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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 on: *July 30, 2021*

Report due by *July 30, 2021* covering the MCE's network from *04/01/2021– 06/30/2021*, FY*21* Q*4*

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the June 2021 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (June 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 2020-21 Q4	July 2021	June 30, 2021
FY 2021-22 Q1	October 2021	September 30, 2021
FY 2021-22 Q2	January 2022	December 31, 2021
FY 2021-22 Q3	April 2022	March 31, 2022

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0621* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0621* 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, 2021, for the quarterly report due to the Department on July 30, 2021).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., June 30, 2021, for the quarterly report due to the Department on July 30, 2021).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	94,129	N/A	97,253	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	367	N/A	364	N/A
Primary care practitioners accepting new members	340	92.6%	341	93.7%
Primary care practitioners offering after-hours appointments	110	30.0%	112	30.8%
New primary care practitioners contracted during the quarter	0	0.0%	15	4.1%
Primary care practitioners that closed or left the MCE's network during the quarter	0	0.0%	18	4.9%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
NHP maintained a network of sufficient providers across the region in number and type of primary care practitioners to assure that all covered services are accessible to members immediately. NHP contracted with known willing and eligible PCPs within the region. In the areas that NHP met less than one hundred percent (100%) access it was due to the following: ➢ **Absence of additional Primary Care Practitioners that offer Gynecology services within the time/distance standard within rural and frontier counties to recruit for contracting.** Obstetricians and Gynecologists in NHPs' counties generally do not perform primary care services including those that are part of contracted organizations such as Banner Health and Catholic Charities (Centura). Therefore, the primary care network does not reflect these practitioners. ➢ **Weld County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30-minute radius**. NHP has ninety-nine percent (99%) coverage in the county. Since the majority of the practitioners are in the larger cities of the county such as Greeley, Health First Colorado (formerly Medicaid) members residing on the northeast border of the county bordering Wyoming (which would more accurately define as a rural community than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are no available Primary Care Practitioners to meet the requirement. As a result, one percent (1%) of the NHP members residing in Weld County do not have two (2) providers within the time and distance standard, including in neighboring county of Logan. During the reporting period, Northeast Health Partners (NHP) experience a higher than usual change in practitioners in the network, with eighteen (18) practitioners leaving the network and adding fifteen (15) new practitioners. Part of the reason for this change were staffing updates reported by two (2) large PCMPs, Salud Family Health Centers and Portercare Adventist Health System, some of which were staffing updates prior to the reporting quarter. The changes did not significantly impact access as the updates also included backfill for some of the practitioners that left the practice leading to a net decrease of three (3) practitioners. NHP conducted a review of the Enrollment Summary Report with data of non-contracted providers and the Department of Regulatory Agency (DORA) Registry to identify PCP practices in the region. No additional providers were identified who met the PCP criteria for recruitment within the region. NHP searched for Adult Primary Care and Gynecology practitioners who serve as PCPs across all types of counties within Region 2 (i.e., urban, rural and frontier); however, the search did not yield practitioners for recruitment across the rural and frontier areas of the region. Colorado Plains added one of their existing family practice locations in Morgan county into the network in May 2021.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
NHP connected with the administrators of the practices terminated last fiscal year (FY 2020) due retirement (Dr. Green) or unforeseen circumstances (Dr. Hoppe). Based on those conversations, both locations are currently closed at least through the end of the calendar year. The practice location previously owned by Dr. Hoppe will be initiating renovations to the practice location before they hire a staff physician. NHP will document the progress of these conversations in future quarterly reports. The COVID-19 pandemic has required healthcare practitioners to make changes to the way they deliver services. Our region has seen a dramatic increase in the adoption of telehealth platforms. All PCPs implemented telehealth as a result of COVID pandemic. Practice Transformation team completed PCP annual practice assessments which ask practices about telehealth usage. Based on the completed assessments, NHP identified fifty-two (52) PCMP locations report offering telehealth services in some capacity. This is a forty-nine percent (48.6%) increase from the start of the fiscal year. While some practices have begun to move away from telehealth and are seeing more members in the office, there continues to be some apprehension for patients to be seen in the office and therefore telehealth continues as an option for members. Furthermore, some practices in rural and frontier counties that have adopted telehealth during the last year report that they are not sure how long they plan to continue offering telehealth appointments. This is due to members having limited reliable internet access or who prefer face-to-face care. NHP will continue to work with PCPs to understand member and provider experience and utilization of telehealth services. This will gauge the sustainability of the technology and lasting impact on service delivery.

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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	94,129	N/A	97,253	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG" or BLANKS)	1,924	N/A	1,912	N/A
Behavioral health practitioners accepting new members	1,895	98.5%	1,912	100%
Behavioral health practitioners offering after-hours appointments	570	29.6%	546	28.5%
New behavioral health practitioners contracted during the quarter	127	6.6%	120	6.3%
Behavioral health practitioners that closed or left the MCE's network during the quarter	121	6.2%	132	6.9%

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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	6	11
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	70	100
Total SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	0	0
Total SUD treatment facilities offering ASAM Level 3.5 services	7	15
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	202	360
Total SUD treatment facilities offering ASAM Level 3.7 services	6	7
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	84	203
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	10	11
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	178	191
Total SUD treatment facilities offering ASAM Level 3.7 WM services	3	5
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	60	195

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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
NHP is primarily a rural and frontier region with one (1) urban county, three (3) rural counties, and six (6) frontier counties. The availability of behavioral health providers in frontier and rural areas with capacity to serve all members is limited, specifically providers who offer specialized training and expertise across all ages, levels of abilities, gender identities, and cultural identities. Telehealth options continue to be utilized, particularly for our members who are uncomfortable going into an office based setting. The two CMHCs, North Range Behavioral Health and Centennial Mental Health Center, as well as Lifestance (formerly Heart-Centered Counseling), offer telehealth behavioral health services. NHP maintained a network of providers across the region in number and type of behavioral health practitioners to assure that all covered services are accessible to members. NHP primarily has rural and frontier regions, with limited practitioners to meet one hundred percent (100%) time and distance standards for all provider levels. Although NHP has a strong network of practitioners, particularly within the geographic area of Region 2, NHP met less than one hundred percent (100%) access in some areas for the following reasons: ➢ **Appropriate time/distance standards for members in counties outside the region, especially frontier counties.** It is challenging to recruit and retain practitioners when they expect a small number, if any, referrals of Medicaid members assigned to NHP. Should members in these counties need additional provider options beyond the network, NHP considers Single Case Agreements (SCAs) when appropriate; however, the use of SCAs for NHP members for out of the region providers has been limited which suggests NHP is meeting the needs of its members through its contracted network. For our members outside the region, we can utilize telehealth through our CMHCs or Lifestance, if there is limited availability for the member where they are residing.

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
➢ **Weld County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30 minute radius**. NHPs' network of behavioral health providers in Weld County met ninety-nine percent (99%) of standards. Since the majority of the practitioners are in the city of Greeley and on the border of Larimer County, Medicaid members residing on the northeast border of the Weld County (which would be described better as a rural community rather than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are not a sufficient number of behavioral health providers to meet the requirement. Access in these areas have not been impacted by the addition of practitioners in the county as they are not within a thirty (30) mile radius of where these members reside. The use of telehealth continues to be an added support for access in these areas. ➢ **Lack of incentive for prescribers to contract.** The current *CO Network Adequacy_Network Crosswalk Definitions_0621* does not categorize Physician Assistants (PAs) that have a DEA waiver to prescribe medications. In the current report, there are twenty-six (26) PAs with prescriber capabilities that are uncategorized in the report. NHP continues to be concerned about the requirement to have a network of prescribers after the billing changes in the Uniform Service Coding Standards Manual for Evaluation & Management (E&M) Codes. Since prescribers who do not meet the Behavioral Health Specialty Provider Criteria are required to bill Fee-For-Service for Evaluation & Management (E&M) Codes, they no longer have an incentive to contract with NHP. ➢ **Lack of overall Psychiatric Residential Treatment Facilities and Psychiatric Hospitals and Psychiatric Units in Acute Care Facilities.** Colorado has limited facilities to meet the time/distance standards for a large part of the NHP region, especially in frontier and rural counties. Further, a significant number of contracted facilities that offer critical residential and inpatient services to the NHP membership, are not represented appropriately in the quarterly reports. The manner in which facilities are categorized into a behavioral health provider type affects the overall representation of the geographic access to care in the network. NHP's network has also been impacted by the temporary closure of Tennyson Center for Children's youth residential center, which limits overall access to these services. Its residential program continues to be closed. NHP received update from Tennyson that they are pending an official decision on reopening the residential program. Future reports will document available updates to this facility's status.

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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

- **Contracted facilities are included in the report, but are not part of the GeoAccess Compliance report.** First, NHP has contracts with hospitals and facilities that do not crosswalk to a behavioral health criteria. As part of the *CO Network Adequacy_Network Crosswalk Definitions_0621*, Psychiatric Residential Treatment Facilities (PRTFs, PROVCAT BF142) criteria changed to require that facilities have specific *interChange* provider types and specialty codes. As a result, the number of PRTFs reduced from seventy-six (76) distinct locations on the last quarterly report to only two (2) locations in this quarterly report. At least six (6) locations that mapped to PRTFs in previous quarterly report no longer map to any behavioral health criteria. Second, there are hospitals and facilities that remain uncategorized. The inability to crosswalk these facilities to a behavioral health criterion affects the accurate assessment of geographic access to care in the network in *GeoAccess Compliance*. Third, NHP refined its categorization of BG110 and BG125 to ensure that accurate Taxonomy pulled for practices, which led additional facilities, or practices to be uncategorized.

NHP continued efforts on recruiting, contracting, and credentialing providers for the SUD benefit expansion that was effective on January 1, 2021. NHP developed a statewide network of twenty four (24) contracted providers with sixty-six (66) service locations across all licensure levels, with the exception of residential substance use disorder treatment delivered to those suffering from cognitive impairments (ASAM level 3.3) due to the lack of licensed facilities in the region. Of the contracted providers, seventeen (17) providers with thirty (30) service locations completed their credentialing and included in the file *Network_FAC* and *GeoAccess Compliance*. Network staff are supporting these facilities with the completion of their Health First Colorado (formerly Medicaid) enrollment and credentialing applications to join the network. This includes Mental Health Partners, Sobriety House, Valley Hope Association, Regents of the University Colorado (ARTS), Mile High Behavioral Health Care, Peak View Behavioral Health, Denver Health Hospital Authority, and Community Reach Center.

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
An additional four (4) providers are currently negotiating contracts including: CeDAR, Northpointe Colorado, SummitStone Health Partners, West Pines Behavioral Health. NHP will continue to monitor utilization, network access, and provider Medicaid enrollment to determine the need to recruit additional SUD providers into the network. To ensure access to services and reduce administrative burden, providers who sign a contract and are undergoing the credentialing process have an abridge process for Single Case Agreements (SCAs), specifically the contracted rates are honored and the provider is not required to sign SCAs for each service that meets medical necessity. Providers negotiating their contracts may request SCAs to serve new or on-going members until contract negotiations are complete. Notwithstanding the extensive efforts to build a robust SUD network, NHP did not meet many of the time and distance standards across the urban, most rural and most frontier counties in the region for the new SUD benefit. This issue persists even if we account for the contracted facilities in contracting or credentialing process. There is an overall lack of sufficient SUD treatment facilities across all ASAM levels located within the region, which affects the ability to meet the standard. Within the region, as reported previously, there are six (6) SUD treatment providers. These includes: • North Range Behavioral Health (NRBH) that offers the continuum of SUD services located in Weld County, • Behavioral Treatment Services with one (1) contracted location in Weld County, and • Advantage Treatment Center located in Logan County. Although NHP has established contracts with SUD facilities statewide, access to beds are limited not only due to volume Medicaid need, but also due to facility contracts with other funding sources that carve out beds to those programs. Furthermore, access to SUD services within the region is impacted by ongoing statewide workforce shortages, which will require partnership with other RAEs, HCPF and OBH to address. NHP is seeking ways to increase the availability of services for members, including incentivizing providers to offer continuum of services within the region through rate negotiations. NHP will also leverage telehealth services to expand access for services where this modality may be an appropriate such as outpatient SUD services, Intensive Outpatient Program (IOP) and Medication Assisted Treatment (MAT) for the therapy component of their care.

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 its overall behavioral health network, NHP continued to pursue the following strategies to fill the gaps for behavioral health services within the region:

1- **Tracked utilization, Single Case Agreement (SCA) data, and historical claims information to identify providers who are currently providing services to Health First Colorado (Medicaid) members.** As part of the on-going monitoring of the SCA data, NHP outreached providers that have received multiple SCAs in the previous six (6) months. During the reporting quarter, about a tenth of a percent (0.1%) of NHP members received services through an SCA. NHP continued to work with contracted groups such as Lifestance (formerly Heart Centered Counseling), and KidStuff Child and Family Counseling to credential their providers. These are large contracted groups with high levels of provider staff changes, both addition and terminations. Due to their location relative to NHP membership, these large groups receive a high volume of member referrals that are served through their new providers as they are on boarded. While their new providers complete credentialing, the groups use SCAs for these providers to start working with NHP members. As a result, their providers have a large number of members under SCA in this quarterly report for whom NHP is working to transition through credentialing and into the network. Beacon, on behalf of NHP, is working with large contracted groups (100 or more providers) to delegate credentialing which will allow approved groups to conduct the credentialing under Beacon oversight. This will improve the timeframe providers join the network.

2- **Successfully credentialed behavioral health providers by monitoring operational processes.** Although NHP focused on credentialing facilities for the new SUD benefit, staff continued to support providers through education on the application process and outreach to ensure accurate documentation. Staff continues to outreach Melissa Memorial Hospital located in Phillips County to complete contract and credential for outpatient behavioral health services that will help improve access for members in the region.

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
3- **Expanded utilization of telehealth services throughout the region for specialty services and members located in our rural and frontier areas.** NHP has seen an increase in the adoption of telehealth services for behavioral health care. During the reporting period, sixty-four (64) providers reported to offer telehealth services. This is a 220% increase of behavioral health providers offering the services from the twenty (20) providers reported in the first quarter report. The majority of providers that are rendering care through telehealth are utilizing it as an additional option for members, especially larger groups or facilities. Some solo providers have shifted to rendering most services via telehealth as it affords more flexibility and lower overhead costs. NHP retained the expanded use of telehealth services, which has allowed providers to continue to build capacity for a sustainable telehealth service program. NHP continues to educate providers about the benefit as well as updating their information in the system. Furthermore, NHP continues to monitor the changing environment of telehealth to identify additional ways to support providers in expanding these services and monitoring compliance. Telehealth should be captured under our network adequacy as it is a key component of care and access that has sustainability in serving our members versus the providers who are briefly in the region and can't fiscally sustain the office based services.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Specialty care practitioners that closed or left the MCE's network during the quarter	N/A	N/A	N/A	N/A

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

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

3. Network Changes and Deficiencies

Network Changes

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

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
NHP did not experience a change in its network related to quality of care, competence, or professional conduct during this reporting period.

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

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

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Inadequate Network Policies

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

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

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

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

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

Table 8-CHP+ MCO Provider Network Changes: Discussion

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

Appointment Timeliness Standards

Supporting contract reference: The MCE shall provide coverage of emergency and non-urgent medical services. The MCE shall have written policies and procedures describing how members can receive coverage of emergency services or urgently needed services while temporarily absent from the MCE's service area.

Table 9-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Primary care providers are required to maintain established office/service hours and access to appointments for new and established Medicaid members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. Audits conducted April 2021 through June 2021 across sixteen (16) primary care provider practices assessed appointment availability for new Medicaid members, existing Medicaid members, and whether same day appointments were offered. Results from the audits were as follows: • Eighty-one percent (81%) reported availability within standards for a new Medicaid member. • Eighty-one percent (81%) reported availability within standards for an established Medicaid member. • Eighty-eight percent (88%) offered same day appointments. • Eighty-one percent (81%) met all the standards. • The availability of appointments within standards for new members changed from eighty-three percent (83%) to eighty-one percent (81%) from the audits that were conducted last quarter. Following the audit, providers received notification of results in writing which also outlined the standards. Those who did not meet the appointment timeliness standard receive outreach and support or education on the expectations. A follow up audit will be conducted in ninety (90) days. Through the outreach already conducted we learned providers are working to meet these standards and may be unable at times due to high volume, though they continue to work to meet the requirement. However, should a provider be unable to meet the standard after repeat audits and exhibit an inability to meet the standard, the provider will be subject to a corrective action plan, as recommended through our HSAG external quality review.

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Table 10-Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Behavioral health providers are expected to maintain access to appointments with standards established by the State of Colorado. The standards indicate providers should have appointment availability for members within seven (7) days of request, and urgent access is available within twenty-four (24) hours from the initial identification of need. Audits conducted April 2021 through June 2021 across eighteen (18) behavioral health providers assessed appointment availability for new Medicaid members and existing Medicaid members. Results from the audits were as follows: • Twenty-two percent (22%) reported availability within standard for a new Medicaid member. • Twenty-two percent (22%) reported availability within standards for an established Medicaid member. • Twenty-two percent (22%) met all the standards. • The availability of appointments within standards for new members remained at twenty-two (22) for quarter four. Providers continue to report reduced capacity and full caseloads due to higher demand and members continuing to engage in services. NHP is outreaching and reviewing with provider's expectations of availability of appointments and the expectations for the providers audited this quarter. We have been trying to be conscientious in this outreach as, unfortunately, some of the full caseloads are due to limited space and face-to-face capacity within offices and the comfortability and willingness for members to attend appointments with individuals based on who is or is not vaccinated. Following the audit, providers received notification of results in writing which also outlined the standards. Those who did not meet the appointment timeliness standard receive outreach and support or education on the expectations. A follow up audit will be conducted in ninety (90) days. Through the outreach already conducted we learned providers are working to meet these standards and may be unable at times due to high volume, though they continue to work to meet the requirement. However, should a provider be unable to meet the standard after multiple audits and exhibit no effort to meet the standard, the provider will be subject to a corrective action plan. NHP is offering ongoing education on access requirements and impact on our members quality of care. This will be presented in our multiple communications (newsletter, roundtables).

5. Time and Distance Standards

Health Care Network Time and Distance Standards

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

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

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

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

A practitioner/practice site/entity should only be counted one time in the MCE's data submission 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 urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
NHP has one (1) urban county, Weld, which is where to the majority of NHPs' members reside or are attributed. The requirement for an urban county is to have one hundred percent (100%) coverage of two (2) providers within thirty (30) miles or thirty (30) minutes. Behavioral Health Within Weld County, NHP did not have one hundred percent (100%) coverage of members within the time/distance requirement for any Network Categories. Weld County had a ninety-nine and a half percent (99.5%) coverage of provider to members for the following behavioral health provider types: • General Psychiatrists and Other Psychiatric Prescribers • General Behavioral Health • General SUD Treatment Practitioner • Pediatric Psychiatrists and Other Psychiatric Prescribers • Pediatric Behavioral Health • Pediatric SUD Treatment Practitioner Urban counties outside of NHP region had 100% coverage expect for the following, which had less than ninety-five percent (95%) coverage for General or Pediatric Psychiatric and other Psychiatric Prescribers, or General or Pediatric SUD Treatment Practitioners: Arapahoe, Clear Creek, El Paso and Elbert counties. Should members in these counties need additional provider options beyond the network, NHP considers Single Case Agreements (SCAs) or offers telehealth services, as appropriate. Weld County had significant access to Psychiatric Units in Acute Care Facilities with eighty-six percent (86%) coverage. Other Urban counties had limited access, including Adams, Arapahoe, Boulder, Clear Creek, Douglas, El Paso, Gilpin, Pueblo, and Teller. In most counties at least one Psychiatric Units in Acute Care Facilities is within the time and distance; however, there was no option for two (2) facilities in every Urban county as required, thus the standard is waived. *SUD Benefit* Effective January 1, 2021, NHP provides the full continuum of Substance Use Disorder (SUD) benefits for Medicaid members. NHP is recruiting all available facilities serving NHP members to participate in its network. Based on the specifications of this quarterly report, NHP had limited coverage for members in Weld County by service level as follows: • Ninety-three percent (93%) coverage for Clinically Managed Low-Intensity Residential Services (ASAM level 3.1) and Clinically Managed High-Intensity Residential Services (ASAM level 3.5)

- Ninety-one percent (91%) for Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
- Seventy-nine percent (79%) coverage for Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
- Seventy-three (73%) for Medically Monitored Intensive Inpatient Services (ASAM level 3.7). Although there is no facility with this licensed level in the region, NHP contracted with facility in border county to enable access the service.
- NHP had zero percent (0%) coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3) due to lack of providers that have the license level within the standard time and distance.

Physical Health

NHP did not have one hundred percent (100%) coverage for members within the time/distance requirement for any Network Categories. Weld had a ninety-nine percent (99%) coverage of provider to members for the following categories:

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

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

Table 12–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Logan, Morgan, and Phillips Counties are qualified as rural counties. The majority of the members had access to two (2) providers within the required distance of forty-five (45) minutes or forty-five (45) miles for PCPs, and sixty (60) minutes or sixty (60) miles for behavioral health providers. Behavioral Health All of the rural counties within the NHP region met the standards for an adequate network. General and Pediatric SUD Treatment Practitioners had nearly one hundred percent (99.9%) coverage and noted as not met access per the guidelines of the file *GeoAccess Compliance*.

- NHP had zero percent (0%) coverage for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. In most counties one of these facilities is within the time and distance; however, there was no option for two (2) facilities in NHPs' rural counties as required by the standards. If fewer than two providers exist in a particular area, standards for member choice/proximity to providers are not required.

For rural counties outside NHP, most met the standards except for Eagle, Garfield, and Routt for General and Pediatric SUD Treatment Practitioners. This quarter, Delta and Montrose met the access to care standard for the same provider types, which was an improvement from previous quarter. Should members in these counties need additional provider options beyond the network, NHP considers Single Case Agreements (SCAs) or offers telehealth services, as appropriate.

Psychiatric Units in Acute Care Facilities within standard distance and ratio are limited for all rural counties with NHP members. In most counties one of these facilities is within the time and distance; however, there was no option for two (2) facilities in rural counties as required by the standards, thus the standard did not apply.

SUD Benefit

NHP is contracting with all available facilities to participate in its network. Based on the specifications of this quarterly report, NHP had limited coverage for members in rural counties by service level. NHP saw an improvement in coverage for Clinically Managed High-Intensity Residential Services (ASAM level 3.5) across all rural counties with 100% coverage in Logan (from 0% in previous quarter), ninety-nine (99%) percent in Morgan (from 70%), and ninety-six percent (96%) in Phillips (from 0%). This was a result of Advantage Treatment Center located in Logan County joining the network.

The other SUD levels of care remained the same from previous report. In Morgan County, there was seventy percent (70%) coverage for Clinically Managed Low-Intensity Residential Services (ASAM level 3.1) and Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM). In Logan and Phillips, there was no coverage for all other services levels.

<u>Physical Health</u>

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

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

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

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

Table 13–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
The majority of the counties within Region 2 qualify as frontier including Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma. Most of the members within these counties had access to two (2) providers within the required distance for all provider types within the required distance of sixty (60) minutes or sixty (60) miles for PCPs, and ninety (90) minutes or ninety (90) miles for behavioral health. Behavioral Health The six (6) frontier counties met the time/distance and ratios requirement for all the Network Categories with the exception of Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. Similarly, the majority of the frontier counties outside Region 2 with NHP members met the access requirements for all Network Categories with the exception of Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. If a member needs services with providers outside of those available in the area, then NHP, connects the member with the closest available provider and assists the member with transportation if necessary. *SUD Benefit* Due to the contracting of Advantage Treatment Center located in Logan County for Clinically Managed High-Intensity Residential Services (ASAM level 3.5), Cheyenne, Sedgwick and Washington counties met the standards from zero coverage previous report. Further, Yuma had a ninety-five percent (95%) coverage for the same level of care. Access to other SUD levels of care remained the same with only Lincoln County with eighty-six percent (86%) coverage to Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM), sixty-seven percent (67%) coverage for Medically Monitored Intensive Inpatient Services (ASAM level 3.7), and sixty-three percent (63%) coverage for Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM). Physical Health For Physical Health, NHP had full coverage across its frontier counties for the following categories: • Adult Primary Care (MD, DO, NP)

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

For Lincoln, Washington and Yuma counties NHP met one hundred percent (100%) coverage of members within the time/distance and ratios requirements for the Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA) categories.

NHP conducted a GeoAccess analysis of coverage, which showed almost one hundred percent (99.8%) coverage in Kit Carson County for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). The improvements are related to the template changes to these Provider Types for this quarterly report as there were no changes in the network from previous quarter. Further, Washington County had a ninety percent (90%) coverage for Gynecology, OB/GYN (MD, DO, NP).

Cheyenne and Sedgwick had less than fifty percent (50%) coverage for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). The following counties had zero percent (0%) coverage for Gynecology, OB/GYN (MD, DO, NP) and Gynecology, OB/GYN (PA): Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma. Frontier counties lack practitioners with specialties such as Primary Care Providers that offer Gynecology services within the time/distance standard for contracting.

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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					
POUDRE VALLEY HEALTH CARE INC	9000169084	Larimer	BF085	ASAM Level 3.7 WM	[redacted]
SUMMITSTONE HEALTH PARTNERS	9000190608	Larimer	BF085	ASAM Level 3.5	[redacted]
COLORADO NORTHPOINTE	9000190963	Larimer	BF085	ASAM Level 3.7 WM	[redacted]
AMARAL-KUNZE, JENNIFER	63723093	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
BAGWELL, STEPHANIE	9000149084	Larimer	BV120	Psychologists (PhD, PsyD) - General	[redacted]
BARCELO, DANIELLE	9000183792	Boulder	BV080	Licensed Addiction Counselors (LACs)	[redacted]
BARRON-KRIER, NATAEAH	9000151724	Larimer	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
BRANDT, FAITH	00135038	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
COFFMAN, ERIN	9000172261	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
CONNER, ABBIE	24320056	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
DEBORD, DAVID	9000164778	Denver	BV132	Licensed Professional Counselors (LPCs)	[redacted]

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
DOTSON, DAMOND	54078369	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
FESTA, NICOLE	9000166266	Adams	BV080	Licensed Addiction Counselors (LACs)	[redacted]
FITZGERALD, MORNING	9000168307	Boulder	BV131	Licensed Marriage & Family Therapists (LMFTs)	[redacted]
FROST, HELEN	38812541	Weld	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
GERARDO, SANDRA	9000188222	Boulder	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
GERBER, VICTORIA	9000154004	Larimer	BV132	Licensed Professional Counselors (LPCs)	[redacted]
HARGETT, HARL	07015662	Jefferson	BV080	Licensed Addiction Counselors (LACs)	[redacted]
LUTZ, JAMES	42120250	Weld	BV132	Licensed Professional Counselors (LPCs)	[redacted]
MATRA, DANIELLE	9000155124	Larimer	BV130	Licensed Clinical Social Workers (LCSWs)	[redacted]
PRESTON, MARY	57230064	Larimer	BV080	Licensed Addiction Counselors (LACs)	[redacted]
RITCHIE, JEFF	04135121	Adams	BV103	Psychiatric CNS - General	[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
Out-of-network providers can request Single Care Agreements (SCAs) to render services for NHP members for the purpose of continuity of care or specialty services that are not available through the current network. The following comments apply to the nineteen (19) individual providers who received SCAs during the reporting period: ➢ One (1) completed their credentialing during the reporting period, Danielle Matra which is part of Lifestance and identified in the previous report as a high volume provider. ➢ Nine (9) were part of contracted groups and are undergoing credentialing. Lifestance (formerly Heart Centered Counseling) and KidStuff Child and Family Counseling are large groups within the network, have a strong relationship with NHP, and receive a high volume of referrals. While their providers complete credentialing, the groups use SCAs for their providers to start working with NHP members. These providers account for a large number of members under SCAs in this report. Specifically, James

Lutz with 28 members and pending completion of their credentialing. Providers in the credentialing process and who are using SCAs to render services are monitored to ensure they complete credentialing and formally join the network.

- Three (3) providers were identified for potential recruitment due to the volume of members they are seeing through SCAs. These are: Erin Coffman, Nicole Festa, and Helen Frost.
- Six (6) providers were being monitored for number of SCAs to identify if they are appropriate for recruitment. NHP monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process.

As additional SUD providers completed credentialing and joined the network, the need for SCAs has diminished. The three (3) SUD providers listed on the report are negotiating their contracts or amendments to add the level of care. They continue to request SCAs to serve on-going or new members during this process. Contracted providers pending credentialing did not require SCAs. The process improved transitions of care, increased provider satisfaction, and reduced administrative burden. NHP is monitoring SCAs for the new SUD benefit to identify potential providers for recruitment.

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.