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Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: Rocky Mountain Health Plans

Line of Business: RAE

Contract Number: 19-107507

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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, FY20-21 Q3

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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	164,527	N/A	174,358	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	638	N/A	638	N/A
Primary care practitioners accepting new members	623	97.65%	623	97.65%
Primary care practitioners offering after-hours appointments	47	7.37%	47	7.37%
New primary care practitioners contracted during the quarter	0	0.00%	6	0.94%
Primary care practitioners that closed or left the MCE's network during the quarter	7	1.10%	6	0.94%

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
Rocky Mountain Health Plans (RMHP) offers a robust and diverse network of primary care providers, particularly considering that all counties in the service area are designated as rural or frontier. Due to the composition of the RAE service area, there are fewer specialized providers practicing in the area as compared to urban areas. RMHP tracks provider shortages in the region through federally designated Health Professional Shortage Area (HPSA) maps. Ten counties in the RAE service area – Delta, Gunnison, Jackson, Lake, La Plata, Mesa, Montezuma, Montrose, Ouray and Rio Blanco – are designated as low-income population HPSAs for primary care and eight counties – Archuleta, Dolores, Grand, Moffat, Montrose, Routt, San Juan and San Miguel – are designated as geographic HPSAs for primary care. Much like the last reporting period, with the extension of the Public Health Emergency (PHE), a large number of primary care providers continued to use telemedicine. RMHP sends quarterly Provider Attributes surveys to primary care providers, specialists, and behavioral health providers to collect important demographic information that is displayed in our provider directories. For the reporting period, RMHP received a total of 327 survey responses across all provider types. 281 of the survey responses received (86%) indicated that the provider offers telehealth appointments. Note: at this time the data is not broken out by provider type. We intend to include a provider type breakout in future submissions of this report. RAE Members have benefited from the availability of an on-demand telehealth platform which allows them to chat with a medical provider at their convenience, at no cost; which is particularly important for the rural and frontier counties. Telehealth has also provided a level of safety for some of our Members as they did not have to travel in adverse weather conditions for medical services during the winter months. As previously reported, RMHP is in the early discussion stages with community stakeholders regarding the development of an e-Consult platform that would create a resource between specialists and primary care providers. RMHP has partnered with Mesa County Physicians IPA (MCPIPA) as well as Quality Health Network (QHN), to continue developing a system where primary care physicians can consult with specialists for guidance on providing care to their patients. The system will be piloted in Mesa County before being released to other regions. In combination with existing telehealth options, as well as with the upcoming e-Consult system, opportunities to reduce barriers in the rural and frontier areas continue to expand.

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	164,527	N/A	174,358	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,602	N/A	3,626	N/A
Behavioral health practitioners accepting new members	3,591	99.69%	3,618	99.78%
Behavioral health practitioners offering after-hours appointments	220	6.11%	225	6.21%
New behavioral health practitioners contracted during the quarter	15	0.42%	35	0.97%
Behavioral health practitioners that closed or left the MCE's network during the quarter	29	0.81%	11	0.30%

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	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	N/A	86
Total SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total SUD treatment facilities offering ASAM Level 3.5 services	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	N/A	51
Total SUD treatment facilities offering ASAM Level 3.7 services	N/A	2
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	N/A	33

Requirement	Previous Quarter	Current Quarter
	Number	Number
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	N/A	133
Total SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	6
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	175

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
RMHP remains successful at providing a robust RAE Behavioral Health network in the region. Challenges exist in that the entirety of Region 1 is either rural or frontier in nature and has a shortage of more specialized providers practicing in the area. Notably, there are only two counties – Mesa and Larimer – with acute care psychiatric facilities in the region. Another constant challenge, as previously documented, is that the region offers very few pediatric specialists; more specifically child psychiatrists. RMHP tracks provider shortages in the region through federally designated Health Professional Shortage Area (HPSA) maps. All 22 counties in the RAE service area are designated as geographic HPSAs for mental health. Larimer County Members, if and when services are not available, have access to providers in the Denver Metro area, while Members in the western portion of Region 1 tend to commute to Mesa County for services. RMHP contracts with many providers outside of the Region 1 geographical area and implements single case agreements when appropriate and needed.

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
Much like the last reporting period, with the extension of the Public Health Emergency (PHE), a large number of behavioral health providers continued to use telemedicine. RMHP sends quarterly Provider Attributes surveys to primary care providers, specialists, and behavioral health providers to collect important demographic information that is used in our provider directories. For the reporting period, RMHP received a total of 327 survey responses across all provider types. 281 of the survey responses received (86%) indicated that the provider offers telehealth appointments. Note: at this time the data is not broken out by provider type. We intend to include a provider type breakout in future submissions of this report. RMHP received 98,014 behavioral health claims for RAE Members during the reporting period and of those, 47,794 or 48.76% were for behavioral health *telehealth* services. RMHP continues efforts to expand the network and to add to existing contracts to meet the needs of the expanded behavioral health benefit that includes residential and inpatient services for substance use disorders (SUD). RMHP will continue to enroll newly identified SUD providers as they meet credentialing and contracting requirements. Our Provider Contracting and Utilization Management teams work together on single case agreements for admissions when needed. Additionally, we are in the process of adding an ASAM Level 3.3 provider to our network and they will be included in the next quarterly submission. One of the main barriers to incorporating the ASAM levels of care into the network has been that many entities were – or still are – in the process of licensing with the Office of Behavioral Health (OBH) and/or enrolling with Health First Colorado. RMHP is unable to contract with facilities that are not licensed through OBH or enrolled with Health First Colorado.

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
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
There is no significant variation in our network since the last reporting period with the exception of the SUD network.

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
RMHP recently switched from conducting Member Appointment Availability Surveys annually to quarterly. The first quarterly surveys were sent at the end of February 2021 to a sample size of RAE Members who received services from primary care physicians from October 1, 2020 through December 31, 2020. To obtain a valid statistical sample of surveys to send, claims data extraction reports were requested to determine the total number of Members who saw primary care physicians, then duplicate names and deceased Members were removed before completing final counts. Sample sizes were calculated with a margin of error and confidence level percentage. Surveys were then sent to Members, along with a return envelope in the hopes of simplifying response participation. Responses are still being received by RMHP. Once RMHP is confident all responses have been received, survey response data will be analyzed by survey type, as well as by line of business, along with access complaints received, sample surveys and actions RMHP will take if any deficiencies are identified.

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
RMHP recently switched from conducting Member Appointment Availability Surveys annually to quarterly. The first quarterly surveys were sent at the end of February 2021 to a sample size of RAE Members who received services from prescribing and non-prescribing behavioral health providers from October 1, 2020 through December 31, 2020. Note: although RMHP does not cover prescriptions for RAE Members, the behavioral health surveys are broken out this way per NCQA guidelines and we find the feedback from Members who see prescribing providers to be valuable regardless of payer source. To obtain a valid statistical sample of surveys to send, claims data extraction reports were requested to determine the total number of Members who saw behavioral health providers. Duplicate names and deceased Members were removed before completing final counts. Sample sizes were calculated with a margin of error and confidence level percentage. Surveys were then sent to Members, along with a return envelope in the hopes of simplifying response participation. Responses are still being received by RMHP. Once RMHP is confident that all responses have

been received, survey response data will be analyzed by survey type, as well as by line of business, along with access complaints received, sample surveys and actions RMHP will take if any deficiencies are identified.

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
There are no urban counties in the RAE service area.

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
Within the Region 1 behavioral health provider network, the following rural counties – Alamosa, Archuleta, Chaffee, Conejos, La Plata, Logan, Montezuma, Morgan, Park, Phillips, Rio Grande, Otero, Phillips and Prowers – have some deficiencies in general and/or pediatric behavioral health providers. Physical health providers commonly provide medication management for behavioral health. Due to the service area formation, there are numerous behavioral health providers in the area that serve both adult and pediatric populations, however; they do not classify themselves as a "pediatric provider" only, and therefore are not categorized as such. RMHP's Care Coordination team assists Members who need a particular service that isn't available in their community. Care Coordinators work with participating providers in nearby communities to facilitate appointment scheduling and transportation. RAE Members continue to benefit from utilizing telehealth platforms which allow them to receive the health services they need without having to travel.

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
Within the Region 1 behavioral health provider network, the following frontier counties – Dolores, Gunnison, Hinsdale, Jackson, Mineral, Moffat, Rio Blanco, San Juan, and San Miguel – have some deficiencies including proximity to a psychiatric hospital or residential facility as well as to pediatric behavioral health providers.

RMHP's Care Coordination team assists Members who need a particular service that isn't available in their community. Care Coordinators work with participating providers in nearby communities to facilitate appointment scheduling and transportation. RAE Members continue to benefit from utilizing telehealth platforms which allow them to receive the health services they need without having to travel.

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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					
Sobriety House	9000127716	Denver	BF085	SUD Treatment Facility	
Northpoint Colorado LLC	9000190963	Larimer	BF085	SUD Treatment Facility	

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
RMHP uses SCAs for specific Member needs such as specialized care (in or outside the region) or special circumstances (e.g., hardships around transportation or travel or an existing relationship with a provider who is not in the network). In the event that RMHP becomes aware of a provider through the SCA process that is enrolled in Health First Colorado and is willing to join the network, RMHP offers to contract with the provider. RMHP also offers providers assistance with the Health First Colorado enrollment process. Note: ASAM levels were not included for the SUD treatment facilities listed in Table A-1 due to the pending status of the facilities' Health First Colorado enrollment. This is also the reason that SCAs were implemented, as RMHP cannot contract with a provider until their Health First Colorado enrollment is complete.

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.