COLORADO
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*

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Report Submitted on: *April 29, 2022*

Report due by 04/29/2022, covering the MCE's network from *01/01/2022 – 03/31/2022*, FY*22* Q*3*

—Draft Copy: March 2022 Release—

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the March 2022 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 Q2	January 2022	December 31, 2021
FY 2021-22 Q3	April 2022	March 31, 2022
FY 2021-22 Q4	July 2022	June 30, 2022
FY 2021-22 Q1	October 2021	September 30, 2021

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0322* 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 (PCPs)	X	X	X
Physical Health Specialists	X	X	
Behavioral Health Specialists *(RAEs' network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)*	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

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

2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 30, 2022, for the quarterly report due to the Department on April 29, 2022).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 30, 2022, for the quarterly report due to the Department on April 29, 2022).
  - 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	101,947	N/A	103,413	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	369	N/A	373	N/A
Primary care practitioners accepting new members	346	93.8%	350	93.8%
Primary care practitioners offering after-hours appointments	112	30.4%	112	30.0%
New primary care practitioners contracted during the quarter	6	1.6%	4	1.1%
Primary care practitioners that closed or left the MCE's network during the quarter	2	0.5%	0	0.0%

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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
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. NHP maintained a network of PCMPs across the region by type of licensure level. For the counties that did not meet access for one or more type of licensure level, we consider the following barriers: 1- Lack of primary care practitioners to recruit, particularly Physician Assistants (PAs). 2- Absence of additional Primary Care Practitioners that offer Gynecology services within the time/distance standard within rural and frontier counties to recruit for contracting. 3- Loss of two (2) practices in FY 2020 due to retirement (Dr. Green) or unforeseen circumstances (Dr. Hoppe. NHP is monitoring the reopening under new ownership and, as of this report, they have not reopened. 4- Weld County, although it has an urban designation, has territories that are more rural where a practitioner is not within the required 30 miles/30 minutes radius. 5- HCPF standards require 100% of members meet geoaccess standards when industry standards are between 90%-95% of members to have geoaccess standards. 3. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** The NHP PCMP network included practitioners that offer family planning services, particularly FQHCs and Planned Parenthood. NHP ensures member access to family planning services through the following strategies, for example: 1- Member education on all benefits, including family planning, and how to access the services through monthly onboarding sessions. 2- Member Services assists members in finding family planning services within the NHP network or larger Medicaid network. Member Services uses the State's provider directory to assist members with accessing providers outside the network. 3- Member Services monitors all member complaints regarding access to services. During the reporting period, there were no complaints regarding access to family planning services.

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 continues to work on an analysis of family planning usage based on available claims data. NHP expected to have this ready by end of reporting period, however, was unable to prepare a report capturing all family planning services for comprehensive analysis. NHP will continue to work on this report and will provide follow up in future quarterly reports. **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.** NHP monitors the availability and usage of telehealth by surveying PCMP practices about their capacity and utilization of telehealth on an annual basis. Twenty-eight (28) PCMP practices report offering telehealth services. In the second quarter of the fiscal year, the utilization for physical health services via telehealth was 4.14% of total claims paid through Fee-For-Services (FFS) Medicaid. Data for the third quarter was not available due to data lag. NHP reviewed the data differently from previous quarters in two (2) aspects: (1) NHP pulled data only for dates of service in the second quarter of FY 2022 instead of a full year, and (2) NHP isolated claims data for its PCMP network and not across statewide providers. As a result, the findings are different from the one percent (1%) identified in the previous report. The change in the reporting logic will allow targeted monitoring of telehealth within the network quarter over quarter. NHP incorporated the availability and utilization of telehealth on practice assessments which were initiated in this quarter. The practices report a successful platform and have updated workflows that support the use and documentation of telehealth. While PCMP locations report offering telehealth services in some capacity, they report low usage of telehealth for primary care services, particularly as they have returned to treating members in person. The practices offer telehealth when patients are unable to attend an in-person appointment. Additionally, smaller practices did not offer telehealth services beyond those required during the early days of the pandemic. Although the utilization of telehealth is minimal, it is not insignificant as those members may have otherwise not received care or had their care delayed. NHP considers the continued availability of telehealth an important option for members to access care without delay. NHP will continue to promote the modality and support providers to maintain its availability.

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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	101,947	N/A	103,413	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,166	N/A	3,291	N/A
Behavioral health practitioners accepting new members	3,166	100%	3,291	100%
Behavioral health practitioners offering after-hours appointments	963	30.4%	1,024	31.1%
New behavioral health practitioners contracted during the quarter	269	8.5%	188	5.7%
Behavioral health practitioners that closed or left the MCE's network during the quarter	203	6.4%	63	1.9%

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	19	20
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	495	539
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	22	23
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	617	661
Total SUD treatment facilities offering ASAM Level 3.7 services	13	13
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	444	444

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	14	14
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	381	381
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	5
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
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. Although NHP has a strong network of practitioners, particularly within the geographic area of Region 2, NHP met less than one hundred percent (100%) access in some areas for the following reasons: 1- Weld County, although it has an urban designation, has territories that are more rural where a practitioner is not within the required 30 miles/30 minutes radius. 2- Lack of overall Psychiatric Residential Treatment Facilities and Psychiatric Hospitals and Psychiatric Units in Acute Care Facilities statewide, particularly within the NHP region. 3- Requirement to contract with prescribers when the RAE is not financially responsible for the payment of Evaluation & Management (E&M) Codes. 4- HCPF standards require 100% of members meet geoaccess standards when industry standards are between 90%-95% of members to have geoaccess standards.

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

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.

NHP uses telehealth to help ensure all members have access to covered services. Telehealth is an option for members to obtain outpatient services and some higher levels of care such as intensive outpatient (IOP) outside of their geographic area. NHP monitors the availability of telehealth services by requesting that providers report offering telehealth services as part of their demographic data. NHP monitors the utilization of telehealth quarterly, through review of paid claims data. In the second quarter of FY 2022, thirty-one percent (31.25%) of all service costs were rendered through telehealth. The data for the third quarter is still not available due to claims lag. However, telehealth does not help overcome barriers to accessing residential and inpatient services. NHP supports members in accessing services not available or appropriate via telehealth by connecting them to transportation 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.

NHP worked diligently to implement ASAM levels of care into the full continuum of SUD treatment for its members. NHP faced the following barriers to incorporate ASAM levels of care:

1- Provider adherence to authorization and documentation requirements.
2- Ensuring practice sites are enrolled correctly in Medicaid for their specific level of care.
3- Lack of additional SUD treatment sites with ASAM levels within the region.

NHP reduced the impact of the above listed barriers since the implementation of the ASAM levels of care using the following strategies:

1- NHP trained all current providers on authorization procedures and documentation requirements. As a result, NHP is seeing fewer questions or problems in these areas but continues to address issues such as coordination of care in utilization management reviews.
2- NHP identifies providers with Medicaid enrollment discrepancies and conducts provider outreach and education on the enrollment process and guides them to appropriate resources.
3- NHP addressed the concern of limited SUD sites by coordinating the majority (more than 50%) of SUD services through North Range Behavioral Health, as the service needs are concentrated in the Weld County area.

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 monitors the availability of treatment beds at each ASAM level. This is accomplished through continuous communication between NHP's Clinical Department and SUD facilities. NHP's Clinical Department requests that SUD facilities inform us if the facility is unable to place referred members in covered levels of care due to a lack of bed capacity. This information is tracked internally to manage placements and coordinate access to outpatient treatment and case management services.

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

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

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

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

4. Network Changes and Deficiencies

Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes or deficiencies in MCE Networks related to access to care.

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
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. For the PCMP network, NHP did not experience a material change to the network that affected delivery, availability, or capacity within the network. For the behavioral health network, NHP experienced anticipated changes to the network resulting from facilities reporting changes to their staff providers, and providers joining the network. Due to the Marshall Fire in December 2021, Centennial Peaks temporarily evacuated and closed the facility. NHP worked with HCPF, Centennial Peaks, and local facilities to safely evacuate and admit members to other mental health facilities. NHP did not submit formal notification of this temporary closure as this was statewide knowledge and NHP was in communication with HCPF on the emergency transfer of members to other facilities. NHP monitored Centennial Peaks' progress to re-open effective mid-February 2022.

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 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
NHP expects PCMPs, within the region, to meet the service availability and access to care requirements established by Health First Colorado. PCMPs are to offer service/office hours that are convenient to Health First Colorado members. Additionally, PCMPs are required to have open availability access for members within seven (7) days of request, and urgent access availability within twenty-four (24) hours from the initial member need. The access availability includes in person or telehealth services. NHP conducts access to care audits for PCMPs within the region. These access to care audits are performed once a year for each PCMP location. The entire PCMPs list of locations is divided into four (4) quarters. Each quarter NHP audits providers within a three (3) month timeframe. PCMPs are outreached by email and/or phone call. PCMPs are asked three (3) pass or fail questions that are reviewed by NHP to understand the NHP network access to care. 1. When is your next available appointment for a new Health First Colorado member? 2. When is your next available routine appointment for an established Health First Colorado member? 3. Do you offer same day (urgent) appointments? NHP audited fourteen (14) PCMP locations in the third quarter. There were seven (7) or fifty percent (50%) of PCMPs that met the requirement of next available appointment for a new Health First Colorado member within seven (7) days. Twelve (12) or eighty-six percent (86%) of PCMPs met the requirement of next available routine appointment for an established Health First Colorado member. Lastly, fourteen (14) or one hundred percent (100%) of PCMPs offer same day (urgent) appointments. PCMPs that did not meet the access to care availability requirements received a letter by email of the entire audit findings. In addition to the PCMPs audit findings, NHP let the provider know in the access to care audit letter that there will be a re-audit in ninety (90) days. NHP performed an access to care re-audit for the two (2) PCMPs that failed to meet the access to care requirements established by Health First Colorado in the first quarter. Of the two (2) PCMPs, zero (0) met the access to care requirements after re-audit. NHP will email letters to the PCMPs that failed the access to care re-audit to request a corrective action plan (CAP).

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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
Service availability and access to care requirements are established by Health First Colorado to which NHP expects Behavioral Health Providers, within the region, to meet. Behavioral Health Providers are to offer service/office hours that are convenient to Health First Colorado members. And Behavioral Health Providers are to have open availability access for members within seven (7) days of request, and urgent access availability within twenty-four (24) hours from the initial member need. The access availability includes in person or telehealth services. NHP conducts access to care audits for Behavioral Health Providers within the region. These access to care audits are performed once a year for each Behavioral Health Provider's location. The entire Behavioral Health Provider in network list of locations is divided into four (4) quarters. Each quarter NHP audits providers within a three (3) month timeframe. Behavioral Health Providers are outreached by email and/or phone call. Behavioral Health Providers are asked three (3) pass or fail questions that are reviewed by NHP to understand the NHP network access to care. The questions used in the audit are the following. • When is your next available appointment for a new Health First Colorado member? • When is your next available routine appointment for an established Health First Colorado member? • Do you offer same day (urgent) appointments? NHP audited eleven (11) Behavioral Health Providers in the third quarter. • Thirty-six percent (36%) or four (4) of Behavioral Health Providers met the requirement of next available appointment for a new Health First Colorado member within seven (7) days. • Fifty-five percent (55%) or six (6) of Behavioral Health Providers met the requirement of next available routine appointment for an established Health First Colorado member within seven (7) days. • Seventy-three percent (73%) or eight (8) of Behavioral Health Providers met the requirement to offer same day (urgent) appointments. Behavioral Health Providers that did not meet the access to care availability requirements received a letter by email of the entire audit findings. In addition to the Behavioral Health Providers audit findings, NHP let the provider know in the access to care audit letter that there will be a re-audit in ninety (90) days. NHP re-audited Behavioral Health Providers this quarter from the first quarter audit. There were five (5) Behavioral Health Providers re-audited to which three (3) Behavioral Health Providers met the requirements. NHP will email letters to the Behavioral Health Providers that failed the access to care re-audit to request a corrective action plan (CAP).

6. 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).

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. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health 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

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

NHP has one (1) urban county, Weld, which is where the majority (65%) of NHPs' members reside. 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. For Weld County, NHP did not meet the standard by very small amounts across licensure levels for both physical health and behavioral health. The exceptions were ASAM Levels 3.7 WM, 3.7, and 3.3, as well as Psychiatric Hospital or Psychiatric Units in Acute Care Facilities resulting from limited facilities with those services within the region and statewide.

List the specific contracted urban counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.

Physical Health

Licensure Level	Percentage Coverage
Adult Primary Care (MD, DO, NP)	99.7%
Adult Primary Care (PA)	99.5%
Pediatric Primary Care (MD, DO, NP)	99.7%
Pediatric Primary Care (PA)	99.6%
Family Practitioner (MD, DO, NP)	99.7%
Family Practitioner (PA)	99.6%
Gynecology, OB/GYN (MD, DO, NP)	99.1%
Gynecology, OB/GYN (PA)	88.5%

Behavioral Health

Licensure Level	Percentage Coverage
Pediatric Psychiatrists and Other Psychiatric Prescribers	99.6%
Pediatric Behavioral Health	99.6%
General Psychiatrists and Other Psychiatric Prescribers	99.6%
General Behavioral Health	99.6%
Pediatric SUD Treatment Practitioner	99.6%
General SUD Treatment Practitioner	99.6%
SUD Treatment Facilities, ASAM 3.1	98.1%
SUD Treatment Facilities, ASAM 3.2 WM	97.9%
SUD Treatment Facilities, ASAM 3.5	92.8%
SUD Treatment Facilities, ASAM 3.7 WM	79.7%
SUD Treatment Facilities, ASAM 3.7	74.3%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	9.7%
SUD Treatment Facilities, ASAM 3.3	0.0%

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.

NHP ensures access to care for members within Weld County through telehealth and, if appropriate, care coordination services such as transportation assistance.

NHPs' network continues to have a limited number of PCMPs that offer Gynecology services within the region as noted in Table 1B. Members are able to access family planning services through their PCMP if it offers these services or any Medicaid-enrolled provider of their choice. NHPs' Member Services assist members in finding family planning services within the NHP network or larger Medicaid network. **NHP is creating an analysis of family planning usage based on available claims data, which is expected to be available for review in the next reporting period.**

For behavioral health, higher levels of care continue to be unavailable within time/distance requirements for members. NHP provides members with care coordination services, including transportation services, to reach needed residential and/or inpatient care.

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. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health 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
Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. NHP has three (3) of its ten (10) counties qualified as rural counties, which are the following: 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. For mental health services, all of the rural counties within the NHP region met the standards for an adequate network for the following: • General Behavioral Health • General Psychiatrists and Other Psychiatric Prescribers • Pediatric Behavioral Health • Pediatric Psychiatrists and Other Psychiatric Prescribers Additionally, NHP met standards for Psychiatric Hospital or Psychiatric Units in Acute Care Facilities in Phillips County. For SUD services, NHP met the standards for General SUD Treatment Practitioner and Pediatric SUD Treatment Practitioner in both Logan and Morgan counties. NHP met access in Logan County for ASAM Level 3.5. All other SUD levels of care were not met due to facilities not available within time/distance standards. 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) • Adult Primary Care (MD, DO, NP) In addition, NHP met one hundred percent (100%) coverage of members within the time/distance standards and ratio requirements in Morgan County for Adult Primary Care (PA), Pediatric Primary Care (PA), Family Practitioner (PA), and Gynecology, and OB/GYN (MD, DO, NP).

List the specific contracted rural counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.

Physical Health

Licensure Level	Counties not meet access	Percentage Coverage
Adult Primary Care (PA)	Logan, CO	99.8%
Family Practitioner (PA)	Logan, CO	99.8%
Gynecology, OB/GYN (MD, DO, NP)	Logan, CO	4.5%
Gynecology, OB/GYN (PA)	Logan, CO	0.0%
Pediatric Primary Care (PA)	Logan, CO	99.8%
Gynecology, OB/GYN (PA)	Morgan, CO	0.4%
Adult Primary Care (PA)	Phillips, CO	96.2%
Family Practitioner (PA)	Phillips, CO	96.0%
Gynecology, OB/GYN (MD, DO, NP)	Phillips, CO	0.0%
Gynecology, OB/GYN (PA)	Phillips, CO	0.0%
Pediatric Primary Care (PA)	Phillips, CO	96.3%

Behavioral Health

Licensure Level	Counties not meet access	Percentage Coverage
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Logan, CO	0.7%
SUD Treatment Facilities, ASAM 3.1	Logan, CO	0.0%
SUD Treatment Facilities, ASAM 3.2 WM	Logan, CO	0.0%
SUD Treatment Facilities, ASAM 3.3	Logan, CO	0.0%
SUD Treatment Facilities, ASAM 3.7	Logan, CO	0.0%
SUD Treatment Facilities, ASAM 3.7 WM	Logan, CO	0.0%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Morgan, CO	0.0%
SUD Treatment Facilities, ASAM 3.1	Morgan, CO	71.5%
SUD Treatment Facilities, ASAM 3.2 WM	Morgan, CO	71.1%
SUD Treatment Facilities, ASAM 3.3	Morgan, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Morgan, CO	99.7%
SUD Treatment Facilities, ASAM 3.7	Morgan, CO	1.2%

SUD Treatment Facilities, ASAM 3.7 WM	Morgan, CO	1.2%
General SUD Treatment Practitioner	Phillips, CO	95.0%
Pediatric SUD Treatment Practitioner	Phillips, CO	94.7%
SUD Treatment Facilities, ASAM 3.1	Phillips, CO	0.0%
SUD Treatment Facilities, ASAM 3.2 WM	Phillips, CO	0.0%
SUD Treatment Facilities, ASAM 3.3	Phillips, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Phillips, CO	98.3%
SUD Treatment Facilities, ASAM 3.7	Phillips, CO	0.0%
SUD Treatment Facilities, ASAM 3.7 WM	Phillips, CO	0.0%

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.

NHP offers telehealth as an option to ensure access to care for members within our rural counties for both primary medical care and behavioral health services. Additionally, NHPs' care coordination entity, NCHA, assists members to access services where they are available.

NHPs' network continues to have a limited number of Primary Care Practitioners that offer Gynecology services within the region as noted in Table 1B. Members are able to access family planning services through their PCMP if it offers these services or any Medicaid-enrolled provider of their choice. NHPs' Member Services Department assists members in finding family planning services within the NHP network or larger Medicaid network. NHP is creating an analysis of family planning usage based on available claims data, which is expected to be available for review in the next reporting period.

For behavioral health, higher levels of care continue to be unavailable within the time/distance requirements for members. NHP provides members with care coordination services, including transportation services, to reach needed residential and/or inpatient care.

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. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health 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
Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. 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 (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. For mental health services, all of the frontier counties within the NHP region met the standards for an adequate network for: • General Behavioral Health • General Psychiatrists and Other Psychiatric Prescribers • Pediatric Behavioral Health • Pediatric Psychiatrists and Other Psychiatric Prescribers Additionally, NHP met standards for Psychiatric Hospital or Psychiatric Units in Acute Care Facilities in Sedgwick County. For SUD services, NHP met one hundred percent (100%) access for SUD Treatment Practitioners for all ages in frontier counties except for Kit Carson and Yuma County resulting from providers no longer practicing in those areas. Additionally, NHP met standards for ASAM 3.5 (SUD Treatment Facilities) in Cheyenne, Sedgwick, and Washington Counties. 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) NHP met standards for the following categories by county: • Adult Primary Care (PA) – Washington and Yuma Counties • Pediatric Primary Care (PA) – Washington and Yuma Counties • Family Practitioner (PA) – Kit Carson, Lincoln, Washington, and Yuma Counties

List the specific contracted frontier counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.

Physical Health

Licensure Level	Counties not meet access	Percentage Coverage
Adult Primary Care (PA)	Cheyenne, CO	26.9%
Adult Primary Care (PA)	Kit Carson, CO	99.9%
Adult Primary Care (PA)	Lincoln, CO	99.9%
Adult Primary Care (PA)	Sedgwick, CO	22.0%
Family Practitioner (PA)	Cheyenne, CO	27.1%
Family Practitioner (PA)	Kit Carson, CO	99.9%
Family Practitioner (PA)	Lincoln, CO	99.9%
Family Practitioner (PA)	Sedgwick, CO	24.6%
Gynecology, OB/GYN (MD, DO, NP)	Cheyenne, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Kit Carson, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Lincoln, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Sedgwick, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Washington, CO	94.2%
Gynecology, OB/GYN (MD, DO, NP)	Yuma, CO	0.3%
Gynecology, OB/GYN (PA)	Cheyenne, CO	0.0%
Gynecology, OB/GYN (PA)	Kit Carson, CO	0.0%
Gynecology, OB/GYN (PA)	Lincoln, CO	0.0%
Gynecology, OB/GYN (PA)	Sedgwick, CO	0.0%
Gynecology, OB/GYN (PA)	Washington, CO	0.0%
Gynecology, OB/GYN (PA)	Yuma, CO	0.0%
Pediatric Primary Care (PA)	Cheyenne, CO	27.4%
Pediatric Primary Care (PA)	Sedgwick, CO	23.4%

Behavioral Health

Licensure Level	Counties not meet access	Percentage Coverage
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Cheyenne, CO	0.0%
SUD Treatment Facilities, ASAM 3.1	Cheyenne, CO	21.0%
SUD Treatment Facilities, ASAM 3.2 WM	Cheyenne, CO	21.0%
SUD Treatment Facilities, ASAM 3.3	Cheyenne, CO	0.0%
SUD Treatment Facilities, ASAM 3.7	Cheyenne, CO	0.0%
SUD Treatment Facilities, ASAM 3.7 WM	Cheyenne, CO	0.0%
General SUD Treatment Practitioner	Kit Carson, CO	21.2%
Pediatric SUD Treatment Practitioner	Kit Carson, CO	16.6%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Kit Carson, CO	0.0%
SUD Treatment Facilities, ASAM 3.1	Kit Carson, CO	0.0%
SUD Treatment Facilities, ASAM 3.2 WM	Kit Carson, CO	0.0%
SUD Treatment Facilities, ASAM 3.3	Kit Carson, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Kit Carson, CO	8.4%
SUD Treatment Facilities, ASAM 3.7	Kit Carson, CO	0.0%
SUD Treatment Facilities, ASAM 3.7 WM	Kit Carson, CO	0.0%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Lincoln, CO	1.6%
SUD Treatment Facilities, ASAM 3.1	Lincoln, CO	33.6%
SUD Treatment Facilities, ASAM 3.2 WM	Lincoln, CO	86.3%
SUD Treatment Facilities, ASAM 3.3	Lincoln, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Lincoln, CO	16.6%
SUD Treatment Facilities, ASAM 3.7	Lincoln, CO	71.7%
SUD Treatment Facilities, ASAM 3.7 WM	Lincoln, CO	66.7%
SUD Treatment Facilities, ASAM 3.1	Sedgwick, CO	0.0%
SUD Treatment Facilities, ASAM 3.2 WM	Sedgwick, CO	0.0%
SUD Treatment Facilities, ASAM 3.3	Sedgwick, CO	0.0%

SUD Treatment Facilities, ASAM 3.7	Sedgwick, CO	0.0%
SUD Treatment Facilities, ASAM 3.7 WM	Sedgwick, CO	0.0%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Washington, CO	7.6%
SUD Treatment Facilities, ASAM 3.1	Washington, CO	35.6%
SUD Treatment Facilities, ASAM 3.2 WM	Washington, CO	13.2%
SUD Treatment Facilities, ASAM 3.3	Washington, CO	0.0%
SUD Treatment Facilities, ASAM 3.7	Washington, CO	3.5%
SUD Treatment Facilities, ASAM 3.7 WM	Washington, CO	3.5%
General SUD Treatment Practitioner	Yuma, CO	96.2%
Pediatric SUD Treatment Practitioner	Yuma, CO	95.3%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Yuma, CO	92.4%
SUD Treatment Facilities, ASAM 3.1	Yuma, CO	0.0%
SUD Treatment Facilities, ASAM 3.2 WM	Yuma, CO	0.0%
SUD Treatment Facilities, ASAM 3.3	Yuma, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Yuma, CO	95.6
SUD Treatment Facilities, ASAM 3.7	Yuma, CO	0.0%
SUD Treatment Facilities, ASAM 3.7 WM	Yuma, CO	0.0%

Describe the MCE's approach to ensuring access to care for members residing in its <u>contracted frontier</u> Colorado counties where the MCE does not meet the time/distance requirements.

NHP offers telehealth as an option for members within frontier counties for both primary medical care and behavioral health services to ensure access to care. Additionally, NHPs' care coordination entity, NCHA, assists members to access services where they are available.

NHPs' network continues to have a limited number of Primary Care Practitioners that offer Gynecology services within the region as noted in Table 1B. Members are able to access family planning services through their PCMP if it offers these services or any Medicaid-enrolled provider of their choice. NHPs' Member Services assist members in finding family planning services within the NHP network or larger Medicaid network. NHP is creating an analysis of family planning usage based on available claims data, which is expected to be available for review in the next reporting period.

For behavioral health, higher levels of care continue to be unavailable within time/distance requirements for members. NHP provides members with care coordination services, including transportation services, to reach needed residential and/or inpatient care.

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					
AVENT-HENRY, NICOLE	9000142289	Denver	BV132	Licensed Professional Counselors (LPCs)	[redacted]
BAGWELL, STEPHANIE	9000149084	Larimer	BV120	Psychologists (PhD, PsyD) - General	[redacted]
BARRON-KRIER, NATAEAH	9000151724	Larimer	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
BEHREND, KACY	9000152374	Arapahoe	BV132	Licensed Professional Counselors (LPCs)	[redacted]
COFFMAN, ERIN	9000172261	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
CONNER, ABBIE	24320056	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
DEBORD, DAVID	9000164778	Denver	BV132	Licensed Professional Counselors (LPCs)	[redacted]
DERR-MOORE, ABIGAIL	9000159543	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
EDSON, KAYLA	9000177607	Weld	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
GERBER, VICTORIA	9000154004	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
KUIK, DENNIS	9000176514	El Paso	BV130	Licensed Clinical Social Workers (LCSWs)	[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
PRESTON, MARY	57230064	Larimer	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
RICHTER, MARNIE	9000162860	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
JOHNSTOWN HEIGHTS BEHAVIORAL HEAL	9000197846	Weld	BF085	ASAM Level 3.7 WM	[redacted]
JOHNSTOWN HEIGHTS BEHAVIORAL HEAL	9000197846	Weld	BF085	ASAM Level 3.7	[redacted]
LUTHERAN MEDICAL CENTER	98851365	Jefferson	BF085	ASAM Level 3.7 WM	[redacted]
NARCONON COLORADO-A LIFE WORTH SAV	9000187266	Larimer	BF085	ASAM Level 3.2 WM	[redacted]
NARCONON COLORADO-A LIFE WORTH SAV	9000187266	Larimer	BF085	ASAM Level 3.1	[redacted]
POUDRE VALLEY HEALTHCARE INC	9000171090	Larimer	BF085	ASAM Level 3.7	[redacted]
TURNING POINT CTR F OR YTH AND FMLY	9000181227	Larimer	BF085	ASAM Level 3.1	[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
Describe the MCE's approach to expanding access to care for members with the use of SCAs. NHP approves SCA requests for out-of-network providers when: • Specialty service is not available through the current network, • Member is located outside the time/distance standard for service, or • Member has an established relationship with provider and deemed necessary for purposes of continuity of care. Additionally, NHP uses SCAs when providers are actively engaged in the contracting and credentialing process. This allows providers to start serving NHP members while they complete the process.

Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.

NHP reviews SCA utilization data to identify high volume providers. NHP makes inquiries about joining the network when providers have more than five (5) SCAs in a quarter. If the provider agrees to join the network, then NHP staff walks through the process and monitors applications to completion. Of the thirteen (13) providers that had one or more SCAs in the reporting period, five (5) completed the credentialing process and joined the network before the end of the third quarter. Additionally, all five (5) facilities with an SCA for SUD services are in the process to contract and credential for those services.

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.