COLORADO
Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: ***Rocky Mountain Health Plans-RAE***

Line of Business: ***RAE***

Contract Number: ***19-107507A9-B7***

Contact Name: ***Jeremiah Fluke***

Report Submitted by: ***Kendra Peters***

Report Submitted on: ***10/31/2022***

Report due by ***10/31/2022***, covering the MCE's network from ***07/01/2022 – 09/30/2022***, **FY*23 Q1***

—Final Copy: September 2022 Release—

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Health Care Policy & Financing

Contents

1. Instructions for Using the Network Adequacy Quarterly Report Template 1-1
Definitions 1-1
Report Instructions 1-2
Questions 1-2

2. Network Adequacy 2-1
Establishing and Maintaining the MCE Network 2-1

3. Network Changes and Deficiencies 3-1
Network Changes 3-1
Inadequate Network Policies 3-2

4. Appointment Timeliness Standards 4-1
Appointment Timeliness Standards 4-1

5. Time and Distance Standards 5-2
Health Care Network Time and Distance Standards 5-2

A Appendix A. Single Case Agreements (SCAs) A-1

B Appendix B. Optional MCE Content B-2
Instructions for Appendices B-2
Optional MCE Content B-2

C Appendix C. Optional MCE Content C-1

1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the September 2022 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, or RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (September 2022 version).

The practitioners, practice sites, and entities included in the quarterly NA report will include ordering, referring, and servicing contractors that provide care through a Colorado Medicaid or CHP+ MCE. To ensure consistent data collection across MCEs, each MCE must use this HCPF-approved report template (MS Word and MS Excel templates) to present the MCE's quarterly NA report and data for the corresponding practitioners, practice sites, and entities. Report due dates will align with those outlined in the MCE's contract, unless otherwise stated.

Fiscal Year Quarter Reported	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2022-23 Q1	October 2022	September 30, 2022
FY 2022-23 Q2	January 2023	December 31, 2022
FY 2022-23 Q3	April 2023	March 31, 2023
FY 2022-23 Q4	July 2023	June 30, 2023

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0922* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0922* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource
  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.

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

Report Instructions

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

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

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

Questions

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

Establishing and Maintaining the MCE Network

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

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2022, for the quarterly report due to the Department on October 31, 2022).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., September 30, 2022, for the quarterly report due to the Department on October 31, 2022).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

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

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

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	197,519	N/A	193,018	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	971	N/A	972	N/A
Primary care practitioners accepting new members	937	96.50%	938	96.50%
Primary care practitioners offering after-hours appointments	60	6.18%	57	5.86%
New primary care practitioners contracted during the quarter	15	1.54%	14	1.44%
Primary care practitioners that closed or left the MCE's network during the quarter	3	0.31%	13	1.34%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. Describe how the MCE ensures members' access to family planning services offered by any appropriate physical health practitioner, practice group, or entity. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.
CHP+ MCO, Medicaid MCO, RAE
There have not been material changes in the size of our networks since the last reporting period. Rocky Mountain Health Plans (RMHP) provides an inclusive network of Primary Care Medical Providers (PCMPs) in the Regional Accountable Entity (RAE) service area, with 201 PCMP service locations and a tiered structure for Per Member Per Month (PMPM) administrative payments and Key Performance Indicator (KPI) incentive payments. The structure ranges from Tier 1 practices that are open to all Medicaid Members and have accomplished the highest demonstrated practice transformation competencies through Tier 4 practices that meet minimum participation requirements. 40.4% of all practice sites are currently participating at Tier 1 or Tier 2. RMHP met the time and distance requirements, ensuring accessibility and Member choice to primary care and family planning services, for the majority of network categories in the 14 rural and 8 frontier counties of RAE Region 1. The *Adult Primary Care Practitioner (PA)* time/distance standard was not met in Moffat County. The remaining identified time and distance deficiencies are in the *Gynecology/OB/GYN (MD, DO, NP, CNS)* and *Gynecology/OB/GYN (PA)* network categories. The GeoAccess report template does not account for Certified Nurse Midwives in this metric, however they are an important part of how this care is delivered. RMHP continues to offer RAE Members access to *CirrusMD for RMHP*, which is a free, text-based platform which allows Members to visit with a provider if they have a medical question or are not sure if they should go to the urgent care or emergency room, or if they need to talk to someone quickly and cannot wait for an appointment. As previously noted, *CirrusMD for RMHP* utilization data is not separated between Prime and RAE; however, it is separated across Medicaid, Medicare, and CHP+. In July, there were a total of 84 encounters across all eligible lines of business (Medicare, Medicaid, and CHP+), 90.48% of which were with Medicaid Members. In August, there were a total of 87 encounters, 86.21% of which were with Medicaid members. In September, there were a total of 60 encounters, 96.67% of which were with Medicaid Members. The total number of encounters decreased by 23.26% from last quarter. RMHP and CirrusMD have a workflow by which CirrusMD providers make referrals to RMHP Care Coordinators when Members have follow-up needs, such as finding a primary care provider. Referrals from CirrusMD providers to RMHP care coordinators decreased by 25% from last quarter, corresponding with the decrease in utilization/encounters.

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	197,519	N/A	193,018	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	3,360	N/A	3,361	N/A
Behavioral health practitioners accepting new members	3,341	99.76%	3,345	99.52%
Behavioral health practitioners offering after-hours appointments	238	7.11%	235	6.99%
New behavioral health practitioners contracted during the quarter	26	0.78%	18	0.54%
Behavioral health practitioners that closed or left the MCE's network during the quarter	15	0.45%	17	0.51%

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	15	15
Total SUD treatment facilities offering ASAM Level 3.3 services	1	1
Total SUD treatment facilities offering ASAM Level 3.5 services	15	15
Total SUD treatment facilities offering ASAM Level 3.7 services	8	8
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	17	17
Total SUD treatment facilities offering ASAM Level 3.7 WM services	12	13

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
Rocky Mountain Health Plans provides a robust network of behavioral health providers to our RAE Membership. RMHP is always open to expanding the network by enrolling new Behavioral Health and SUD providers as they meet our credentialing and contract requirements. RMHP is in the process of integrating our credentialing process with our parent organization, UnitedHealthcare. We are on schedule to be fully integrated beginning January 1, 2023. This will greatly enhance our ability to expedite the credentialing process. RMHP continues to expand our behavioral health and SUD network. During the reporting period, we contracted with Johnstown Heights Behavioral Health, which offers ASAM Level 3.7 WM services. In addition to contracting efforts, RMHP's Care Coordination and Utilization Management teams maintain relationships with SUD providers within the region and other portions of the State to find patients the appropriate ASAM level of care when needed. RMHP met the time and distance requirements, ensuring accessibility and Member choice to behavioral health services, for the majority of network categories in the 14 *rural* and 8 *frontier* counties of RAE Region 1. The *Psychiatric Hospitals, or Psychiatric Units in Acute Care Hospitals* time/distance standard was only met in Larimer and Mesa Counties, as these are the only Region 1 counties with psychiatric hospitals. Most identified deficiencies are within the *SUD treatment facility* network category across all ASAM levels. RMHP contracts with all SUD facilities within RAE Region 1. RAE Region 1 is comprised solely of *rural* and *frontier* counties, all of which fall within the geographic designation for Mental Health Professional Shortage Areas (HPSAs). Overall behavioral health claims for RAE Members decreased by 16.7% from last quarter, however telehealth claims increased by 50.2% as compared to last quarter. Telehealth services represented 42.28% of claims this quarter, as compared to 23.45% of overall behavioral health claims last quarter.

COLORADO
Department of Health Care Policy & Financing

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 or deficiencies in MCE Networks related to access to care.

Table 4–Network Changes: Discussion

If the MCE experienced an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network, describe the change and state whether the MCE notified the Department, in writing, within five (5) business days of the change. Note: If the MCE experienced an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the provider network during the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE during the current measurement period to address the deficiency.
CHP+ MCO, Medicaid MCO, RAE
Valley View Hospital in Glenwood Springs closed their Youth Recovery Center during the reporting period. While not a highly utilized service, this has resulted in care coordinators needing to work with providers outside of the region to meet this specialized need.

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

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

Inadequate Network Policies

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

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

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

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

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

Table 8–CHP+ MCO Provider Network Changes: Discussion

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

Appointment Timeliness Standards

Supporting contract reference: The MCE shall ensure its network is sufficient so that services are provided to members on a timely basis.

Table 9–Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
RMHP's Provider Network Management (PNM) staff distributes Appointment Wait Time Surveys to an adequate sample size of Members throughout all lines of business who received services from primary care practitioners, high-volume specialist, high-impact specialist, and behavioral healthcare practitioners on a quarterly basis. The purpose of these surveys is to determine if appointment availability is sufficient for Members based on performance standards defined by the Division of Insurance (DOI), Colorado Department of Health Care Policy and Financing (HCPF), as well as the National Committee for Quality Assurance (NCQA). To get a statistically valid sample size, claim data reports are requested to first determine the total number of Members who saw the specific practitioner types. All duplicate and deceased Members, as well as any Members who previously received a survey the quarter prior, are excluded from the total numbers. Once total numbers are generated, sample sizes are determined using a survey sample size calculator with a margin of error of 5% and a confidence level of 95%. In an effort to increase the number of respondents, RMHP began increasing the sample size by 50% in May of 2022. For example, in FYQ4 the PCP appointment sample size was 501 with an overall return rate of ███ responses. For specialty services, the sample size was 407 with a return rate of ██ responses. Behavioral Health sample size was 269 with a response rate of ██. As previously noted, RMHP changed the distribution frequency of the survey process from annual to quarterly and started using Qualtrics as an electronic method of distributing the surveys in CY2021 (FY20 – 21). The CY22 Q1Q2 (FYQ3Q4) surveys were sent out in June and August of 2022. Survey results were received in late August of 2022 and, as in previous quarters, the responses were very low. Leadership from the RMHP Provider Network Management department as well as other participants that engage in the Survey Sub-committee have been working to identify and address barriers to improve response rate. The possibility of incentivizing Members to complete the surveys is one potential method being considered. This could include opportunities for Members who complete the surveys in full to be entered into a drawing each quarter for a chance to win a cash valued gift card, for example. Additionally, RMHP is working to increase the number of Member emails available for distribution of these surveys. We believe that a Member incentive program for the completion of surveys and improvement in the quality of Member contact information could improve the response rate and increase survey volume. We have yet to finalize the incentive modality but will implement a new process for surveys issued for CY 2023 Q1 (FYQ3). RMHP will develop a plan to improve responsiveness by the next reporting period.

RMHP is also looking for opportunities to track potential issues through other avenues. RMHP leadership monitors member grievance reports daily for any barrier to care or potential non-compliance of providers. No significant issues or trends have been observed outside of difficulties associated with the rural and frontier nature of portions of RAE Region 1. Currently, we are discussing a way to "shop" providers in a manner that is minimally disruptive to provider office operations.

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
As noted above in Table 9, the Member survey process we currently utilize applies to all priority provider groups and lines of business, including behavioral health services.

5. Time and Distance Standards

Health Care Network Time and Distance Standards

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

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

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).

- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

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

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

Table 11–Urban Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific contracted urban counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
RMHP's service area counties are all designated as *rural* or *frontier*, however; RMHP has Region 1 attributed Members residing in some urban counties such as in the Denver Metro area. RMHP contracts with numerous providers in those areas although they may not cover all services. RMHP enters into single case agreements with providers in these areas when needed.

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

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific contracted rural counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Time/distance deficiencies in one or more network categories exist in several counties, which is a function of provider availability in rural and frontier areas. For example, OB/GYN are not proximately accessible in some counties, while SUD treatment facilities and psychiatric hospitals are limited, despite the inclusion of all active practices and facilities in our networks for the entire geography of Region 1. RMHP's Care Coordination team assists Members who need a particular service that may not be available in their community. Care Coordinators work with participating providers in nearby communities to facilitate appointment scheduling, as well as transportation. RMHP offers RAE Members access to *CirrusMD for RMHP,* which is a free, text-based platform that allows Members to visit with a provider if they have a medical question or are not sure if they should go to the urgent care or emergency room or need to talk to someone quickly and cannot wait for an appointment.

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

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific contracted frontier counties in which the MCE does not meet the time/distance requirements. Each RAE should limit this discussion to counties within its RAE region for both physical and behavioral health time/distance requirements.** **Describe the MCE's approach to ensuring access to care for members residing in its contracted frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Time/distance deficiencies in one or more network categories exist in numerous counties. In many cases this is a function of care being consolidated in one location within a county and in others cases the pattern of care is to travel to neighboring communities for care. RMHP's Care Coordination team assists Members who need a particular service that may not be available in their community. Care Coordinators work with participating providers in nearby communities to facilitate appointment scheduling, as well as transportation. RMHP offers RAE Members access to *CirrusMD for RMHP,* which is a free, text-based platform that allows Members to visit with a provider if they have a medical question or are not sure if they should go to the urgent care or emergency room or need to talk to someone quickly and cannot wait for an appointment.

COLORADO
Department of Health Care Policy & Financing

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					
None					

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 circumstance (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 registered with interChange and is willing to join the network, RMHP offers to contract with the provider and provide assistance with the interChange 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.