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Department of Health Care Policy & Financing

FY 2019–2020
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 due by 1/30/2020, covering the MCE's network from 10/1/2019 – 12/31/2019, SFY Q2

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1. Instructions for Using the Network Adequacy Quarterly Report Template

This document contains 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 fiscal year (FY) 2019-20 Network Adequacy Crosswalk Definitions (December 4, 2019 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	Months Included in the Report
FY 2019-20 Q2	October, November, December
FY 2019-20 Q3	January, February, March
FY 2019-20 Q4	April, May, June
FY 2020-21 Q1	July, August, September

Definitions

- "MS Excel template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Excel Template_F1_1219* spreadsheet.
- "MS Word template" refers to the *CO2019-20_Network Adequacy_Quarterly Report Word Template_F1_1219* document.
- 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" 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.
- An "entity" refers to a hospital, pharmacy, imaging services, and laboratories.

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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.

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 spreadsheet contains 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 (*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	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 providers 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., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
- To count practitioners/practices/entities ("providers"):
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
  - 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 practices or entities 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: Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	138,023	N/A	131,282	N/A
Total practitioners	605	N/A	608	N/A
Practitioners accepting new members	586	97%	589	97%
Practitioners (or practices) offering after-hours appointments	10	0.02%	17	0.03%
New practitioners contracted during the quarter	23	0.04%	19	0.03%
Practitioners that closed or left the MCE's network during the quarter	39	0.1%	28	0.1%
Total behavioral health practitioners	2,352	N/A	2,366	N/A
Behavioral health practitioners accepting new members	2,345	99%	2,357	99%

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Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Behavioral health practitioners (or practices) offering after-hours appointments	180	0.1%	186	0.1%
RAE				
Total PCMP practice sites	204	N/A	204	N/A
PCMP practice sites accepting new members	193	95%	193	95%
PCMP practice sites offering after-hours appointments	14	7%	14	7%

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

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of providers to assure that all covered services will be accessible to members without unreasonable delay.
CHP+ MCO, Medicaid MCO, RAE
RMHP offers a robust, diverse network of physical and behavioral health providers for our RAE Members, especially considering the rural/frontier nature of the RAE region. We are contracted with over 200 unique PCMP sites that serve as a primary care medical home for RAE Members, and have implemented a robust value-based payment model for PCMPs that outlines a clear delineation of provider responsibilities as well as resources available for different levels of accountability. This payment model is outlined in detail in our RAE Resource Guide which is updated regularly and available on the RMHP website. We have an extensive network of independent behavioral health providers, in addition to the four Community Mental Health Centers in the region. Due to the composition of the region, with all 22 counties designated as rural or frontier, there are fewer specialized providers practicing in the area as compared to urban areas. Notably, there are only two acute care psychiatric facilities in the region and generally, there are few child psychiatrists in the region. Another challenge is that while many specialists in the area serve both adult and pediatric populations, they often do not consider themselves to be a "pediatric specialist", and are thus not categorized as such. Mesa County tends to be the catchment area for the Western portion of the region, and Larimer County Members have relatively easy access to providers in the Denver Metro area in the event that services are not available in Larimer County. RMHP contracts with many providers outside of RAE Region 1, and enters into single case agreements with providers outside of our network when warranted. Provider shortages in the region are documented through federally designated Health Professional Shortage Are (HPSA) maps. 10 counties in the RAE region – Delta, Gunnison, Jackson, La Plata, Larimer, Mesa, Montezuma, Montrose, Ouray, and Rio Blanco – are designated as low-income population HPSAs for primary care and 9 counties – Archuleta, Dolores, Grand, Larimer, Moffat, Montrose, Routt, San Juan and San Miguel – are designated as geographic HPSAs for primary care. In addition, all 22 counties in the RAE region are designated as geographic HPSAs for mental health.

Categories Included in Network

Supporting contract reference: The MCE shall ensure that its contracted networks are capable of serving all members, including contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

- To count practitioners/practices/entities ("providers") for Table 2A:
  - Include each unique provider contracted with the MCE and line of business as of the last day of the measurement period (e.g., December 31, 2019, for the quarterly report due to the Department on January 30, 2020).
  - 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 practices or entities 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.
  - Do not include Federally Qualified Health Centers (FQHCs) when counting Essential Community Providers (ECPs).
  - Use the following hierarchy for determining unique providers, with the narrowest definition first (e.g., if a School Based Health Center [SBHC] is also an FQHC or Rural Health Clinic [RHC], report it under the SBHC row in Table 2A):
    - Indian Health Care Providers (i.e., a healthcare program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization)
    - SBHC
    - FQHC
    - RHC
    - Substance Use Disorder Clinics (*interChange* Provider Type 64)
    - Hospitals
    - Community Mental Health Centers (CMHC)
    - Essential Community Providers
      - ECPs include all other private providers that cannot be qualified as a FQHC or SBHC; i.e., Providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of the patient population. To be designated as an "ECP", the provider must demonstrate that it meets the requirements defined in Section 25.5-5-404(2) C.R.S.
    - Other-Primary Care Providers
    - Other-Behavioral Health Providers
  - The providers capable of billing both Medicare and Medicaid category may duplicate providers counted in the categories described above.

Table 2A-Categories in Network: Data

Requirement	Total In-Network
Sample	*0*
CHP+ MCO, Medicaid MCO, RAE	
Indian Health Care Providers	2
School Based Health Centers (SBHC)	14
Federally Qualified Health Centers (FQHC)	15
Rural Health Clinics (RHC; not applicable to Medicaid MCO)	6
Substance Use Disorder Clinics	62
Hospitals	4
Community Mental Health Centers (CMHC)	13
Essential Community Providers (ECP; not applicable to Medicaid MCO)	6
Other-Primary Care Providers	587
Other-Behavioral Health Providers	2,301
CHP+ MCO, Medicaid MCO	
Pharmacies	N/A
CHP+ MCO, Medicaid MCO, RAE	
Providers capable of billing both Medicare and Medicaid	3,146

Table 2B-Categories in Network: Discussion

Describe barriers affecting the MCE's ability to serve all members, including, but not limited to, contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.
CHP+ MCO, Medicaid MCO, RAE
There are minimal barriers to RMHP's ability to serve all Members. The most noteworthy barrier is the limited number of certain provider types in the service area. In cases where driving distance and ratio standards are not met, there are a limited number of providers with the more specialized training necessary for a given Member's needs. Given the rural and frontier nature of the RAE service area, most providers do not have a specific focus in regard to populations served, but rather serve all populations. RMHP surveys providers on a regular basis to collect specific demographic information about their practice such as specialized training and abilities to serve different populations, and lists this information in our provider directory where available.

Access for Special Populations

Supporting contract reference: The MCE shall have the ability to meet the needs of members in special populations. When establishing and maintaining its networks, MCEs shall take the following into consideration: members access to transportation and whether the location provides physical access and accessible equipment for members with disabilities. The MCE shall have the ability to meet the needs of members with limited English proficiency.

Table 3-Access for Special Populations: Discussion

Describe the methods used by the MCE to count providers as having physical access and/or accessible equipment, focusing on updates that have occurred during the current reporting period. This discussion should reflect information about ongoing monitoring activities, rather than policies and procedures.
CHP+ MCO, Medicaid MCO, RAE
RMHP regularly surveys providers to capture this information, along with other important practice details. The survey specifically asks whether the practice has accessible buildings, exam rooms, and medical equipment. The survey also asks whether providers have completed Disability Competent Care and/or Cultural Competency training. RMHP recently implemented a new database system to assist in our tracking and reporting of these provider-reported capabilities and lists this information in our provider directories where available.

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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 have been no significant changes of this nature since our last reporting.

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 provider'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 provider's failure to receive credentialing or re-credentialing from the MCE?
CHP+ MCO

interChange Policies

Supporting contract reference: The MCE shall employ measures to help ensure that the MCE and all of their contracted, ordering or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating provider.

- Retroactively enrolled or providers with a pending contract status are not available to offer services and should be excluded from this discussion.

Table 6-CHP+ MCO *interChange* Policies: Discussion

1. Does the MCE employ measures to help ensure all contracted, ordering, or referring physicians or other professionals providing services under the State plan are enrolled in the *interChange* as a participating provider? **2. Did the MCE have a health care provider that was no longer identified as a participating provider in the *interChange*?** **If the MCE answered "yes" to Requirement 2 above, did the MCE terminate its health care provider contracts for provision of services to members with contracted providers?**
CHP+ MCO

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 7-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

Table 8-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

Table 9-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

4. Appointment Timeliness Standards

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 10-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 contracts require all providers to meet timeliness standards for physical health services. RMHP monitors this by regularly conducting surveys of RAE Members who have received primary care or specialty care regarding their experience with timeliness of appointments. In addition, RMHP tracks any Member complaints received regarding timeliness of physical health services. When issues have arisen they are not unique to the RAE Member population, but are rather a function of the general shortage of certain types of providers in the region. For example, there are very few dermatology practices in the region, and in the areas that do have a dermatology practice, they may be the sole provider. In these instances, patients with all types of health insurance coverage may have longer wait times for non-urgent/emergent appointments.

Table 11-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's provider contracts require all providers to meet timeliness standards for behavioral health services. RMHP monitors this by regularly conducting surveys of RAE Members who have received behavioral health services. In addition, RMHP tracks any RAE Member complaints received regarding timeliness of behavioral health services. When issues have arisen they are not unique to the RAE Member population, but are rather a function of the general shortage of certain types of providers in the region. For example, there are very few psychiatrists in some portions of the region, and in the areas that do have a psychiatrist they may be the sole provider. In these instances, patients with all types of health insurance coverage may have longer wait times for non-urgent/emergent appointments.

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 providers in the MCE's Region.

Enter detailed time and distance results in the MS Excel template. Use Tables 13, 14, and 15 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.

- 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, and NPs) and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the tables below. ***A provider should only be counted one time in the tables below; if a practitioner provides Primary Care and OB/GYN services, they should be counted once under Family Practitioner.***

Table 12-Software Package Used for Time and Distance Calculations

List and describe the software package(s) and/or processes that your MCE uses to calculate provider counts, time/distance results, or other access to care metrics. Please note any reference files (e.g., mapping resources), if needed. If your MCE does not use driving distances when calculating time and distance results, describe the method used.
CHP+ MCO, Medicaid MCO, RAE
RMHP currently uses the Quest Analytics software platform to analyze access to care and network adequacy.

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Table 13–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 RAE Region 1. However, we do have Members who reside in some urban counties outside of our region. The majority of these Members reside in the Denver Metro area – Adams, Arapahoe, Boulder, Denver, Douglas and Jefferson Counties – and Weld County, which borders Larimer County in our region. While RMHP has providers in these areas, all services may not be available. RMHP enters into single case agreements in these areas whenever necessary.

Table 14–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 RAE Region 1, there are deficiencies in psychiatrists/prescribers in Archuleta and Summit Counties; however these services are typically provided by physical health providers in these areas. While many specialists in the region serve both adult and pediatric populations, they do not often consider themselves to be a "pediatric specialist", and are thus not categorized as such. RMHP has Members in several rural counties that are outside of RAE Region 1. These include Alamosa, Chaffee, Conejos, Crowley, Fremont, Logan, Morgan, Otero, Park, Phillips, Prowers, and Rio Grande Counties. All of these counties have some challenges in meeting time/distance requirements, based upon available services.

Table 15–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 RAE Region 1, the frontier counties include Dolores, Gunnison, Hinsdale, Jackson, Moffat, Rio Blanco, San Juan, and San Miguel. All have some deficiencies in meeting time/distance requirements, based upon available services. Gunnison County does not have a psychiatrist within the desired distance, and all counties have the constraint of access to a designated pediatric behavioral health provider, as described previously. Additionally, all have deficiencies in terms of proximity to a residential treatment facility, with the exception of members in San Juan County. RMHP has Members in several frontier counties that are outside of our service

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area of Region 1. These include Baca, Bent, Cheyenne, Costilla, Custer, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Saguache, Sedgewick, Washington, and Yuma Counties. All of these counties have some challenges in meeting time/distance requirements, based upon available services.

Network Directory

Supporting contract reference: For each of the following provider types covered under this contract the MCE must make the following information on the MCE's network providers available to the enrollee in paper form upon request and electronic form:

- Provider's name as an individual or entity, as well as any group affiliations,
- Business street address,
- Telephone number,
- Electronic mail address,
- Website URLs, as appropriate,
- Specialties, as appropriate,
- Whether network providers will accept new enrollees,
- The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training,
- Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

Table 16-Network Directory: Discussion

Please list the MCE's website URL. **Is the MCE provider network information updated at least monthly?** **Did the MCE make the network providers' information available to the enrollee in paper form upon request and electronic form?**
CHP+ MCO, Medicaid MCO, RAE
Our website URL is: https://www.rmhp.org From the RMHP home page, a Member can click the "Find a Provider" link in the top navigation. The URL for RMHP's searchable provider directory: RMHP Online Searchable Provider Directory RMHP's provider directories are updated at least monthly. We update our online, searchable directory at least once per week. Paper copies are available upon request. A printable PDF version is posted to our website and can be found at: https://www.rmhp.org/additional-provider-directories

Appendix A. 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

GeoAccess Report: Please double click on the PDF image to open the document.

RAE Network Analysis

January 29, 2020

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