COLORADO
Department of Health Care Policy & Financing

FY 2020–2021 Network Adequacy Quarterly Report Template

Managed Care Entity: *Northeast Health Partners*

Line of Business: *RAE*

Contract Number: *19-107508*

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Report Submitted by: *Alma Mejorado*

Report Submitted on: July 30, 2020

Report due by *7/31/2020*, covering the MCE's network from *4/1/2020 – 6/30/2020* FY Q*4*

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2020 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (June 2020 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 (FY) Quarter (Q) Reported	Months Included in the Report
FY 2019-20 Q4	April, May, June
FY 2020-21 Q1	July, August, September
FY 2020-21 Q2	October, November, December
FY 2020-21 Q3	January, February, March

Definitions

- "MS Word template" refers to the *CO2020-21_Network Adequacy_Quarterly Report Word Template_F1_0620* document.
- "MS Word MCE Data Requirements" refers to the *CO2020-21_Network Adequacy_MCE_DataRequirements_F1_0620* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO2020-21_Network Adequacy_Quarterly Report Excel Template_<MCE Type>_Geoaccess Compliance* 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	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

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

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2020, for the quarterly report due to the Department on July 30, 2020).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2020, for the quarterly report due to the Department on July 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 practice sites by de-duplicating records by location, such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	75,786	N/A	82,289	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	319	N/A	319	N/A
Primary care practitioners accepting new members	296	92.8%	296	92.8%
Primary care practitioners offering after-hours appointments	109	34.2%	109	34.2%
New primary care practitioners contracted during the quarter	28	8.8%	1	.3%
Primary care practitioners that closed or left the MCE's network during the quarter	8	2.5%	1	.3%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
As a result of the Network Category changes for this reporting period where providers that served both adult and pediatric population are categorized as Family Medicine practitioners, the number of practitioners listed in the R2_GeoAcess_20200731 as adult or pediatric only are limited and therefore show as not meeting the access to care standards for these populations across the region. NHP maintains a strong network of Family Medicine practitioners throughout the region to meet the needs of members of all ages and genders within the access to care standard requirements. Partner FQHCs, *Sunrise Community Health Center* and *Plan de Salud Health Center*, both have a large number of Family Medicine practitioners that serve members of all ages and gender. Both FQHCs also offer women's health and culturally appropriate services. In the rural and frontier regions where practitioners are in short supply, Family Medicine practitioners are better equipped to serve the various needs of the community. Additionally, 23 (37%) of the practices within NHP network provide language other than English. NHP's partner FQHC recruit providers and support staff that speak the language and are part of the culture in the community they serve. All independent providers can access telephone interpreter services for languages not available through their staff by contacting NHP. The plan to ensure that the PCP network has a sufficient number of providers to serve members based on the maximum distance for their county classification, Provider Relations will be: 1- Reviewing the Department of Regulatory Agency (DORA) Registry to identify providers with licensures that meet primary care provider criteria (MD, DO, NP, PA, RN or CNM) and that are located within the region. Provider Relations will outreach identified providers not currently enrolled in Medicaid to educate them about Health First Colorado (Medicaid) and identify potential incentives to encourage them to enroll as a Medicaid provider and join the network. This strategy will be challenging, as there are limited providers in the region with interest in working with Medicaid members and will require time for a successful recruitment. 2- Reviewing the Enrollment Summary Report with data of non-contracted providers to identify PCP practices in the Region that are offering services to Medicaid members, but not currently part of the network. Of the providers found on the report located within the region, the providers did not meet the PCP criteria to proceed with recruitment. They were specialists such as optometrists, hospice care providers and physical therapists. One of the providers identified in this report in previous quarters was Obstetrix Medical Group of Colorado, located in Logan county. The outreach was not successful in this case as they are currently not interested in participating in Medicaid as a PCP practice and prefer to serve members as a specialist only. Provider Relations will continue to quarterly review the Enrollment Summary Report to identify new providers to expand the PCP network in the region.

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
3- Leveraging community connections through PIAC and Health Neighborhood Collaborative meetings to obtain information on potential providers in the frontier and rural counties, which may be poised to join the network. The second benefit of using community-level feedback is that they may offer insight on best way to initiate the recruitment including warm introduction, which may improve the provider's interest in joining the network. 4- Expanding telehealth services through the region for primary care services and members located across the region, especially in rural and frontier areas where there is no sufficient PCPs within maximum distance for the county. As a result of the COVID-19 crisis, which began at the end of the third quarter, telehealth became a key component for practices to continue to serve Medicaid members. NHP worked closely with providers to educate them on telehealth requirements, billing, and documentation for Fee-For-Service Medicaid. This has been driven through Provider Alerts, dedicated webpage with updated information, and weekly provider support calls to address specific provider questions. Provider Relations will be surveying PCP practices to identify which practices will continue to offer telehealth services after COVID-19. NHP is working on adding telehealth as an element collected of all PCP practices during the periodic process for provider data verification to more accurately report these services and track changes in availability. NHP will monitor the progress of the above listed strategies to ensure all efforts used identify available providers. In the event that there are less than two (2) practitioners that meet the PCP standards within the defined area for members in rural and frontier counties, then NHP will notify HCPF to remove the time/distance requirements for the members as outlined in the contract between HCPF and NHP. As part of the access to care monitoring process, NHP has identified that while the majority (92.8%) of the PCP practitioners in the network are accepting new Medicaid members, appointment availability for new and existing members does not meet the access to care standards. Provider Relations staff have discussed with providers the standards and the reason for their deficiency on an individual basis. Additionally, Provider Relations has updated it's training to include information about continued non-compliance such as follow up audits and requests for a Corrective Action Plan. The training is in the process of dissemination through the Provider Support Calls, Provider Handbook updates and monthly newsletter. All of these materials are posted on the NHP website for provider reference. Providers will be re-audited to monitor their compliance. NHP will be updating the outreach strategy based on provider feedback, level of compliance, and best practices to improve access within the network.

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
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. Currently, 59 (95%) practices report reasonable accommodations for members with physical or other disabilities. Provider information in Beacon's data system 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. Outreach to providers is conducted to validate that the information in the Beacon system is accurate to include in the provider directory and network adequacy analysis. Data Management: The provider data that was used in this report was pulled directly from the primary care provider database. For the HCPF Network Categories, NHP conducted a quality check of the providers' National Provider Identifiers (NPIs) and taxonomy codes using several different methods. NHP compared all NPIs and provider taxonomy codes in the provider data against the National Plan & Provider Enumeration System (NPPES) NPI Registry to ensure correct NPI and taxonomy codes for the provider. Additionally, the validated NPI was checked against the MCO Affiliation report to confirm the Medicaid ID based on the NPI and other provider demographics (i.e. facility address and service type). Any identified discrepancies were reviewed with the provider to validate data and update in the database, as appropriate. Once the quality checks were completed, NHP used the HSAG technical specification document (*Network Adequacy Validation (NAV) Crosswalk Definitions for Network Data Mapping; June 2020 Version*) to define provider groupings. This was done using a combination of the provider's taxonomy code, specialty, and degree or credentials. The logic was reviewed to ensure the Primary Care provider network is reported consistent with the provider and HSAG technical specification document. Through this process, NHP found 99% match of NPI, taxonomy and Medicaid ID in the database for the current report. For the identified provider with a discrepancy, the provider was outreached to validate data and make appropriate adjustments for correction of the database. However, NHP did identify that two Medicaid IDs apply to the same PCP practice site for Lincoln Community Hospital and share the PH practitioners. This resulted in 11 PH practitioners showing up with same practice site address twice in the individual practitioner file. NHP has been in conversations with Lincoln Community Hospital who is working with DXC to make appropriate changes to the Medicaid IDs. Once they update the respective Medicaid IDs, then NHP will update the PCP affiliation and reporting. The data used for the Member File was uploaded from the 834 file received from HCPF. Beacon identified that the member file extraction from the 834 file had invalid zip codes or counties in member demographics. Beacon used the address to correct the data for member demographics with the exception of 13 NHP members. In those cases, the Member File does not include the County five-digit FIPS code.

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	75,786	N/A	82,289	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	2,069	N/A	1,805	N/A
Behavioral health practitioners accepting new members	2,069	100%	1,805	100%
Behavioral health practitioners offering after-hours appointments	445	21.5%	493	27.3%
New behavioral health practitioners contracted during the quarter	112	5.4%	150	8.3%
Behavioral health practitioners that closed or left the MCE's network during the quarter	11	0.5%	414	22.9%

Table 2B-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.
CHP+ MCO, Medicaid MCO, RAE
NHP is primarily a rural and frontier region with one (1) urban county, three (3) rural counties, and six (6) frontier counties. The availability of behavioral health and primary care providers in rural and frontier counties is limited, especially those with capacity to serve all Members, including those who offer specialized training and expertise across all ages, levels of abilities, gender identities, and cultural identities. NHP has 150 new providers from the report and removal of 414 providers. The additional providers were due to providers completing credentialing and facilities validating their provider rosters where they reported new providers. The new facility provider rosters removed those providers that have left the facility. The majority of the providers removed from the report were staff providers with no confirmed Medicaid ID or active status within the facility. Additionally, the data management activities conducted during the quarter further corrected provider name spelling. Finally, NHP removed all providers with out of state service address. The out of state provider offering telehealth services to Medicaid members will be included in future reports. These changes resulted in a net reduction of 264 providers for this report. As the data is dynamic and contingent on ongoing validation of the provider record, NHP anticipates the number of providers will continue to fluctuate quarter over quarter. For behavioral health services, NHP has a need for additional providers across all provider types that serve members with differing levels of ability, gender identities and cultural identities, as well as providers with a license to prescribe in all areas. There are limited available providers licensed to prescribe within the region. With the changes in billing practices for Evaluation & Management (E&M) Codes for prescribers that do not meet the Behavioral Health Specialty Provider Criteria, their recruitment and retention will now be more challenging. Efforts are underway to have these providers join the network to increase specialty in adult and pediatric members, SUD services, the capacity for cultural competency, and prescribers. However, many of them are providers outside NHP's ten (10) counties. NHP validates the network through periodic network adequacy reviews regarding the availability of providers who meet or exceed the cultural needs of Medicaid members across all ages, levels of abilities, gender identities, and cultural identities: • Using updated and accurate lists to assess the number of providers with expertise in key culturally based populations and gender; • Validating the behavioral health provider demographic information and services to assess the capacity of the network through GeoAccess analysis within the key population groups; • Determining the number of members, by county, through the enrollment file, within the key population groups; and • Determining any existing gaps by comparing the availability of providers, as well as reviewing findings in Member and Family Affairs surveys available on the NHP website named "Your Opinion Matters" or through contacts/surveys with advocacy organizations of key populations.

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.

CHP+ MCO, Medicaid MCO, RAE

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 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 five (5) and eight (8) languages.

Within Morgan County, it is estimated that between 27 and 40 languages are spoken. 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.

NHP continues to recruit providers to strengthen the network within the region and its bordering counties using the following strategies:

1- Improving operational processes to successfully recruit and report behavioral health providers.

During the reporting period, NHP focused on supporting providers in the credentialing process to complete the application and join the network. This would allow NHP to better assess the need of providers by license, specialty and other capabilities. NHP further improved credentialing processes including:

- Credentialing application through an online system;
- Added one new credentialing staff;
- Implemented process where Provider Relations monitors the applications through the process and identify potential barriers (e.g. incomplete applications, missing documentation, etc.) for successful credentialing; and

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.

CHP+ MCO, Medicaid MCO, RAE

- Dedicated resource to communicate with providers on the status of their application, assist with any required documentation, and coordinate across departments.

These improvements have assisted in our ability to address provider concerns by providing transparency on the status of their application. At the end of the reporting period, there were 312 behavioral health individual providers and facilities across the state in the credentialing process for Medicaid of which 23 are located within Weld County. This was an increase from 168 providers in the credentialing process in the previous quarter. This is largely due to providers outside of the region interested in joining the Region 2 Medicaid network because they have service locations in bordering counties (125 providers). We have also seen an increase of provider groups with multiple practitioners that are including Medicaid as part of their overall contract with Beacon. Overall, 24 providers have been credentialed during the reporting period of which 13 were in Larimer County.

2- Tracking utilization, Single Case Agreement (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, Provider Relations is actively outreaching providers that have received multiple SCAs in the previous six (6) months. During the reporting period, there are five (5) providers that NHP is actively recruiting to join the network of which two (2) are located in Weld County and the other three are located in Larimer or Denver Counties.

3- Expanding telehealth services through the region for specialty services and members located in our rural and frontier areas.

As a result of the COVID-19 crisis, which began at the end of the third quarter, telehealth has become a stronger focus to ensure behavioral health access. NHP worked closely with providers to educate them on telehealth requirements, billing, and documentation. This has been driven through Provider Alerts, a dedicated webpage with updated information, and weekly provider support calls to address specific provider questions. Review of utilization of telehealth services for the calendar year demonstrated that prior to March 1st, the utilization was extremely low. After that date, utilization increased dramatically with the COVID-19 restrictions and the expansion of telehealth services. About 95% of the utilization was for individual and family psychotherapy codes (90832, 90834, 90837, 90846, 90847) with very little use of other codes, including Medical Management codes. The appointment cadence appears to be weekly, which is in alignment with in-person services.

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.

CHP+ MCO, Medicaid MCO, RAE

NHP has been in communication with providers who have reported overall positive engagement with telehealth to continue to serve Medicaid members. Some providers have reported interest in permanently offering telehealth services or expanding their current telehealth appointment schedule. Based on this information, NHP's expectation that Member and provider exposure to telehealth during the current crisis would increase their comfort level with the technology has been accurate. NHP continues to monitor the changing environment of telehealth, specifically expansion of covered codes and telephone as an allowed medium, to support providers as they build capacity towards a sustainable service.

4- Utilizing current listings of Health First Colorado (Medicaid) participating providers and Department of Regulatory Agency (DORA) registry to identify providers within the region.

NHP outreached providers identified through the listings of Health First Colorado participating providers and the Department of Regulatory Agency (DORA) Registry. 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 Centers (CMHCs). There were no independent providers identified through this research for recruitment in Cheyenne, Kit Carson, Phillips, Sedgwick, Lincoln, and Yuma counties. Of the providers identified in previous quarters, Lincoln (1), Logan (7), Morgan (4), Washington (1) and Weld (92), the following has been the update:

- Confirmed providers are staff for a CMHC – Lincoln (1), Logan, (2), Morgan (1), Weld (5)
- Confirmed providers are staff for contracted facilities – Logan (1), Weld (3)
- Unable to confirm information based on the data provided in DORA and continuing research –Morgan (1), Washington (1), Weld (76)
- Recruitment efforts are on-going with limited response – Logan (4), Morgan (2), Weld (8). The outreach has had limited success as these providers are currently not serving Health First Colorado (Medicaid) Members and have limited incentive to join the network. Provider Relations will continue to outreach these providers to understand and address barriers to successfully bring them into the network.

NHP will monitor the progress of the above listed strategies to ensure all efforts used identify available providers. In the event that there are less than two (2) practitioners that meet the behavioral health standards within the defined area for members in rural and frontier counties, then NHP will request HCPF to remove the time/distance requirements for the members as outlined in the contract between HCPF and NHP.

Data Management: Managing the provider data for completeness and accuracy is a continuous process. NHP has various mechanisms in place to capture and correct data discrepancies and audit the provider information entered into the system. NHP anticipates a minimal margin of error in the data accuracy each quarter. NHP is continuing to enhance the data collection and reporting methodology to reduce the margin error.

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.**
CHP+ MCO, Medicaid MCO, RAE
Provider Relations outreached to individual providers, groups, facilities and CMHCs to update their demographic data in the system. This was accomplished through electronic communication, and targeted outreach. CMHCs receive monthly reports of their staff in the database so they can confirm that their changes have been made and submit any new additions, changes and removals to maintain their staff provider information. During this quarter, NHP targeted facilities by issuing them a report of their staff providers to validate their demographic information, including Medicaid ID, and submit any additions, changes or removals to update their rosters in the database. The targeted outreach with the facility level report of their staff resulted in the removal from the report of staff providers that had left the organization. Facility and CMHC requests to update their staff providers were reviewed to ensure it contained all required demographic information, including Medicaid IDs. Any incomplete requests were returned to the Facilities and CMHCs to resubmit completed requests. For the facilities and CMHCs who did not update the demographic information of their staff providers within the reporting period, the providers with incomplete data were removed from the network adequacy report pending updated information. NHP is reviewing the effectiveness of the process to make modifications and improve response as a quarterly effort. The provider data that was used in this report was pulled directly from the behavioral health database. For the HCPF Network Categories, NHP conducted a quality check of provider National Provider Identifiers (NPIs) and taxonomy codes using several different methods. NHP compared all NPIs and provider taxonomy codes in the provider data against the National Plan & Provider Enumeration System (NPPESS) NPI Registry to ensure correct NPI and taxonomy codes for the provider. Additionally, the validated NPI was checked against the MCO Affiliation report to confirm the Medicaid ID based on the NPI and other provider demographics (i.e. facility address and service type). Any identified discrepancies are reviewed with the provider to validate data and update in the system, as appropriate. Once the quality checks were completed, we used the HSAG technical specification document (*Network Adequacy Validation (NAV) Crosswalk Definitions for Network Data Mapping; June 2020 Version*) to define provider groupings. This was done using the provider's taxonomy code and the provider's degree or credentials. The logic is reviewed each quarter to ensure the Primary Care and behavioral health provider networks are reported consistent with the provider and HSAG technical specification document. Through these processes, NHP identified inconsistencies in the database and took steps to review, validate and update the data. Some of the corrections were underway at the time of the reporting and will processed in following reports: • Facility service locations have provider taxonomy and type that are not listed in the HSAG crosswalk. This caused 14 facility service locations to not align with a Network Category and not be part of the GeoAccess report. • Behavioral health providers or facility service locations have taxonomies missing in the behavioral health database. Providers and facilities were outreached to review and submit updated staff provider

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.**
CHP+ MCO, Medicaid MCO, RAE
data, however, not all facilities submitted their data within required timeframe or specification for the reporting period. • Behavioral Health providers have records with similar names or service locations causing potential duplicate records. Following the data validation process, provider records were reviewed. As potential duplicate records were identified, they were submitted for validation and data entry corrections. Not all records were corrected by the reporting period. • Behavioral health providers sharing or missing Medicaid IDs in the behavioral health database, especially facility staff providers. Facilities were outreached to review and submit updated staff provider data, however, not all facilities submitted their data within required timeframe or specification for the reporting period. The providers missing Medicaid IDs were removed from this quarterly report pending validation of the data. Additionally, through this process, NHP identified hospitals which provider behavioral health services had taxonomies that met the criteria as a PF150 (Hospital) which is not an allowed Network Category for a RAE. As a result, these five (5) facilities are not be part of the GeoAccess report.

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

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

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

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

3. Network Changes and Deficiencies

Network Changes

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

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
NHP, the RAE for Region 2, did not experience a change in its network with regards to quality of care, competence, or professional conduct. As such, no notification to the Department was required during the reporting period.

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

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

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Inadequate Network Policies

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

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

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

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

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

Table 8-CHP+ MCO Provider Network Changes: Discussion

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

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 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 publicly insured, fee-for-service individuals), and that services are available 24 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 providers (PCPs) to have availability for members within seven (7) days of request, and that urgent access is available within 24 hours from the initial identification of need. The Access to Care 6-month audits for Primary Care Providers were not conducted in the fourth quarter. This was in response to the PCP feedback on the challenges they were facing with COVID-19 crisis. NHP worked closely with providers to educate them on telehealth requirements, billing, and documentation for Fee-For-Service Medicaid. This was driven through Provider Alerts, a dedicated webpage with updated information, and weekly provider support calls to address specific provider questions. However, many practices reported a reduction in services creating immediate access to available appointments. NHP is scheduled to complete the audit in the first quarter of Fiscal Year 2021 and continues to monitor feedback from practices to challenges related to COVID-19 crisis.

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 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 publicly insured, fee-for-service individuals), and that services are available 24 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 that urgent access is available within 24 hours from the initial identification of need.

Provider Relations continued to conduct outbound phone calls to survey access to care. A total of 21 provider locations were audited during the reporting period. Of those contacted, three (3) provider location met all the standards (14% of audited providers). Most of the providers did not meet the requirement to offer an appointment within seven (7) days of request. Provider Relations notified behavioral health providers on the results and information on the standards. Providers are scheduled for re-audit within 90 days of receiving the results regarding access to care compliance. For providers that continue to not meet the requirement, they will receive a request to submit a corrective action plan.

The calls conducted at the end of the last quarter and this quarter were under the conditions of COVID-19 crisis. This required significant adjustment for behavioral health providers including temporary reduction of hours or services until they adopted telemedicine for outpatient services. When behavioral health providers received the results of their audit, they communicated to Provider Relations their challenges with new conditions that affected their appointment availability. NHP will be monitoring the providers that failed the audit during March, April and May as they undergo the 90-day follow up. Should they fail, NHP will determine additional steps before requesting a corrective action plan from the provider in an effort to support providers challenged by the national crisis.

In June, nine (9) providers that received notice of the results of their audit conducted prior to COVID-19 received the 90-day follow up phone call. Of these, two (2) provider locations met all the standards (22% of those audited). NHP is reviewing the results of the providers that continued to not meet the standards. They will receive a request to submit a corrective action plan to address their deficiency.

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 Adult and Pediatric Primary Care (and is not an OB/Gyn), the MCE should count the practitioner one time under the Family Practitioner network category.

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

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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, which is residence to the majority of NHP's membership. The requirement for an urban county is to have 100% coverage of two (2) providers within 30 miles and minutes and one provider within the county for every 1,800 members by Member Group (i.e. Adult, children, adult females).

Physician Health: NHP does not have 100% coverage of members within the time/distance requirement for any Network Categories. NHP conducted a GeoAccess analysis at 95% coverage and found that members in Weld had 99% coverage for Pediatric Primary Care (MD, DO, NP), Family Practitioner (MD, DO, NP) and PA, as well as Gynecology, OB/GYN (MD, DO, NP). The geographic territory where the 1% of Medicaid Members without two (2) behavioral providers with 30 miles or 30 minutes is on the northeast east part of the County that is more accurately defined as a rural community than urban. In that area, there are no sufficient behavioral health providers within the 30-mile radius to meet the requirement.

NHP meets the member to provider ratio requirements for Pediatric Primary Care (MD, DO, NP) and Mid-Level, Family Practitioner (MD, DO, NP, and PA, as well as Gynecology, OB/GYN (MD, DO, NP). However, there is not sufficient practitioners within Weld County to meet the requirements for Adult Primary Care (MD, DO, NP) and Mid-Level, or Gynecology, OB/GYN (PA).

There are a couple of reasons that explain the insufficient number of participations for adults. First, most practitioners that serve adult patients start seeing members at the age of 18 years. Based on Medicaid guidelines, a child Member is defined as under the age of 21 years old. Second, practitioners in rural and urban counties tend to serve all ages. Based on the Network Category requirements, these practitioners can only be counted in the Family Practitioner network.

As a result of the new Network Adequacy requirements and category changes, the number of Gynecology, OB/GYN (MD, DO, NP) improved from the previous quarter, however, it did not improve the PA Network Category. NHP will continue to recruit for available PAs in the area for recruitment.

Provider Relations will complete the review of the Department of Regulatory Agency (DORA) Registry to identify providers with licensures that meet primary care provider criteria (MD, DO, NP, PA, RN or CNM) that are located within the region. Provider Relations will outreach identified providers not currently enrolled in Medicaid to educate them about Health First Colorado (Medicaid) and identify potential incentives to enroll as a Medicaid provider and join the network.

Behavioral Health: Within Weld County, NHP does not have 100% coverage of members within the time/distance requirement for any Network Categories. Similarly, members in counties of Adams, Arapahoe, Clear Creek, El Paso, Elbert, and Teller did not meet 100% access for all outpatient services. The majority of counties with NHP members did not meet the access for Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities.

NHP conducted a GeoAccess analysis at 95% coverage and found that members in Weld County had 99% coverage for all Network Categories except Psychiatric Residential Treatment Facilities (95%) and Psychiatric Hospitals and Psychiatric Units in Acute Care Facilities (74%). The geographic territory where the 1% of Medicaid members without two (2) behavioral providers with 30 miles or 30 minutes is on the northeast east part of the County that is more accurately defined as a rural community than urban. In that area, there are no sufficient behavioral health providers within the 30-mile radius to meet the requirement.

NHP meets the member to provider ratio requirements for Adult Psychiatrists and Other Psychiatric Prescribers, Adult Mental Health Provider, Adult and Pediatric Substance Abuse Disorder Provider. However, there are not sufficient practitioners within Weld County to meet the requirements for Pediatric Psychiatrists and Other Psychiatric Prescribers, Pediatric Mental Health Provider, Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities.

NHP is currently recruiting 36 behavioral health providers located within Weld county and neighboring county of Larimer, of which eight (8) were identified through DORA, five (5) through SCA reporting, and 23 that are in the credentialing process. NHP is prioritizing providers that are currently serving Members through SCAs or already in the credentialing process.

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
Logan, Morgan, and Phillips counties 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. For Physical Health, each county had different access for members. In Phillips County, NHP meets 100% coverage of members within the time/distance and ratios requirements only for Family Practitioner (MD, DO, NP). All other Network Categories for adult, pediatric and gynecology services are not met. Morgan County: NHP meets 100% coverage of members within the time/distance and ratios requirements for Family Practitioner (MD, DO, NP) and PA, as well as Gynecology, OB/GYN (MD, DO, NP). All other Network Categories for adult, pediatric and gynecology services are not met. There were no practitioners that only served children. Logan County: NHP meets 100% coverage of members within the time/distance and ratios requirements only for Family Practitioner (MD, DO, NP). It met the ratio for Family Practitioner PA, but not the time/distance standard. All other Network Categories for adult, pediatric and gynecology services are not met. There are a couple of reasons that explain the insufficient number of participations for adults and pediatric. First, most practitioners that serve adult patients start seeing members at the age of 18 years. Based on

Medicaid guidelines, a child Member is defined as under the age of 21 years old. Second, practitioners in rural and urban counties tend to serve all ages. Based on the Network Category requirements, these practitioners can only be counted in the Family Practitioner network. As result, the majority of the practitioners in Logan, Morgan and Phillips as Family Practitioners.

As a result of the new Network Adequacy requirements and category changes, the number of Gynecology, OB/GYN (MD, DO, NP) improved from the previous quarter for Morgan county, however, it did not improve the access for other counties and no improvement for the PA Network Category. NHP will continue to research for available practitioners with gynecology as a specialty in the area for recruitment.

Provider Relations will complete the review of the Department of Regulatory Agency (DORA) Registry to identify providers with licensures that meet primary care provider criteria (MD, DO, NP, PA, RN or CNM) that are located within the region. Provider Relations will outreach identified providers not currently enrolled in Medicaid to educate them about Health First Colorado (Medicaid) and identify potential incentives to join enroll as a Medicaid provider and join the network.

For the behavioral health network, Logan, Morgan and Phillips Counties meet the time/distance the Network Categories with the exception of Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. Also, they meet the ratio requirement for the Network Categories except for Pediatric Substance Abuse Disorder Provider in Morgan and Phillips, Adult Substance Abuse Disorder Provider in Phillips, and Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities in all three counties.

The majority of the rural counties outside the RAE Region 2 with NHP members met the access for all Network Categories with the exception of Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities.

Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the NHP region. This will require work with the Department and community partners to address.

NHP is currently recruiting behavioral health providers located in rural counties (Logan (4) and Morgan (2) identified through the DORA registry. NHP will prioritize outreach to those providers that serve pediatric patients, offer SUD services, serve a special population and has cultural competency training. No behavioral health providers were identified as located in Phillips county to pursue recruitment to meet the requirement of two (2) pediatric and adult SUD practitioners that meet the behavioral health standards within the defined area for members in this county. NHP requests HCPF to remove the time/distance requirements for the members as outlined in the contract between HCPF and NHP.

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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
The majority of the RAE Region 2 counties qualify as frontier. The majority of the members have access to providers within the required distance 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. Physical Health: Cheyenne and Washington Counties: NHP meets 100% coverage of members within the time/distance and ratios requirements only for Family Practitioner (MD, DO, NP). All other Network Categories for adult, pediatric and gynecology services are not met. Kit Carson, Lincoln, Sedgwick, Yuma Counties: NHP meets 100% coverage of members within the time/distance and ratios requirements only for Family Practitioner (MD, DO, NP) and PAs. All other Network Categories for adult, pediatric and gynecology services are not met. There are a couple of reasons that explain the insufficient number of practitioners for adults and pediatric. First, most practitioners that serve adult patients start seeing members at the age of 18 years. Based on Medicaid guidelines, a child Member is defined as under the age of 21 years old. Second, practitioners in rural and urban counties tend to serve all ages. Based on the Network Category requirements, these practitioners can only be counted in the Family Practitioner network. As result, the majority of the practitioners in frontier counties are classified as Family Practitioners. Provider Relations will complete the review of the Department of Regulatory Agency (DORA) Registry to identify providers with licensures that meet primary care provider criteria (MD, DO, NP, PA, RN or CNM) that are located within the region. Provider Relations will outreach identified providers not currently enrolled in Medicaid to educate them about Health First Colorado (Medicaid) and identify potential incentives to enroll as a Medicaid provider and join the network. For behavioral health, the six (6) frontier counties meet the time/distance and ratios requirement for all the Network Categories with the exception of Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. Similarly, the majority of the frontier counties outside the RAE Region 2 with NHP members met the access for all Network Categories with the exception of Psychiatric Residential Treatment Facilities and Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. Access to psychiatric hospitals and residential treatment facilities within the required distance is a challenge for large part of the NHP region. This will require work with the Department and community partners to address.

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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 with SCAs and describe the MCE's use for SCAs.

Table A-1-Practitioners with SCAs: Data

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Primary Care*
CHP+ MCO, Medicaid MCO, RAE				
ANTONELLI, LARA	55828876	Larimer		Uncategorized Practitioner
BAILEY, JEFF	9000166374	Larimer	BV132	Licensed Professional Counselors (LPCs)
BINDSEIL, RICHARD	64238334	Boulder	BV100	Psychiatrists
BOSCH, DAVID	53238346	Douglas	BV100	Psychiatrists
BRUSASCHETTI, PAUL	9000175116	Weld		Uncategorized Practitioner
BYE WOLFE, VALERIE	61453731	Adams	BV132	Licensed Professional Counselors (LPCs)
CARSTEN, PATRICIA	9000179975	Mesa	BV132	Licensed Professional Counselors (LPCs)
CASE, CHELSEA	9000177501	Larimer	BV132	Licensed Professional Counselors (LPCs)
CHEEK, DANIEL	72308010	Jefferson	BV100	Psychiatrists
COLE, RYAN	13771868	El Paso	BV121	Psychologists (PhD, PsyD) - Pediatric
COOPER, BRIAN EZAR	36384861	Weld	BV100	Psychiatrists
DAVIS, AVERY	83980059	Jefferson	BV132	Licensed Professional Counselors (LPCs)
FARMER, BRANDON	9000150810	Larimer	BV100	Psychiatrists
FROST, HELEN	38812541	Weld	BV080	Licensed Addiction Counselors (LACs)
GREEN, GABRIEL	98279246	Larimer	BV100	Psychiatrists
HUNTINGTON, MICHAEL	65776551	Larimer	BV100	Psychiatrists
JOHAR, JASJOT	01367077	Larimer	BV100	Psychiatrists

Individual SCA Practitioner	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description
JOHNSON, ALASTAIR	9000176268	Larimer	BV130	Licensed Clinical Social Workers (LCSWs)
KAMENSKI, JEFFREY	37824384	Larimer		Uncategorized Practitioner
KAN, JUSTIN	9000144516	Weld	BV100	Psychiatrists
LARIMORE, KATHERYN	9000163696	Adams	BV100	Psychiatrists
LEE, GARRETT	00120740	Larimer	BV100	Psychiatrists
MCNAB, KEITH	9000162574	Weld	BV100	Psychiatrists
MOORE, MAUREEN	00833843	Weld	BV102	Psychiatric NPs
MORFORD, DERRICK	9000149754	Douglas	BV100	Psychiatrists
MORTENSEN, D KILEY	90002075	Boulder	BV100	Psychiatrists
NEMEJC, CHARLES	86378341	Weld		Uncategorized Practitioner
NETTLES, ANDREA	12382281	Larimer		Uncategorized Practitioner
PEROTTI, KEVIN	91782058	Larimer		Uncategorized Practitioner
RAEBURN, DANIELLE	24037389	Jefferson	BV100	Psychiatrists
RANCH, GARY	53155122	Larimer	BV121	Psychologists (PhD, PsyD) - Pediatric
REICHERT, BROCK	9000151754	Larimer		Uncategorized Practitioner
RISINGER, THERON	9000160172	Weld	BV100	Psychiatrists
ROWH, MARTA	9000170641	Weld	BV100	Psychiatrists
ROY, CAROLINE	9000144936	Boulder	BV130	Licensed Clinical Social Workers (LCSWs)
RUDD, TERRA	9000147724	Boulder		Uncategorized Practitioner
SIMMONS, TIFFANY	9000148880	Weld	BV132	Licensed Professional Counselors (LPCs)
STRINGHAM, ALEXANDRIA	36135143	Boulder	BV100	Psychiatrists
SUNDHEIM, SCOTT	80472320	Larimer	BV100	Psychiatrists
WILL, TONI	03359018	Weld		Uncategorized Practitioner
WOLF, MOLLIE	18656366	Larimer		Uncategorized Practitioner
YEARGIN, KIMBERLEE	11777222	La Plata	BV100	Psychiatrists

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 service for NHP members for the purpose of continuity of care or specialty services that are not available through the current network. Some providers who received SCAs during the reporting period are part of an emergency department or an inpatient episode where choice of network providers may be limited due to hospital privileges. Additionally, providers who are undergoing the credentialing process may request SCAs to start working with NHP members. Provider Relations monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process. 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.

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

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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.