
Nancy Lautenbach	Data Analyst—Provider Data Operations
Donna Luna	Associate Director for Regulatory Response—Provider Data Operations
Elizabeth Lytle	Director of Data Systems & Strategy—Program Analytics
Glen McDaniel	RMHP Regional CIO
Toni Mcintire	Network Program Specialist—Provider Data Operations
Nicole Miller	CEMS Product Owner—834 Eligibility Advocacy Team
Elizabeth Mullin	RMHP Network Program Manager
John Murkin	Associate Director of Reporting—NDAR UHN
Nicole Nemec	Senior Enrollment Quality Analyst—Client Experience & Operations

Interviewee Name	Title
Braden Neptune	RMHP Director of Business Operations
Stephanie Oeverndiek	Manager Data Analytics, UHN Strategy & Analytics
Jeremy Parks	Director Provider Data—Provider Data Operations
Kendra Peters	RMHP CHP+ Contract Manager
Dale Renzi	RMHP VP Provider Network
Vicente Saldivar	Senior Regulatory Consultant—Provider Data Operations
Francine Sartell	Associate Director of General Management—Provider Data Operations
Claudia Stein	Manager Regulator Adherence—Claims Solution & Implementation
Margaret Taylor	RMHP RAE Program Officer
Monika Tuell	RMHP Director of Health Plan 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®) [B-1] Compliance Auditor (CHCA); multiple years of auditing experience with expertise in data integration, information systems, provider data, network adequacy validation, and performance measure development and reporting.
Rachael French, CHCA *Associate Director, Audits, DSAA* *Lead Auditor*	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 network adequacy validation.
Emily Redman *Associate Director, Audits, DSAA* *Lead Auditor*	CHCA; subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review, and analysis, provider data, and network adequacy validation.
Cynthia Anderson, MPH *Analytics Manager III, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review, network adequacy, and analysis.

[B-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Name and Title	Role
Ashlei Carlisle, MS *Auditor, DSAA* *Secondary Auditor*	Audit support team; assists with EQR NAV audit-related projects including implementation, project management, analysis, and reporting.
Casey Deacon, MS *Auditor, DSAA* *Secondary Auditor*	Audit support team; assists with EQR NAV audit-related projects including implementation, project management, analysis, and reporting.
Patricia Bey, MBA *Auditor, DSAA* *Secondary Auditor*	Audit support team; assists with EQR NAV audit-related projects including implementation, project management, analysis, and reporting.
Tamika McLaurin, AAS *Auditor, DSAA* *Secondary Auditor*	Audit support team; assists with EQR NAV audit-related projects including implementation, project management, analysis, and reporting.
Vanessa Munoz, BA, AS *Auditor, DSAA* *Secondary Auditor*	Audit support team; assists with EQR NAV audit-related projects including implementation, project management, analysis, and reporting.
AnnAlisa Cook, MHA *Project Coordinator III, DSAA* *Secondary Auditor*	Audit support team; assists with EQR NAV audit-related projects including implementation, project management, analysis, and reporting.

Appendix C. Network Adequacy Validation Worksheets

Tables C-1 through C-14 present the summary of network adequacy validation findings by MCE for the CMS EQR Protocol 4. Results are presented by MCE and LOB.

CCHA – RAE 6

Table C-1–CCHA-RAE 6–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

CCHA – RAE 7

Table C-2–CCHA-RAE 7–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Community Health Alliance relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

COA CHP+

Table C-3–COA CHP+–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Endocrinology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Endocrinology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Gastroenterology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Gastroenterology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Neurology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Neurology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Surgery provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Surgery provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Urology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Urology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pharmacy within 10 minutes or 10 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pharmacy within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pharmacy within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Cardiology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Endocrinology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Gastroenterology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Neurology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Ophthalmology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Orthopedics providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Otolaryngology/ENT providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Pulmonary Medicine providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Surgery providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Urology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Gynecology, OB/GYN (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Cardiology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Endocrinology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Gastroenterology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Neurology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Ophthalmology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Orthopedics providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Otolaryngology/ENT providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Pulmonary Medicine providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Surgery providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Urology providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

COA – RAE 3

Table C-4–COA-RAE 3–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

COA – RAE 5

Table C-5–COA-RAE 5–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Colorado Access relied on Quest to calculate ratios, and believed that it used all provider locations in calculating the provider-to-enrollee ratio. This would result in systematic overcounting of the number of providers available to enrollees.

DentaQuest

Table C-6–DentaQuest–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Dentist within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one General Dentist within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one General Dentist within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Oral Surgeon within 60 minutes or 60 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Oral Surgeon within 75 minutes or 75 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Oral Surgeon within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Orthodontist within 60 minutes or 60 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Orthodontist within 75 minutes or 75 miles of their home - Rural	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Orthodontist within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Pediatric Dentist within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Pediatric Dentist within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Pediatric Dentist within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	

DHMP CHP+

Table C-7–DHMP CHP+–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pharmacy within 10 minutes or 10 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of General Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Gastroenterology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Neurology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of General Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of General Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	
Ratio of General Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of General Urology providers to Members - All Regions	Addressed	High confidence	
Ratio of Gynecology, OB/GYN (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Gastroenterology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Neurology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Ophthalmology providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Urology providers to Members - All Regions	Addressed	High confidence	

DHMP MCO

Table C-8–DHMP MCO–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one General Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pediatric Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one Pharmacy within 10 minutes or 10 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate confidence	Although the methodology for calculating this indicator was sound, Denver Health used straight line distance for measuring distance which does not align with the state's expectations.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of General Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Gastroenterology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Neurology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of General Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of General Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	
Ratio of General Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of General Urology providers to Members - All Regions	Addressed	High confidence	
Ratio of Gynecology, OB/GYN (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Gynecology, OB/GYN (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Gastroenterology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Neurology providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Urology providers to Members - All Regions	Addressed	High confidence	

Kaiser

Table C-9–Kaiser–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one General Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pediatric Urology provider within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least one Pharmacy within 10 minutes or 10 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	No confidence	Since Kaiser is using a different standard (i.e., 90%) than State requirements, there are elements determined to have Significant Bias, resulting in a "No confidence" validation rating.
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Cardiology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Endocrinology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Gastroenterology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Neurology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Ophthalmology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Orthopedics providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Otolaryngology/ENT providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Pulmonary Medicine providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Surgery providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of General Urology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Gynecology, OB/GYN (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Cardiology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Endocrinology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Gastroenterology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Neurology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Ophthalmology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Orthopedics providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Otolaryngology/ENT providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Pulmonary Medicine providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Surgery providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.
Ratio of Pediatric Urology providers to Members - All Regions	Addressed	Moderate confidence	Since Kaiser used provider locations rather than unique providers to report the provider to enrollee ratio, this can inflate the ratio, resulting in a "Moderate Confidence" validation rating.

NHP – RAE 2

Table C-10–NHP–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate Confidence	Northeast Health Partners' future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

HCI – RAE 4

Table C-11–HCI–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 20 minutes or 20 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High Confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 30 minutes or 30 miles of their home - Urban	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High Confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 30 minutes or 30 miles of their home - Urban	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	Moderate Confidence	Health Colorado's future reviews should consider whether correct code is used to deduplicate behavioral health providers with multiple credentials.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	Moderate Confidence	Health Colorado relied on Quest to calculate ratios, and may have used all provider locations in calculating the provider-to-enrollee ratios. This could result in systematic overcounting of the number of providers available to enrollees.

RMHP CHP+

Table C-12–RMHP CHP+–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Endocrinology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Endocrinology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Gastroenterology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Gastroenterology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Neurology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Neurology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Surgery provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Surgery provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Urology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Urology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pharmacy within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pharmacy within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of General Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Gastroenterology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Neurology providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of General Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of General Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	
Ratio of General Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of General Urology providers to Members - All Regions	Addressed	High confidence	
Ratio of Gynecology, OB/GYN (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Endocrinology providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Gastroenterology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Neurology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Urology providers to Members - All Regions	Addressed	High confidence	

RMHP Prime

Table C-13–RMHP-Prime–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Cardiology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Endocrinology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Endocrinology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Gastroenterology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Gastroenterology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Neurology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Neurology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Ophthalmology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Orthopedics provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Otolaryngology/ENT provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Pulmonary Medicine provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Surgery provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Surgery provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one General Urology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one General Urology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Cardiology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Endocrinology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Gastroenterology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Neurology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Ophthalmology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Orthopedics provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pediatric Otolaryngology/ENT provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Pulmonary Medicine provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Surgery provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 100 minutes or 100 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pediatric Urology provider within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Pharmacy within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Pharmacy within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Gynecology, OB/GYN (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of General Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Gastroenterology providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of General Neurology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of General Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of General Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	
Ratio of General Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of General Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of General Urology providers to Members - All Regions	Addressed	High confidence	
Ratio of Gynecology, OB/GYN (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Gynecology, OB/GYN (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Cardiology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Endocrinology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Gastroenterology providers to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Neurology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Ophthalmology providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Orthopedics providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Otolaryngology/ENT providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Pulmonary Medicine providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Surgery providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Urology providers to Members - All Regions	Addressed	High confidence	

RMHP – RAE 1

Table C-14–RMHP-RAE 1–Worksheet 4.7 Summary of Network Adequacy Validation Findings

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 30 minutes or 30 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one Psychiatric Hospital or Psychiatric Unit in an Acute Care Hospital within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.1 within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.2 WM within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.3 within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.5 within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 WM within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least one SUD Treatment Facility - ASAM 3.7 within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Adult Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Family Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two General SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Behavioral Health Providers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (MD, DO, NP, CNS) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 45 minutes or 45 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Primary Care Practitioners (PA) within 60 minutes or 60 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Proportion of enrollees who have access to at least two Pediatric Psychiatrists and other Psychiatric Prescribers within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 60 minutes or 60 miles of their home - Rural	Addressed	High confidence	
Proportion of enrollees who have access to at least two Pediatric SUD Treatment Practitioners within 90 minutes or 90 miles of their home - Frontier	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Adult Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Family Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of General Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of General Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of General SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	

Network Adequacy Indicator	Did the MCE address this indicator?	Validation Rating	Comments
Ratio of Pediatric Behavioral Health Providers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (MD, DO, NP, CNS) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Primary Care Practitioners (PA) to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric Psychiatrists and other Psychiatric Prescribers to Members - All Regions	Addressed	High confidence	
Ratio of Pediatric SUD Treatment Practitioners to Members - All Regions	Addressed	High confidence	

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,[D-1] 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

[D-1] Colorado Secretary of State. 10 CCR 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: Apr 11, 2024.

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
Montezuma				X	X

CO County	COA CHP+ MCO	DHMP CHP+	Kaiser	RMHP CHP+	DentaQuest
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 will present tables detailing the network categories selected for each MCE type by the Department for inclusion in the FY 2023–2024 NAV analyses, similar to the tables presented in the Department-approved FY 2023–2024 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 2023–2024 NAV analysis.

CHP+ MCO

Table E-1—CHP+ MCO Minimum Network Requirements, as of December 31, 2023

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	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

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
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
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	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	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	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	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 Behavioral Health[2]	BV102, BV103, BV120, BV130, BV131, BV132, BG126, BG127	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	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	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

Table E-2—DHMP Medicaid MCO Minimum Network Requirements, as of December 31, 2023

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
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

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
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
Acute Care Hospitals	PF150	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
Behavioral Health—Specialists[4]						
Pediatric Behavioral Health[1]	BV104, BV103, BV102, BV121, BV120, BV130, BV131, BG126, BG127	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	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	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	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-ASAM 3.1	BF085 with ASAM_L 31>0	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 ASAM_L 33>0	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 ASAM_L 35>0	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 ASAM_L 37>0	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 (Withdrawal Management)	BF085 with ASAM_L 32WM>0	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 ASAM_L 37WM>0	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

Table E-3—RMHP Prime Medicaid MCO Minimum Network Requirements, as of December 31, 2023

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
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

Network Category Description	PROVCAT Code(s)	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance Standard	Frontier Time/Distance Standard	Ratio
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
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

Table E-4—PAHP Minimum Network Requirements, as of December 31, 2023

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

Table E-5—RAE Minimum Network Requirements, as of December 31, 2023

Network Category Description	PROVCAT Code(s)	Required Within Standard	Minimum Urban Time/Distance Requirement	Minimum Rural Time/Distance Requirement	Minimum 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	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	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	Minimum Urban Time/Distance Requirement	Minimum Rural Time/Distance Requirement	Minimum Frontier Time/Distance Requirement	Ratio
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	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	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
SUD Treatment Facilities-ASAM 3.1	BF085 with ASAM_L31>0	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 ASAM_L33>0	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 ASAM_L35>0	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 ASAM_L37>0	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 ASAM_L32WM>0	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 ASAM_L37WM>0	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.