COLORADO
Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: Colorado Access

Line of Business: *RAE 3*

Contract Number: 19-107514A6

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Report Submitted on: 4/30/2021

Report due by 04/30/2021, covering the MCE's network from 01/01/2021 – 03/31/2021 FY*21* Q*3*

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the March 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 (March 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 Q3	April 2021	March 31, 2021
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

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0321* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0321* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

2. Network Adequacy

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 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., March 31, 2021, for the quarterly report due to the Department on April 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	307,830	N/A	316,476	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	3,626	N/A	3,964	N/A
Primary care practitioners accepting new members	2,347	64.7%	2,616	65.9%
Primary care practitioners offering after-hours appointments	1,446	39.9%	1,549	39.07%
New primary care practitioners contracted during the quarter	229	6.3%	339	8.55%
Primary care practitioners that closed or left the MCE's network during the quarter	98	2.7%	271	6.83%

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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
COA is not experiencing any barriers to maintaining a sufficient network in number and type of primary care practitioners/PCMP practice sites. Both the size and scope of our primary care practitioners and associated sites ensures that all covered services are accessible to our members without unreasonable delay. *Table 1A of this report shows an increase in primary care practitioners that closed or left the MCE's network during the quarter. This is due to Colorado Access terming the contracts of those providers who did not complete revalidation by the deadline set by HCPF. Following HCPF guidelines, we termed these providers from our network for lack of revalidation during the reporting period. HCPF then notified the RAEs that because of a backlog of revalidation paperwork on the part of the state, we were to continue paying claims and not term them from our network. Our configuration team is currently in the process of reinstating these previously termed providers.* *Table 1A of this report shows an increase in primary care practitioners who were contracted during the quarter. This increase is because anytime a change is made to a contract in our system, in this case date of revalidation, it is assigned a new effective date even though the provider has been contracted with our network prior to the reporting period.* *We continue to encourage providers to render services by telehealth using the new rules put into place for COVID-19. We have seen a marked increase in telehealth utilization since the COVID19 pandemic began. When CMS announced new guidelines and rules around telemedicine due to the COVID-19 pandemic, many providers that had not previously been able or willing to provide telehealth services began to do so. Anecdotally, we are also hearing from our providers that their no-show rates have gone down since the expanded use of telehealth. Transportation can be a barrier to care for many of our Medicaid members. Telehealth helps with this barrier.* *COA provides members with information on which providers in our network have telehealth availability through our customer service department and our online provider directory. COA monitors the availability of telehealth services through phone outreaches by the provider relations team and captures this information through our contracting of new providers. Additionally, we monitor telehealth usage using a telehealth claims dashboard developed by our claims department. COA also designed a 15-question survey to better understand how our network of providers have utilized telemedicine, and how they have been impacted by these new guidelines. This survey was disseminated via the Navigator, our monthly e-newsletter, between July and October.* *Telehealth has been a critical and valuable tool for providers and members during COVID-19.*

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	307,830	N/A	316,476	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	6,060	N/A	6,010	N/A
Behavioral health practitioners accepting new members	3,703	61.1%	3,682	61.26%
Behavioral health practitioners offering after-hours appointments	1,467	24.2%	1,441	23.97%
New behavioral health practitioners contracted during the quarter	133	2.2%	142	23.62%
Behavioral health practitioners that closed or left the MCE's network during the quarter	64	1.1%	242	4.02%

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	NA	2
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	NA	12
Total SUD treatment facilities offering ASAM Level 3.3 services	NA	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	NA	0
Total SUD treatment facilities offering ASAM Level 3.5 services	NA	3
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	NA	55
Total SUD treatment facilities offering ASAM Level 3.7 services	NA	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	NA	48

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	NA	4
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	NA	119
Total SUD treatment facilities offering ASAM Level 3.7 WM services	NA	1
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	NA	12

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
Both the size and scope of this network ensures that all covered services continue to be accessible to members without unreasonable delay. COA continues to grow this network on a regular basis. *Table 2A of this report shows an increase in behavioral health practitioners that closed or left the MCE's network during the quarter. This is due to Colorado Access terming the contracts of those providers who did not complete revalidation by the deadline set by HCPF. Following HCPF guidelines, we termed these providers from our network for lack of revalidation during the reporting period. HCPF then notified the RAEs that because of a backlog of revalidation paperwork on the part of the state, we were to continue paying claims and not term them from our network. Our configuration team is currently in the process of reinstating these previously termed providers.* *Table 2A of this report shows an increase in behavioral health practitioners who were contracted during the quarter. This increase is because anytime a change is made to a contract in our system, in this case date of revalidation, it is assigned a new effective date even though the provider has been contracted with our network prior to the reporting period.* *We continue to encourage providers to render services by telehealth using the new rules put into place for COVID-19. We have seen a marked increase in telehealth utilization since the COVID19 pandemic began. When CMS announced new guidelines and rules around telemedicine due to the COVID-19 pandemic, many*

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
providers that had not previously been able or willing to provide telehealth services began to do so. Before March of 2020, when the pandemic began, telehealth represented a small fraction of behavioral health claims. Since March of 2020, roughly 1/3 of all behavioral health claims are for telehealth. Anecdotally, we are also hearing from our behavioral health providers that their no-show rates have gone down significantly since the expanded use of telehealth. Transportation can be a barrier to care for many members. Telehealth overcame this barrier. *COA provides members with information on which providers in our network have telehealth availability through our customer service department and our online provider directory. COA monitors the availability of telehealth services through phone outreaches by the provider relations team and captures this information through our contracting of new providers. Additionally, we monitor telehealth usage using a telehealth claims dashboard developed by our claims department. COA also designed a 15-question survey to better understand how our network of providers have utilized telemedicine, and how they have been impacted by these new guidelines. This survey was disseminated via the Navigator, our monthly e-newsletter, between July and October.* *Telehealth has been a critical and valuable tool for behavioral health providers and members during COVID-19.* *The biggest barrier to incorporating the ASAM levels of care for some SUD practitioners was helping them understand authorizations, medical necessity, and clinical criteria. Our utilization management team has been meeting 1:1 with each provider to help them better understand our processes.* *Colorado Access is contracting with existing and new SUD providers for the recently implemented ASAM levels. We are actively working to recruit new SUD providers at all ASAM levels for the network. We are using a rigorous process to clinically assess these providers which impacts the pace with which we can increase our network.* *COA currently captures the number of SUD beds per facility during the contracting process. As the State develops its "bed tracker" we will utilize it to see the availability of open beds statewide. This will help to identify open beds available for placement and monitor capacity to determine if our network continues to be adequate.*

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

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

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
For this quarter, there were no positive or negative changes to the network related to quality of care, competence, or professional conduct.

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
Colorado Access continuously monitors timeliness requirements for members' access to physical health services. This is done through a secret shopper program as well as through customer service, care management, and member grievance departments. If a member notifies Colorado Access of an appointment timeliness issue, the provider relations team is notified, and the concern is addressed with the provider. If the issue continues, the quality and compliance teams are notified to take further action, up to and including placing the provider on a corrective action plan (CAP). *In the reporting quarter, Colorado Access did not receive or identify any concerns about appointment timeliness.* *COA continues to encourage providers to render services by telehealth in treating members remotely using the new rules put into place for COVID-19 during the pandemic.*

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
Colorado Access continuously monitors timeliness requirements for members' access to behavioral health services. This is done through a secret shopper program as well as through the customer service, care management, and member grievance departments. If a member notifies Colorado Access of an appointment timeliness issue, the provider relations team is notified, and the concern is addressed with the provider. If the issue continues, the quality and compliance teams are notified to take further action, up to and including placing the provider on a corrective action plan (CAP). *In the reporting quarter, Colorado Access did not receive or identify any concerns about appointment timeliness.*

COA continues to encourage providers to render services by telehealth in treating members remotely using the new rules put into place for COVID-19 during the pandemic.

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; if a practitioner provides primary care for the Adult-Only or Pediatric network categories (and is not an Obstetrician/Gynecologist), the MCE should count the primary care practitioner one time under the Family Practitioner network category.

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
We recognize that we do not meet all time/distance standards at 100% but are very close to 100% in most instances. Most of the categories that were not met were SUD providers with newly implemented ASAM reporting requirements. *Colorado Access is contracting with existing and new SUD providers for the recently implemented ASAM levels. We are not yet meeting the time/distance standards for all the ASAM levels. We are actively working to recruit new SUD providers at all ASAM levels for the network. We are using a rigorous process to clinically assess these providers which impacts the pace with which we can increase our network.*

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
N/A

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
N/A

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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	
Chrysalis Behavioral Health	0000000	Baca	BF085	SUD Treatment Facility, ASAM Levels 3.1 and 3.3	
CHP+ MCO, Medicaid MCO, RAE					
Centennial Peaks Hospital	10886753	Boulder	BF140	Mental Hospital	
Cinnamon Hills Youth Crisis Center	47973765	Out of State	BV100R	Residential Treatment Center	
HMH Cedar Crest, LLC	9000169320	Out of State	BV100R	Residential Treatment Center	

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

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
When necessary, COA enters into a SCA with a non-participating provider (based on requests from our UM and/or Care Management department). Once a SCA is completed, we will reach out to the provider to ask them if they are interested in joining the network or amending their contract to add the service. If interested, we follow our usual policy and procedures with respect to the contracting process.

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.