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 due by *10/31/2022* covering the MCE's network from *07/01/2022– 09/30/2022*, FY23Q1

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the September 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 2022 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 2022-23 Q1	October 2022	September 30, 2022
FY 2022-23 Q2	January 2023	December 31, 2022
FY 2022-23 Q3	April 2023	March 31, 2023
FY 2022-23 Q4	July 2023	June 30, 2023

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0922* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0922* 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.

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2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2022, for the quarterly report due to the Department on October 31, 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., September 30, 2022, for the quarterly report due to the Department on October 31, 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	105,717	N/A	107,833	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	367	N/A	368	N/A
Primary care practitioners accepting new members	341	92.9%	342	92.9%
Primary care practitioners offering after-hours appointments	112	30.5%	112	30.4%
New primary care practitioners contracted during the quarter	0	0.0%	1	0.3%
Primary care practitioners that closed or left the MCE's network during the quarter	6	1.6%	0	0.0%

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's regional network of Primary Care Medical Providers (PCMP) is maintained by licensure level type. In analyzing the data for counties that did not satisfy access standards for one or more type of licensure, a range of barriers were identified. One such barrier was a shortage of PCMPs to recruit for contracting, specifically Physician Assistants (PA) as well as providers who offer Gynecology services in rural and frontier counties within the time/distance standard. Weld County is designated as urban, despite the fact that it contains rural areas where there are no practitioners located within the required 30 miles/30 minutes radius. This "dual-designation" status can be beneficial in some counties, such as Larimer County. However, it is a challenge for Weld County to comply with urban standards given its rural areas. An additional barrier that impacts NHPs ability to maintain a sufficient network is the HCPF standard, which requires 100% of members to meet geoaccess standards for PCMPs. Industry standards require 90%-95% of members to meet geoaccess standards. **Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity.** Practitioners who provide family planning services, specifically Federally Qualified Healthcare Centers (FQHC) and Planned Parenthood, are included in NHPs PCMP network. NHP utilizes several strategies to guarantee that members can access family planning services. One such strategy is to educate members about family planning and other benefits, including how to access services via onboarding sessions that occur monthly. Members can also receive assistance from Member Services with locating family planning services within NHPs network. If services in the region are unavailable, Member Services utilizes the State's provider directory to help members to access providers outside of the network, within the broader Medicaid network. All member complaints concerning access to services are overseen by Member Services. No complaints about family planning services access were filed during the reporting period.

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
Family planning usage was analyzed by NHP on a quarterly basis using available claims data. According to state claims data for family planning services, 2,501 members received family planning services during Q4 of FY22. 1,676 members out of those (or 67%) obtained services within RAE Region 2. A portion of those services were provided by PCMPs who are within the NHP network, including North Colorado Family Medicine, Sunrise Community Health, Yuma District Hospital, Rocky Mountain Planned Parenthood, and the County of Weld. The remaining services included in the data were provided by facilities such as hospitals, imaging, and urgent care centers, which would not fit the criteria for PCMPs. **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.** Every year, PCMPs are surveyed by NHP about their utilization of telehealth. In Q4 of FY22, the utilization for physical health services via telehealth accounted for 5.43% of the total claims paid through Fee-For-Service (FFS) Medicaid. Data for Q1 FY23 was not available due to claims data lag.

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	105,717	N/A	107,833	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,308	N/A	3,298	N/A
Behavioral health practitioners accepting new members	3,308	100%	3,298	100%
Behavioral health practitioners offering after-hours appointments	1,067	32.2%	1,081	32.8%
New behavioral health practitioners contracted during the quarter	155	4.7%	97	2.9%
Behavioral health practitioners that closed or left the MCE's network during the quarter	138	4.2%	107	3.2%

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	24	27
Total SUD treatment facilities offering ASAM Level 3.3 services	1	3
Total SUD treatment facilities offering ASAM Level 3.5 services	29	31
Total SUD treatment facilities offering ASAM Level 3.7 services	17	18
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	16	19
Total SUD treatment facilities offering ASAM Level 3.7 WM services	5	8

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. NHP maintains a robust network of practitioners in Region 2. Starting Q1 FY23, the requirement to meet time and distance standards for the provider type mental health practitioners moved from 100% to 90% member coverage. This resulted in access being met for mental health provider types. Additionally, due to an increased number of SUD treatment facilities in the network, NHP saw improvements in the access for those levels of care across the region. NHP continues to be impacted by barriers to geoaccess for specific services within RAE Region 2.

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 continues to experience an overall lack of sufficient SUD treatment facilities across all ASAM levels within the region, which significantly affects our ability to meet full member coverage. When members need this level of care, NHP coordinates transportation for services outside of the region.   Further, Region 2 is predominantly lacking in Psychiatric Residential Treatment Facilities, Psychiatric Hospitals, and Psychiatric Units in Acute Care Facilities. It is not feasible for a business operation to be launched and sustained given the population density in this region.   Finally, the main services that prescribers bill for are Evaluation & Management (E&M) services. NHP is required to contract with prescribers when it is not financially responsible for the payment of these E&M codes. As a result of this, prescribers no longer have an incentive to contract for NHP.   **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.**   Members' access to covered services has expanded with NHPs continued utilization of telehealth services. Through the use of telehealth, members are able to receive services outside of their geographic areas including outpatient services and intensive outpatient programs (IOP). During this reporting period, NHP began contract discussions with Charlie Health, which offers virtual IOP services for youth ages 11 and older. To better track the availability of telehealth services, NHP asks providers to report whether telehealth services are included within the services they offer. NHP monitors the utilization of telehealth quarterly through a review of paid claims data. In Q4 of FY22, 8.37% of all service costs were rendered through telehealth (data for Q1 FY23 not available due to data lag). This was a reduction in telehealth utilization based on paid claims from Q3 FY22 at 25.24%. The rate of telehealth utilization in Q4 FY22 remained higher than pre-pandemic levels of 1% to 2% of telehealth utilization. NHP expects telehealth modality to continue to be an important component of the network to ensure timely access and member choice, particularly for those residing in rural and frontier sections of the region. Further, some services such as residential treatment or inpatient services, require in-person treatment rather than telehealth. When these situations arise, NHP assists members with acquiring transportation so they can obtain the services they need.   **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.**

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
Despite ongoing efforts by NHP to incorporate ASAM levels of care into the complete range of SUD treatment, the barriers that were observed in previous quarters continued to present challenges. Among these barriers were provider adherence to authorization and documentation requirements, securing correct enrollment in Medicaid for practice sites' specific level of care, and a shortage of additional SUD treatment sites with ASAM levels within the region. The negative effects of these barriers have improved since the ASAM levels of care were implemented. NHP has used the following strategies previously and continues to do so as they have been yielded effective results: • Existing providers are being trained on authorization procedures and documentation requirements. Due to this training regimen, NHP has noted less difficulty surrounding these elements as well as improved care coordination. • NHP provides outreach as well as education on the enrollment process and member resources to practices that display discrepancies in Medicaid enrollment. This has resulted in less discrepancies with Medicaid enrollment. NHP continues to address the concern of limited SUD sites by coordinating the majority (more than 50%) of SUD services through North Range Behavioral Health. Further, NHP began contracting discussions with Johnstown Heights Medical Center to add IOP SUD, which opened during the reporting period, and ASAM level 3.7 to their current contract. With the use of ongoing communication among NHPs Clinical Department and SUD facilities, NHP is able to track the accessibility of treatment beds at each ASAM level. Information regarding whether a SUD facility is unable to place a member in covered levels of care because they lack bed capacity is monitored internally. Utilizing this internal tracking system, placements can be managed and access to outpatient treatment and case management services can also be coordinated.

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

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3. 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. NHP did not experience any material changes to the network or network deficiencies during this quarter that impacted service delivery, availability, or capacity.

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

<u>Supporting contract reference:</u> 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

Access to care standards for Health First Colorado members are analyzed by NHP. NHP audits contracted PCMP physical locations within the RAE 2 Region annually to understand access to care appointment timeliness standards. Outreach is performed by NHP through email and telephone calls. NHP initiates three contact attempts to retrieve audit results from PCMPs.

NHP focuses on the following four elements to determine access to care availability with the RAE 2 Region:

1. Appointment availability for new Health First Colorado members within seven days of request.
2. Appointment availability for established Health First Colorado members within seven days of request.
3. Urgent access appointment availability within 24 hours of request.
4. Well Care appointment availability within one month after the request unless an appointment is required sooner to ensure the provision of screenings in accordance with HCPF's accepted Bright Futures schedule.

Telehealth visits and in-person appointments are both acceptable appointment types in meeting the access to care standards for Health First Colorado members.

PCMP Audit Reporting Period	Q1 Audits	Q2 Audits	Q3 Audits	Q4 Audits
Total PCMP Locations Audited within the NHP Region	17	N/A	N/A	N/A
PCMP Total Locations Audited Counts	16	N/A	N/A	N/A
New Health First Colorado Routine/Non-Urgent appointments within Seven days: Met Requirements	10	N/A	N/A	N/A
Established Health Colorado Routine/ Non-Urgent appointment within seven days Next Available: Met Requirements	14	N/A	N/A	N/A
Urgent Access 24 hours: Met Requirements	14	N/A	N/A	N/A
Well-Care Access (1 month): Met Requirements	13	N/A	N/A	N/A
Follow up audits from previous quarters	6	N/A	N/A	N/A
All Requirements Met	1	N/A	N/A	N/A

N/A – Not Available

NHP contacted PCMPs with access to care standards pass or fail results. If any PCMP failed the audit, a letter with information on access to care standards was delivered. In addition, PCMPs that failed the audit will be reaudited in 90 days. NHP may require a corrective action plan if any PCMP fails the access to care audit twice.

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 annually evaluates contracted Behavioral Health Providers by location for Health First Colorado members' access to care standards throughout the RAE 2 Region. Audits are conducted through email and telephone calls. NHPs access to care standards are as follows:

- Appointment availability for new members within seven days of request.
- Appointment availability for established members within seven days of request.
- Urgent appointment access availability either within 15 minutes by phone or within one hour face-to-face for urban/suburban areas (within two hours after contact in rural/frontier areas).
- Emergency Access by phone within 15 minutes after the initial contact, including TTY accessibility; in-person within one hour of contact in urban and suburban areas, in-person within two hours after contact in rural and frontier areas.

NHP accepts in-person or telehealth appointments as meeting the Health First Colorado member access to care standards.

BH Audit Reporting Period	Q1 Audits	Q2 Audits	Q3 Audits	Q4 Audits
Total BH Locations within the NHP Region	29	N/A	N/A	N/A
BH Total Location Audited Counts	23	N/A	N/A	N/A
New Health First Colorado Routine/Non-Urgent appointments within seven days: Met Requirements	12	N/A	N/A	N/A
Established Health First Colorado Routine/Non-Urgent appointment within seven days: Met Requirements	17	N/A	N/A	N/A
Urgent Access 24 hours: Met Requirements	16	N/A	N/A	N/A
Emergency Access By phone within 15 minutes after the initial contact, including TTY accessibility; in person within one hour of contact in urban and suburban areas, in person within two hours after contact in rural and frontier areas.	11	N/A	N/A	N/A
Follow up audits from previous quarters	5	N/A	N/A	N/A
All Requirements Met	4	N/A	N/A	N/A

N/A – Not Available

NHP reviews Behavioral Health Providers access to care standards results on a quarterly basis. Behavioral Health Providers that pass or failed the audit receive a letter from NHP. NHP includes in the letter information regarding access to care standards. Behavioral Health Providers who failed the audit will be reaudited in 90 days. NHP may require corrective actions plans for a Behavioral Health Provider that has failed the audit two times.

5. Time and Distance Standards

Health Care Network Time and Distance Standards

Supporting contract reference: The MCE shall ensure that its network has a sufficient number of practitioners, practice sites, and entities who generate billable services within their zip code or within the maximum distance for their county classification. The MCE must use GeoAccess or a comparable service to measure the travel time and driving distance between where members live and the physical location of the practitioners/practice sites/entities in the MCE's Region.

Enter time and distance compliance results (e.g., "Met" or "Not Met") in the MS Excel template. Use Tables 11, 12, and 13 for additional relevant information regarding the MCE's compliance with time and distance requirements in its contracted counties, including region-specific contracted counties for RAEs' behavioral health networks. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care. For physical health time and distance requirements, MCEs are only required to report compliance with minimum time and distance requirements for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report compliance with minimum time and distance requirements for all members regardless of county residence.

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).
- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

There are two levels of primary care practitioners: primary practitioners that can bill as individuals (e.g., MDs, DOs, NPs, and CNS') and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

A practitioner/practice site/entity should only be counted one time in the MCE's data submission for each associated network category (PROVCAT code). If a practitioner provides primary care for adult and pediatric members at a specific location, count the practitioner once under the Adult Primary Care Practitioner PROVCAT code, once under the Pediatric Primary Care Practitioner PROVCAT code, and once under the Family Practitioner PROVCAT code. For example, a primary care nurse practitioner (NP) that serves adult and pediatric members can be categorized with the PV063, PV064, and PV065 PROVCAT codes. That practitioner will then be counted for the minimum network standards for pediatric primary care practitioner (NP) (PV064 and PV065); adult primary care practitioner (NP) (PV063 and PV064); and family practitioner (NP) (PV064).

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 County, where the majority (65%) of NHPs members reside, is NHPs only urban county. For PCMPs, the requirement for an urban county is to have 100% coverage of two providers within 30 miles or 30 minutes. NHP barely missed the standards across licensure levels for physical health. This remained consistent from the previous reporting period with the exception of Gynecology, OB/GYN (PA), which increased from 88.2% to 96.3% coverage.

For behavioral health practitioners, the requirement for an urban county is to have 90% coverage of two providers within 30 miles or 30 minutes. Additionally, it is required to have 100% coverage for two SUD practitioners and one facility of SUD and psychiatric services within 30 miles or 30 minutes. NHP met the standard for behavioral health practitioners, and barely missed the standard for SUD practitioners and all SUD facility ASAM Levels. NHP improved access for SUD Treatment Facilities 3.7 and 3.7 Withdrawal Management from 74.8% and 79.8% coverage respectively to 96.8% for both levels 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)	99.7%
Family Practitioner (MD, DO, NP)	99.7%
Family Practitioner (PA)	99.7%
Gynecology, OB/GYN (MD, DO, NP)	99.4%
Gynecology, OB/GYN (PA)	96.3%
Pediatric Primary Care (MD, DO, NP)	99.7%
Pediatric Primary Care (PA)	99.7%

Behavioral Health

Licensure Level	Percentage Coverage
General SUD Treatment Practitioner	99.6%
Pediatric SUD Treatment Practitioner	99.6%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	20.8%
SUD Treatment Facilities, ASAM 3.1	99.3%
SUD Treatment Facilities, ASAM 3.2 WM	99.2%
SUD Treatment Facilities, ASAM 3.3	96.6%
SUD Treatment Facilities, ASAM 3.5	99.3%
SUD Treatment Facilities, ASAM 3.7	96.8%
SUD Treatment Facilities, ASAM 3.7 WM	96.8%

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.

Members who reside in Weld Country are guaranteed access to care by NHP with the utilization of telehealth. If deemed necessary or appropriate, care coordination services such as transportation assistance are also employed to help members obtain proper access to care.

NHP has strong coverage (over 95%) for behavioral health higher levels of care and physical health practitioners within the time/distance requirements. NHP continues to provide members with care coordination services, including transportation resources, to obtain needed services including 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 of NHPs 10 counties are designated as rural counties (Logan County, Morgan County, and Phillips County). Members within these counties must have access to two providers within the required distance of 45 minutes or 45 miles for PCMPs. Additionally, NHP is required to have 90% coverage of members within 60 minutes or 60 miles for behavioral health providers. It is also required that there be 100% coverage for two SUD practitioners and one facility of SUD and psychiatric services within 60 minutes or 60 miles.

For behavioral health services, NHP met the standard for all rural counties with the exception of General and Pediatric SUD Treatment Practitioners in Phillips County. NHP continued to meet standards for Psychiatric Hospital or Psychiatric Units in Acute Care Facilities in Phillips County. NHP met access in Logan and Phillips county for ASAM Level 3.5.

For Physical Health, NHP continued to have full coverage across all three rural counties for MD, DO, NP practitioners for all ages. NHP again met 100% coverage of members within the time/distance standards in Morgan County for Adult Primary Care (PA), Pediatric Primary Care (PA), Family Practitioner (PA), and Gynecology, and OB/GYN (MD, DO, NP). Further, Logan County met standards for Pediatric Primary Care (PA), which was an improvement from last quarter's coverage of 99.8%.

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 meeting access	Percentage Coverage
Adult Primary Care (PA)	Logan, CO	99.9%
Family Practitioner (PA)	Logan, CO	99.9%
Gynecology, OB/GYN (MD, DO, NP)	Logan, CO	5.2%
Gynecology, OB/GYN (PA)	Logan, CO	0.0%
Gynecology, OB/GYN (PA)	Morgan, CO	6.7%
Adult Primary Care (PA)	Phillips, CO	99.3%
Family Practitioner (PA)	Phillips, CO	99.2%
Pediatric Primary Care (PA)	Phillips, CO	99.2%
Gynecology, OB/GYN (MD, DO, NP)	Phillips, CO	0.0%
Gynecology, OB/GYN (PA)	Phillips, CO	0.0%

Behavioral Health

Licensure Level	Counties not meeting access	Percentage Coverage
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Logan, CO	1.2%
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	95.4%
SUD Treatment Facilities, ASAM 3.2 WM	Morgan, CO	81.5%
SUD Treatment Facilities, ASAM 3.3	Morgan, CO	10.2%
SUD Treatment Facilities, ASAM 3.5	Morgan, CO	99.9%
SUD Treatment Facilities, ASAM 3.7	Morgan, CO	8.7%
SUD Treatment Facilities, ASAM 3.7 WM	Morgan, CO	8.7%
General SUD Treatment Practitioner	Phillips, CO	99.4%
Pediatric SUD Treatment Practitioner	Phillips, CO	98.0%
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 3.7	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.

Access to both primary medical care and behavioral health services can be expanded in our rural counties with the utilization of telehealth, which NHP continues to provide. Northern Colorado Health Alliance (NCHA), NHPs care coordination entity, is continuing to help members to obtain services where they are accessible. NHP connects members with care coordination resources, including transportation, so they can receive necessary residential and/or inpatient care. As a result, members can secure higher levels of behavioral health care, which are not otherwise obtainable within the time/distance requirements.

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 NHPs counties (six out of 10) are designated as frontier counties (Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma). The members within these counties are required to have access to two providers (for all provider types) within the required distance of 60 minutes or 60 miles for PCMPs. Additionally, NHP is required to have 90% coverage of members within 90 minutes or 90 miles for behavioral health providers. It is also required to have 100% coverage for two SUD practitioners and one facility of SUD and psychiatric services within 90 minutes or 90 miles.

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For behavioral health services, NHP met the standard for all frontier counties with the exception of General and Pediatric SUD Treatment Practitioners in Yuma County. NHP continued to meet standards for Psychiatric Hospital or Psychiatric Units in Acute Care Facilities in Sedgwick County. NHP met access in Logan and Phillips county for ASAM Level 3.5. Additionally, NHP continued to meet standards for ASAM 3.5 (SUD Treatment Facilities) in Cheyenne, Sedgwick, and Washington Counties.

Because of added SUD Treatment Facilities in the network, NHP improved access for SUD services in Kit Carson for ASAM 3.5, Washington for ASAM 3.1 and 3.2 WM, and Lincoln county across all levels of care with the exception of ASAM 3.3.

NHP continues to meet standards for Physical Health with full coverage across its frontier counties for MD, DO, NP practitioners for all ages. NHP met access for Kit Carson, Lincoln, Washington, and Yuma counties for PA practitioners for all ages.

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	40.1%
Pediatric Primary Care (PA)	Cheyenne, CO	41.6%
Family Practitioner (PA)	Cheyenne, CO	40.5%
Gynecology, OB/GYN (MD, DO, NP)	Cheyenne, CO	0.0%
Gynecology, OB/GYN (PA)	Cheyenne, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Kit Carson, CO	0.0%
Gynecology, OB/GYN (PA)	Kit Carson, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Lincoln, CO	1.9%
Gynecology, OB/GYN (PA)	Lincoln, CO	0.0%
Adult Primary Care (PA)	Sedgwick, CO	34.6%
Pediatric Primary Care (PA)	Sedgwick, CO	42.4%
Family Practitioner (PA)	Sedgwick, CO	37.2%
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	94.7%
Gynecology, OB/GYN (PA)	Washington, CO	0.0%
Gynecology, OB/GYN (MD, DO, NP)	Yuma, CO	46.1%
Gynecology, OB/GYN (PA)	Yuma, CO	0.0%

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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	27.1%
SUD Treatment Facilities, ASAM 3.2 WM	Cheyenne, CO	27.1%
SUD Treatment Facilities, ASAM 3.3	Cheyenne, CO	0.0%
SUD Treatment Facilities, ASAM 3.7	Cheyenne, CO	3.0%
SUD Treatment Facilities, ASAM 3.7 WM	Cheyenne, CO	3.0%
General SUD Treatment Practitioner	Kit Carson, CO	88.2%
Pediatric SUD Treatment Practitioner	Kit Carson, CO	86.1%
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	91.1%
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	5.5%
SUD Treatment Facilities, ASAM 3.1	Lincoln, CO	95.6%
SUD Treatment Facilities, ASAM 3.2 WM	Lincoln, CO	95.6%
SUD Treatment Facilities, ASAM 3.3	Lincoln, CO	0.0%
SUD Treatment Facilities, ASAM 3.5	Lincoln, CO	96.2%
SUD Treatment Facilities, ASAM 3.7	Lincoln, CO	99.8%
SUD Treatment Facilities, ASAM 3.7 WM	Lincoln, CO	99.8%
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	25.0%
SUD Treatment Facilities, ASAM 3.1	Washington, CO	70.4%
SUD Treatment Facilities, ASAM 3.2 WM	Washington, CO	69.3%
SUD Treatment Facilities, ASAM 3.3	Washington, CO	8.2%
SUD Treatment Facilities, ASAM 3.7	Washington, CO	15.8%
SUD Treatment Facilities, ASAM 3.7 WM	Washington, CO	15.8%
General SUD Treatment Practitioner	Yuma, CO	99.2%
Pediatric SUD Treatment Practitioner	Yuma, CO	98.9%
Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities	Yuma, CO	93.8%

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	98.5%
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 contracted frontier Colorado counties where the MCE does not meet the time/distance requirements.

In an effort to guarantee access to care, NHP continues to provide the opportunity for members who reside in frontier counties to utilize telehealth for both primary medical care and behavioral health services. NCHA helps members to obtain services where they are available.

Care coordination resources, including transportation services, are offered to members by NHP so they can obtain necessary residential and/or inpatient care. Through these care coordination resources, members are able to receive higher levels of behavioral health care, which are not otherwise accessible within the time/distance requirements.

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*	
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	
CHP+ MCO, Medicaid MCO, RAE					
AVENT-HENRY, NICOLE	9000142289	Denver	BV132	Licensed Professional Counselors (LPCs)	
CONNER, ABBIE	24320056	Larimer	BV130	Licensed Clinical Social Workers (LCSWs)	
DERR-MOORE, ABIGAIL	9000159543	Weld	BV132	Licensed Professional Counselors (LPCs)	
FORD, HALEY	9000151934	Larimer	BV120	Psychologists (PhD, PsyD) - General	
FRICK, MELISSA	9000200771	Boulder	BV132	Licensed Professional Counselors (LPCs)	
GERTNER, KARIN	9000166740	Morgan	BV132	Licensed Professional Counselors (LPCs)	
LEE, STEVEN	9000193087	Adams	BV120	Psychologists (PhD, PsyD) - General	
WOODY, TYLER	9000201055	Larimer	BV132	Licensed Professional Counselors (LPCs)	

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.

Under certain circumstances, such as when a specialty service is unavailable through the current network, NHP approves SCA requests for out-of-network providers. NHP may also approve such requests when a member resides outside of the time/distance standard for service, or when a member has an established relationship with the provider, and it is deemed necessary for continuity of care.

NHP also utilizes SCAs to allow providers who are actively engaged in the contracting and credentialing process to begin serving members while they are completing the process.

Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
SCA utilization data is analyzed by NHP to identify high volume providers. When providers are found to have more than five SCAs in a quarter, NHP outreaches the provider to inquire about them joining the network. If the provider decides the join network, NHP staff educates the provider on the credentialing process and oversees the application process until it is finalized.

In this reporting period, zero providers had more than five SCAs. NHP identified two providers who received SCAs in Q4 of FY22 as well as in this reporting period. The providers are Abbie Conner and Haley Ford, who are scheduled to join the network in the Q2 of FY23.

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.