COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.90

NETWORK ADEQUACY STANDARDS AND REPORTING GUIDANCE FOR HEALTH BENEFIT PLANS

I. Background and Purpose

The purpose of this bulletin is to provide carriers offering health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network adequacy filings. The standards will serve as Colorado's measurable requirements for adequate networks. The reporting guidelines contained in this bulletin will help ensure that the Division receives complete network adequacy filings. Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor a final determination of issues or rights.

II. Applicability and Scope

This bulletin is intended to inform carriers that offer health benefit plans[1], of specific standards and documents required by current Colorado law[2]. This bulletin does not pertain to any other filings not otherwise required by statute or regulation.

III. Definitions

A. "Mental health, behavioral health, and substance abuse disorder care" means, for the purposes of this bulletin, health care services for a range of common mental or behavioral health conditions, or substance abuse disorders provided by a physician or non-physician professionals.

B. "Mental health, behavioral health, and substance abuse disorder care providers" for the purposes of this bulletin and for the purposes of network adequacy measurements, includes psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, licensed marriage and family counselors, and licensed professional counselors.

C. "Counties with Extreme Access Considerations" or "CEAC" mean, for the purposes of this bulletin, counties, as defined by U.S. Centers for Medicare & Medicaid Services (CMS), with a population density of less than ten (10) people per square mile, based on U.S. Census Bureau population and density estimates (calendar year 2013).

D. "Covered person" means, for the purposes of this bulletin, a person entitled to receive benefits or services under a health coverage plan.

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[1] § 10-16-102(32), C.R.S.

[2] §§ 10-16-704(1), (3), (5), (6), and (9), C.R.S

E. "Enrollment" means, for the purposes of this bulletin, the number of covered persons enrolled in a specific health plan or network.

F. "Emergency services" means, for the purposes of this bulletin:

1. A medical or mental health screening examination that is within the capability of the emergency department of a hospital or freestanding emergency room, including ancillary services routinely available to the emergency department to evaluate the emergency medical or mental health condition; and

2. Within the capabilities of the staff and facilities available at the hospital, further medical or mental health examination and treatment as required to stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition.[3]

G. "Essential community provider" or "ECP" means, for the purposes of this bulletin, a provider that serves predominantly low-income, medically underserved individuals, such as health care providers defined in the federal law and under part 4 of article 4 of title 25.5, C.R.S.[4]

H. "Home health" means, for the purposes of this bulletin and for the purposes of network adequacy measurements, means home health services as defined in Section 25.5-4-103(7), C.R.S., which are provided by a home health agency certified by the Department of Public Health and Environment.

I. "Network" means, for the purposes of this bulletin, a group of participating providers providing services under a managed care plan. Any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.[5]

J. "Primary care" means, for the purposes of this bulletin, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider.

K. "Primary care provider" or "PCP" means, for the purposes of this bulletin, a participating health care professional designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children includes Physicians (Pediatrics, General Practice, Family Medicine, Internal Medicine, Geriatrics, Obstetrician/Gynecologist); and Physician Assistants and Nurse Practitioners supervised by, or collaborating with, a primary care physician.

L. "Specialist" means, for the purposes of this bulletin, a physician or non-physician health care professional who:

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[3] § 10-16-704(5.5)(b)(II), C.R.S.

[4] § 10-16-704 (1.5)(a)(II), C.R.S.

[5] Managed Care Plan is defined at § 10-16-102(43), C.R.S.

1. Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

2. Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

M. "Telemedicine" or "telehealth" means, for the purposes of this bulletin, a mode of delivery of health care services through telecommunications systems, including information, electronic and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. The terms include synchronous interactions and store-and-forward transfers. The terms do not include the delivery of health care services via telephone, facsimile machine or electronic mail systems.[6]

N. "Urgent care facility" means, for the purposes of this bulletin, a facility or office that generally has extended hours, may or may not have a physician on the premises at all times, and is only able to treat minor illnesses and injuries. Urgent care does not typically have the facilities to handle an emergency condition, which includes life or limb threatening injuries or illnesses, as defined under emergency services.

IV. Division Position

Colorado insurance statutes and regulations require the filing and/or approval of insurance rates and forms, and network adequacy filings, concurrent with or prior to their dissemination and use. Existing law requires insurers to submit all filings through the NAIC System for Electronic Rate and Form Filing ("SERFF").

Colorado will use the "County Types" designations defined by CMS in "CMS **C**Y2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance". The methodology used to define county types and the designations for Colorado counties are in Appendix A of this bulletin.

The following four (4) measurement standards will be used to evaluate a carrier's network adequacy. Detailed instructions, definitions, measurement details, and reporting methodologies are presented in "Colorado PPACA Network Adequacy Filing Procedures for *each plan year*" and "Colorado Network Access Plans Filing Procedures for *each plan year*." Attestations to and certifications of adequate networks will be provided for ACA-compliant policies by plan and group type on the "Colorado Carrier Attestation Form" submitted with the Binder filing. Provider types and groupings that will be used in the standards below are specified in Appendix B.

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[6] § 10-16-123(3)(e), C.R.S.

A. Colorado Network Adequacy Standards

1. **Access to Service/Waiting Time Standards** – All carriers must meet these standards

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care – Routine, non-urgent, non-emergency	Within 7 calendar days	Met ≥ 90% of the time
Prenatal Care	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hrs./ 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care - non urgent	Within 60 calendar days	Met ≥ 90% of the time

2. **Availability Standards** – "Provider to Enrollee" ratio for different provider types will be reported in the "Enrollment Document". The groupings/categories for the specific providers are listed in Appendix B. The standards listed below will be used to measure Network Adequacy, along with Geographic Access Standards, in counties with Large Metro, Metro and Micro status, as defined in Appendix A, for the specific provider types listed below. The carrier shall attest that it is compliant with the "provider to enrollee" ratios standards below.

Provider/Facility Type	Large Metro	Metro	Micro
Primary Care	1:1000	1:1000	1:1000
Pediatrics	1:1000	1:1000	1:1000
OB/GYN	1:1000	1:1000	1:1000
Mental health, behavioral health and substance abuse disorder Care Providers	1:1000	1:1000	1:1000

3. **Geographic Access Standards** – The carrier shall attest that at least one of each of the providers listed below are available within the maximum road travel distance of any enrollee in each specific carrier's network. In some circumstances, access may require crossing of county or state lines. These standards will be used to measure Network Adequacy in all Colorado counties, as defined in Appendix A, for the specific provider/facility types listed on the table.

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
	Maximum Distance (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiovascular Disease	10	20	35	60	85
Chiropracty	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation/Radiation Oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physiatry, Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER MEDICAL PROVIDER	15	40	75	90	130
Dental	15	30	60	75	110
Pharmacy	5	10	20	30	60
Acute Inpatient Hospitals	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)	Maximum Distance (miles)
Cardiac Catheterization Services	15	40	120	120	140
Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facilities	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100
Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Inpatient Psychiatric Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

4. **ECP Standards** – Qualified Health Plan (QHP), Stand Alone Dental Plan (SADP), and dual (both medical and dental) carriers are required to have a sufficient number and geographic distribution of essential community providers (ECPs), where available. Inclusion of a sufficient number of ECPs ensures reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas, as described in 45 *Code of Federal Regulations* (CFR) 156.235. The Centers for Medicare & Medicaid Services (CMS) has established two ECP standards for carrier ECP submissions: the general ECP standard and the alternate ECP standard:

    a. General ECP standard. General ECP standard carriers are asked to demonstrate in their ECP/Network Adequacy Template that at least 30 percent of available ECPs in each plan's service area participate in the plan's network. This standard applies to all carriers except those that qualify for the alternate ECP standard.

    b. Alternate ECP standard. Alternate ECP standard carriers are asked to demonstrate in their ECP/Network Adequacy Template, and justifications, that they have the same number of ECPs as defined in the general ECP standard (calculated as 30 percent of the ECPs in the carrier service area), but the ECPs should be located within Health Professional Shortage Areas (HPSAs) or five-digit ZIP codes in which 30 percent or more of the population falls below 200 percent of the federal poverty level (FPL). CMS defines an alternate ECP standard carrier as one that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.

B. Requirements for Annual Network Adequacy Reporting

Network Adequacy filings for plan year 2017 will consist of two (2) portions, both attached to the Binder filings. All Network Adequacy documents will be filed by CARRIER NETWORKS, not by plan type or group size. One portion will consist of the filing of Network Access Plans, Enrollment Documents, and maps for each network in the carrier's system. The second portion of the filing will be the submittal of the ECP/Network Adequacy Templates in each applicable binder. Each network that is included on the Network Templates filed in any of the carrier's 2017 Binder filings shall be included in the carrier's ECP/Network Adequacy Template filing.

It is imperative that data provided in the documents listed below apply to each Network, i.e. HMO, PPO, EPO, etc., in the carrier's service area. Networks that are not service area specific may be rejected.

The following documents shall be provided for each network that is included on the Network Templates filed in any of the carrier's 2017 Binder filings. Templates and instructions specified by the Insurance Commissioner will be used, and are provided in "Colorado PPACA Network Adequacy Filing Procedures for 2017".

1. **Network Provider and Facilities Template** – All carriers MUST submit Network Provider and Facility Listings on the ECP/Network Adequacy Template, in the Binder filing. All Essential Community Providers (ECPs) in each network will be included in this template. The templates will be completed and filed as described in the QHP Applications Instructions, "Colorado PPACA Network Adequacy Filing Procedures for 2017". Templates will require validation before submittal to the Division. The Division will require carriers to submit a justification if any of the requirements are not met. The justification should include the reason that the requirement was not met and any corrective actions that will be taken by the carrier. The Division will review the justification and provide feedback on a case by case basis.

2. **Network Access Plan (and Cover Sheet)** – All carriers MUST submit access plans for each network, pursuant to § 10-16-704(9), C.R.S. Carriers must also submit a copy of the Network Access Plan Cover Sheet with the Access Plan for each network, as described in the instructions for filing Network Access Plans. These will be attached as Supporting Documentation on the Binder filing. The Network Access Plans and Cover Sheets will be completed according to Bulletin 4.91, Network Access Plan Standards and Reporting Guidance for Health Benefit Plans.

3. **Enrollment Document** - All carriers MUST submit a separate Enrollment Document <u>for each network</u>. Enrollment document instructions are provided in "Colorado PPACA Network Access Plan Filing Procedures for 2017." Enrollment documents must be submitted in Excel format using the DOI Enrollment Document Template. Counts used for this document should be based on the projected enrollment of all members in the carrier's individual, small group or large group plans utilizing that specific network.

4. **Maps** - All carriers MUST submit maps showing geographic access standards for selected providers and facilities <u>for each network</u>. Instructions for required maps are provided in "Colorado PPACA Network Access Plan Filing Procedures for 2017."

5. **Essential Community Provider (ECP) Supplemental Response Form** – All carriers must submit a copy of the federal "ECP Supplemental Response Form" as part of the 2017 Network Adequacy filing. Specific requirements for submitting the ECP Supplemental Response Plan are provided in the Instructions in "Colorado Network [Access/Adequacy] Plans Filing Procedures for 2017."

C. Required Attestations

The following attestations will be made on the "Colorado Network Adequacy Carrier Attestation Form" submitted with the Binder:

1. Carrier attests that each of its health benefit plans will maintain a provider network(s) that meets the standards in this Bulletin B-4.90 and is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that the services will be accessible without unreasonable delay.

2. Carrier attests that each of its health benefit plans include in their provider network(s) a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas.

V. Additional Division Resources

Colorado Insurance Regulation 4-2-39
Colorado Insurance Regulation 4-2-41
Colorado Insurance Bulletin No. B-4.81

For More Information

Colorado Division of Insurance
Life and Health Rates and Forms Section
1560 Broadway, Suite 850
Denver, CO 80202
Tel. 303-894-7499
Internet: http://www.dora.colorado.gov/insurance

VI. History

- Issued March __, 2016

APPENDIX A – DESIGNATING COUNTY TYPES

From: CMS CY2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance

The county type, Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC), is a significant component of the network access criteria. CMS uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Density parameters are foundationally based on approaches taken by the U.S. Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the Office of Management and Budget (OMB) in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with population greater than one million *and* a density greater than or equal to 1,000 persons per square mile (sq. mile) is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated "Large Metro" if *any* of the three Large Metro population-density combinations listed in the following table are met; a county is designated as "Metro" if any of the five Metro population-density combinations listed in the table are met; etc.).

Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
Metro	≥ 1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

CMS applies these parameters to US Census Bureau population estimates to determine, annually, appropriate county type designations. Current population and density estimates (calendar year 2013) are available at http://quickfacts.census.gov/qfd/download_data.html

COLORADO COUNTY DESIGNATIONS

County	Classification	County	Classification
Adams	Metro	Kit Carson	CEAC
Alamosa	Rural	Lake	Rural
Arapahoe	Metro	La Plata	Micro
Archuleta	CEAC	Larimer	Metro
Baca	CEAC	Las Animas	CEAC
Bent	CEAC	Lincoln	CEAC
Boulder	Metro	Logan	Rural
Broomfield	Metro	Mesa	Micro
Chaffee	Rural	Mineral	CEAC
Cheyenne	CEAC	Moffat	CEAC
Clear Creek	Rural	Montezuma	Rural
Conejos	CEAC	Montrose	Rural
Costilla	CEAC	Morgan	Rural
Crowley	CEAC	Otero	Rural
Custer	CEAC	Ouray	CEAC
Delta	Rural	Park	CEAC
Denver	Large Metro	Phillips	CEAC
Dolores	CEAC	Pitkin	Rural
Douglas	Metro	Prowers	CEAC
Eagle	Micro	Pueblo	Micro
Elbert	Rural	Rio Blanco	CEAC
El Paso	Metro	Rio Grande	Rural
Fremont	Rural	Routt	CEAC
Garfield	Micro	Saguache	CEAC
Gilpin	Rural	San Juan	CEAC
Grand	CEAC	San Miguel	CEAC
Gunnison	CEAC	Sedgwick	CEAC
Hinsdale	CEAC	Summit	Rural
Huerfano	CEAC	Teller	Rural
Jackson	CEAC	Washington	CEAC
Jefferson	Metro	Weld	Metro
Kiowa	CEAC	Yuma	CEAC

APPENDIX B – DESIGNATING PROVIDER/FACILITY TYPES

Provider Types – For ECP/Network Adequacy Template and Enrollment Document
Primary Care (including General Practice, Family Medicine, Internal Medicine, and Geriatric physicians, and Primary Care Physician Assistants and Nurse Practitioners)
Gynecology, OB/GYN
Pediatrics - Routine/Primary Care
Allergy and Immunology
Cardiovascular Disease
Chiropracty
Dermatology
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Infectious Diseases
Nephrology
Neurology
Neurological Surgery
Medical Oncology & Surgical Oncology
Radiation Oncology
Ophthalmology
Orthopedic Surgery
Physiatry, Rehabilitative Medicine (including physiatrist, physical medicine and rehabilitation specialist)
Plastic Surgery
Podiatry
Psychiatry
Pulmonology
Rheumatology
Urology
Vascular Surgery
Cardiothoracic Surgery
Licensed Clinical Social Worker
Psychology
OTHER MEDICAL PROVIDER
Dental

Facility Types – For ECP/Network Adequacy Template and Enrollment Document
Pharmacy
General Acute Care Hospital
Cardiac Surgery Program
Cardiac Catheterization Services
Critical Care Services - Intensive Care Units (ICU)
Outpatient Dialysis
Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
Skilled Nursing Facilities
Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
Mammography
Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)
Occupational Therapist
Speech Therapy
Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
Orthotics and Prosthetics
Home Health
Durable Medical Equipment
Ambulatory Health Care Facilities – Infusion Therapy/Oncology/ Radiology
Heart Transplant Program
Heart/Lung Transplant Program
Kidney Transplant Program
Liver Transplant Program
Lung Transplant Program
Pancreas Transplant Program
OTHER FACILITIES