

Suggested Questions from Stakeholders, Partners, and Advocates:

For the RAE panel (Colorado Access + Rocky Mountain)

Member assignment and continuity

1. What triggers a member's RAE assignment to change, and does anything other than a move do it? Does seeing a provider located in another region change a member's assignment?
2. When an assignment changes, when is the member notified? Is it before the effective date or after? When is the treating provider notified?
3. How many members changed RAEs mid-treatment episode in the last twelve months, and how many of those changes were member-initiated?
4. When a member with an open treatment episode moves into your region and their treating provider isn't in your network, what happens to that episode of care?
5. What are your criteria for approving a single case agreement for a member already in treatment? How many were requested and how many approved in the last twelve months?

Network adequacy

6. What does "at network capacity" mean operationally? Is it measured by service line, by geography, by appointment availability, or by contracted provider count?
7. Can a network be closed to new providers in a service line while access standards for that same service line are unmet? Who checks?
8. If a contracted provider relocates an office within your region, is that treated as a new credentialing request? Why?
9. Does your directory distinguish providers who are contracted from providers currently accepting new members? How is that verified, and how often?

Payment stability

10. When a rate changes, how is the change communicated to providers – in aggregate, or code by code? If an aggregate figure is published, how should a provider understand what happens to a specific service line?
11. How many payment recoupments did you initiate in the last twelve months, what were the top three causes, and what share were later reversed as errors on your side?
12. What is your look-back period on recoupment, and what is the median time to resolve a provider dispute?
13. On third-party liability specifically: what real-time tool does a provider have to check for other coverage before rendering a service, and why is the discovery mechanism retrospective rather than prospective?

Care coordination

14. What care coordination is delegated to PCMPs and what do you perform directly? How do you verify the delegated work is happening?

15. Do you have visibility into coordination and navigation being performed by entities you don't pay – local public health agencies, county staff, safety-net providers? If a capitated PCMP refers that work out, does any payment follow it?
16. Closing question: what would the person you serve say about how this system works for them?

For the national context presenter (Milbank)

17. Which states have continuity-of-care protections that survive a mid-year plan or region reassignment, and what do they require?
18. Which network adequacy standards bind in practice – time-and-distance, appointment-availability testing, secret-shopper – and which ones just get reported?
19. What remedies do states use when a managed care entity is out of compliance, and which ones have changed behavior?
20. Do any states differentiate rates by practice capability or member acuity rather than paying a uniform fee schedule regardless of setting? What did they learn?
21. Where do managed care savings come from in the evidence, and what claims haven't held up?
22. How do states with multiple regional entities handle duplicated administrative functions across those entities?