COLORADO
Department of Health Care Policy & Financing

FY 2019–2020 Network Adequacy Quarterly Report Template

Managed Care Entity: *Northeast Health Partners*

Line of Business: *RAE*

Contract Number: *19-107508*

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Report due by 1/30/2020, covering the MCE's network from 10/1/2019 – 12/31/2019, SFY 2020 Q2

—Final Copy—

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains 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 fiscal year (FY) 2019-20 Network Adequacy Crosswalk Definitions (December 4, 2019 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	Months Included in the Report
FY 2019-20 Q2	October, November, December
FY 2019-20 Q3	January, February, March
FY 2019-20 Q4	April, May, June
FY 2020-21 Q1	July, August, September

Definitions

- "MS Excel template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Excel Template_F1_1219* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_1219* document.
- 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" 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 hospital, pharmacy, imaging services, and laboratories.

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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.

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 spreadsheet contains 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 (*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	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

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

Establishing and Maintaining the MCE Network

Supporting contract reference: The MCE shall maintain a network that is sufficient in numbers and types of providers 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., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
- To count practitioners/practices/entities ("providers"):
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
  - 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 practices or entities 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: Data

Requirement	Previous Quarter [1]		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	79,183	N/A	78,469	N/A
Total practitioners[2]	990	N/A	299	N/A
Practitioners accepting new members[2]	873	88.18%	268	89.63%
Practitioners (or practices) offering after-hours appointments[2]	347	35.05%	105	35.12%
New practitioners contracted during the quarter[2]	279	28.18%	1	0%
Practitioners that closed or left the MCE's network during the quarter[2]	0	0%	0	0%
Total behavioral health practitioners[2]	1,027	N/A	1,968	N/A

Requirement	Previous Quarter [1]		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners accepting new members[2]	1,027	100%	1,968	100%
Behavioral health practitioners (or practices) offering after-hours appointments[2]	55	53.55%	445	22.61%
RAE				
Total PCMP practice site	51	N/A	61 [3]	N/A
PCMP practice sites accepting new member	43	84.31%	53 [3]	86.89%
PCMP practice sites offering after-hours appointments	14	27.45%	17 [3]	27.87%

(1) Data reported on the section "Previous Quarter" is based the data stated on the Network Adequacy report for the first quarter of fiscal year 2020. Reduction on the counts from first to second quarter is due to how the locations were calculated from one quarter to the next. Duplicate count of locations and individual providers were removed in the version two submission of the second quarter report.

(2) Data reported is individual practitioners only.

(3) Practice sites are un-duplicated by location address and Medicaid ID. There are service address locations with more than one Medicaid IDs and they are counted as separated PCMP practice sites.

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of providers to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
Behavioral Health Network In previous network adequacy reports, NHP identified the following areas to enhance its established regional and state-wide network of behavioral health providers to comply with the network access to care standards: 1- Create full coverage of mental health providers for both adults and children in the northeast part of Weld County; 2- Recruit SUD providers located in counties with limited or no SUD providers such as Cheyenne, Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma; and 3- Credential more CORE providers to the network. The NHP region is primarily comprised of rural and frontier communities with a limited availability of behavioral health providers to recruit within its boundaries. NHP furthered recruitment strategies to address network gaps during the second quarter of the year: 1- Utilized current listings of Health First Colorado participating providers and Department of Regulatory Agency (DORA) Registry to identify providers within the region.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of providers to assure that all covered services will be accessible to members without unreasonable delay.

Provider Relations utilizes current listings of Health First Colorado participating providers and the Department of Regulatory Agency (DORA) Registry to identify SUD licensed providers within the region. The majority of the providers with service locations in the rural and frontier counties identified through these listings are associated with the local Community Mental Health Center. However, the research on DORA yielded SUD licensed providers not associated with a CMHC for recruitment in the following counties: Lincoln (1), Logan (7), Morgan (4), Washington (1) and Weld (92). These providers are not Health First Colorado enrolled providers based on the available information. There were no independent providers identified through this research for recruitment in Cheyenne, Kit Carson, Phillips, Sedgwick, and Yuma counties. Provider Relations is outreaching the SUD licensed providers identified in the region to invite them to join the network. Since these providers are currently not serving Medicaid members, Provider Relations will orient the providers and their staff on Health First Colorado and Northeast Health Partners, as well as, the Medicaid Enrollment process. Interested providers will receive technical assistance to complete their Medicaid Enrollment, and Beacon credentialing and contracting documentation to assist in successfully join the network.

1- Track utilization, single case agreement data, and historical claims information to identify providers who are currently providing services to Health First Colorado Members

Provider Relations conducts monthly reviews of the single case agreement (SCA) data to identify non-contracted providers who are currently providing services to NHP assigned members. During the reporting period, eighteen (18) providers requested SCA's of which eight (8) completed their credentialing during the reporting period, and two (2) providers are in the credentialing process to become network providers. However, the remaining eight (8) non-contracted providers are initiating work with NHP members through SCAs only, and as Provider Relations identifies this type of provider, they are using that as an opportunity to introduce NHP, learn about their services and recruit them to join the network as a provider.

2- Work with county DHS departments to identify CORE providers and work with these providers in becoming credentialing within the system

NHP engages with county DHS departments to connect with CORE providers. This includes inviting them to provider trainings, Town Halls, provider support calls, and community events. Provider Relations continues to work with these providers to join the network. This includes outreach to the individual providers, education and assistance on the Medicaid enrollment process, and assistance with the credentialing process. During the reporting period, one (1) CORE provider completed credentialing and joined the network. However, there remains several other CORE providers that have not initiated the credentialing process and Provider Relations will be focusing efforts to recruit them. This will be accomplished through face-to-face visits, close follow up, and participation in DHS department events.

3- Offer telemedicine services to members in rural and frontier areas who have psychiatry and other specialty needs

For services in counties where behavioral health providers are limited, NHP has network providers that offer telehealth services to members in our rural and frontier areas. There has been an increased interest from Medicaid enrolled providers to offer telehealth services. They report using telehealth services when patients are not able to travel long distances to keep their appointment. Telehealth allows providers to serve members residing outside their city or driving distance and expand access to care within a reasonable time. As an example, a network provider located in Ouray rendered behavioral health services via telehealth to two (2) NHP members residing in Kit Carson, County. Provider Relations sees this as an opportunity to educate and recruit providers into the network.

4- Improve operational processes to successfully credential providers recruited to join the network

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of providers to assure that all covered services will be accessible to members without unreasonable delay.

During the last reporting quarter, Beacon implemented new processes to streamline the credentialing application through an online system and added new staffing. Separately, the Provider Relations Department hired a dedicated staff resource in Colorado to assist providers through the credentialing process. Once fully trained, the staff will track providers through the completion of credentialing, communicate with providers on the status of their application, assist with any required documentation, and coordinate across departments. These improvements will assist with recruitment by addressing provider concerns with undertaking a lengthy and cumbersome credentialing process by providing transparency on the status of their application.

Physical Health Network

NHP continues to explore how to identify providers to recruit and maintain a sufficient network in a region with limited available primary care providers. Based on the data from this reporting period, there is a strong need across the region for Gynecology and OB/GYN providers of all levels including physicians and physician assistants. It limits the ability to serve members of all ages and genders without delays. NHP's barrier will be identifying the available providers in the region with this expertise and recruiting them to serve Medicaid members.

Provider Relations reviews the Medicaid Enrollment data of non-contracted providers to identify PCMP practices in the Region offering services to Medicaid members but not currently a part of the network. Because of this review, Provider Relations is targeting PCMPs for potential recruitment, including one OBGYN practice, Obstetrix Medical Group of Colorado, located in Sterling within Logan County.

Provider Relations furthered the contract discussions with Keene Clinic located within Weld County and expects to execute a contract during the third quarter of 2020. Similar discussions are underway with PMCP Wayne E Hoppe with one practitioner in Burlington and located within Kit Carson County; and Boulder Community Clinic, which opened two locations in Erie within Weld County.

NHP has identified a need to increase access to care with network providers to ensure covered services are available to members without unreasonable delay. Access to care audit findings report that only 60% of the PCP practices have appointments for new members within seven (7) days (for more details about the audit, please reference Table 10). NHP initiated strategies to improve extended or weekend availability in the previous quarter:

1- Conduct a cross-reference of the provider with other sources such as Medicaid provider directory website to validate accuracy of extended or weekend availability;
2- Use provider forums to educate and discuss with provider methods and resources to increase extended or weekend availability in their practices; and
3- Target providers based on provider type without availability to review options available to provider and members that ensure access to care within the network.

During the reporting period, the focus was primarily on cross-referencing the provider with other sources to validate the information. Future reports will offer information in the outcomes of the general and targeted provider education. NHP is monitoring the response of providers and the data to evaluate their effectiveness and adjust strategies accordingly to increase access to care within the network.

Categories Included in Network

Supporting contract reference: The MCE shall ensure that its contracted networks are capable of serving all members, including contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

- To count practitioners/practices/entities ("providers") for Table 2A:
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
  - 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 practices or entities 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.
  - Do not include Federally Qualified Health Centers (FQHCs) when counting Essential Community Providers (ECPs).
  - Use the following hierarchy for determining unique providers, with the narrowest definition first (e.g., if a School Based Health Center [SBHC] is also an FQHC or Rural Health Clinic [RHC], report it under the SBHC row in Table 2A):
    - Indian Health Care Providers (i.e., a healthcare program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization)
    - SBHC
    - FQHC
    - RHC
    - Substance Use Disorder Clinics (*interChange* Provider Type 64)
    - Hospitals
    - Community Mental Health Centers (CMHC)
    - Essential Community Providers
      - ECPs include all other private providers that cannot be qualified as a FQHC or SBHC; i.e., Providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of the patient population. To be designated as an "ECP", the provider must demonstrate that it meets the requirements defined in Section 25.5-5-404(2) C.R.S.
    - Other-Primary Care Providers
    - Other-Behavioral Health Providers
  - The providers capable of billing both Medicare and Medicaid category may duplicate providers counted in the categories described above.

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Table 2A-Categories in Network: Data

Requirement	Total In-Network
Sample	*0*
CHP+ MCO, Medicaid MCO, RAE [4]	
Indian Health Care Providers	0
School Based Health Centers (SBHC)	2
Federally Qualified Health Centers (FQHC)	66
Rural Health Clinics (RHC; not applicable to Medicaid MCO)	56
Substance Use Disorder Clinics	41
Hospitals	275
Community Mental Health Centers (CMHC)	285
Essential Community Providers (ECP; not applicable to Medicaid MCO) [5]	0
Other-Primary Care Providers	39
Other-Behavioral Health Providers	204
CHP+ MCO, Medicaid MCO	
Pharmacies	N/A
CHP+ MCO, Medicaid MCO, RAE[6]	
Providers capable of billing both Medicare and Medicaid	2,861

(4) The data reported is at the PH and BH service locations (i.e. practice sites and entities).

(5) There were no reported ECPs in the network due to being reported in other provider types (i.e. FQHCs and CMHCs) based on the hierarchy.

(6) The data reported includes PH and BH service locations and individual provider.

Table 2B-Categories in Network: Discussion

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE
NHP has only one Urban county, however, has three (3) rural counties and six (6) frontier counties. The availability of behavioral health and primary care providers in rural and frontier counties are limited, especially those with capacity to serve all members including those who offer specialized training and expertise across all ages, levels of abilities, gender identifies and cultural identifies. Based on the data from this reporting period, there is a strong need across the region for Gynecology, OB/GYN providers of all levels including physicians and physician assistants. It limits the ability to serve members of all

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

ages and genders without delays. NHP's barrier will be identifying the available providers in the region with this expertise and recruiting them to serve Medicaid members.

NHP monitors the network through periodic network adequacy reviews regarding the availability of providers who meet or exceed the cultural needs of Medicaid members by:

- Use of an updated and accurate list, in assessing the number of providers with expertise in key culturally based populations and gender, specifically women for gynecology care;
- Determining the number of members, by county, through the enrollment file, within the key population groups;
- Determining any existing gaps by a comparison of availability of providers as well as reviewing findings in Member and Family Affairs surveys or through contacts/surveys with advocacy organization of key populations; and
- Increasing capacity of providers who meet or exceed cultural needs of Medicaid members through specialized provider training on Cultural Competency.

For behavioral health providers, Beacon engaged specialty provider groups and facilities based on the identified need through the network monitoring, such as providers who have:

- A unique specialty or clinical expertise;
- License to prescribe in all areas: APRN/APN, NP, PA, MD/DO (Board Certified Child and Adult Psychiatrists);
- Capability to treat in a foreign language, ASL, and/or, have specific cultural experience;
- Capability of billing both Medicare and Medicaid;
- Practice located in regional organization's service areas considered rural or frontier where there are fewer providers;
- Telehealth, especially for prescriber services;
- Alignment with primary care and co-located in an integrated model;
- Capability to serve unique populations and disorders;
- Specialties such as Intellectual Disabilities, Autism, Members with Traumatic Brain Injuries or other groups that provide behavioral health services in addition to their non-covered specialty. Also, providers with experience in specialty care, long-term services and supports (LTSS), managed service organizations and their networks of substance use disorder providers, dental and other ancillary providers; and
- Behavioral health providers that span inpatient, outpatient, and all other covered mental health and substance use disorder services.

Medicaid members in RAE Region 2 rely on NHP partner CMHCs, *North Range Behavioral Health* and *Centennial Mental Health Center* and partner FQHCs, *Sunrise Community Health Center* and *Plan de Salud Health Center* as primary sources for specialized behavioral health and primary care services, respectively. As a result, our partner providers take steps to ensure they have accessible and expertise to serve members across all ages, levels of abilities, gender identifies and cultural identifies.

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
Our partner CMHCs utilize specialty programs to address the culture and language needs of the community. For example, North Range Behavioral Health Center employs numerous Americorps workers who speak multiple languages to assist families in accessing services and addressing healthcare needs. The average number of languages spoken by the Americorps workers is between 5 to 8 languages. Within Morgan County, it is estimated that between 27 to 40 languages are spoken and the local law enforcement has been nominated to work on a national grant to ensure the availability of culturally appropriate services and interventions. Our goal is to partner within the community to ensure we are providing individualized, culturally aware services. Navigation of systems, with the language spoken by the individual, is also available through the Global Refugee Center of Northern Colorado. Within the Primary Care Provider Network, our partner FQHC recruits providers and support staff that speak the language and are part of the culture in the community they serve. Sunrise Community Health Center utilizes Stratus Video to assist with the interpretation needs of the members at the point of receiving medical care. Status Video is a unique onsite interpretation solution, which connects the Clinic directly with local interpreters, improving scheduling visibility. The interpretation units are touch screen so staff may select the language they need and connect to the live interpreter.

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Access for Special Populations

Supporting contract reference: The MCE shall have the ability to meet the needs of members in special populations. When establishing and maintaining its networks, MCEs shall take the following into consideration: members access to transportation and whether the location provides physical access and accessible equipment for members with disabilities. The MCE shall have the ability to meet the needs of members with limited English proficiency.

Table 3-Access for Special Populations: Discussion

Describe the methods used by the MCE to count providers as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.
CHP+ MCO, Medicaid MCO, RAE
Beacon, on behalf of NHP, monitors if there are sufficient providers in the network with the ability for physical access, reasonable accommodations, and accessible equipment for members with physical or other disabilities. Provider data in the Beacon systems is used to identify provider locations as accessible in the provider directory and to count the number of providers that meet the requirements in the network adequacy analysis. Provider Relations has trainings available on the RAE 2 website to educate providers on how they can directly update their demographic information through Beacon's Provider Portal and CAQH, which includes reporting the physical access and/or accessible equipment information for each of their practice locations. Additionally, Beacon integrates data from CAQH to maintain accurate records for network providers in the Beacon's system that in turn populates the Provider Directory and network adequacy analysis. Finally, Provider Relations conducts on-going phone outreaches to providers that do not have a CAQH profile to validate the information on the Provider Directory. Providers that want to learn more about physical access and/or accessible equipment for practice locations may request Provider Relations staff to conduct an assessment of their facilities for members with physical and other disabilities. There were no requests for these assessments during the reporting period and the assessments will continue to be promoted at provider support calls. This is an opportunity to engage with the practices and increase accessible facilities in the network.

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
Northeast Health Partners, RAE Region 2, maintained the network with no changes in quality of care, competence or professional conduct that required notification to the Department.

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 provider'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 provider's failure to receive credentialing or re-credentialing from the MCE?**
CHP+ MCO
N/A

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interChange Policies

Supporting contract reference: The MCE shall employ measures to help ensure that the MCE and all of their contracted, ordering or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating provider.

- Retroactively enrolled or providers with a pending contract status are not available to offer services and should be excluded from this discussion.

Table 6-CHP+ MCO *interChange* Policies: Discussion

1. Does the MCE employ measures to help ensure all contracted, ordering, or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating provider? **2. Did the MCE have a health care provider that was no longer identified as a participating provider in the *interChange*?** **If the MCE answered "yes" to Requirement 2 above, did the MCE terminate its health care provider contracts for provision of services to members with contracted providers?**
CHP+ MCO
N/A

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Inadequate Network Policies

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

Table 7-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 8-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 9-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

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 10-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 and behavioral health providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially-insured or public fee-for-service-insured individuals), and that services are available twenty-four hours a day, seven days a week, when medically necessary. Access to care standards, set by the State of Colorado, require all participating primary care medical providers (PCMPs) to have availability for members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. The Provider Network Subcommittee approved the policy to monitor access to care standards across the physical health and behavioral health networks during the reporting period. The policy specifies all Primary Care Provider are audited every six (6) months. Providers that do not meet standards receive education and are reviewed within ninety (90) days of initial contact to ensure compliance is achieved. Provider Relations conducted a second audit of network providers in December of 2019, the first audit was conducted in June of 2019. Of the PCP locations contacted via phone during the December audit, 57% met all the standards. The survey identified that PCPs have better availability for established members than for new members with 90% of providers having same day and routine appointment availability for established members and 60% of provider had availability within standard for a new member. These results for appointment availability for established members was similar to the audit conducted six months prior at 91%. However, the results of provider location meeting the appointment availability standard for new members reduced from 78% to 60%. In order to improve compliance with access to care standards, Provider Relations conducted an educational provider alert to all PCPs to remind them of the standards ahead of the December audit. Primary care providers will receive direct communication on their results and provide education on the standards. More importantly, providers will receive focused attention to identify the barriers causing the deficiency, including review of the practice's policy for new members, and potential methods to achieve compliance and ensure member access to

care for members. Providers will be re-audited within ninety (90) days of receiving education and results regarding access to care compliance.

Table 11-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 established office/service hours and access to appointments with standards established by Beacon and/or as may be required by Health First Colorado. The provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially-insured or public fee-for-service-insured individuals), and that services are available twenty-four hours a day, seven days a week, when medically necessary. Access to care standards, set by the State of Colorado, require all participating behavioral health providers to have availability for members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. Provider Network Subcommittee approved the policy to monitor access to care standards across the physical health and behavioral health networks during the reporting period. The policy specifies five (5%) of the behavioral health provider network within the region is audited each month on a rotating basis. Providers that do not meet standards receive education and are reviewed within 90 days of initial contact to ensure compliance is achieved. Provider Relations conducted the first audits of network providers in December of 2019. For behavioral health providers, seven (7) provider locations received a phone call to survey access to care. Of those contacted, only 14% met all the standards. Similar number of providers had same day and routine appointment for established members (29%) and new members (14%). The providers surveyed were located in Logan, Morgan, Weld and Yuma counties. Provider Relations will be communicating with behavioral health providers on the results and provide education on the standards. More importantly, providers will receive focused attention to identify the barriers causing the deficiency and potential methods to achieve compliance and ensure member access to care. Providers will be re-audited within ninety (90) days of receiving education and results regarding access to care compliance.

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 providers in the MCE's Region.

Enter detailed time and distance results in the MS Excel template. Use Tables 13, 14, and 15 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.

- 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, and NPs) and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the tables below. ***A provider should only be counted one time in the tables below; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under Family Practitioner.***

Table 12-Software Package Used for Time and Distance Calculations

List and describe the software package(s) and/or processes that your MCE uses to calculate provider counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed. **If your MCE does not use driving distances when calculating time and distance results, describe the method used.**
CHP+ MCO, Medicaid MCO, RAE
Beacon uses the latest Quest Analytics, an industry-standard application, to conduct a geographic access (geoaccess) mapping analysis for time and distance from member residence driving to the closest available provider based on the county classification. This application is also used to calculate the provider to member ratios at region and county level by provider type. For the second submission of the Q2 Report, Beacon identified a way to use the logic that excluded out of area members for the behavioral health ratio and time/distance standard analysis. This will facilitate the comparison of the data between the two submissions.

The provider data that was used in this report was pulled directly out of the physical health and behavioral health databases hosted by Beacon Health Options, on behalf of NHP. The data was pulled directly out of the database using the SQL editor Toad. The requested data elements for the Individual PH Practitioner and Individual BH Practitioner tabs are available in the databases and were pulled directly. This is also the case for the Practice Sites and the Entity Locations tabs. The Members by County tab was a simple calculation of enrolled Members by their county of residence broken out per the Members by County Instructions. The Provider Locations by County tab was calculated by summing the number of locations by their county name per the instructions of the Provider Locations by County Instructions.

As for the HCPF Network Categories, we began by conducting a quality check of provider NPIs and taxonomy codes using a couple of different methods. For the NPI quality check, we bounced all NPIs in our provider data against the list of NPIs in the monthly ATN report to confirm those providers had valid NPIs. Additionally, there was a manual review of provider taxonomy codes against the NPPESS data to ensure correct taxonomy codes. Once the quality checks were completed, we used the HSAG technical specification document (*FY2019-20 Network Adequacy Validation (NAV) Crosswalk Definitions for Network Data Mapping; December 4, 2019 Version*) to define provider groupings. This was done using the provider's taxonomy code and the provider's degree or credentials. This allowed us to roll-up our provider counts by provider group code.

The technical tools used to complete this reporting requirement were Toad as well as Microsoft Excel. Toad was used to pull the data from Beacon Health Options databases and, where appropriate, conducted the data aggregation calculations. The results of this aggregation were manually entered into the designated Network Adequacy template, which is in an Excel file format.

For behavioral health providers, Northeast Health Partners (NHP) has been working to refine the reporting logic after the first submission of the Quarter 2 Network Adequacy Report in preparation for future quarterly reports. We shifted the analysis of behavioral health provider data to the local reporting team to align with how it is being done for the primary care side. The benefit of having the data reporting locally is that the team is more familiar with the network providers and Colorado requirements. We streamlined the process for validation and adjustments to the logic to enhance the quality of the reporting. As a result of these changes, HCI conducted an in-depth review of the reporting logic This analysis identified the need to adjust the logic for the Quarter 3 Report. While this was underway, we received the feedback from the first submission of the Quarter 2 Report. This feedback was incorporated into the adjustments of the logic for both Quarters. Overall, the changes to the logic included:

- Data cleaned to remove duplicate providers due to name spelling and other data entry errors
- Data cleaned to validate Medicaid IDs and exclude providers missing Medicaid IDs
- Distinguish licensure levels for LPC and LCSW
- Reviewed and updated the categories to capture additional applicable licensure levels
- Reviewed and updated the logic to better capture unlicensed staff under Community Mental Health Centers

The changes outlined above resulted in a net increase of 85 individual behavioral health providers for the second submission of the Quarter 2 Report. The first submission reported 1,883 individual providers, and the second submission reported 1,968 individual providers.

NHP conducted an analysis to determine the impact the changes had in the variance between the two submissions. A total of 211 providers were removed due to: duplicate records (73), missing Medicaid IDs (85), or changes to the code (53). However, a total of 296 providers were added to the report due to changes to the reporting logic (66), and changes to the facility staff rosters (230). The highest impact was the changes to the facility staff rosters; therefore, we conducted a deeper analysis. We identified that the roster changes submitted by the facilities were retroactive to cover the reporting period, which is why they appeared in the second submission. Facilities may retroactively report staff providers to process a clean claim. Facilities are required to include a rendering provider NPI for a clean claim.

NHP has stronger confidence in the data reported in the second submission. We are continuing to enhance the data collection, as well as, the reporting methodology. We will address new findings through NHP's internal process and guidance from the Department.

Table 13–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
NHP has one urban county, Weld, in which nearly all adult and pediatric membership have access to providers for each Provider type within the time and distance requirement for both behavioral health and primary care. The exception is access to Pediatric Primary Care Mid-level and Gynecology, OB/GYN Physician Assistants as there are zero providers under these provider types in the network. NHP will work with network PCP practices to identify opportunities to recruit Pediatric Primary Care Mid-level and Gynecology, OB/GYN Physician Assistants into their practices and identify additional PCPs in the area that have these provider types. For the second submission of the Q2 Report, Beacon identified a way to use the logic that excluded out of area members for the behavioral health ratio and time/distance standard analysis. This will facilitate the comparison of the data between the two submissions.

Table 14–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
Logan, Morgan and Phillips are qualified as rural counties. The majority of the members have access to providers within the required distance of 45 minutes or 45 miles for PCPs and 60 minutes or 60 miles for behavioral health providers. There are not sufficient providers under Pediatric Primary Care Mid-Level, Psychiatric Residential Treatment Facilities and Gynecology, OB/GYN (MD, DO, NP) or (PA) throughout the three rural counties. NHP will work with network PCP practices to identify opportunities to recruit Pediatric Primary Care Mid-level and Gynecology, OB/GYN (PA) into their practices and identify additional PCPs in the area that have these provider types. For the second submission of the Q2 Report, Beacon identified a way to use the logic that excluded out of area members for the behavioral health ratio and time/distance standard analysis. This will facilitate the comparison of the data between the two submissions.

Table 15–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
The majority of the RAE Region 2 qualify as frontier counties. The following counties did not meet access for all provider types within the required distance of 60 minutes or 60 miles for PCPs and 90 minutes or 90 miles for behavioral health: Cheyenne County did not have any Pediatric Primary Care Mid-levels, Psychiatric Residential Treatment Facilities, Gynecology, OB/GYN (MD, DO, NP) or (PA). Kit Carson, Lincoln, Sedgwick, Washington, and Yuma Counties did not have any Pediatric Primary Care Mid-levels, Gynecology, OB/GYN (MD, DO, NP) or (PA). NHP will work with network PCP practices to identify opportunities to recruit Pediatric Primary Care Mid-level and Gynecology, OB/GYN (PA) into their practices and identify additional PCPs in the area that have these provider types.

For the second submission of the Q2 Report, Beacon identified a way to use the logic that excluded out of area members for the behavioral health ratio and time/distance standard analysis. This will facilitate the comparison of the data between the two submissions.

Network Directory

Supporting contract reference: For each of the following provider types covered under this contract the MCE must make the following information on the MCE's network providers available to the enrollee in paper form upon request and electronic form:

- Provider's name as an individual or entity, as well as any group affiliations,
- Business street address,
- Telephone number,
- Electronic mail address,
- Website URLs, as appropriate,
- Specialties, as appropriate,
- Whether network providers will accept new enrollees,
- The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training,
- Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

Table 16-Network Directory: Discussion

Please list the MCE's website URL. **Is the MCE provider network information updated at least monthly?** **Did the MCE make the network providers' information available to the enrollee in paper form upon request and electronic form?**
CHP+ MCO, Medicaid MCO, RAE
Northeast Health Partners lists the Provider Directory on the following URL https://www.northeasthealthpartners.org/members/find-a-provider/. A member can contact Member Services to request the provider directory in paper form and electronic form by calling 1-888-502-4189. The data is edited when providers report a change through Beacon provider portal or by calling Provider Relations. When NHP identifies a change, the provider is contacted to verify the information and submit any appropriate changes. The Provider Directory in the NHP website is updated at least once a month.

Appendix A. 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 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.