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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*

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Report Submitted by: *Alma Mejorado*

Report Submitted on: *July 25, 2022*

Report due by *07/29/2022*, covering the MCE's network from *04/01/2022– 06/30/2022*, FY22Q4

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 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_0622* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0622* 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., June 30, 2022, for the quarterly report due to the Department on July 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., June 30, 2022, for the quarterly report due to the Department on July 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	103,413	N/A	105,717	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	373	N/A	367	N/A
Primary care practitioners accepting new members	350	93.8%	341	92.9%
Primary care practitioners offering after-hours appointments	112	30.0%	112	30.5%
New primary care practitioners contracted during the quarter	4	1.1%	0	0.0%
Primary care practitioners that closed or left the MCE's network during the quarter	0	0.0%	6	1.6%

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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
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 continues to maintain its regional network of PCMPs by type of licensure level. For the counties that did not meet access for one or more type of licensure level, we considered 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- 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. Some counties, such as Larimer County, benefit from having this "dual-designation" status, but Weld County must adhere to urban standards despite its rural areas. 4- HCPF standards require 100% of members meet geoaccess standards when the industry standards are between 90%-95% of members to meet 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 Federally Qualified Healthcare Centers (FQHCs) and Planned Parenthood. NHP ensures member access to family planning services through the following strategies: 1- Provide member education on all benefits, including family planning, and how members can access the services through monthly onboarding sessions. 2- Member Services assists members in finding family planning services within the NHP network or the larger Medicaid network if no services are available in the region. Member Services uses the State's provider directory to assist members with accessing providers outside of the network. 3- Member Services continues to monitor 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 completed a process to analyze family planning usage based on available claims data. Based on the review of state claims data for family planning services, the top twenty (20) providers in the state account for almost three-quarters of the utilization (71.4%). Of those top twenty providers, twelve (12) are PCMPs that are part of the NHP network (or 60% of the top 20 providers). This includes North Colorado Family Medicine, Sunrise Community Health, Yuma District Hospital, Rocky Mountain Planned Parenthood, and the County of Weld. The other providers that appear in the data are providers that would not meet PCMP criteria such as imaging or urgent care centers.

If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitor the availability and usage of telehealth services.

NHP surveys PCMP practices about their capacity and utilization of telehealth on an annual basis. In the third quarter of the fiscal year, the utilization for physical health services via telehealth accounted for 6.82% of the total claims paid through Fee-For-Service (FFS) Medicaid. Data for the fourth quarter was not available due to data lag.

NHP incorporated questions on the 2022 practice assessments regarding the availability and utilization of telehealth services in the third quarter. Based on the practice assessments completed as of the end of the quarter, practices reported successful implementation and use of telehealth platforms within the clinics, and updated workflows to support the use of appropriate documentation of telehealth. While PCMP locations report offering telehealth services in some capacity, they report low usage of telehealth for preventive 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. NHP has found that smaller practices did not offer telehealth services beyond what was required during the early days of the pandemic and have subsequently discontinued the service. Overall, although PCMPs have incorporated telehealth services to their practice, its utilization remains low (6.82% of utilization). Although the utilization of telehealth remains minimal for NHP, its usage is not insignificant as those members who use it may have otherwise not received care or had their care delayed. NHP is committed to the continued availability of telehealth an important option for members to timely access care. 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	103,413	N/A	105,717	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,291	N/A	3,308	N/A
Behavioral health practitioners accepting new members	3,291	100%	3,308	100%
Behavioral health practitioners offering after-hours appointments	1,024	31.1%	1,067	32.2%
New behavioral health practitioners contracted during the quarter	188	5.7%	155	4.7%
Behavioral health practitioners that closed or left the MCE's network during the quarter	63	1.9%	138	4.2%

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	20	24
Total SUD treatment facilities offering ASAM Level 3.3 services	0	1
Total SUD treatment facilities offering ASAM Level 3.5 services	23	29
Total SUD treatment facilities offering ASAM Level 3.7 services	13	17
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	14	16
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	5

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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. Similar to previous reports in this fiscal year, 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 many areas. However, NHP continues to have barriers in geoaccess for all areas for the following reasons: 1- Weld County is designated as an urban county however it has territories that are more rural where a practitioner is not within the required 30 miles/30 minutes radius. 2- NHP's region has a lack of overall Psychiatric Residential Treatment Facilities and Psychiatric Hospitals and Psychiatric Units in Acute Care Facilities. Further, NHP's population density is not conducive to opening a sustainable business operation in the region. 3- NHP is required to contract with prescribers when the RAE is not financially responsible for the payment of Evaluation & Management (E&M) Codes, the primary services billed by prescribers. 4- HCPF standards for geoacess is for 100% of members to have two (2) providers within time and distance when industry standards are between 90%-95% of members to meet geoaccess standards. **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 continues to use telehealth to help increase members' access to covered services. Telehealth enables 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 self-report whether they offer telehealth services as part of their menu of services. NHP monitors the utilization of telehealth quarterly through a review of paid claims data. In the third quarter of FY 2022, a quarter (25.7%) of all service costs were rendered through telehealth. The data for the fourth quarter is not available due to claims lag. While telehealth is an effective service modality across a number of clinical situations, it is not an appropriate modality when in-person treatment is required, such as accessing residential treatment services or inpatient services. In these instances, NHP supports members by connecting them to transportation services when appropriate so the member can receive their required services

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Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE, please describe.

If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.

For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.

CHP+ MCO, Medicaid MCO, RAE

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 expand ASAM levels of care into the full continuum of SUD treatment for its members. NHP continued to face the same barriers as in previous quarters to incorporate ASAM levels of care. These are:

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 has seen a marked improvement in addressing the impact of the above listed barriers since the implementation of the ASAM levels of care. The strategies listed below were utilized previously and were continued across quarters due to their efficacy. These strategies are:

1- Training current providers on authorization procedures and documentation requirements. As a result, NHP is seeing fewer questions or problems in these areas and has seen improvement with coordination of care in utilization management reviews.
2- NHP identifies providers with Medicaid enrollment discrepancies. NHP supports these practices through provider outreach and providing education on the enrollment process and guiding members to appropriate resources. As a result, NHP has seen a reduction on issues with Medicaid enrollment discrepancies.

NHP addressed the concern of limited SUD sites by coordinating the majority (more than 50%) of SUD services through North Range Behavioral Health. NHP continues to monitor the availability of treatment beds at each ASAM level through continuous communication between NHP's Clinical Department and SUD facilities. SUD Facilities inform NHP if the facility is unable to place referred members in covered levels of care due to bed capacity. This information is tracked internally to manage placements and coordinate access to outpatient treatment and case management services.

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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 again did not experience a material change to the network that affected delivery, availability, or capacity within the network for this quarter. For the behavioral health network, NHP continued to experience anticipated changes to the network resulting from facilities reporting changes to their staff providers, and providers joining the network. During the reporting period, NHP had 138 behavioral health practitioners leave the network and 155 unique behavioral health practitioners join the network. The number of new unique practitioners was largely due to an increase in the number of providers who completed credentialing, in addition to, facilities who reported changes within their service locations. The number of practitioners who left the network from the previous report are due to changes in the facilities staff as well as practitioners having closed their practice to accepting new Medicaid members.

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

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

Inadequate Network Policies

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

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

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

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

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

Table 8–CHP+ MCO Provider Network Changes: Discussion

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

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 monitors Access to Care standards for Health First Colorado members by auditing Primary Care Providers annually. NHP contacts each Primary Care Provider contracted within RAE region 2 and requests the following information: 1. Appointment availability for new Health First Colorado members within seven (7) days of request. 2. Appointment availability for established Health First Colorado members within seven (7) days of request. 3. Urgent access appointment availability within twenty-four (24) hours. 4. Well Care appointment availability within one (1) month after the request; unless an appointment is required sooner to ensure the provision of screenings in the accordance with the Department's accepted Bright Futures schedule. NHP considers telehealth appointment availability as meeting Access to Care standards for Health First Colorado members. Outreach to Primary Care Providers for Access to Care audits consist of three (3) attempts to gather information. NHP's first outreach is by email and the second by telephone call using the contact information on file. If the first two (2) attempts to outreach a provider is unsuccessful then a third attempt is made by email and/or telephone contact information through expanded outreach efforts using the internet Primary Care Provider search. The results of the audits across quarters for the 2022 fiscal year are outlined below.

PCMP Audit Reporting Period	Q1 Audits	Q2 Audits	Q3 Audits	Q4 Audits
Total PCMP Locations Audited within the NHP Region	14	15	14	14
PCMP Total Audit Counts	14	15	14	14
New Health First Colorado Routine/Non-Urgent appointments within Seven (7) days: Met Requirements	7	9	7	9
Established Health Colorado Routine/ Non-Urgent appointment within seven (7) days Next Available: Met Requirements	11	9	12	10

Urgent Access 24 hours: Met Requirements	12	8	14	12
Well-Care Access (1 month): Met Requirements	NA	NA	NA	12
Follow up audits from previous quarters	NA	NA	2	6
All Requirements Met	NA	NA	1	6

NHP mailed letters to Primary Care Practice Providers who did not respond to the Access to Care audit. These providers will be reaudited in ninety (90) days if a continued no response to the Access to Care audit. Any Primary Care Provider that failed the Access to Care audit is contacted, educated on the standards, and then reaudited within ninety (90) days. If providers fail the Access to Care audit two (2) times, then providers may be placed on a corrective action plan (CAP), if appropriate.

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

NHP evaluates Access to Care for Health First Colorado members by auditing Behavioral Health Providers Access to Care. Behavioral Health Providers with RAE Region 2 are audited one (1) time per year. NHP outreaches Behavioral Health Providers to gather Access to Care standards by email. If there is no response to the e-mail outreach, then NHP will attempt to outreach the provider via the telephone. If these two (2)outreach attempts are unsuccessful due to providers not maintaining accurate contact information in the directory, NHP performs an expanded internet search for telephone and/or email contact information.

Once contact is established with a Behavioral Health Provider, NHP requests Access to Care information which includes the following:

1. Appointment availability for new members within seven (7) days of request.
2. Appointment availability for established members within seven (7) days of request.
3. Urgent appointment access availability either within fifteen (15) minutes by phone or within one (1) hour face-to-face for Urban/Suburban areas (within two (2) hours after contact in Rural/Frontier areas).

NHP considers either in-person or telehealth appointment availability for a Health First Colorado member as acceptable to meeting Access to Care standards.

BH Audit Reporting Period	Q1 Audits	Q2 Audits	Q3 Audits	Q4 Audits
Total BH Locations within the NHP Region	9	12	12	12
BH Total Audit Counts	9	12	11	8

New Health First Colorado Routine/Non-Urgent appointments within seven (7) days: Met Requirements	7	3	4	1
Established Health First Colorado Routine/Non-Urgent appointment within seven (7) days: Met Requirements	8	5	6	4
Urgent Access 24 hours: Met Requirements	NA	4	8	4
Follow up audits from previous quarters	NA	NA	2	4
All Requirements Met	NA	NA	2	2

If any Behavioral Health Provider does not meet the Access to Care standards, NHP outreaches, educates, and reaudits providers within ninety (90) days. For Behavioral Health Providers that fail the Access to Care reaudit, NHP may place a provider on a corrective action plan if deemed appropriate.

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).

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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. 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.

Weld Counts is NHP's only urban county and is where the majority (65%) of NHP's 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 barely missed the standards across licensure levels for both physical health and behavioral health. The exceptions in this quarter were again ASAM Levels 3.7 WM, and 3.7, as well as Psychiatric Hospital or Psychiatric Units in Acute Care Facilities resulting from limited facilities with those services within the region and statewide. NHP had a significant improvement in access for ASAM 3.3 (92.9%) after adding facilities with this level of care.

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)	99.6%
Family Practitioner (MD, DO, NP)	99.7%
Family Practitioner (PA)	99.6%
Gynecology, OB/GYN (MD, DO, NP)	99.2%
Gynecology, OB/GYN (PA)	88.2%
Pediatric Primary Care (MD, DO, NP)	99.7%
Pediatric Primary Care (PA)	99.6%

Behavioral Health

Licensure Level	Percentage Coverage
General Behavioral Health	99.6%
General Psychiatrists and Other Psychiatric Prescribers	99.6%
General SUD Treatment Practitioner	99.5%

Pediatric Behavioral Health	99.6%
Pediatric Psychiatrists and Other Psychiatric Prescribers	99.6%
Pediatric SUD Treatment Practitioner	99.5%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	9.9%
SUD Treatment Facilities, ASAM 3.1	98.0%
SUD Treatment Facilities, ASAM 3.2 WM	97.8%
SUD Treatment Facilities, ASAM 3.3	92.9%
SUD Treatment Facilities, ASAM 3.5	98.1%
SUD Treatment Facilities, ASAM 3.7	74.8%
SUD Treatment Facilities, ASAM 3.7 WM	79.8%

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

As noted on Table 1B, NHP's network continues to have a limited number of Primary Care Practitioners offering Gynecology services within the region. PCMPs offer family planning services as part of primary care services. NHPs' Member Services Department supports members in finding family planning services within the NHP network or the larger Medicaid network. As described in Table 1B, NHP conducted an analysis of family planning usage based on available claims data. The data indicates that the NHP is contracted with 60% of the top 20 providers rendering family planning services.

Higher levels of care continue to be unavailable within time/distance requirements for members seeking behavioral health services. As with physical health, 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.

Three (3) of NHP's ten (10) counties are designated as rural counties. These include Logan County, Morgan County, and Phillips County. 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. During the reporting period, there was no change in the rural counties that met time and distance standards based on provider type.

For mental health services, all of the rural counties within the NHP region continued to meet 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

Within Phillip County, NHP continued to meet standards for Psychiatric Hospital or Psychiatric Units in Acute Care Facilities.

For SUD services, NHP continued to meet the standards for General SUD Treatment Practitioner and Pediatric SUD Treatment Practitioner in both Logan and Morgan Counties. NHP continued to meet access in Logan County for ASAM Level 3.5. NHP continued to not meet the time/distance standard in other SUD levels of care. This was due to facilities not available within time/distance standards.

For Physical Health, NHP continued to have 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)

NHP again 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 <u>contracted rural</u> 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 meeting 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	4.6%
Gynecology, OB/GYN (PA)	Logan, CO	0.0%

Pediatric Primary Care (PA)	Logan, CO	99.8%
Gynecology, OB/GYN (PA)	Morgan, CO	0.5%
Adult Primary Care (PA)	Phillips, CO	96.9%
Family Practitioner (PA)	Phillips, CO	96.8%
Gynecology, OB/GYN (MD, DO, NP)	Phillips, CO	0.0%
Gynecology, OB/GYN (PA)	Phillips, CO	0.0%
Pediatric Primary Care (PA)	Phillips, CO	96.4%

Behavioral Health

Licensure Level	Counties not meeting access	Percentage Coverage
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Logan, CO	0.6%
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	71.0%
SUD Treatment Facilities, ASAM 3.2 WM	Morgan, CO	70.6%
SUD Treatment Facilities, ASAM 3.3	Morgan, CO	7.7%
SUD Treatment Facilities, ASAM 3.5	Morgan, CO	99.8%
SUD Treatment Facilities, ASAM 3.7	Morgan, CO	1.3%
SUD Treatment Facilities, ASAM 3.7 WM	Morgan, CO	1.3%
General SUD Treatment Practitioner	Phillips, CO	95.0%
Pediatric SUD Treatment Practitioner	Phillips, CO	93.0%
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	97.8%
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 continues to offer telehealth as an option to increase access to care for members within our rural counties across both primary medical care and behavioral health services. Additionally, NHPs' care coordination entity, NCHA, continues to assist members with accessing services where they are available.

As noted with NHP's contracted urban counties, NHP's network continues to have a limited number of Primary Care Practitioners offering Gynecology services within the region as noted in Table 1B. PCMPs offer family planning services as part of primary care services. NHPs' Member Services Department supports members in finding family planning services within the NHP network or the larger Medicaid network. As described in Table 1B, NHP conducted an analysis of family planning usage based on available claims data. The data indicates that NHP is contracted with 60% of the top 20 providers rendering family planning services.

NHP offers members with care coordination services, including transportation services, to reach needed residential and/or inpatient care. This assists members obtain behavioral health higher levels of care which are not available within the time/distance requirements for members.

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.

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

The majority of the NHP's counties [six (6) out of the ten (10)] are designated as frontier counties. These include Cheyenne County, Kit Carson County, Lincoln County, Sedgwick County, Washington County, and Yuma County. 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. During the reporting period, there was no change in the rural counties that met time and distance standards based on provider type.

NHP continues to meet standards for mental health services in all of the frontier counties within the NHP region for:

- General Behavioral Health
- General Psychiatrists and Other Psychiatric Prescribers
- Pediatric Behavioral Health
- Pediatric Psychiatrists and Other Psychiatric Prescribers

NHP continues to meet standards for Psychiatric Hospital or Psychiatric Units in Acute Care Facilities in Sedgwick County.

NHP continues to meet one hundred percent (100%) access for SUD Treatment Practitioners for all ages in frontier counties except for Kit Carson and Yuma County. Additionally, NHP continues to meet standards for ASAM 3.5 (SUD Treatment Facilities) in Cheyenne, Sedgwick, and Washington Counties.

NHP continues to meet standards for Physical Health with 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 continues to meet 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	26.5%
Pediatric Primary Care (PA)	Cheyenne, CO	27.7%
Family Practitioner (PA)	Cheyenne, CO	25.9%
Gynecology, OB/GYN (MD, DO, NP)	Cheyenne, CO	0.0%
Gynecology, OB/GYN (PA)	Cheyenne, CO	0.0%
Adult Primary Care (PA)	Kit Carson, CO	99.9%
Family Practitioner (PA)	Kit Carson, CO	99.9%
Gynecology, OB/GYN (MD, DO, NP)	Kit Carson, CO	0.0%
Gynecology, OB/GYN (PA)	Kit Carson, CO	0.0%
Adult Primary Care (PA)	Lincoln, CO	99.8%

Family Practitioner (PA)	Lincoln, CO	99.8%
Gynecology, OB/GYN (MD, DO, NP)	Lincoln, CO	0.0%
Gynecology, OB/GYN (PA)	Lincoln, CO	0.0%
Adult Primary Care (PA)	Sedgwick, CO	23.4%
Pediatric Primary Care (PA)	Sedgwick, CO	25.5%
Family Practitioner (PA)	Sedgwick, CO	23.5%
Gynecology, OB/GYN (MD, DO, NP)	Sedgwick, CO	0.0%
Gynecology, OB/GYN (PA)	Sedgwick, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Washington, CO	93.7%
Gynecology, OB/GYN (PA)	Washington, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Yuma, CO	0.3%
Gynecology, OB/GYN (PA)	Yuma, CO	0.0%

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	21.3%
SUD Treatment Facilities, ASAM 3.2 WM	Cheyenne, CO	21.3%
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	21.1%
Pediatric SUD Treatment Practitioner	Kit Carson, CO	15.9%
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	8.5%
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	1.8%
SUD Treatment Facilities, ASAM 3.1	Lincoln, CO	88.0%
SUD Treatment Facilities, ASAM 3.2 WM	Lincoln, CO	87.9%
SUD Treatment Facilities, ASAM 3.3	Lincoln, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Lincoln, CO	68.7%
SUD Treatment Facilities, ASAM 3.7	Lincoln, CO	70.4%
SUD Treatment Facilities, ASAM 3.7 WM	Lincoln, CO	65.7%
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	7.4%
SUD Treatment Facilities, ASAM 3.1	Washington, CO	35.6%
SUD Treatment Facilities, ASAM 3.2 WM	Washington, CO	12.3%
SUD Treatment Facilities, ASAM 3.3	Washington, CO	1.7%
SUD Treatment Facilities, ASAM 3.7	Washington, CO	3.2%
SUD Treatment Facilities, ASAM 3.7 WM	Washington, CO	3.2%
General SUD Treatment Practitioner	Yuma, CO	96.4%
Pediatric SUD Treatment Practitioner	Yuma, CO	96.0%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Yuma, CO	92.6%
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	95.8%
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 continues to offer telehealth as an option for members within frontier counties for both primary medical care and behavioral health services to ensure access to care. NCHA, NHPs' care coordination entity, continues to assist members to access services where they are available.

As noted with NHP's contracted urban counties, NHP's network continues to have a limited number of Primary Care Practitioners offering Gynecology services within the region as noted in Table 1B. PCMPs offer family planning services as part of primary care services. Additionally, any Medicaid-enrolled provider of their choice. NHPs' Member Services Department assists members in finding family planning services within the NHP network or the larger Medicaid network. As described in Table 1B, NHP conducted an analysis of family planning usage based on available claims data. The data indicates that NHP is contracted with 60% of the top 20 providers rendering family planning services.

NHP offers members with care coordination services, including transportation services, to reach needed residential and/or inpatient care. Care coordination services assist members obtain behavioral health higher levels of care, which are not unavailable within the time/distance requirements for members.

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Appendix A. Single Case Agreements (SCAs)

Individual practitioners with single case agreements (SCAs) are not counted as part of the MCE's health care network and should be excluded from tabulations in the body of this MS Word report and the associated MS Excel report(s). However, the Department acknowledges the role of SCAs in mitigating potential network deficiencies and requests that the MCE use Tables A-1 and A-2 below to list individual practitioners 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]
CONNER, ABBIE	24320056	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
DERR-MOORE, ABIGAIL	9000159543	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
EDSON, KAYLA	9000177607	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
FORD, HALEY	9000151934	Larimer	BV121	Psychologists (PhD, PsyD) - Pediatric	[redacted]
FRICK, MELISSA	9000200771	Boulder	BV132	Licensed Professional Counselors (LPCs)	[redacted]
GERBER, VICTORIA	9000154004	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
MANNELLO, DENA	9000199671	Weld	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
WINCHESTER, AMY	9000147659	Boulder	BV132	Licensed Professional Counselors (LPCs)	[redacted]
WOODY, TYLER	9000201055	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
COLORADO NORTHPOINTE	9000190963	Larimer	BF085	ASAM Level 3.7 WM	[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
JOHNSTOWN HEIGHTS BEHAVIORAL HLTH	9000197846	Weld	BF085	ASAM Level 3.7	[redacted]
JOHNSTOWN HEIGHTS BEHAVIORAL HLTH	9000197846	Weld	BF085	ASAM Level 3.7 WM	[redacted]
NARCONON COLORADO-A LIFE WORTH SAV	9000187266	Larimer	BF085	ASAM Level 3.2 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
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 the provider and is deemed necessary for purposes of continuity of care. Additionally, NHP continues to use SCAs when providers are actively engaged in the contracting and credentialing process to allow 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 continues to review SCA utilization data to identify high volume providers and 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 the provider through the credentialing process and monitors the application to completion. In this reporting period, only one (1) provider had more than five (5) SCAs, Kayla Edson, and they joined the network during the reporting period. Another provider in the report (Dena Mannello) and two (2) facilities (Johnstown Heights Behavioral Health and Narconon Colorado-A Life Worth Living) also completed the process to join the network during this reporting period. An additional three (3) providers and Colorado Northpointe are in the process of joining the network.

Appendix B. Optional MCE Content

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

Instructions for Appendices

To add an image:

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

To add an additional Appendix:

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

Optional MCE Content

Free text

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Appendix C. Optional MCE Content

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