COLORADO

Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: *Health Colorado, Inc.*

Line of Business: *RAE*

Contract Number: *19-107515*

Contact Name: *Jackie Driscoll*

Report Submitted by: *Alma Mejorado*

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Report due by *04/30/2021*, covering the MCE's network from *01/01/2021 – 03/31/2021*, FY21 Q3

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1. Instructions for Using the Network Adequacy Quarterly Report Template

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

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

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

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0321* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0321* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

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2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 30, 2021).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 30, 2021).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
1tThTotal members	135,531	N/A	138,634	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with “PV” or “PG”)	505	N/A	510	N/A
Primary care practitioners accepting new members	501	99.2%	502	98.4%
Primary care practitioners offering after-hours appointments	158	31.3%	158	31.0%
New primary care practitioners contracted during the quarter	58	11.5%	5	1.0%
Primary care practitioners that closed or left the MCE’s network during the quarter	3	0.06%	0	0.0%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay.   **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE

Health Colorado, Inc. (HCI) works to ensure that our PCP network has a sufficient number of providers to serve Members based on the maximum distance for their county classification. During this reporting period, HCI maintained a network of providers across the region in number and type of Primary Care Practitioners (PCPs) to assure that all covered services will be accessible to Members. HCI met time and distance standards for the majority of our membership during the reporting period but continue to see a very low number of Obstetricians and Gynecologists providers that serve as primary care providers.

HCI has two big challenges to meet the time and distance standard as defined by HSAG are due to the problems that are inherent challenges that exist in rural and frontier counties. These are:

- **Pueblo County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30-minute radius**. HCI's network of behavioral health providers in Pueblo County met ninety-nine (99%) percent of standards. Since the majority of the practitioners are in the city of Pueblo, Health First Colorado (formerly Medicaid) Members residing on the southern border of the county (which would more accurately define as a rural community than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are no available Primary Care Practitioners to meet the requirement. As a result, one (1%) percent of the HCI Members residing in Pueblo County do not have two (2) providers within the time and distance standard.
- **Absence of additional Primary Care Practitioners that offer Gynecology services within the time/distance standard within rural and frontier counties to recruit for contracting.** Obstetricians and Gynecologists in HCI's counties generally do not perform primary care services including those that are part of contracted organizations such as Catholic Health Initiatives (Centura). The PCPs refer to obstetricians and gynecologists as a specialty, not as part of primary care. Therefore, the primary care network does not reflect these practitioners within the region.

This quarter, HCI contracted with two (2) new practices located in Pueblo County: Steel City Pediatrics and Comfort Care Family Practice. The latter was identified through the Enrollment Summary Report and successfully recruited into the network. HCI will continue to use the Enrollment Summary Report to identify and recruit potential providers into the network, focusing on counties and specialties of need. San Luis Valley Behavioral Health Group opened its new PCP practice; they are working with HCI to affiliate the practice as a PCP, with an expected effective date in the fourth quarter FY20-21. HCI initiated contract discussions with a primary care clinic in Pueblo, SOCO Primary Care Clinic. The addition of new practices will offer HCI Members additional choices within the network and increase access. HCI will document the progress on these conversations in future reports.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
The COVID-19 pandemic has required healthcare practitioners to make changes to the way they deliver services. Our region has seen a dramatic increase in the adoption of telehealth platforms. During this reporting period our Practice Transformation team worked to complete PCP annual practice assessments. Based on the completed assessments, HCI identified forty-three (43) practices that offer telehealth services in some capacity. Many PCPs that implemented telehealth prior to the pandemic have experienced an increase in patient demand for these services and have used this opportunity to expand capacity of these services. Some practices in our rural and frontier counties that have adopted telehealth during the last year report that they are not sure how long they plan to continue offering telehealth appointments. This is due to Members having limited reliable internet access or who prefer face-to-face care. HCI will continue to work with PCPs to understand Member and provider experience and utilization of telehealth services. This will gauge the sustainability of the technology and lasting impact on service delivery. Despite expansion of telehealth services during the pandemic, we continue to see lower volume of claims for wellness and prevention services. Many practices are ramping up to increase wellness and prevention services for Members that they did not serve during the height of the pandemic. PCPs expect that the majority of these services will be conducted through face-to-face visits. Additionally, PCPs that are part of hospital systems or integrated practices report offering some form of telehealth services in their clinic for gaps in specialty care including behavioral health, psychiatry, and medical specialties such as infectious disease and family planning. HCI continues to promote Care On Location, a statewide network of providers offering telehealth services, for virtual urgent care services on the HCI website. On the file *R4_Network_INDIV_20210430*, the capacity field for the individual provider is blank because the current collected data is at the practice level rather than individual level. HCI is working to identify how to collect data at the individual level for purposes of reporting.

Table 2A-Establishing and Maintaining the MCE Network: Behavioral Health Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	135,531	N/A	138,634	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	1,917	N/A	1,923	N/A

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners accepting new members	1,917	100%	1,894	98.5%
Behavioral health practitioners offering after-hours appointments	497	25.9%	570	29.6%
New behavioral health practitioners contracted during the quarter	96	5.0%	127	6.6%
Behavioral health practitioners that closed or left the MCE's network during the quarter	51	2.6%	121	6.3%

Table 2B-Establishing and Maintaining the MCE Network: Substance Use Disorder (SUD) Treatment Facilities

Requirement	Previous Quarter	Current Quarter
	Number	Number
Sample	*0*	*0*
RAE		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	N/A	6
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	N/A	70
Total SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total SUD treatment facilities offering ASAM Level 3.5 services	N/A	7
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	N/A	202
Total SUD treatment facilities offering ASAM Level 3.7 services	N/A	6
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	N/A	84
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	N/A	10
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	N/A	178
Total SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	60

Table 2C-Establishing and Maintaining the MCE Network: Behavioral Health Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
HCI maintained a network of providers across the region in number and type of behavioral health practitioners to assure that all covered services will be accessible to Members immediately. HCI primarily has rural and frontier regions, which has limited practitioners within the region to meet one-hundred (100%) time and distance standards for all provider levels. Although HCI has a strong network of practitioners, with particular attention to the geographic area of Region 4, HCI met less than one-hundred (100%) access it is in some areas for the following reasons: ➢ **Pueblo County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30-minute radius**. HCI's network of behavioral health providers in Pueblo County met ninety-nine (99%) percent of standards. Since the majority of the practitioners are in the city of Pueblo, Health First Colorado (formerly Medicaid) Members residing on the southern border of the county (which would more accurately define as a rural community than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are not a sufficient number of behavioral health providers to meet the requirement. ➢ **Appropriate time/distance standard for Members in counties outside the region, especially frontier counties.** It is challenging to recruit and retain practitioners when they expect a small number, if any, referrals of Health First Colorado (formerly Medicaid) Members assigned to HCI. Should Members in these counties need additional provider options beyond the network, HCI considers Single Case Agreements (SCAs) when appropriate; however, the use of SCAs for HCI Members for out of the region providers has been limited which suggests HCI is meeting the needs of its members through its contracted network.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE

- **Lack of overall Psychiatric Residential Treatment Facilities, and Psychiatric Hospitals and Psychiatric Units in Acute Care Facilities.** Colorado has limited facilities to meet the time/distance standards for a large part of the HCI region, especially in frontier and rural counties. A significant number of contracted facilities that offer critical residential and inpatient services to the HCI membership are not represented appropriately in the quarterly reports. The manner in which facilities are categorized into a behavioral health provider type affects the overall representation of the geographic access to care in the network. HCI's network has also been impacted by the temporary closure of Tennyson Center for Children's youth residential center, which limits overall access to these services. The facility and its individual practitioners were closed to new members as of this quarterly report. Future reports will document any changes to this facility's status.

- **Contracted facilities are included in the report, but not part of GeoAccess Compliance report.** HCI has contracts with hospitals and facilities that do not crosswalk to a behavioral health criteria. As part of the *CO Network Adequacy_Network Crosswalk Definitions_0321*, Psychiatric Residential Treatment Facilities (PRTFs, PROVCAT BF142) criteria changed to require that facilities have specific *interChange* provider types and specialty codes. As a result, the number of PRTFs reduced from seventy-six (76) distinct locations on the last quarterly report to only two (2) locations in this quarterly report. At least six (6) locations that mapped to PRTFs in previous quarterly report no longer map to any behavioral health criteria. Finally, there are hospitals and facilities with taxonomies that met the criteria of PF150 (Hospital) which is not an allowed Network Category for a RAE. Review of the NPI did not yield additional taxonomies that would crosswalk to behavioral health criteria. The inability to crosswalk these facilities to a behavioral health criterion affects the accurate assessment of geographic access to care in the network.

- **Lack of incentive for prescribers to contract.** HCI continues to be concerned about the requirement to have a network of prescribers after the billing changes in the Uniform Service Coding Standards Manual for Evaluation & Management (E&M) Codes. Since prescribers who do not meet the Behavioral Health Specialty Provider Criteria are required to bill Fee-For-Service for Evaluation & Management (E&M) Codes, they no longer have an incentive to contract with HCI thus HCI has stopped recruiting these providers to join the network.

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Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE

During the reporting period, HCI focused efforts on recruiting, contracting, and credentialing providers for the SUD benefit expansion that was effective on January 1, 2021. HCI developed a statewide network of nineteen (19) contracted providers with fifty-seven (57) service locations across all licensure levels, with the exception of residential substance use disorder treatment delivered to those suffering from cognitive impairments (ASAM level 3.3) due to the lack of licensed facilities in the region. Of the contracted providers, eleven (11) providers completed their credentialing by the end of the reporting period (i.e. March 31, 2021) and were included in the file *Network_FAC* and *GeoAccess Compliance*. Network staff are supporting these facilities with the completion of their Health First Colorado (formerly Medicaid) enrollment and credentialing applications to join the network. An additional four (4) providers are currently negotiating contracts with HCI. HCI is continuing to monitor utilization and network access to determine the need to recruit of additional SUD providers into the network. To ensure access to services and reduce administrative burden, providers who sign a contract and are undergoing the credentialing process have an abridge process for Single Case Agreements (SCAs), specifically the contracted rates are honored and the provider is not required to sign SCAs for each service that meets medical necessity. Providers negotiating their contracts may request SCAs to serve new or on-going Members until contract negotiations are complete.

Based on the GeoAccess Compliance report, HCI did not meet time and distance standards across the urban, most rural and most frontier counties in the region for the new SUD benefit. This issue persists even if we account for the contracted facilities pending credentialing. There is an overall lack of sufficient SUD treatment facilities across all ASAM levels located within the region, which affects the ability to meet the standard. Within the region, there are six (6) SUD treatment providers. These includes:

- HCI partners Health Solutions and Southeast Health Group,
- Crossroads Turning Point with multiple contracted locations in Pueblo and Alamosa counties,
- Resada located in Bent County, and
- Advantage Treatment Center located in Alamosa and Bent counties, currently in the contracting process.

HCI implemented an SUD Workgroup that includes partner Community Mental Health Centers (CMHCs) to monitor utilization of and access to SUD treatment services. The SUD Workgroup is using utilization, claims and network data to identify network needs and identify solutions to expand access for a full continuum of SUD services within the HCI counties.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe.   **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**   **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE

HCI continued to pursue the following strategies to fill the gaps for behavioral health services within the region:

- **Tracked utilization, SCA data, and historical claims information to identify providers who are currently providing services to Health First Colorado (Medicaid) Members.** As part of the on-going monitoring of the SCA data, HCI is working to recruit providers that have agreed to multiple SCAs in the previous six (6) months. During the reporting period, one provider, Mark Jankelow, PMHP-BC was identified through this process and subsequently joined the network. No additional provider(s) have been identified as appropriate for recruitment during the reporting period.

- **Monitored operational processes to successfully credential recruited behavioral health providers.** Although HCI focused on credentialing facilities for the new SUD benefit, network staff continued to monitor and support providers through education on the application process and outreach to ensure accurate documentation.

- **Expanded utilization of telehealth services throughout the region for specialty services and Members located in our rural and frontier areas.** HCI's network of telehealth providers are within the State of Colorado. Based on the utilization of the service, we identify that a majority of providers are leveraging telehealth to enhance their services with Health First Colorado (formerly Medicaid) Members and offer safe alternatives during the COVID-19 pandemic. Providers that are rendering care through telehealth are utilizing it as an additional option for Members, especially larger groups, or facilities. Some solo providers have shifted to rendering most services via telehealth as this affords providers more flexibility and lower overhead costs. HCI retained the expanded use of telehealth services for the near future. This has allowed providers to continue to build capacity for a sustainable telehealth service program. HCI continues to monitor the changing environment of telehealth to identify further ways to support providers in expanding these services. Additionally, HCI is continuing to monitor utilization and, if appropriate, renew engagement with providers outside the State of Colorado to increase access to care.

Table 3A-Establishing and Maintaining the MCE Network: Specialty Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO				
Total members	N/A	N/A	N/A	N/A
Total specialty care practitioners (i.e., PROVCAT codes beginning with "SV" or "SG")	N/A	N/A	N/A	N/A
Specialty care practitioners accepting new members	N/A	N/A	N/A	N/A
Specialty care practitioners offering after-hours appointments	N/A	N/A	N/A	N/A
New specialty care practitioners contracted during the quarter	N/A	N/A	N/A	N/A
Specialty care practitioners that closed or left the MCE's network during the quarter	N/A	N/A	N/A	N/A

Table 3B-Establishing and Maintaining the MCE Network: Specialty Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of specialty care practitioners to assure that all covered services will be accessible to members without unreasonable delay. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.
CHP+ MCO, Medicaid MCO
N/A

3. Network Changes and Deficiencies

Network Changes

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

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, HCI did not experience a change in its network related to quality of care, competence, or professional conduct.

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

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

Inadequate Network Policies

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

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

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

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

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

Table 8-CHP+ MCO Provider Network Changes: Discussion

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

4. Appointment Timeliness Standards

Appointment Timeliness Standards

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

Table 9-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Primary Care Providers are required to maintain established office/service hours and access to appointments for new and established Health First Colorado (formerly Medicaid) Members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. Practices audited in the previous reporting period and did not meet the availability standards will receive a follow up audit to monitor access. Of the thirty-eight (38) locations audited: • Eighty-nine (89%) percent (or thirty-four (34) locations) offer same day appointments • Eighty-two (82%) percent (or thirty-one (31) locations) reported availability within standard for a new Health First Colorado (formerly Medicaid) Member. • Eighty-seven (87%) percent (or thirty-three (33) locations) reported availability within standards for an established Health First Colorado (formerly Medicaid) Member. • Eighty-two (82%) percent (or thirty-one (31) locations) met all the standards. • The availability of appointments within standards for new Members changed from forty-five (45%) percent to eighty-two (82%) percent from the audit last quarter.

Table 10-Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Behavioral health providers are expected to maintain access to appointments with standards established by the State of Colorado. The standards indicate providers should have appointment availability for Members within seven (7) days of request, and that urgent access is available within twenty-four (24) hours from the initial identification of need.

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Practices audited via phone surveys in the previous reporting period that did not meet the availability standards will be subject to a follow-up audit to monitor their access. Of the thirty (30) providers audited: • Twenty-seven (27%) percent reported availability within standards for a new Health First Colorado (formerly Medicaid) Member. • Thirty (30%) percent-reported availability within standards for an established Health First Colorado (formerly Medicaid) Member. • Twenty-seven (27%) percent met all the standards. The availability of appointments within standards for new Members changed from twenty-four (24%) percent from the audit last quarter, representing a reduction of twenty-one (21%) percent. The reduction is reportedly attributed to full caseloads, while some providers report they are able to provide an appointment within seven (7) days as they prioritize new client requests for adolescents or high acuity Members. Providers reported they are able to prioritize requests based on age and acuity but are not able to consistently meet the standards are not included in the number of providers meeting the metric.

COLORADO
Department of Health Care Policy & Financing

5. Time and Distance Standards

Health Care Network Time and Distance Standards

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

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

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

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

A practitioner/practice site/entity should only be counted one time in the MCE's data submission; if a practitioner provides primary care for the Adult-Only or Pediatric network categories (and is not an Obstetrician/Gynecologist), the MCE should count the primary care practitioner one time under the Family Practitioner network category.

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has one (1) urban county, Pueblo, which is the residence of the majority of HCI's membership. The requirement for an urban county is to have one-hundred (100%) percent coverage of two (2) providers within thirty (30) miles or thirty (30) minutes. Behavioral Health In Pueblo County, HCI had ninety-nine (99%) percent coverage within standards for all behavioral health categories with the exception of Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities (ninety-five (95%) percent). HCI met one-hundred (100%) percent of the standard for the majority of the urban counties outside HCI's geographic area. HCI had approximately ninety (90%) percent coverage in Adams, El Paso, Jefferson, Teller, and Weld Counties for General Psychiatrists and Other Psychiatric Prescribers, General Behavioral Health, General SUD Treatment Practitioner, Pediatric Psychiatric and other Psychiatric Prescribers, Pediatric Mental Health Provider, and/or Pediatric Substance Abuse Disorder Provider. HCI had eighty (80%) percent coverage for General SUD Treatment Practitioner and Pediatric SUD Treatment Practitioner in Elbert County, and fifty-seven (57%) percent coverage in Clear Creek for General SUD Treatment Practitioner. Should Members in these counties need additional provider options from those available, HCI will consider SCAs when appropriate. Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for a large part of the HCI region. This will require work with HCPF and community partners to address. *New SUD benefit* - Effective January 1, 2021, HCI provides the full continuum of Substance Use Disorder (SUD) benefits for Health First Colorado (formerly Medicaid) Members. Although HCI did not meet one-hundred (100%) percent coverage for Members in Pueblo County by service level, HCI did have a strong level of coverage. HCI had coverage in the following areas: ninety-eight (98%) percent coverage for Clinically Managed Low-Intensity Residential Services (ASAM level 3.1), Clinically Managed High-Intensity Residential Services (ASAM level 3.5), Medically Monitored Intensive Inpatient Services (ASAM level 3.7), and Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM). HCI had zero (0%) percent coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3) and Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM) due to lack of licensed facilities that cover the time/distance within the region.

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Physical Health HCI did not have one-hundred (100%) percent coverage for Members within the time/distance requirement for any Network Categories. HCI conducted a GeoAccess analysis and found that ninety-nine (99%) percent of the Members in Pueblo had coverage in all categories with the exception of Gynecology, OB/GYN (PA) with zero (0%) percent coverage. There is a lack of Physician Assistants (PA) that serve as primary care with Gynecology, OB/GYN specialty in the area. HCI overall saw an improvement in this report from previous reports as it added two new facilities in the area. Additionally, the overall improvement of the GeoAccess for Pueblo County may have been in part because of changes to the template changes to these Provider Types.

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

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
HCI has nine (9) counties that qualify as rural counties, including Alamosa, Chaffee, Conejos, Crowley, Fremont, Lake, Otero, Prowers, and Rio Grande. Rural counties require coverage of two (2) providers with the distance of forty-five (45) minutes or forty-five (45) miles for PCPs and sixty (60) minutes or sixty (60) miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each rural county. Behavioral Health HCI met one-hundred (100%) percent of standards for all its rural counties within the region. For counties outside the region, HCI improved overall access this reporting period with the majority of the areas meeting one-hundred (100%) percent of the standard. The exceptions are the following counties which had above ninety (90%) percent coverage: • General SUD Treatment Practitioner – Archuleta, Eagle, Grand • Pediatric SUD Treatment Practitioner – Eagle and Grand The following counties outside of the region had coverage less than ninety (90%) percent: • General SUD Treatment Practitioner – Delta, Garfield, Montrose, Ouray, Routt • Pediatric SUD Treatment Practitioner – Delta, Garfield, Montrose, Routt

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template.

List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.

CHP+ MCO, Medicaid MCO, RAE

Psychiatric Units in Acute Care Facilities within standard distances are limited for all rural counties with HCI Members. In most counties one (1) of these facilities is within the time and distance, however, there is no option for two (2) facilities as required by the standards.

New SUD benefit - HCI contracted with available facilities in its rural counties, as well as any facilities in surrounding counties. Based on the analysis, HCI had limited coverage for Members in rural counties by service level.

- Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
  - One-hundred (100%) percent in Crowley and Otero Counties
  - Ninety-three (93%) percent in Fremont County
  - Seventy-eight (78%) percent in Prowers County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, and Rio Grande Counties
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3)
  - Zero (0%) percent across the frontier counties due to no licensed facilities.
- Clinically Managed High-Intensity Residential Services (ASAM level 3.5)
  - Ninety-seven (97%) percent in Crowley County
  - Ninety-four (94%) percent in Fremont County
  - Forty (40%) percent in Otero County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, Prowers, and Rio Grande Counties
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)
  - Ninety-seven (97%) percent in Crowley County
  - Ninety-four (94%) percent in Fremont County
  - Forty (40%) percent in Otero County
  - Zero (0%) percent in Alamosa, Chaffee, Conejos, Lake, Prowers, and Rio Grande Counties
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
  - One-hundred (100%) percent in Alamosa, Conejos, Crowley, Otero, and Rio Grande
  - Ninety-seven (97%) percent in Fremont County
  - Seventy-eight (78%) percent in Prowers County
  - Zero (0%) percent in Chaffee and Lake County
- Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
  - Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.

Physical Health

HCI had a strong physical health network during the reporting in the rural counties with one-hundred (100%) percent coverage of Members within the time/distance for:

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
• Adult Primary Care (MD, DO, NP) • Family Practitioner (MD, DO, NP) • Pediatric Primary Care (MD, DO, NP) Additionally, eight (8) of the nine (9) counties had one-hundred (100%) percent coverage of Members within the time/distance for Adult Primary Care (PA), Family Practitioner (PA), and Pediatric Primary Care (PA). For the exception, Powers had these provider types; Prowers had ninety-nine (99%) percent coverage. HCI had good coverage across the region for Gynecology, OB/GYN (MD, DO, NP): one-hundred (100%) percent coverage in Alamosa, Chaffee, Crowley, Fremont, Lake and Otero; ninety-nine (99%) percent coverage in Prowers; ninety-three (93%) coverage in Rio Grande, and eighty-five (85%) coverage in Conejos County. However, for Gynecology, OB/GYN (PA), HCI had zero (0%) percent coverage in all rural counties. If a Member needs services with providers outside of those available in the area, then HCI, through a Care Coordinator, connects the Member with the next closest available provider and assists the Member with transportation, if necessary.

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

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
HCI has nine (9) frontier counties, which are Baca, Bent, Costilla, Custer, Huerfano, Kiowa, Las Animas, Mineral, and Saguache. Standards for members residing in a frontier county require two (2) providers within sixty (60) minute or sixty (60) miles for a PCP, and ninety (90) minutes or ninety (90) miles for behavioral health providers. HCI met the time and distance requirement for a majority of the provider types in each frontier county. Behavioral Health For the behavioral health network, the nine (9) frontier counties met the time/distance and ratios requirement for all the Network Categories. The majority of the frontier counties outside the RAE Region 4 with HCI Members met the access for all Network Categories. The exceptions are General SUD Treatment

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template.

List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.

CHP+ MCO, Medicaid MCO, RAE

Practitioners in Moffat and Rio Blanco, and Pediatric SUD Treatment Practitioner in Moffat. This was an improvement in coverage from previous reporting period. Should Members in these counties need additional provider options from those available, HCI will consider SCAs when appropriate.

Psychiatric Units in Acute Care Facilities within standard distance and ratio is limited for all frontier counties with HCI Members. In most counties one (1) of these facilities is within the time and distance, however, there is no option for two (2) facilities as required by the standards.

New SUD benefit - HCI contracted with available facilities within and surrounding counties in of its frontier region. Based on the analysis, HCI had limited coverage for Members in frontier counties by service level.

- Clinically Managed Low-Intensity Residential Services (ASAM level 3.1)
    - One-hundred (100%) percent in Custer and Huerfano
    - Ninety-seven (97%) percent in Las Animas County
    - Ninety (90%) percent in Kiowa County
    - Sixty-six (66%) percent in Baca County and fifty-two (52%) percent in Cheyenne County
    - Less than fifty (50%) percent in Saguache and Zero (0%) percent in Mineral County
- Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3)
    - Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region.
- Clinically Managed High-Intensity Residential Services (ASAM level 3.5)
    - One-hundred (100%) percent in Custer and Huerfano
    - Ninety-six (96%) percent in Las Animas County
    - Ninety (90%) percent in Kiowa County
    - Less than fifty (50%) percent in Costilla and Saguache
    - Zero (0%) percent in Baca, Cheyenne, Kiowa, and Mineral
- Medically Monitored Intensive Inpatient Services (ASAM level 3.7)
    - One-hundred (100%) percent in Custer and Huerfano
    - Ninety-six (96%) percent in Las Animas County
    - Less than fifty (50%) percent in Costilla and Saguache
    - Zero (0%) percent in Baca, Cheyenne, Kiowa, and Mineral
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
    - One-hundred (100%) percent in Costilla, Custer, Huerfano, Las Animas and Mineral
    - Ninety-nine (99%) percent in Saguache County
    - Ninety (90%) in Kiowa County
    - Sixty-six (66%) percent in Baca and fifty-two (52%) in Cheyenne County
- Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.
CHP+ MCO, Medicaid MCO, RAE
○ Zero (0%) percent across the frontier counties due to no licensed facilities that cover the time/distance for the region. Physical Health HCI met one-hundred (100%) percent coverage of Members within the time/distance across all nine (9) frontier counties for all provider types with the exception of Gynecology, OB/GYN (MD, DO, NP) and Gynecology, OB/GYN (PA). HCI had good coverage across the region for Gynecology, OB/GYN (MD, DO, NP): one-hundred (100%) percent coverage in Bent, Costilla, Custer, Huerfano, and Saguache, ninety-nine (99%) percent coverage in Kiowa and Las Animas, seventy-seven (77%) coverage in Baca County, and zero (0%) percent coverage in Mineral County. However, for Gynecology, OB/GYN (PA), HCI had seventy-five (75%) percent coverage in Saguache, and zero (0%) percent coverage in all other frontier counties. If a Member needs services with providers outside of those available in the area, then HCI, through a Care Coordinator, connects the Member with the next closest available provider and assists the Member with transportation, if necessary.

Appendix A. Single Case Agreements (SCAs)

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

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

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	0000000	Denver	PV050	Adult Only Primary Care	1
Chrysalis Behavioral Health	0000000	Baca	BF085	SUD Treatment Facility, ASAM Levels 3.1 and 3.3	3
CHP+ MCO, Medicaid MCO, RAE					
Crossroads Turning Points Inc	9000187246	Alamosa	BF085	ASAM Level 3.2 WM	12
Crossroads Turning Points Inc	9000187246	El Paso	BF085	ASAM Level 3.2 WM	3
Crossroads Turning Points Inc	9000187246	Pueblo	BF085	ASAM Level 3.7	4
Crossroads Turning Points Inc	9000187246	Pueblo	BF085	ASAM Level 3.1	1
Crossroads Turning Points Inc	9000187246	Pueblo	BF085	ASAM Level 3.5	15
Crossroads Turning Points Inc	9000187246	Las Animas	BF085	ASAM Level 3.2 WM	7
Crossroads Turning Points Inc	9000187246	Pueblo	BF085	ASAM Level 3.2 WM	12
Health Solutions	9000187318	Pueblo	BF085	ASAM Level 3.7	1
Lutheran Medical Center	99820099	Jefferson	BF085	ASAM Level 3.7 WM	1
North Range Behavioral Health	9000164589	Weld	BF085	ASAM Level 3.5	1
Poudre Valley Health Care Inc	9000169084	Larimer	BF085	ASAM Level 3.7 WM	1
Resada	9000176893	Bent	BF085	ASAM Level 3.2 WM	5

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SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Southeast Mental Health Services	9000153848	Otero	BF085	ASAM Level 3.2 WM	10
Croswaite Brindle, Khara	57150257	Denver	BV132	Licensed Professional Counselors (LPCs)	1
Davis, Chelsea	9000168563	El Paso	BV132	Licensed Professional Counselors (LPCs)	3
Festa, Nicole	9000166266	Adams	BV080	Licensed Addiction Counselors (LACs)	3
Jaramillo-Ford, Carla	01631357	El Paso	BV103	Psychiatric CNS - General	1
Lewis, Eirin	71850066	Denver	BV130	Licensed Clinical Social Workers (LCSWs)	1
Myers, Carol	47510501	El Paso	BV132	Licensed Professional Counselors (LPCs)	1
Rye, Kathleen	90422546	Jefferson	BV102	Psychiatric NPs	1
Seiferd, Ida	23371218	Fremont	BV130	Licensed Clinical Social Workers (LCSWs)	4

Table A-2-Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
CHP+ MCO, Medicaid MCO, RAE
Out-of-network providers are able to request SCAs to render services for HCI Members for the purpose of continuity of care or specialty services that are not available through the current network. Of the eight (8) individual providers who received SCAs during the reporting period: ➢ Two (2) providers are part of an inpatient episode where choice of network providers may be limited due to hospital privileges. ➢ Three (3) are part of contracted groups and currently undergoing credentialing. While the group's new providers complete credentialing, the groups use SCAs for their providers to start working with HCI Members. Providers in the credentialing process and who are using SCAs to render services are monitored to ensure they complete credentialing and formally join the network. ➢ Three (3) providers are being monitored for number of SCAs to identify if they are appropriate for recruitment. HCI monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process. The first quarter of the new SUD benefit, HCI used SCAs to ensure access to the new benefit. Providers negotiating their contracts were able to request SCAs to serve on-going or new Members. Contracted providers pending credentialing did not require SCAs. The process improved transitions of care, increased

Describe the MCE's approach to expanding access to care for members with the use of SCAs. Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
CHP+ MCO, Medicaid MCO, RAE
provider satisfaction, and reduced administrative burden. HCI is monitoring SCAs for the new SUD benefit to identify potential providers for recruitment.

Appendix B. Optional MCE Content

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

Instructions for Appendices

To add an image:

- Go to “Insert” and click on “Pictures”.
- Select jpg file and click “Insert”.

To add an additional Appendix:

- Go to “Layout” and click on “Breaks”.
- Select “Next Page” and a new page will be created.
- Go to “Home” and select “HSAG Heading 6”.
- Type “Appendix C.” and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

Optional MCE Content

Free text

Appendix C. Optional MCE Content

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