NETWORK ACCESS PLAN

1. INTRODUCTION

Name of Carrier	UnitedHealthcare of Colorado, Inc./HIOS 59036
Name of Network/Network ID	**Choice** / CON005 Binder Filing # UHLC-CO24-125116798
Type of Network/General Description	The Choice plan gives you the freedom to use any doctor or hospital in our national network. However, you must seek care from UnitedHealthcare Choice network providers to receive benefits. You do not need to choose a primary care physician and you do not need a referral to see a specialist. Emergency care is covered at the network level of benefits for you and your covered dependents, anywhere in the world.
Specific Geographic area(s) covered by network	Statewide
Website	https://www.uhc.com/legal/required-state-notices/colorado
Contact Information	Contact information can be found on member ID Card

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESSES

Evaluation Criteria	Response
A. Summary of the carrier's network adequacy standards measured and results of measurements. This is a **written summary** of the number of providers and facilities within a reasonable distance as reported on the Enrollment Document. If any network adequacy standards are not met, this section must identify the provider(s)/facility(ies) that are not adequate. This information will also be included on the Network Adequacy Cover Sheet. The inclusion of measurement tables or specific data is not appropriate.	Our current ratios for the network of providers serving our projected membership has been reviewed and determined to be adequate in each county or within a reasonable driving distance as defined by county designation time/distance specifications. Our analysis reveals that we have **7,414 projected members** in the State of Colorado. To serve these members we have: • 14,254 PCP's • 21,388 Specialists • 7,230 OB/GYN • 12,605 Pediatricians • 20,087 BH/MH and SUD Providers • 881 Pharmacies • 87 Hospitals • 87 Emergency Facilities • 162 Urgent Care Facilities • 335 BH/MH and SUD Facilities
B. The carrier's documented quantifiable and measurable process for monitoring and assuring the sufficiency of the network in order to meet the health care needs of populations enrolled in managed care plans on an ongoing basis. This section requires a description of how telehealth is used (or not used) to meet healthcare needs and network adequacy standards.	UnitedHealthcare has specific, quantifiable standards for numeric (provider to member ratios) and geographic (distance) availability of participating providers and providers and practitioners. The network composition is measured against these standards at least annually to ensure the network is sufficient in number and type of practitioner to ensure services are accessible without unreasonable delay. An analysis of the network is also conducted as to how well the network meets member needs and cultural preferences. **Telehealth** Telemedicine and Telehealth services, which are services where the physician or other healthcare professional and the patient are not at the same site, are a covered expense. This policy applies to all products and all network and non-network physicians and other qualified health care professionals. Examples of such services are those that are delivered over the phone, via the Internet or using other communication devices. Telehealth can be used by an enrollee to meet their healthcare needs. Telehealth is not used to meet network adequacy standards.
C. The factors the carrier uses to build its provider network, including a description of the network and the criteria used to select and/or tier providers.	**Identification of High-Volume Specialty Care Practitioners** Top HVS are identified at least annually. For some products more frequent identification of HVS is conducted to meet state, federal and/or other regulatory requirements. Due to differences in data sources and regulatory requirements, methods to identify high volume specialists vary by product type.

	Commercial/Marketplace Health Plans Identification of HVS is based on visits per 1000 members' data. These data are used to identify the top three high volume specialties. If OB/GYN's are not identified in the top three, then they are added as a fourth specialty. **Identification of High Impact Specialty Care Practitioners** Top HIS are identified, at least annually. Due to differences in data sources and regulatory requirements, methods to identify HIS vary by product type. HVS practitioners may also be designated as HIS when appropriate. **High Volume Specialty (HVS) Care Practitioners**: A type of specialist who treats a significant portion of an organization's membership. **High Impact Specialist(s) (HIS)** A type of specialist who treats specific conditions that have serious consequences for the member and require significant resources. These processes are consistent across commercial products; Choice, Choice Plus and Options Networks.
D. The carrier's quality assurance standards, which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care in a network. The inclusion of a corporate quality assurance manual is not appropriate, but a summary and reference to such a manual should be included.	Annually, UnitedHealthcare completes an assessment of Network Adequacy in order to identify areas for improved member access to services. Included in the Network Adequacy assessment are evaluation of Availability (geographic, numeric, cultural and linguistic availability of practitioners), Accessibility (access to appointments based on Consumer Assessment of Healthcare Providers and Systems (CAHPS®1) Health Plan Survey data, other member surveys/data or other member experience data for routine, urgent and after hours care and access to high volume and high impact specialty care. An assessment of complaints and appeals related to access to care is integrated into the analysis. Requests for out-of-network utilization of services are included in the analysis. As a result of this Annual Assessment, High Priority Opportunities are identified and an Intervention plan of action is implemented with an effectiveness report of said intervention being part of the next Annual Assessment.
E. The carrier's description of corrective action processes that will be used to remedy networks found to be inadequate. This plan should include possible remedies, proposed timeframes and schedules for implementation, and proposed notification and communications with the Division, providers, and policyholders.	UnitedHealthcare maintains standards for the numeric and geographic availability of participating practitioners and providers, adopted from the CMS Medicare Advantage standards for measuring network accessibility. UnitedHealthcare analyzes the networks against these established standards at least annually. At least biennially, UnitedHealthcare conducts an assessment of how well the network meets members' cultural needs and preferences. Interventions related to both analyses are identified and implemented to improve availability when needed. Assessments are conducted in accordance with state, federal and regulatory requirements.
F. If a network is found to be inadequate, the carrier will explain/describe specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification & communications with the Division, providers and policyholders. A summary of these corrective actions will be reported on the Carrier Network Adequacy Summary and Attestation Form.	Based on UnitedHealthcare's 2022 provider and facility data extract for the Network Adequacy review, UnitedHealthcare identified provider services that did not meet Network Adequacy. The specific category and in each county in which the network is found to be inadequate is listed in Attachment D under the "Network Adequacy Summary and Attestation Form" section under "Supporting Documentation" section in SERFF. Actions: • UnitedHealthcare is committed to continued research for additional providers entering the market for viable recruitment candidates. If additional providers are identified locally and determined to be viable recruitment candidates, UnitedHealthcare will outreach to those providers to determine their interest in participation. Additionally, as part of our policy, we will negotiate rates for treatment with any available out-of-network provider for members without access on a case by case basis and ensure that members are held harmless from "balance-billing" or any amounts beyond the copayment, deductible, and coinsurance percentage that we would have paid had the insured received services from an in-network provider. • UnitedHealthcare's free Health4Me mobile app provides members the ability to easily locate nearby health care providers, convenience care, urgent care, and emergency care facilities. • Continue specialty physician access in 2022 • Continue expansion and member education of Telehealth/Virtual care. • Continue to work with individual offices and urgent care centers to extend open hours and weekend coverage.

<table>
<tr>
<td>G. The carrier's process to assure that a covered person is able to obtain a covered benefit, at the in-network level of benefit, from a non-participating provider should the carrier's network prove to be inadequate.</td>
<td>Out-of-Network Requests: UnitedHealthcare also has a documented process for providing services, when necessary, outside of the network. Upon receipt of a provider or member's coverage request to begin or continue treatment with an out-of-network provider, the procedures under the utilization management program provide for administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements

The purpose of this process is to provide timely and consistent determinations and notices for all out of network coverage requests. Examples of Out of Network Coverage Requests include the following:

• Network Gaps: A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.</td>
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<td>H. The carrier's process for monitoring access to in-network physician specialist services for emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at its participating facilities.</td>
<td>Access Standards and Measures
The plans measure member accessibility to medical services and member services against at least one of the standards for each type of service shown in the table below.
<table>
<tr><th>Type of Service</th><th>Standards/Measures</th></tr>
<tr><td>Preventive Care</td><td>Within 4 Weeks
Percentage of members responding through member satisfaction survey that they get an appointment for routine care as soon as needed. *

*Access complaint volume threshold per 1000 members</td></tr>
<tr><td>Regular/Routine Care Appointment</td><td>Within 14 days
Percentage of members responding through a member satisfaction survey that an appointment for routine care was obtained as soon as needed.*

*Access complaint volume threshold per 1000 members</td></tr>
<tr><td>Urgent Care Appointment</td><td>Same day
Percentage of members responding through a member satisfaction survey that an appointment for care needed right away was obtained as soon as needed.*

*Access complaint volume threshold per 1000 members</td></tr>
<tr><td>After-Hours Care</td><td>24 hours/7 days a week for primary care
Percentage of members responding through a member satisfaction survey that they were able to access after-hours care as soon as needed.*
Percentage of member responding through a member satisfaction survey that an appointment for care needed right away was obtained as soon as needed.*

*Access complaint volume threshold per 1000 members</td></tr>
<tr><td>High Volume and High Impact Specialty Care</td><td>Percentage of members responding through a member satisfaction survey that they were able to access specialty care as soon as needed.*
Percentage of requests for out-of-network (OON) services by HVS and HIS specialist practitioner types fall within established variance range from benchmark (regional performance)
Average days to wait for new patient and established patient appointment times as reported by survey of practitioners.

*Access complaint volume threshold per 1000 members</td></tr>
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3. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

Evaluation Criteria	Response
A. Location(s)/availability of a provider directory(ies), how often it is updated, and availability in other languages [A provider directory is a comprehensive listing, made available to covered persons and primary care providers, of the carrier's network of participating providers and facilities]	Members have access to myuhc.com a website with online directories to search for doctors, clinics, or facilities, with the option to print results. Additionally, there is a link for native language choices. This information is updated on a continual basis with the date of last update in lower left corner of page.
B. Full description of the referral process, including at a minimum: 1. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health benefit plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers. 2. A process for timely referrals for access to specialty care. 3. A process for expediting the referral process when indicated by medical condition. 4. A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse. 5. A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse. 6. A health benefit plan that offers variable deductibles, coinsurance, and/or copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees;	UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in-network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified. **Specialist Referral:** The member's assigned PCP coordinates the member's care and submits electronic referrals to UnitedHealthcare before the member sees another network physician. If a network specialist identifies the need for a member to see another specialist, the specialist must ask the member's PCP, who decides whether or not to issue an additional referral. **Referral Process:** Notification to the member should complete in a timely manner, not to exceed five business days of a request for non-urgent care, or 72 hours of a request for urgent care. When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. **Out-of-Network Requests and Continuing Care:** UnitedHealthcare also has a documented process for providing services, when necessary, outside of the network. Upon receipt of a provider or member's coverage request to begin or continue treatment with an out-of-network provider, the procedures under the utilization management program provide for administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements. If the individual's benefit plan coverage of services is exhausted while the individual still needs care, the organization will offer services, as required, to educate the consumer about alternatives for continuing care and how to obtain care. The purpose of this process is to provide timely and consistent determinations and notices for all out of network coverage requests and to ensure members have needed information regarding alternatives for continuing care. Examples of Out of Network Coverage Requests include the following: • **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise. • **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly covered consumer who is receiving ongoing care a transition period before they are required to transfer from an out-of-network provider to an in-network provider and to receive network benefits under the terms of the employer health benefits or government program contract for the transition period.

C. The carrier's process for allowing members to access services outside the network when necessary.	• **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.

4. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

Evaluation Criteria	Response
A. In the network access plan for each network offered, a carrier shall explain its method for informing covered persons of the plan's services and features through disclosures and notices to policyholders.	The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits including but not limited to: • Member rights and responsibilities • QI Program activities and accomplishments • Case management programs • Disease Management programs • Financial incentives related to utilization management (UM decisions) • Benefits coverage, exclusions, restrictions and costs of care • Pharmacy and UM procedures and benefits • Notification requirements and medical services • Evaluation of new technology • Finding a network physician or hospital • Obtaining routine, preventive and specialty care; urgent, ER and hospital; after-hours, out of state/area and behavioral care • Looking up and submitting claims, obtaining and ID card • How to submit a complaint or appeal • External appeal processes • Language assistance and TDD/TYY services • Notice of Privacy Practices Methods of communication include, but are not limited to, distribution of the Certificate of Coverage, Welcome Guide, Quick Start Guide, and the annual Rights and Resource Disclosure Booklet (ARRD). Members also have access to myuhc.com, a website with resources for accessing personal health records, finding physicians, and encouraging healthy behaviors.

B. Required disclosures, pursuant to § 10-16-704(9), C.R.S., shall include: 1. The carrier's grievance procedures, which shall be in conformance with Division regulations concerning prompt investigation of health claims involving utilization review and grievance procedures; 2. The extent to which specialty medical services, including but not limited to physical therapy, occupational therapy, and rehabilitation services are available; 3. The carrier's procedures for providing and approving emergency and non-emergency medical care; 4. The carrier's process for choosing and changing network providers; 5. The carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities; 6. The carrier's documented process to identify the potential needs of special populations; and 7. The carrier's methods for assessing the health care needs of covered persons, tracking and assessing clinical outcomes from network services, assessing needs on an on-going basis, assessing the needs of diverse populations, and evaluating consumer satisfaction with services provided.	UnitedHealthcare's member grievance process, including the form, submission address and timeframes can be located at myuhc.com, as well as in the *UnitedHealthcare Provider Administrative Guide*. UnitedHealthcare members can go to myuhc.com, scroll down to the bottom and locate the Popular Forms sections and click the View Forms link. From there, scroll to the Tax, Legal and Appeals Forms section and click Appeals and Grievance Medical and Prescription Drug Request Form. There is information identifying what a member will need to file a request. The member can then click the Start Request button to begin the process. UnitedHealthcare members can also locate the process for grievances in their Certificate of Coverage document, in the Appeals and Complaints section. UnitedHealthcare members can call the phone number on the back of their ID card for assistance in filing a grievance/complaint. The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits, including finding a network physician, which include specialty medical services, including but not limited to physical therapy, occupational therapy, and rehabilitation services are available. The *Welcome Guide* and the *Getting The Most From Your Health Care Coverage* document within the *Annual Rights and Resource Disclosure* notice information provides information and resources for selecting a network provider. Detailed information regarding covered benefits and making Primary Care Physician changes can be found in the member's *Schedule of Benefits*. Covered persons have access to all covered services in and out-of-network in all circumstances. Emergency care is a covered service and is accessible in and out-of-network in all circumstances. Members receive plan specific *Certificate of Coverage* or *Evidence of Coverage* documents upon enrollment. Documents can also be accessed online at www.myuhc.com. Information is also listed on the back of the member's ID card. UnitedHealthcare completes an annual assessment of Network Adequacy, which includes the needs of special populations through the The Health Equity Services (HES) program. To enable services to be provided in a culturally competent manner and accessible to all members, an assessment of the cultural/linguistic needs of the members is conducted at least biennially. Based on the analysis of this assessment, adjustments may be made to the health plan networks to improve cultural availability. UnitedHealthcare's member can find resources related to Language Assistance and Nondiscrimination Notice at myuhc.com.

5. PLANS FOR COORDINATION AND CONTINUITY OF CARE

Evaluation Criteria	Page Number for Supporting Documentation
A. The carrier's documented process for ensuring the coordination and continuity of care	UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in-

for covered persons referred to specialty providers.	network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified. UnitedHealthcare members can locate the Continuity of Care information through their portal, which explains how to apply for continuity of care for new or existing members.
B. The carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources.	UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in-network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified. UnitedHealthcare members can locate the Continuity of Care information through their portal, which explains how to apply for continuity of care for new or existing members.
C. The carrier's documented process for ensuring appropriate discharge planning.	**Transitional Case Management:** Transitional Case Management (TCM) is the collaborative process of evaluating and coordinating post-hospitalization needs for members identified as being at risk of re-hospitalization or as frequent users of high-cost services. The goal of TCM is to facilitate access to services so that the member receives timely provider and home health services, medications, medical equipment, oxygen, therapies and other support as required. TCM can be accessed by contacting UnitedHealthcare via the provider portal.
D. The carrier's process for enabling covered persons to change primary care providers.	The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits, including finding a network physician. The *Welcome Guide* and the *Getting The Most From Your Health Care Coverage* document within the *Annual Rights and Resource Disclosure* notice information provides information and resources for selecting a network provider. Detailed information regarding covered benefits and making Primary Care Physician changes can be found in the member's *Schedule of Benefits*. As part of UnitedHealthcare's most recent NCQA Corporate survey, detailed instructions and screenshots were included in the myuhc.com demo, showing members how to change their Primary Care Physician selection online.
E. The carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process must include an explanation of how covered persons shall be notified in the case of a provider contract termination, the carrier's insolvency, or of any other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner.	UnitedHealthcare's *Provider Administrative Guide* and provider participation agreements include language that addresses continued access after termination to ensure continuity of care for specific medical conditions. Procedures are in place to ensure that members are notified when any of their active providers terminate participation agreements and that when clinically appropriate, members are allowed continued access to terminated providers at an in-network benefit level. Additionally, provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations. The language states: "Medical Group will not bill or collect payment from the Customer or seek to impose a lien, for the difference between the amount paid under this Agreement and Medical Group's billed charge or Customary Charge, for any amounts denied or not paid under this Agreement due to: i) Medical Group's failure to comply with the Protocols, ii) Medical Group's failure to file a timely claim, iii) Payer's payment policies, iv) inaccurate or incorrect claim processing, or v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable laws to assure that its Customers not be billed in such circumstances.
F. A carrier must file and make available upon request the fact that the carrier has a "hold harmless" provision in its provider contracts, prohibiting contracted providers from balance-billing covered persons in the event of the carrier's insolvency or other inability to continue operations in compliance with § 10-16-705(3), C.R.S. Network access plan requirements and demonstrations.	Provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations. The language states: "Medical Group will not bill or collect payment from the Customer or seek to impose a lien, for the difference between the amount paid under this Agreement and Medical Group's billed charge or Customary Charge, for any amounts denied or not paid under this Agreement due to: i) Medical Group's failure to comply with the Protocols, ii) Medical Group's failure to file a timely claim, iii) Payer's payment policies, iv) inaccurate or incorrect claim processing, or v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable laws to assure that its Customers not be billed in such circumstances.

PLANS FOR COORDINATION AND CONTINUITY OF CARE

Coordination Activities

An annual quantitative and qualitative analysis is conducted to review the continuity and coordination of medical care provided to UnitedHealthcare members across settings and or during transitions of care

The scope of activities includes managing and coordinating aspects of medically necessary care between inpatient and various outpatient settings and between primary physicians and specialists through care coordination and providing communications to bridge gaps between treating practitioners and providers. The primary activities may include but are not limited to:

- Prescription of controlled substances
- Member satisfaction with continuity and coordination of medical care
- Provider satisfaction with coordination of medical care
- Steerage to transplant centers of excellence
- Continuity of care between dialysis centers and nephrologist
- Postpartum care
- Transitional Case Management Opportunity
- Monitoring of Quality of Care Complaints

UnitedHealthcare staff partner with OptumHealth and OptumRx to identify gaps and develop strategies to act on opportunities to improve continuity and coordination of medical care.

Continuity of Care

UnitedHealthcare's *Provider Administrative Guide* and provider participation agreements include language that addresses continued access after termination to ensure continuity of care for specific medical conditions. Procedures are in place to ensure that members are notified when any of their active providers terminate participation agreements and that when clinically appropriate, members are allowed continued access to terminated providers at an in-network benefit level. Additionally, provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations.

UnitedHealthcare members can locate the Continuity of Care information through their portal, which explains how to apply for continuity of care for new or existing members.

Ongoing Monitoring

In accordance with UnitedHealthcare's *Availability of Practitioners and Providers* policy, we conduct a thorough assessment annually to ensure that the network is sufficient in numbers and types of providers, geographic distribution and cultural/linguistic features to meet the documented needs of our members.

Needs of Special Populations

The Health Equity Services (HES) program was established to help address health disparities. The HES program helps reduce health disparities by improving our culturally sensitive initiatives that promote health and prevent avoidable health care cost. To accomplish this, the HES program operates with four key focus areas:

- Collecting data to better understand our membership and their cultural characteristics
- Identifying gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language
- Growing multicultural capabilities to enhance the member experience

We continue to significantly enhance our HES programs and offerings through:

- Employee training for more insight about providing services to our members from diverse cultural backgrounds
- Customized member outreach and communication
- Enhanced data analytics to address identified health disparities

The Health Equity Services program completed an enterprise compliance assessment of the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and is at industry standard or better for all 15 standards. Despite being at industry standard or better for all CLAS standards, we continue to plan and implement improvements that will further our efforts to reduce identified member health outcome disparities.

Evaluation of members' cultural, ethnic, racial and linguistic needs may be measured using the following data sources:

- CAHPS® data
- Member Satisfaction Survey Data
- U.S. Census Data
- Network Database (NDB)
- Enrollment Data
- Medicare/Medicaid eligibility files
- Focus Groups
- American Community survey
- Other Sources As Required Or Needed

To enable services to be provided in a culturally competent manner and accessible to all members, an assessment of the cultural/linguistic needs of the members is conducted at least biennially. Based on the analysis of this assessment, adjustments may be made to the health plan networks to improve cultural availability.

Health Needs Assessment

UnitedHealthcare's *Assessing Member Experience* policy is to assess member experience with its services and programs, at least annually, and identify areas for potential improvement. When opportunities for improvement are identified, actions are taken to improve member experience.

Primary data collection sources include member complaints and appeals, UM consumer concerns, and member experience surveys. Member experience surveys may include, but are not limited to:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS®)
- Key Member Indicators (KMI) Survey
- Member Focus Groups
- Complex Case Management Surveys
- Disease Management Surveys
- State, Federal and Regulatory Surveys

Telehealth

"Telehealth" means 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. This term includes;

(A) Synchronous interactions
(B) Store-and-forward transfers and
(C) Services provided through HIPAA compliant interactive audio-visual communication or the use of a HIPAA compliant application via a cellular telephone

Telehealth" does not include delivery of health care services via:

Voice-only telephone communication or text messaging;
(A) Facsimile machine; or
(B) Electronic mail systems
(C) Electronic mail systems.