ROCKY MOUNTAIN VALLEY HMO NETWORK

INCLUDING COLORADO OPTION STANDARDIZED PLANS

ACCESS PLAN CON004

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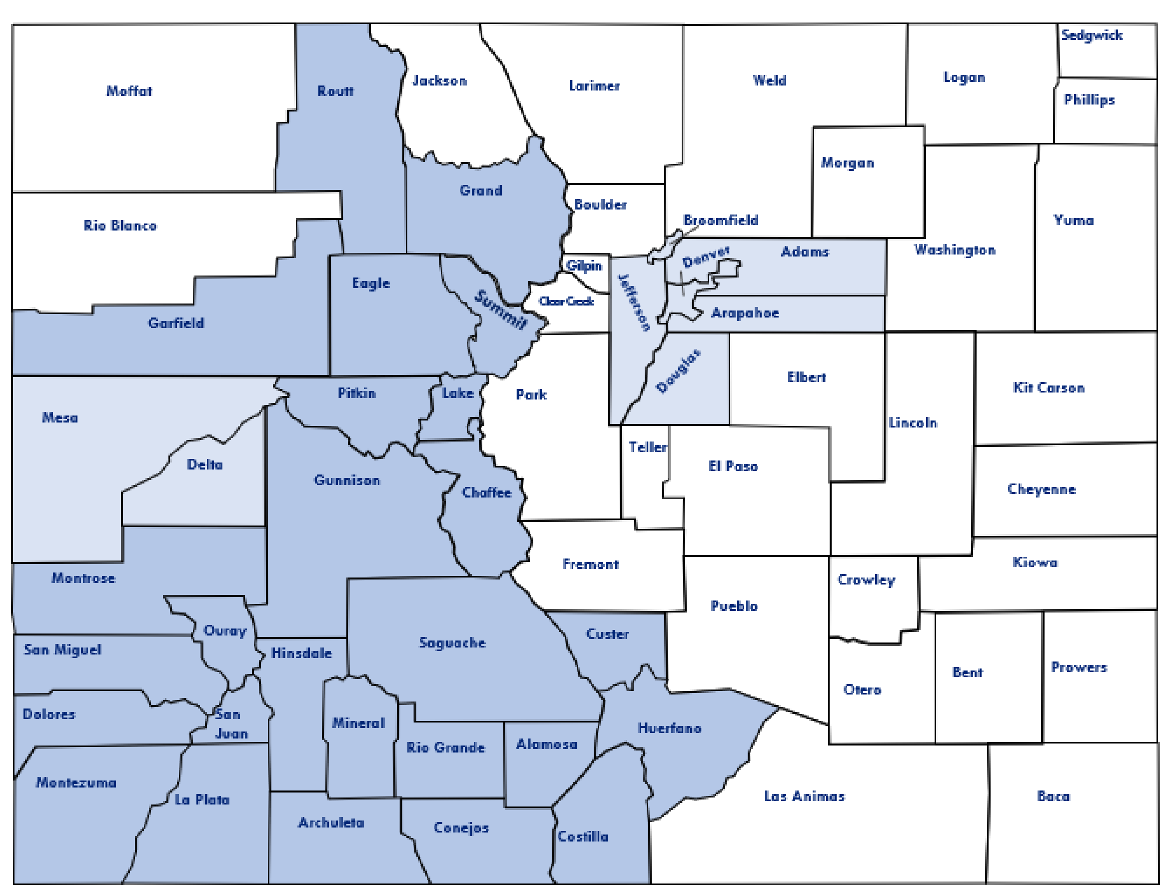
I. Introduction

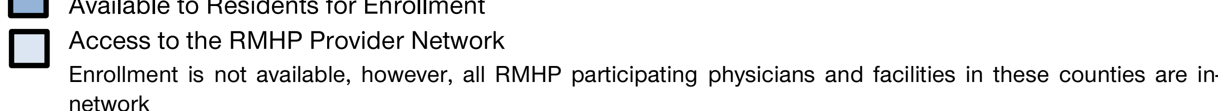
This Access Plan (Access Plan) contains general information regarding the Rocky Mountain Health Maintenance Organization, Inc. a wholly owned subsidiary of United Healthcare (dba Rocky Mountain Health Plans or RMHP) Rocky Mountain Valley HMO Network (Network ID CON004) and certain policies and procedures of RMHP. The Access Plan is not, and in no event shall be, construed as a contract between RMHP and Members covered under RMHP plans; nor does it grant any rights, privileges, or benefits to any person. Rights and Responsibilities of Members covered under RMHP plans are governed by the Member Evidence of Coverage, whether such provisions are also specified or referred to in this Access Plan. Members have the right to request a copy of this or any Access Plan. Copies can be reviewed online at **UHC.com**.

The Rocky Mountain Valley HMO Network includes a high-performing network of providers available to Archuleta, Dolores, Eagle*, Garfield, Gunnison, Hinsdale, La Plata, Montezuma, Montrose, Ouray, Routt, Pitkin, San Juan, and San Miguel County residents. The network includes an extensive network of local Western Slope providers, all Denver- area physicians, and facilities, as well as a broad pharmacy network.

RMHP Member Service is available for Members Monday – Friday 8:00 a.m. to 5:00 p.m. at 888-809-6539 (TTY: 711), email RMHP Member Service at **RMHPCustomer.Service@uhc.com** visit our website at **UHC.com.**

Rocky Mountain Valley HMO Network Access




Available to Residents for Enrollment

Access to the RMHP Provider Network

Enrollment is not available, however, all RMHP participating physicians and facilities in these counties are in-network

II. Network Adequacy and Corrective Action Processes

A. Network adequacy standards and results summary

RMHP standards are defined by the Colorado Division of Insurance (DOI), as well as internally. These standards include measuring and analyzing network adequacy in the following areas:

- Access to service (appointment availability)
- Number of practitioners as compared to the number of members for required provider types
- Geographic and drive time distance distribution of providers in proximity to membership

Access to Services Analysis

The following Service Types did not meet the Access to Service standards and/or RMHP's goals:

- Emergency Care
- Routine, non-urgent Primary Care
- After-hours Primary Care access
- Preventive visits / well visits
- Non-urgent Specialty Care

RMHP distributes Appointment Wait Time Surveys quarterly to an adequate sample size of Members who receive services from primary care providers, certain specialists, and behavioral health providers during the previous quarter to ensure appointment availability is sufficient for Member's when needing care.

Provider to Member Ratio Analysis

Provider to Member ratios standards were met.

Geographic Access Analysis

All Practitioner Types met the Geographic Access standards and/or RMHP's goals.

RMHP offers a sustainable network, with options for Members who have limited access residing outside of the specified counties to providers by utilizing either telehealth or out-of-network services; both explained in detail within this Access Plan.

B. Process for monitoring and assuring network adequacy

Defining population and density parameters

The Centers for Medicare and Medicaid Services (CMS) designates Colorado counties by type based upon the county's population. This method is also used by the DOI for Individual and Family Plan Members. Below is the explanation of how counties are designated per the DOI's Regulation 4-2-53 and updated by DOI Regulation 4-2-80 for plan filings under the Colorado which has updated the designations of certain counties.

"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

Methodology for monitoring network adequacy

Access to Services

RMHP Provider Network Management (PNM) staff distributes Appointment Availability Surveys quarterly to an adequate sample size of Members who receive services from specific Service Type providers to ensure appointment availability is sufficient for Member's when needing care. To get a valid statistical sample of Members to send surveys to, claims data extraction reports are requested to first determine the total number of Members who received services from specific Service Type providers the prior year. All duplicates and deceased Members are excluded from the total numbers.

Access to Service Standards		
Service Type	**Time Frame**	**Goal**
Emergency Care Medical, Behavioral, Substance Use	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 Use Disorder Care Initial and follow-up appointments for routine, non-urgent, non-emergent	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 24hrs/ 7 days a week by answering service or instructions on how to reach a physician	Met ≥90% of the time
Preventive visits/ well visits	Within 30 calendar days	Met ≥90% of the time
Specialty Care Non-Urgent	Within 60 calendar days	Met ≥90% of the time

Provider to Member Ratios

RMHP gathers information regarding network availability from provider and Member enrollment data. GeoAccess reports are calculated utilizing the five population designations (Large Metro, Metro, Micro, Rural and CEAC) set forth by the DOI for each county that has membership. Annually, RMHP analyzes the proportion of providers to members against performance goals.

Provider to Member Ratios			
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 use disorder care providers	1:1000	1:1000	1:1000

Geographic Access

RMHP gathers information regarding network availability from provider and Member enrollment data. GeoAccess reports are calculated utilizing the five population designations (Large Metro, Metro, Micro, Rural and CEAC) set forth by the DOI for each county that has membership. Annually, RMHP analyzes member distribution by provider type against performance goals.

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

Individual and Family Plan Network Geographic Standards					
Specialty	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Distance (miles)				
Primary Care (Includes Family Practice and Internal Medicine Providers)	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
Certified Nurse Midwives**	5	10	20	30	60
Chiropractic	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	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Optometry for routine pediatric vision	15	30	60	75	110
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
Dentist	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
Cardiac Catheterization Services	15	40	120	120	140
Critical Care Services – Intensive Care	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

****CNM's have been added to the matrix above in compliance with DOI Regulation 4-2-80**

Telehealth

Telemedicine services are a benefit available to Members which allow health care services through telecommunications systems such as a smartphone, tablet, or computer. Coverage is provided through Dr. On Demand, allowing Members to connect with Board Certified doctors and therapists 24 hours a day 7 days a week. Virtual visits may be subject to Copays, Coinsurance and Deductibles applicable to the type of care provided. To learn more about Dr. On Demand please visit Dr On Demand at **doctorondemand.com** or call RMHP's Member Service. Additionally, RMHP provides payment and benefits to members who receive appropriate telehealth services from any of our network providers including primary care, behavioral health, and specialty care.

C. Provider network factors

RMHP offers a narrowed network through its Rocky Mountain Valley HMO products. For the Rocky Mountain Valley HMO Network, RMHP assesses network adequacy according to defined standards based on the service area of the products offered. Practices and facilities within the service area of the products offered that have demonstrated the ability, resources, and commitment to deliver efficient, patient-centered care are invited to join the network.

D. Providers and Services, Care Coordination, Community Health Workers

In addition to our Hospitals, Physicians, Professional Providers, Ancillary, and other Facility Providers, RMHP has Care Coordinators to cover the Plan Service Area. RMHP believes the most successful model of care coordination is to incorporate the care coordination team into the geographic community in which the member lives.

Rocky has its own Care Coordination Teams and in addition, RMHP has partnered with community entities that are doing care coordination/navigation to perform Care Coordination activities. RMHP refers to these contracted community partners as, Integrated Community Care Teams (ICCTs). RMHP also has RMHP care coordination staff across the region to fill in where there are no ICCTs or in the case of more densely populated areas, to supplement the community care coordination needs. RMHP care coordinators are RNs, Social Workers, Behavioral Health Specialists, and general care coordinators, to meet the various needs of the population.

The majority of RMHP's Care Coordination Teams utilize a shared care coordination computer platform. This ensures high quality results, information sharing and consistency among the teams. RMHP also works collaboratively and shares a computer platform with the four local Community Mental Health Centers (CMHCs) and have granted access to partners such as Grand Junction Housing Authority and Garfield County Human Services to facilitate communication and integrated documentation. RMHP care coordinators also work closely and collaboratively with local Community Centered Boards (CCBs), CMHCs, Department of Human Services (DHS) offices and other local community entities.

RMHP care coordinators complete targeted outreach of members through Clinical Event Management and Special Populations. Clinical events are when a member is admitted to or discharged from a medical or behavioral health (BH) facility, goes to the Emergency Department (ED) or calls the crisis line. RMHP gets notified through alerts in the internal computer platform and a care coordinator reaches out to the member. When the member is reached, the RMHP care coordinator will determine if the member has received the post-discharge services ordered (like home care or DME), if the member understands their medication routine and will help the member obtain a follow-up appointment with their primary care/specialty provider. Where appropriate follow up appointments will be made, and any other needs identified will be managed.

Special Populations are cohorts of members with similar needs who have been identified either through Health Care Policy and Finance (HCPF), stratification or RMHP such as Complex Members, High-Risk Pregnancy, Criminal Justice Involved, Foster Children and members who are in Colorado Over-Utilization Program (COUP), to name a few.

These members are placed into a work queue, known as a Campaign and outreach is performed by the care coordination teams, to determine if the members have any physical, behavioral, or social needs that care coordinators can assist with.

Referrals can be made through our one-call number. Referrals come from several sources such as inbound calls, warm referrals from primary care, behavioral health providers, social services, Single Entry Points, member advocacy groups, human services, non-profits, member self-referral and any community organizations.

Care Coordinators use screening tools designed specifically for each Campaign. When a need is identified through screening, Care Coordinators arrange a face-to-face meeting to complete a Comprehensive Assessment with the member. The Comprehensive Assessment includes evidence-based tools such as the GAD 7 tool, PHQ 2, PHQ 9 & the AUDIT Tool (these are screening tools used to identify conditions such as Anxiety, Depression, Alcohol use etc.). CCs assess the Member's health and health behavior risks, medical and non-medical needs, social determinants of health needs, including determining if a care plan exists and creating a care plan if one is needed. The Care Coordinator develops a care coordination plan that reflects the needs of the member to achieve their desired health outcomes and that promotes the member's empowerment, healthy lifestyle choices and informed decision making.

RMHP has one licensed Promotora, several Spanish speaking care coordinators and all care coordinators have access to a language line that aids in most languages spoken as well as assistance for hearing impaired individuals.

RMHP Care coordinators are also out in the community on a regular basis. They are present at local homeless shelters and resource centers, soup kitchens, parole offices and other locations, where they can connect with our members face to face and work collaboratively with community entities.

E. Quality assurance standards

Rocky Mountain Health Plans can attest that this network used for the CO Option Standardized plan network is not more narrow than the narrowest network the Plan offers. The Network and Network ID that is being designated for this is our Monument Health One HMO Network, and Network I.D. CON002.

RMHP has begun a process of determining workflows and modifications to meet the complex requirements of a culturally responsive network, as specified in Colorado Insurance Regulation 4-2-80 and will be fully organized and operational beginning in January of 2023. RMHP and UHG have already developed a survey tool and are in the process of evaluating our provider networks. Many of our providers overlap and are part of all UHG and RMHP plans and networks and work is being completed now to insure that there is a little duplication as possible in the demographic analysis requirement set forth in 4-2-80.

F. Obtaining a covered benefit from a non-participating provider

In limited circumstances, RMHP will preauthorize services for nonparticipating providers when there is not a participating provider for the covered service. In these limited cases, Members do not pay any more for these services than they would if they saw a participating provider for the same service.

G. Monitoring access from in-network physician specialist services

RMHP contracts with all providers in the area that meet our credentialing guidelines, are willing to negotiate in good faith, and willing to participate with RMHP under our general and customary contractual terms; there is no specific criteria for selection. RMHP does not use quality measures, Member experience measures, or cost-related measures to select practitioners or facilities. In establishing and maintaining our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

H. Creating a culturally responsive network

It is an organizational priority to reduce health disparity, improve health equity and improve culturally and linguistically appropriate services (CLAS) for Rocky Mountain Health Plans (RMHP) Members. RMHP is currently pursuing a National Committee for Quality Assurance (NCQA) Health Equity Accreditation (HEA) to address racial and ethnic disparities and the impacts of social determinants of health for Members across all lines of business in order to improve health care quality and serve culturally, linguistically and socially diverse populations. NCQA HEA Standards cover the following areas:

- Organizational readiness of building a diverse staff and promoting diversity, equity, and inclusion among staff.
- Development of the organizations electronic data systems to be able to receive, store and retrieve individual-level data for race/ethnicity, language, gender identity, and sexual orientation data. Assure that privacy protections and notifications are in place for this standardized data.
- The organization provides access and availability of interpretation and translation services via written documents, spoken language services and support for and notification of language services in threshold languages to include competent translators. Supporting practitioners in providing compete language services including notification of language services.
- The organization will maintain a practitioner network that can serve its diverse Membership and its responsiveness to Member needs and preferences. Includes assessment of and availability of practitioner information and enhancing network responsiveness.
- The organization maintains and annually evaluates quality program documents including a written program description for improving culturally and linguistically appropriate services. Involvement of diverse community members, advocates, agencies that serve populations of interest are involved.
- Reducing healthcare disparities through the reporting of HEDIS stratified measures, using data to assess disparities and monitor and assess services, measure CLAS and Disparities.

Additionally, RMHP has incorporated Health Equity into organizational goals and objectives. A health equity focus is to be integrated into all QIC committees, subcommittees and workgroup activities and processes.

A cultural and linguistic needs assessment is performed annually to assess Member characteristics in order to develop interventions to meet membership needs. The report includes a review of language, race and ethnicity data and services available to meet Member needs. Recommendations for interventions are presented and discussed at the Member Experience Advisory Committee (MEAC).

RMHP performs several activities to further identify and support Member needs including but not limited to the following:

- Culturally competent disease management
- Member Advisory councils
- Latinx community outreach
- Language assistance
- ABIDE (Ambassadors for Belonging, Inclusion, Diversity, and Equity) Employee Advisory Council
- Employee training
- Provider training
- Deaf and hard of hearing community engagement
- Disability competent care trainings for providers
- Value based payment to address disparities

A Population Health Assessment is completed annually using integrated data to systematically assess the characteristics and need of our Membership. The assessment includes the identification of characteristics and needs for Members of racial and ethnic groups and for Members with limited English proficiency.

RMHP assesses Member experience within its services and programs. Actions are taken on identified opportunities. Member experience data includes but is not limited to the following:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS) Survey
- Member appeals and grievance data analysis
- Case Management surveys
- Post Call surveys
- Net Promoter Score (NPS) Surveys

I. Identifying, evaluating, and remediating problems relating to access, continuity, and quality of care

Annually, RMHP completes a Network Adequacy Assessment as well as a Appointment Availability Analysis in an effort to identify opportunities for improvement to better Members access to services. We are always looking for technology, tools, and processes to better inform and improve our stakeholders, Members, and providers network experience.

The Network Adequacy Assessment includes evaluation of the following: Availability of practitioners and providers (hospitals/facilities); provider/Member ratios, geographic distribution (distance and drive time) as well as cultural and linguistic needs.

Appointment Availability Analysis is performed to ensure appointment availability is sufficient for Members from all product lines. Surveys are distributed to Members on a quarterly basis to measure access to primary care, high-volume and high-impact specialist, and high-volume behavioral healthcare providers.

In addition to the Appointment Wait Time surveys, RMHP also utilizes response data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan survey questions pertaining to access to appointments, assessment of complaint and appeal data related to access of care and Member out of network utilization.

RMHP also employs a Network Advisory Committee (NAC), which is represented by a large segment of our Provider Network Management team, Member Service, Quality Improvement and Care Management Teams. This Committee meets on a quarterly basis and reviews issues, complaints and other data and reports their findings and suggests strategies for improvement to our Senior Leadership. All opportunities for improvement are prioritized and interventions are implemented accordingly. Each year, the interventions are assessed to identify whether they had/have a positive impact on meeting set goals.

J. Corrective actions summary

Rocky Mountain Health Plans will continue monitoring any areas not meeting standards for any new providers who are willing to participate with us. In the meantime, RMHP has options for those Members who have limited access to providers by utilizing either out-of-network services with prior preauthorization approval, Single Case Agreements, or telehealth services.

K. Corrective actions summary

Rocky Mountain Health Plans is in the process of reviewing our current process and how it will integrate these efforts upon our migration and transition to United Health Care operations. As Rocky continues to use and employ an “any willing provider” provider strategy which allows providers to participate with us if they can pass our credentialing standards and can accept the terms and rates in our contracts which are based on current industry standards and acceptable and reasonable market rates for all provider types including Primary Care Providers, Specialist Care Providers, non-physician Professional Service Providers and Behavioral Health Providers and facilities.

We do not deny providers access to our networks unless they do not meet our credentialing standards which are industry standards meeting all required regulatory specifications or cannot agree to the terms of our contract which outline all duties and responsibilities for the Provider as well as the Health Plan. All contract terms are based on current industry standards. Providers may be unwilling or unable to accept the rates which are based on current and fair market values.

Rocky Mountain Health Plans in collaboration with United Healthcare in the process of developing both tools and workflows that will address in detail those demographic standards outlined in Section 5 of Division of Insurance Regulation 4-2-80. The enterprise is actively developing written information and a survey tool and workflows to the subsequent reporting of Network provider data to include Written Training materials for providers and staff outlining our request for the voluntary reporting of demographic data outlined in Section 5.b.(1)

III. Network Access Plan Procedures for Referrals

A. Provider directories

Members can utilize RMHP's online provider directory by visiting **UHC.com**, selecting "Find a Provider", then choosing "Guest provider search" or signing into **UHC.com** and then searching for services or providers by name, specialty, or type. Advanced search options also allow Members to search providers by gender, if a provider is accepting new patients, language, specialty, group affiliation and admitting privileges. The online provider directory is updated weekly.

A PDF version of the directory is also available for Members to download or contact Member Service to request a printed copy or a copy in other languages. The PDF/printable directories are updated within 30 calendar days of receiving new information from providers.

B. Referral process

RMHP does not currently require referrals to get specialty services from any network provider that is qualified to provide benefits. We do require prior authorization (also referred to as preauthorization) for some care or services before the Member gets it. This section will include RMHP's prior authorization processes in place of referral processes. Providers can submit referrals online at the United Healthcare Provider Portal at UHCprovider.com.

1. Referral options

Members of the Rocky Mountain Valley HMO Network can obtain consultation and treatment from in-network specialist physicians and mid-level providers without a referral from the PCP. The Member must be eligible to receive services under a Rocky Mountain Valley HMO Network health plan at the time services are provided and the services that the Member receives must be covered services as specified in the Member's Evidence of Coverage. Services that are urgent, emergent, or are an immediate follow up to a visit to an emergency room or urgent care do not require a referral. Services such as OB/GYN care or behavioral health services also do not require a referral. More information on services that require a referral is available at **UHCprovider.com.** Primary care providers can submit a referral at **UHCprovider.com**. Members enrolled in a non-Colorado Public Option plan do not need to have a referral for any services. Out of network services require prior authorization, and once obtained a referral is not needed.

Certain Rocky Mountain Valley HMO Network plans encourage the use of certain providers through variable deductible and copayments. When RMHP does offer such variable deductible and copayments we provide adequate and clear disclosure of such variable deductible and copayments to our Members.

2. Timeliness of preauthorization requests

In limited circumstances, Members may obtain covered specialty care services from out-of-network/out-of-plan providers at the in-network benefit level, subject to obtaining RMHP's approval by preauthorization. Such approval shall be in a timely manner relative to the Member's condition and adequate information is submitted in the request.

3. Expedited preauthorization requests

Expedited preauthorization requests are reviewed with priority status and should only be used for medically urgent or life-threatening conditions.

4. Retrospective preauthorization denial

If RMHP preauthorizes care in writing, we cannot deny the benefit after the Member gets the care. This does not apply in case of fraud or abuse by the Subscriber or Member.

5. Changes to approved preauthorization requests

Approved preauthorization requests for health care services that Members are eligible to receive under their health care plan are not changed unless there is evidence of fraud or abuse.

6. Variable deductibles, coinsurance and/or copays

Clear disclosure of variable deductibles and copayments/coinsurance is made available to Members in the Coverage Schedule section of their Evidence of Coverage. This section lists how much Members pay for covered health care services. Disclosure also includes benefits that are limited to a specific number of treatments, days, visits or dollar amount. Member ID cards reflect deductible and copayment/coinsurance amount.

C. Accessing services out of the network

Services from out-of-network providers are approved in limited circumstances. If a Member needs care and it is covered by the plan but not offered by a network provider, Members may receive preauthorization to see an out-of- network provider. Members must have written approval from RMHP before receiving care from an out-of-network provider, except for urgent services outside the RMHP service area and medical emergencies.

IV. Network Access Plan Disclosures and Notices

A. Informing Members of plan services and features

The Annual Notice is a document that includes notices and information RMHP is required to provide Members on an annual basis. The notices that must be provided differ, according to individual and family plans, as well as by line of business. Notices include, but are not limited to, information on RMHP's privacy policy, Member rights and responsibilities, and Notice of Women's Health and Cancer Rights. The Annual Notices are updated as new requirements are identified.

B. Required disclosures

1. Grievance procedures

RMHP is committed to providing our Members with the best possible service and we want RMHP Members to be satisfied with the care received and the services we provide. There are several ways for Members to present questions, concerns, grievances or submit an appeal. The following is a summary of the procedures; Members should refer to their Evidence of Coverage for full details regarding filing a grievance or appeal. This description of those procedures does not replace the terms and conditions of the Evidence of Coverage and is intended only to serve as a summary of the procedures.

Grievance (also referred to as a complaint)

A grievance is a verbal or written statement about a concern or dissatisfaction. Members can file a grievance, or complaint, for concerns related, but not limited to, a network provider, the inability to find a network provider, waiting times at provider offices, RMHP's Member Service, etc.

Grievances may be filed by using any of the following methods:

- Member Portal at **UHC.com**
- Fax: 888-404-0949
- Mail: P.O. Box 6111
  MS CA-0197
  Cypress CA, 90630

Appeals

If RMHP make a decision a Member is unsatisfied with, the decision may be appealed. An appeal is the formal process to ask us to review the situation again. Members can file an appeal for decisions concerning, but not limited to, a denied claim, a denied preauthorization request, etc.

An appeal must be submitted within 180 days from the date listed on the notice. The notice is the document that details the decision the appeal is regarding, such as a denial letter or Explanation of Benefits. We are unable to accept appeals more than 180 days from the date on the written notice.

If a Member is appealing on behalf of someone else; or someone is submitting an appeal for a Member, a Designated Representative Form must be signed and included. The only exception is if the Member is a parent appealing a decision for their minor child.

All Appeals must be in writing unless urgent:

- Urgent Only Phone: 888-809-6539
- Member Portal at **UHC.com**
- Fax: Standard- 888-404-0949
  Urgent- 888-808-9123
- Mail: P.O. Box 6111
  MS CA-0197
  Cypress CA, 90630

Standard Appeal (1st Level)

An appeal coordinator may call the Member to discuss the appeal and a letter will be sent telling the Member more about the appeal process. RMHP will review the appeal and a decision made by someone who was not involved in the initial decision. If a medical decision is required, a physician with the same or similar expertise as the requesting physician will make the decision or be consulted. An appeal decision will be issued in writing within 30 days of receiving the appeal. If the appeal is denied the Member is provided with possible additional appeal rights.

Fast/Expedited Appeal

If a Member thinks their life or health would be in danger or they might not be able to get completely well or get back to normal unless care is received soon then a Fast/Expedited Appeal can be requested. RMHP will make a decision in 72 hours or sooner if health conditions require us to do so. If RMHP decides the requirements for a fast appeal were not met, notification will be made within 72 hours and the appeal will be reviewed as a Standard Appeal. For situations involving urgent care or an ongoing course of treatment a Member can ask for an external expedited review while RMHP reviews the appeal internally.

Second Level Appeal or External Review Requests

If a Member does not agree with the Standard Appeal (1st Level) decision a request for a second level appeal may be available. External Reviews are also an option. More details can be found for both in the Evidence of Coverage.

Members have the right to call or write the Colorado Division of Insurance (DOI) about any complaint, dispute, or disagreement at any time at:

- Phone: 800-930-3745
- Mail:
  Colorado Division of Insurance
  Department of Regulatory Affairs
  1560 Broadway, Suite 850
  Denver, CO 80202

2. Availability of specialty medical services

RMHP's Rocky Mountain Valley HMO Network consists of a broad specialty medical services network including physician specialties (such as allergists, immunologists, rheumatologists, dermatologists, gynecologists, gastroenterologists, pulmonologists, etc.), behavioral health specialists (addiction counselors, psychiatrists, marriage & family therapy,

licensed clinical social workers, etc.), rehabilitative therapists (physical, occupational, speech), facilities (acute hospitals, rehabilitation facilities, surgical centers, etc.) and many other provider types including clinical labs, imaging, home health, durable medical equipment, orthotics, etc.

Members may receive covered specialty care from any network provider that accepts the Rocky Mountain Valley HMO Network. A referral may be required ; however, in most cases, the cost sharing for network specialist visits will be higher than when seeing a primary care physician. Some health care services must be preauthorized before they are received.

3. Process for providing emergent and non-emergent medical care

Urgent and Emergent, life and limb-threatening care is available, without prior authorization, for all Members 24 hours a day, 7 days a week. Additionally, Members may receive Emergency Services and Urgently Needed Services while temporarily outside the service area. The attending emergency physician, or the provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. RMHP will not deny payment for urgent or emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services.

Members do not need to call a primary care physician or get preauthorization from RMHP before getting emergency care from network, non-network hospitals or emergency facilities. In an emergency Members have the following options:

- Call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent
- Call the local emergency number; or
- Go to an emergency room

If a Member has a condition that is not an emergency but still needs prompt treatment they are urged to contact their PCP first. If the PCP is not available, the Rocky Mountain Valley HMO Network includes urgent care/after hour clinics throughout the state who offer extended evening and/or weekend hours.

As a Member enrolled in the Rocky Mountain Valley HMO plan, designating a primary care physician is not required. RMHP knows that preventive care is key to managing health, so we encourage all RMHP Members to select a primary care physician to manage their care.

4. Process for choosing and changing network providers

RMHP contracts with all providers in the area that meet our credentialing guidelines, are willing to negotiate in good faith, and willing to participate with RMHP under our general and customary contractual terms; there is no specific criteria for selection.

In establishing and maintaining our network of providers, RMHP strives to provide care within a reasonable travel time and distance to Members. To achieve this, RMHP contracts with all willing acute care hospitals, primary care physicians, specialists and sub-specialists who meet RMHP's credentialing and quality standards within the service area.

RMHP requires providers to contact us immediately if the following information changes in the status of their practice:

- Address and/or telephone number have changed
- Added an additional practice location and/or phone number
- If a provider is planning to leave a practice
- RMHP requires a minimum of a 60-day advance notification from a provider who intends to terminate their contract to allow RMHP time to notify Members.
- Changes to the physician group
- Intend to open or close the practice to accepting new patients

The online provider directory is updated weekly, and provider directories are updated within 30 days of receiving new information from providers. Members are notified by written communication when their primary care physician or a specialist is leaving the Rocky Mountain Valley HMO Network.

5. Needs of special populations

RMHP performs an annual assessment to ensure the organization is meeting cultural, ethnic and linguistic needs of our Members. In addition to collecting data that identifies the race, ethnicity, and primary language needs of our Members, RMHP performs several activities to further support Member needs. Some of the services include, but are not limited to:

- Communication Accommodation SOP contains instructions for our Member Service Representatives to assist members in need of Deaf/Blind/ASL assistance
- Identifying network providers in provider directories who speak languages other than English, including American Sign Language
    - o When a bilingual provider is not accessible, interpretation services are made available
- Translate Member materials into any language
    - o Some common materials are already available in Spanish
- RMHP contracts with a language services vendor to provide translation services for non-English speaking Members
- RMHP values diversity and encourages all network providers to be aware and sensitive to the cultural differences within our Membership by participating in various cultural competency programs and/or trainings
- RMHP Member Service and Care Management staff training on diversity, cultural competency, special needs of Members and heath disparities

6. Special population needs

For Members with complex medical and social needs, RMHP case managers work with people to coordinate the health care and other community services that our Members need, when they need them, and for the best value. Members may complete a Transition of Care Form at enrollment. This form helps identify Members who have special needs to develop complex or chronic health conditions. RMHP staff, PCPs, or other providers may refer to Members for case and disease management. As health needs are realized, the case managers streamline care to aid a Member's condition. The Member's progress toward recovery or resuming life activities is assessed.

7. Determining health care needs

RMHP has a variety of mechanisms in place to assess and track our Member's needs, including case management services, individual health appraisals, Care Management (CM), and quality improvement activities.

The CM team conducts concurrent and retroactive reviews of utilization data to discover which Members use what services and why. From this information, we evaluate how services provided by contracted providers match our Member's needs.

The Quality Improvement Committee evaluates several activities to assess Member needs including Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance, Member feedback from surveys focused on clinical programs and satisfaction with providers, Member appeals and grievances, and provider feedback. Opportunities for improvement are identified and quality improvement initiatives are developed to improve the quality of care and service for our Members.

V. Plans for Coordination and Continuity of Care

A. Coordination and continuity of care to specialty providers

RMHP offers a comprehensive Care Management Program for its eligible Members to promote enhanced coordination of care by meeting the needs of Members across a continuum of settings. Case Management focuses on enhancing and coordinating care across an episode of establishing a continuum of care. These interactions will promote the best overall health care results and quality of life for the Member.

At no additional cost, Rocky Mountain Health Plans offers registered nurses, certified case managers and care coordinators to work one-on-one with your patients to help them in:

- Following their treatment plan
- Understanding their diagnosis and treatment options

- Managing their chronic conditions
- Coordinating their health care services
- Understanding their RMHP benefits

In addition, we offer:

- Consistent support to change behaviors necessary to better accomplish the treatment plan you and the patient have devised
- Timely reminders encouraging proactive self-care activities to help your patients manage their chronic conditions according to your treatment plan
- Reinforced understanding of the meaning and significance of the treatment goals you have established
- Encouragement to get the medicines and stay on the medication regimen prescribed for them
- Accurate information about nutrition, stress, depression, and available community services

Rocky Mountain Health Plans offers formal Case Management Programs in the following areas:

- **Oncology Case Management**: A specially trained nurse provides support and coordinates services that help your patients better understand their treatment plans
- **Special Needs Case Management**: Our Nurse Case Manager's help your RMHP Prime patients, and their families negotiate the health care system by improving continuity of care and facilitate communication
- **Catastrophic Case Management**: Patients experiencing a catastrophic event can become overwhelmed. Our Nurse Case Managers will work with you and your Members to develop a comprehensive and coordinated approach to their care
- **High-Risk OB Case Management**: Qualified RNs assist you with coordination of care to ensure Member receives adequate support, education, and resources to minimize risk during pregnancy and the postpartum period
- **Transplant Case Management**: The program is designed to reinforce the care and treatment you provide to your patients. The focus of this program is to educate and help your patients take a more active and responsible role in managing their health

Additional Coordination and Continuity of Care

Rocky Mountain Health Plans allows continuation of treatment for Members undergoing an Active Course of Treatment.

"Active Course of Treatment" is defined as:

- An ongoing course of treatment for a life-threatening condition
- An ongoing course of treatment for a serious acute condition, chronic condition, or life-limiting illness
- The second or third trimester of pregnancy through the postpartum period; or
- An ongoing course of treatment for a health condition, whether physical health, mental health, behavioral health, or substance abuse disorder, for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

A Member must have been undergoing treatment or have been seen at least once in the last (12) months, by the provider being removed or leaving the network for that Member to be considered in an Active Course of Treatment. Prior authorization is required, benefit limitations apply, and treatment may be extended upon approval by RMHP's Medical Director.

The continuity of care period in the event of provider removal or leaving of the network or a Member undergoing an Active Course of Treatment shall extend to the earlier of: (1) the termination of the course of treatment by the Member or the treating provider; (2) ninety (90) days after the effective date of the provider's departure or termination, unless RMHP's Medical Director determines that a longer period is necessary; (3) the date that care is successfully transitioned to a participating provider; (4) benefit limitations under the plan are met or exceeded; or (5) care is no longer medically necessary. The continuity of care period for Members who are in their second or third trimester of pregnancy shall extend through the postpartum period.

RMHP shall make a good faith effort to provide written notice within fifteen (15) working days of the provider being removed or leaving the network to Members who are in an Active Course of Treatment. If RMHP becomes insolvent or unable to continue operations for any reason, all Members will be given written notice within fifteen (15) days of such an event. RMHP participating providers will continue to provide benefits to Members through the date of termination of RMHP's contract with the Department to prov ide services and will continue care for Members confined in an inpatient facility until their discharge. RMHP providers cannot seek reimbursement from RMHP Members for covered services received during this period, except for any applicable copayments, coinsurance, or deductibles.

A continuity of care request can only be granted when: (1) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to RMHP for that Member as provided in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and RMHP; and (2) the provider agrees in writing not to seek any payment from the Member for any amount for which the Member would not have been responsible if the provider were still a participating provider.

Any decisions regarding continuity of care are subject to the internal and external Member appeal procedures as set forth in the evidence of coverage. To request case management for a Member, please call Member Services or send an email to **rmhpcaremanagementreferrals@uhc.com**.

B. Ancillary services

RMHP supports and encourages primary care physicians to coordinate the Members care. Requests for assistance are directed to RMHPs Case Management staff, who consider services that may be provided by ancillary providers, including social services or other community resources.

For new Members who are currently involved in active treatment, RMHP may consider approving the continued use of non-participating providers. RMHPs Care Management Department maintains a process for facilitating coordination of care for new Members. Services from non-participating providers must be evaluated and approved before treatment is continued and services are received by the Member. RMHPs Care Management staff will contact the non- participating provider and obtain a treatment plan and agreement from the nonparticipating provider not to balance bill the Member.

C. Discharge planning

Discharge Planning is initiated by the attending physician, hospital staff, and/or Care Manager Coordination staff upon the patient's admission. This process is performed through the identification of patient / family needs, distribution of community resource information, and recommendation to the attending physician of specific resources available to meet the patient / family needs. A physician's order is required for discharge.

D. Changing primary care providers

Members should follow these guidelines when selecting or changing to a new primary care physician (PCP):

- Each covered family member may pick a different PCP
- If a Member is new to a PCP's office, be sure to call the office to ensure they are accepting new RMHP Rocky Mountain Valley HMO Network patients
- If a Member is changing to a new PCP have medical records transferred to the new PCP's office

When RMHP receives notification from a primary care physician, written communication is sent to the Member notifying them their primary care physician is terming with RMHP. Members are encouraged to find another primary care physician and to contact Member Service with any questions, concerns or to aid with finding a new primary care physician.

E. Contract termination continuity of care proposed plan

In the event of provider termination, RMHP provides continuity of care for Members who are in an active course of treatment according to 10-16-704(9) (j) C.R.S. RMHP shall provide written notice within thirty (30) calendar days of the termination to Members who have been undergoing treatment or have been seen at least once in the last twelve (12) months by the provider being removed.

Such notifications will describe continuity of care and will inform the Member of provider termination procedures. If the contract termination involves a PCP, all Members who are patients of that PCP will be notified and will be instructed on

how to choose a new PCP. Case Management will assist Members in selecting a new PCP upon request. Appropriately trained Case Management staff are available to assist the Member/family and or guardian with the transition to a new provider.

RMHP's Care Management Department maintains a process for facilitating continuity and coordination of care in the following circumstances: a practitioner's contract is discontinued, a Member joins the health plan, benefit coverage ends and additional services are required.

F. "Hold harmless" provisions

All RMHP provider contracts contain a provision that in no event, including but not limited to nonpayment by RMHP or RMHPs insolvency or any breach of the provider contract, shall a provider bill, charge or collect a deposit from or seek compensation, remuneration from or have any recourse against any covered Member for covered services.

If RMHP becomes insolvent or unable to continue operations for any reason, all Members will be given written notice within fifteen (15) days of such an event. RMHP participating providers will continue to provide benefits to covered persons through the date of termination of RMHP's contract with the State to provide services and will continue care for Members confined in an inpatient facility until their discharge. RMHP providers cannot seek reimbursement from RMHP Members for covered services received during this period, except for any applicable copayments, coinsurance, or deductibles.

VI. Attachments Colorado Standard Option Plans

UHC and RMHP have developed an enterprise-wide strategy for the reporting Network Provider Demographic data in regulation 4-2-80 and Section 5.1 and 5.2 using the Network Access Plan Reporting Template attached.