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Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: *Northeast Health Partners*

Line of Business: *RAE*

Contract Number: *19-107508*

Contact Name: *Kari Snelson*

Report Submitted by: *Alma Mejorado*

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the September 2021 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, or 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 (September 2021 version).

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

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

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0921* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0921* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2021, for the quarterly report due to the Department on October 29, 2021).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2021, for the quarterly report due to the Department on October 29, 2021).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	97,253	N/A	99,269	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	364	N/A	365	N/A
Primary care practitioners accepting new members	341	93.7%	341	93.4%
Primary care practitioners offering after-hours appointments	112	30.8%	112	30.7%
New primary care practitioners contracted during the quarter	15	4.1%	3	0.8%
Primary care practitioners that closed or left the MCE's network during the quarter	18	4.9%	2	0.6%

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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. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** **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 had limited changes in the network during the reporting period. NHP preserved its network of providers across the region in number and type of primary care practitioners to help assure that all covered services are accessible to members immediately. NHP conducted a review of the Enrollment Summary Report with data of non-contracted providers and the Department of Regulatory Agency (DORA) Registry to identify PCMP practices in the region. No additional providers were identified who met the PCMP criteria for recruitment within the region. Specifically, NHP continues to search for Adult Primary Care and Gynecology practitioners who serve as PCMPs across all types of counties within Region 2 (i.e., urban, rural, and frontier); however, the search did not yield additional practitioners for recruitment across the rural and frontier areas of the region. NHP is scheduled to follow-up in the following quarter with the administrators of the practices terminated in FY 2020 due to retirement (Dr. Green) or unforeseen circumstances (Dr. Hoppe). Based on previous conversations, both locations continue to be closed at least through the end of the calendar year. The practice location previously owned by Dr. Hoppe will be initiating renovations to the practice location before they hire a staff physician. NHP will keep in touch with these practices and continue to document the progress of these conversations in future quarterly reports. NHP maintained the number of PCMP practices which offer telehealth services from previous quarter. NHP identified fifty-two (52) PCMP locations that report offering telehealth services in some capacity. NHP will include telehealth provider experience, availability, and utilization in FY 2022 Practice Assessments slated for the end of the third quarter. We deem this important to gauge the sustainability of telehealth and lasting impact on service delivery.

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	97,253	N/A	99,269	N/A

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	1,912	N/A	3,100	N/A
Behavioral health practitioners accepting new members	1,912	100%	3,100	100%
Behavioral health practitioners offering after-hours appointments	546	28.5%	988	31.9%
New behavioral health practitioners contracted during the quarter	120	6.3%	1,386	44.7%
Behavioral health practitioners that closed or left the MCE's network during the quarter	132	6.9%	196	6.3%

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

Requirement	Previous Quarter	Current Quarter
	Number	Number
Sample	*0*	*0*
RAE		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	11	18
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	100	353
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	15	22
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	360	617
Total SUD treatment facilities offering ASAM Level 3.7 services	7	13
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	203	444
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	11	13
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	191	239
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	5

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	195	195

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
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 providers in frontier and rural areas with capacity to serve all members is limited, specifically, providers who offer specialized training and expertise across all ages, levels of abilities, gender identities, and cultural identities. NHP saw a change in the number of behavioral health practitioners from 1,912 to 3,100, which is an increase of 1,188 from the previous reporting period. In the final quarters of the previous fiscal year, NHP conducted a targeted outreach to facilities to submit information of their staff providers. NHP focused on the fifty-teen (15) CMHCs outside NHP region after identifying that they had not reported updates to their staff providers recently. As a result of NHP's outreach, an increased number of facilities submitted staff practitioner updates. Due to the timing and processing of the submissions, the changes are reflected in this quarterly report which resulted in the notable surge of practitioners. The changes in the practitioner data did not significantly impact the GeoAccess within the region as the data changes were facilities outside the region. NHP will continue targeted educational efforts to ensure accurate and updated provider information which may result in additional fluctuations in the data. *Mental health Services:* NHP maintained a network of providers across the region in number and type of behavioral health practitioners to assure that all covered services are accessible to members. Telehealth services continue to provide an important part of the network to ensure access and member choice. During the reporting period, seventy-seven (77) providers reported offering telehealth services. This is a twenty percent (20%) increase of behavioral health providers offering the services from the previous report.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
SUD Services: NHP maintained a network of providers across the region in number and type of SUD outpatient practitioners to assure that all covered services are accessible to members with ninety percent (90%) to one hundred percent (100%) coverage across the region, including frontier and rural counties. The exception was Kit Carson and Yuma County resulting from providers no longer practicing in those areas. NHP will collaborate with Centennial Mental Health Center, which serves these counties, on filling the gap and ensuring there is access to these services in these areas. During the reporting period, NHP continued efforts on recruiting, contracting, and credentialing providers for the SUD benefit expansion that was effective on January 1, 2021. NHP has a statewide network of twenty-one (21) providers with forty-two (42) service locations that completed their credentialing by the end of the reporting period and were included in the file *Network_FAC* and *GeoAccess Compliance*. Network staff continue to support facilities (i.e., Valley Hope Association and Denver Health Hospital Authority) with their completion of credentialing applications to join the network. An additional four (4) facilities continue their contract discussions, including the following: CeDAR, Northpointe Colorado, SummitStone Health Partners, and West Pines Behavioral Health. Although NHP contracted and credentialed all available SUD providers in the region, NHP did not meet many of the time and distance standards across the urban, most rural, and most frontier counties in the region for the SUD benefit. Within the region, there are three (3) SUD treatment providers with a total of six (6) service locations which all have successfully joined the NHP network. These include the following: Advantage Treatment Center, Behavioral Treatment Services, and North Range Behavioral Health (NRBH). The overall lack of sufficient SUD treatment facilities across all ASAM levels located within the region, which affects the ability to meet the standard. NHP coordinates SUD services through its statewide network of facilities to ensure members receive needed treatment.

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%*

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

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

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

3. Network Changes and Deficiencies

Network Changes

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

Table 4–Network Changes: Discussion

If the MCE experienced 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, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. **Note: If the MCE experienced 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 during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
NHP did not experience a change in its network related to quality of care, competence, or professional conduct during this 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 PCMPs 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 PCMPs: Discussion

Did the MCE fail to maintain an adequate network that provides members with access to PCMPs 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 ensure its network is sufficient so that services are provided to members on a timely basis.

Table 9–Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Primary care providers are required to maintain established office/service hours and access to appointments for new and established Medicaid members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. For the reporting period July 2021 through September 2021, fourteen (14) primary care practices (PCMPs) were audited on appointment availability for the following: (1) new Medicaid members, (2) existing Medicaid members, and (3) if same-day appointments are offered to members. The results for this auditing period were as follows: • Fifty percent (50%) reported availability within standards for a new Medicaid member. • Seventy-nine percent (79%) reported availability within standards for an established Medicaid member. • Eighty-six percent (86%) offered same-day appointments. • Sixty-four percent (64%) met all the standards. • The availability of appointments within standards for new members changed from eighty-one percent (81%) to fifty percent (50%) from the audits that were conducted last quarter. Providers were notified of audit results via email, which including an outline of the standards. Those practices that did not meet the standards received additional outreach and either support or education on the standards and the expectations. NHP has updated its policy to include additional outreach efforts and online research to find additional phone numbers or modes of contact, specifically two (2) additional outreach attempts for a total of three (3) outreach attempts. NHP researches the practices online for those providers that do not respond to the outreach attempts to obtain further contact information such as a phone number or email address. NHP also updates provider data such as provider phone numbers for appointments or email addresses in the system to reflect in the provider directory. NHP will continue to outreach practices that did not meet the standards to ensure compliance with the standards. It is important to note that practices continue to experience impacts from the COVID-19 crisis, especially impacts to operations including staff shortages.

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Table 10–Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Behavioral health providers are expected to maintain access to appointments with standards established by the State of Colorado. The standards indicate providers should have appointment availability for members within seven (7) days of request, and urgent access is available within twenty-four (24) hours from the initial identification of need. NHP surveyed nine (9) behavioral health providers on the following per the audits conducted during the July 2021 through September 2021 reporting period: (1) appointment availability for new and (2) existing Medicaid members. Results for this reporting period were as follows: • Seventy-eight percent (78%) reported availability within standard for a new Medicaid member. • Eighty-nine percent (89%) reported availability within standards for an established Medicaid member. • Fifty-six percent (56%) met all the standards. • The availability of appointments within standards for new members increased from twenty-two percent (22%) from the previous quarter to seventy-eight percent (78%) in this reporting period. It is important to note that providers continue to experience impacts from the COVID-19 crisis, especially impacts to operations including staff shortages. Telehealth has aided in increased access for members. In continued support to our members, providers can request single case agreements to help ensure that our members have access to services. Providers were notified of audit results via email, which including an outline of the standards. Those practices that did not meet the standards received additional outreach and either support or education on the standards and the expectations. NHP has updated its policy to include additional outreach efforts and online research to find additional phone numbers or modes of contact, specifically two (2) additional outreach attempts for a total of three (3) outreach attempts. NHP researches the practices online for those providers that do not respond to the outreach attempts to obtain additional contact information such as phone numbers or email addresses. NHP also updates provider data such as phone numbers for appointments or email addresses for the provider in the system to reflect in provider directory. NHP will continue to outreach practices that did not meet the standards to ensure compliance with the standards. NHP continues to offer providers education on the standards via multiple communication efforts, including newsletters and provider roundtables.

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 in its contracted counties, including region-specific contracted counties for RAEs' behavioral health networks. 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 compliance with minimum time and distance requirements for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report compliance with minimum time and distance requirements 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 for each associated network category (PROVCAT code). If a practitioner provides primary care for adult and pediatric members at a specific location, count the practitioner once under the Adult Primary Care Practitioner PROVCAT code, once under the Pediatric Primary Care Practitioner PROVCAT code, and once under the Family Practitioner PROVCAT code. For example, a primary care nurse practitioner (NP) that serves adult and pediatric members can be categorized with the PV063, PV064, and PV065 PROVCAT codes. That practitioner will then be counted for the minimum network standards for pediatric primary care practitioner (NP) (PV064 and PV065); adult primary care practitioner (NP) (PV063 and PV064); and family practitioner (NP) (PV064).

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

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific contracted 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 its contracted urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
NHP has one (1) urban county, Weld, which is where the majority of NHPs' members reside or are attributed. The requirement for an urban county is to have one hundred percent (100%) coverage of two (2) providers within thirty (30) miles or thirty (30) minutes. Mental Health Services Within Weld County, NHP had a ninety-nine and a half percent (99.5%) coverage of providers to members for the following behavioral health provider types: • General Psychiatrists and Other Psychiatric Prescribers • General Behavioral Health • Pediatric Psychiatrists and Other Psychiatric Prescribers • Pediatric Behavioral Health Weld County did not meet access to Psychiatric Units in Acute Care Facilities within thirty (30) miles or thirty (30) minutes. SUD Services NHP had a ninety-nine and a half percent (99.5%) coverage of providers to members for General SUD Treatment Practitioner and Pediatric SUD Treatment Practitioner. NHP showed a slight improvement in access compared to the previous quarter in Weld County in the following SUD services: • Clinically Managed Low-Intensity Residential Services (ASAM level 3.1): Ninety-nine percent (99%) • Clinically Managed High-Intensity Residential Services (ASAM level 3.5): Ninety-four percent (94%) • Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM): Ninety-eight percent (98%) NHP had no change in access for the following services: • Seventy-nine percent (79%) coverage for Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM) • Seventy-three percent (73%) for Medically Monitored Intensive Inpatient Services (ASAM level 3.7). • NHP had zero percent (0%) coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3) due to lack of providers that have the license level within the standard time and distance. Physical Health NHP had no changes in access to physical health services from the previous report. Weld had a ninety-nine percent (99%) coverage of providers to members for the following categories: • Adult Primary Care (MD, DO, NP)

- Adult Primary Care (PA)
- Pediatric Primary Care (MD, DO, NP)
- Pediatric Primary Care (PA)
- Family Practitioner (MD, DO, NP)
- Family Practitioner (PA)
- Gynecology, OB/GYN (MD, DO, NP)

NHP had eighty-nine percent (89%) coverage for Gynecology, OB/GYN (PA).

If fewer than two (2) providers exist in a particular area, standards for member choice/proximity to providers are not required.

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 contracted 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 its contracted rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
NHP has three (3) of its ten (10) counties qualified as rural counties, which are: Logan, Morgan, and Phillips. Members within these counties are required to have access to two (2) providers within the required distance of forty-five (45) minutes or forty-five (45) miles for PCMPs, and sixty (60) minutes or sixty (60) miles for behavioral health providers. Mental Health Services All of the rural counties within the NHP region met the standards for an adequate network for Psychiatrists and Other Psychiatric Prescriber as well as Behavioral Health for all ages. NHP had zero percent (0%) coverage for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. SUD Services NHP met access in Morgan County for SUD Treatment Practitioners of all ages. NHP met ninety-nine percent (99%) in Logan and ninety-three percent (93%) in Phillips for the same services. NHP had no significant change in access for SUD services. • Clinically Managed Low-Intensity Residential Services (ASAM level 3.1): Seventy percent (70%) in Morgan, and zero percent (0%) access in Logan and Phillips Counties. • Clinically Managed High-Intensity Residential Services (ASAM level 3.5): One-hundred percent (100%) in Logan, Ninety-nine percent (99%) in Morgan, and ninety-six percent (96%) in Phillips • Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM): Seventy percent (70%) in Morgan, and zero percent (0%) access in Logan and Phillips Counties.

- NHP had zero percent (0%) coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3), Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM), and Medically Monitored Intensive Inpatient Services (ASAM level 3.7) due to lack of providers that have the license level within the standard time and distance.

Physical Health

For Physical Health, NHP had full coverage across all three (3) rural counties for the following categories:

- Pediatric Primary Care (MD, DO, NP)
- Family Practitioner (MD, DO, NP)

In addition, NHP met one hundred percent (100%) coverage of members within the time/distance standards and ratio requirements for Adult Primary Care (MD, DO, NP) in Logan and Phillips Counties. In Morgan County, Adult Primary Care (PA), Pediatric Primary Care (PA), Family Practitioner (PA), and Gynecology, and OB/GYN (MD, DO, NP) NHP met one hundred percent (100%) coverage.

NHP had almost one hundred percent (99.8%) coverage in Logan County for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). Further, Phillips County had a ninety-five percent (95%) coverage for those same Provider Types. There was no coverage for Gynecology, OB/GYN (MD, DO, NP), and (PA) in all rural counties with the exception of Morgan County which has full coverage for Gynecology, and OB/GYN (MD, DO, NP).

If fewer than two (2) providers exist in a particular area, standards for member choice/proximity to providers are not required.

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 contracted 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 its contracted frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
The majority of the counties [six (6) of ten (10)] within Region 2 qualify as frontier including Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma. The members within these counties are required to have access to two (2) providers within the required distance for all provider types within the required distance of sixty (60) minutes or sixty (60) miles for PCMPs, and ninety (90) minutes or ninety (90) miles for behavioral health. Mental Health Services All of the frontier counties within the NHP region met the standards for an adequate network for Psychiatrists and Other Psychiatric Prescriber as well as Behavioral Health for all ages.

SUD Services

NHP met one-hundred percent (100%) access for SUD Treatment Practitioner for all ages in frontier counties except for Kit Carson and Yuma County resulting from providers no longer practicing in those areas. NHP will collaborate with Centennial Mental Health Center to address this gap.

NHP maintained its access for SUD services in frontier counties:

- Clinically Managed High-Intensity Residential Services (ASAM level 3.5): One-hundred percent (100%) in Cheyenne, Sedgwick, and Washington Counties. In addition, ninety-five percent (95%) in Yuma, and less than thirty percent (30%) to zero access for Kit Carson and Lincoln.
- Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM): Lincoln County had eighty-seven (87%) access and all others had (less than 30%) to zero percent (0%) access within standards.
- NHP had less than thirty percent (30%) or zero percent (0%) coverage due to lack of providers that have the license level within the standard time and distance for:
    - Clinically Managed Low-Intensity Residential Services (ASAM level 3.1),
    - Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3),
    - Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM) – except Lincoln county with sixty-three percent (63%) coverage, and
    - Medically Monitored Intensive Inpatient Services (ASAM level 3.7) – except Lincoln county with sixty-seven percent (67%) coverage.

Physical Health

For Physical Health, NHP had full coverage across its frontier counties for the following categories:

- Adult Primary Care (MD, DO, NP)
- Pediatric Primary Care (MD, DO, NP)
- Family Practitioner (MD, DO, NP)

For Lincoln, Washington, and Yuma Counties, NHP met one hundred percent (100%) coverage of members within the time/distance and ratios requirements for the following categories:

- Adult Primary Care (PA)
- Pediatric Primary Care (PA)
- Family Practitioner (PA)

NHP had almost one hundred percent (99.8%) coverage in Kit Carson County for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). Further, Washington County had a ninety percent (90%) coverage for Gynecology, OB/GYN (MD, DO, NP).

NHP had less than fifty percent (50%) coverage for the following:

- Adult Primary Care (PA) – Cheyenne, Sedgwick
- Pediatric Primary Care (PA) – Cheyenne, Sedgwick
- Family Practitioner (PA) – Cheyenne, Sedgwick
- Gynecology, OB/GYN (MD, DO, NP): Cheyenne, Kit Carson, Lincoln, Sedgwick, and Yuma.
- Gynecology, OB/GYN (PA): Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma.

If fewer than two (2) providers exist in a particular area, standards for member choice/proximity to providers are not required.

COLORADO
Department of Health Care Policy & Financing

Appendix A. Single Case Agreements (SCAs)

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

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

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	[redacted]
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	[redacted]
CHP+ MCO, Medicaid MCO, RAE					
AMARAL-KUNZE, JENNIFER	63723093	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
BAGWELL, STEPHANIE	9000149084	Larimer	BV120	Psychologists (PhD, PsyD) - General	[redacted]
BARCELO, DANIELLE	9000183792	Boulder	BV080	Licensed Addiction Counselors (LACs)	[redacted]
BARRON-KRIER, NATAEAH	9000151724	Larimer	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
COFFMAN, ERIN	9000172261	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
CONNER, ABBIE	24320056	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
DOTSON, DAMOND	54078369	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
FESTA, NICOLE	9000166266	Adams	BV080	Licensed Addiction Counselors (LACs)	[redacted]
FITZGERALD, MORNING	9000168307	Boulder	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
FROST, HELEN	38812541	Weld	BV080	Licensed Addiction Counselors (LACs)	[redacted]

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
GASKINS, COURTNEY	9000192349	Weld	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
GONZALES, MELISSA	9000177903	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
LUTZ, JAMES	42120250	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
MOOREHOUSE, SUZANNE	9000141654	Laramie	BV132	Licensed Professional Counselors (LPCs)	[redacted]
PRESTON, MARY	57230064	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
ROY, CAROLINE	9000144936	Boulder	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
LUTHERAN MEDICAL CENTER	98851365	Jefferson	BF085	ASAM Level 3.7 WM	[redacted]
SUMMITSTONE HEALTH PARTNERS	9000190608	Larimer	BF085	ASAM Level 3.5	[redacted]
COLORADO NORTHPOINTE	9000190963	Larimer	BF085	ASAM Level 3.7	[redacted]
COLORADO NORTHPOINTE	9000190963	Larimer	BF085	ASAM Level 3.7 WM	[redacted]

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
During the reporting period, sixteen (16) individual providers and three (3) facilities received Single Case Agreements (SCAs). Northpointe is listed twice in the report because they received SCAs for two (2) different levels of care. Out-of-network providers can request SCAs to render services for NHP members for the purpose of continuity of care or specialty services that are not available through the current network. ➢ Three (3) completed their credentialing during the reporting period: Danielle Barcelo, Morning Fitzgerald, and James Lutz. Of which, Mr. Lutz was identified as a high volume SCA provider in previous and current reports. For a fourth provider, Nicole Festa, the facility (H.E.A.R.T Counseling Center, LLC) under which they work was credentialed during the reporting quarter, which will eliminate future SCA needs. ➢ Six (6) are in the process of contracting or credentialing, including providers identified in the previous report as potential recruitment due to the volume of members they have seen through SCAs. These are Erin Coffman and Helen Frost.

- Four (4) providers were identified for potential recruitment due to the volume of members they are seeing through SCAs. These are Jennifer Amaral-Kunze, Abbie Conner, Damond Dotson, and Caroline Roy.
- Two (2) providers were being monitored for the number of SCAs to identify if they are appropriate for recruitment. NHP monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process.

As additional SUD providers completed credentialing and joined the network, the need for SCAs has diminished. The three (3) SUD providers listed on the report are negotiating their contracts or amendments to add the level of care. SummitStone Health Partners has signed a contract to add ASAM 3.5 and pending completion of their credentialing. NHP is negotiating contracts with Colorado Northpointe and Lutheran Medical Center (West Pines). They continue to request SCAs to serve ongoing or new members during this process. Contracted providers pending credentialing did not require SCAs.

Appendix B. Optional MCE Content

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

Instructions for Appendices

To add an image:

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

To add an additional Appendix:

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

Optional MCE Content

Free text

Appendix C. Optional MCE Content

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