ROCKY MOUNTAIN STATEWIDE HMO NETWORK ACCESS PLAN CON001

Revised June 2020

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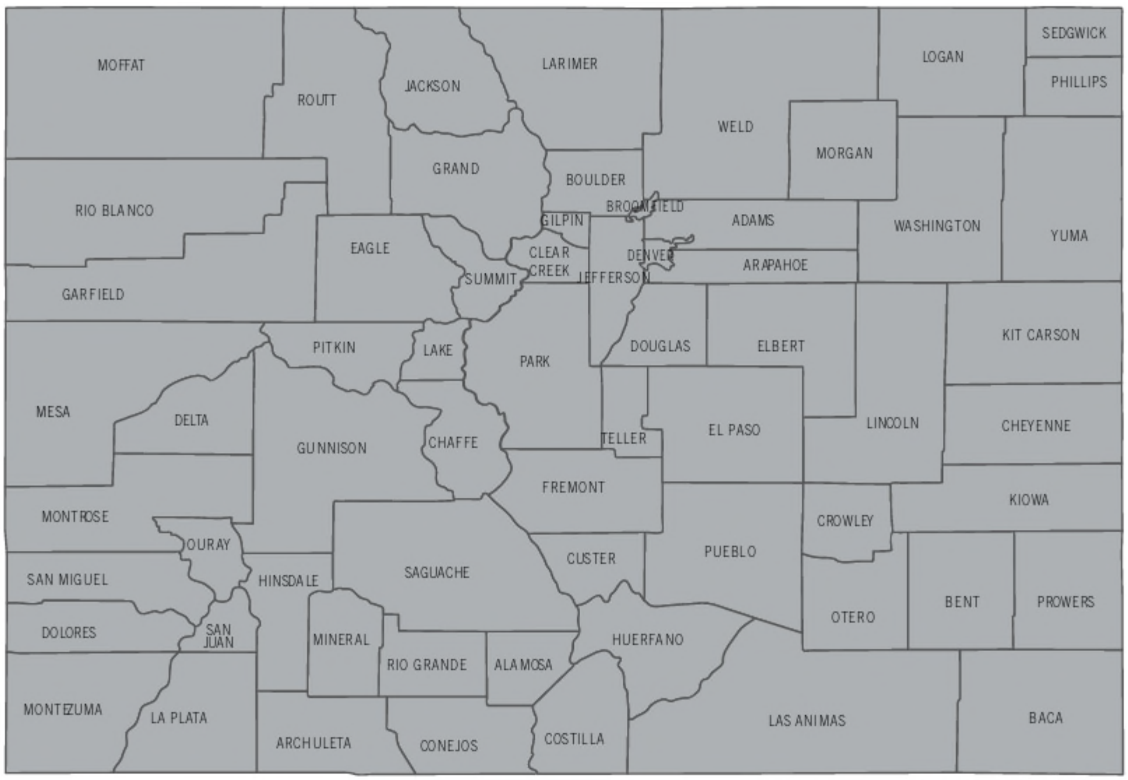
1. INTRODUCTION

This Access Plan (Access Plan) contains general information regarding the Rocky Mountain Health Maintenance Organization, Inc. (dba Rocky Mountain Health Plans or RMHP) Rocky Mountain Statewide HMO Network (Network ID CON001) 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 at our offices and online at https://www.rmhp.org/additional-provider-directories under RMHP Access Plans.

The Rocky Mountain Statewide HMO Network is one of the largest provider networks in Colorado. The network includes more than 20,000 doctors, specialists and hospitals, as well as access to more than 800 pharmacies.



Available to residents statewide with access to the RMHP provider network

RMHP Customer Service is available for Members Monday – Friday 8:00 a.m. to 5:00 p.m. at 800-346-4643 and Providers may contact RMHP by calling Customer Service Monday – Friday 8:00 a.m. to 5:00 p.m. at 800-854-4558. Members and Providers may also email RMHP Customer Service at customer_service@rmhp.org or visit our website at https://www.rmhp.org.

2. 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:

- Number of practitioner 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 service and appointment waiting times

Provider to Member Ratio Analysis Results

All Provider to Member ratio standards were met.

Geographic Analysis Results

The following Provider Types in certain County Types did not meet the geographic standards and/or RMHP's goal of ≥ 90%:

- Pediatrics: Rural and CEAC
- Cardiothoracic Surgery: Rural
- Endocrinology: Rural
- Gastroenterology: Rural
- Gynecology Only: Rural
- Nephrology: Rural
- Ophthalmology: CEAC
- Rheumatology: Rural
- Acute Inpatient Hospitals: Rural
- Outpatient Dialysis: Rural and CEAC
- Surgical Services: Rural
- Speech Therapy: Rural
- Inpatient Psychiatric Facility: Rural and CEAC
- Outpatient Infusion / Chemotherapy: Rural

Member geographic access is limited in select parts of Colorado due to the topography of the state. Natural barriers, and lack of infrastructure in certain areas is the major cause of reduced geographic access to the Provider Types in the County Types listed above. RMHP contracts with all willing providers who meet credentialing criteria so there may not be willing providers to contract with.

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

Access to Service Analysis Results

In the past, RMHP has sent out Appointment Wait Time Surveys annually in July 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. In 2020 RMHP planned to make some changes and send surveys quarterly in attempts to improve the response rate. Due to COVID-19, resources that were needed for the survey project were redirected elsewhere and/or extremely limited. Surveys for services during 2nd quarter 2020 are scheduled to begin late July/early August 2020.

B. Process for monitoring and assuring network sufficiency

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 Commercial Members. Below is the explanation of how counties are designated per the DOI's Regulation 4-2-53.

"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

Colorado County Designations			
County Type	**Classification**		
Large Metro	Denver		
Metro	Adams	Broomfield	El Paso
	Arapahoe	Douglas	Jefferson
	Boulder	Eagle	
Micro	Garfield	Larimer	Pueblo
	La Plata	Mesa	Weld
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
	Dolores	Moffat	Washington
	Grand	Ouray	Yuma
	Gunnison	Park	

Methodology for monitoring Provider to Member Ratios and 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 the proportion of providers to members as well as member distribution by provider type against performance goals.

Provider to Member Ratios			
Service 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 & Substance Abuse Disorder Care	1:1000	1:1000	1:1000

Geographic Access Standards					
Provider Type	**Large Metro** **Maximum Distance** (miles)	**Metro** **Maximum Distance** (miles)	**Micro** **Maximum Distance** (miles)	**Rural** **Maximum Distance** (miles)	**CEAC** **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 & 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
Orthopaedic 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

Geographic Access Standards					
Provider Type	**Large Metro** **Maximum Distance** (miles)	**Metro** **Maximum Distance** (miles)	**Micro** **Maximum Distance** (miles)	**Rural** **Maximum Distance** (miles)	**CEAC** **Maximum Distance** (miles)
Other Medical Providers	15	40	75	90	130
Dentist	15	30	60	75	100
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 Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or Ambulatory Surgical Centers)	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

Methodology for monitoring Access to Service

RMHP Provider Network Management (PNM) staff distributes Appointment Wait Time Surveys quarterly, starting in 2020, 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. Once total numbers are determined, sample sizes are calculated with a margin of error of 4% and a confidence level of 95%.

Access to Service Standards		
Service Type	**Time Frame**	**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, Substance Use	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 – Routine, non0urgent, 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	Within 7 calendar days	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

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 https://www.doctorondemand.com/.

C. Provider network factors

In many communities, and particularly in rural areas, RMHP's philosophy is to contract with all the available physicians, pharmacies, Essential Community Providers, and hospitals that meet RMHP's credentialing and quality standards. This inclusive concept results in high provider participation levels in most of RMHP's marketing area, thereby resulting in a large enough provider base to ensure accessibility and range of services for all our Members.

D. Quality assurance standards

RMHP's Quality Improvement (QI) Program establishes a formal process for developing and implementing an effective clinical quality improvement program, promotes objective and systematic monitoring and evaluation of clinical and service related activities, and acts on opportunities for improvement. The program focuses on activities related to care quality, patient safety, physician access and availability, Member satisfaction, continuity and coordination of care, care management, pharmacy management, and Member rights and responsibilities. The QI Program also fulfills obligations to provide an ongoing review of the quality of health care services pursuant to 42 U.S.C.A. Section 300e(c)(6), Sections 10-16401(4)(m) and 10-16-402(1)(b)(II), C.R.S., and regulations promulgated under such laws.

The objective of the QI Program is to monitor, measure, and take effective actions on identified opportunities to improve the quality and safety of health care and services through the cycle of objective evaluation, intervention and reevaluation. These activities are the summation of efforts by several Departments including Quality Improvement, Care Management, Pharmacy, Provider Network Management, Customer Service, Health Promotions, Claims, Home Health, Member Administration, Marketing, Information Technologies, and effective professional peer review. Pertinent activities from all of these processes are reported and integrated into the QI Program.

E. Corrective actions process

In the event a Network need is identified, based on Membership, RMHP will contact providers in the area that meet our credentialing guidelines and are willing to negotiate in good faith within 45 days. RMHPs goal is to add new providers within 30 days of the signed contract. New providers will be made public via the online directory. In rural areas where adequate providers are not available, RMHP will monitor the area for new providers.

F. Corrective actions summary

Rocky Mountain Health Plans will continue monitoring the 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, or telehealth services provided through Dr. On Demand.

G. Obtaining a covered benefit from a nonparticipating 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.

H. Monitoring access process

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.

3. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

A. Provider Directories

Members can utilize RMHP's online provider directory by visiting https://www.rmhp.org, selecting "Find a Provider" and then searching by their health plan, provider or facility. Advanced search options also allows Members to search providers by location, 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 Customer 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 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 before the Member gets it. This section will include RMHP's prior authorization processes in place of referral processes.

1. Referral options

Members of the Rocky Mountain Statewide Health HMO Network are able to 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 Statewide 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.

Certain Rocky Mountain Statewide 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 preauthorizations

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 amounts.

C. Accessing services out-of-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.

4. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

A. Informing members of plan's 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 group 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 in regards to 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 customer service, etc.

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

- Email: customer_service@rmhp.org
- Phone: 800-346-4643
- Fax: 970-244-7828
- Mail:
  Rocky Mountain Health Plans
  Attn: Member Appeals Department
  PO Box 10600
  Grand Junction, CO 81502-5600

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 in regards to, 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.

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

- Email: customer_service@rmhp.org
- Phone: 800-346-4643
- Fax: 970-244-7828
- Mail:
  Rocky Mountain Health Plans
  Attn: Member Appeals Department
  PO Box 10600
  Grand Junction, CO 81502-5600

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 requires 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 Statewide 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 Statewide HMO network. A referral is not 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 actually 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 Statewide 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 Statewide 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 Statewide 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 a number of activities to further support Member needs. Some of the services include, but are not limited to:

- Identifying network providers in provider directories who speak languages other than English, including American Sign Language
    - When a bilingual provider is not accessible, interpretation services are made available
- Translate Member materials in to any language
    - 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 Customer 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 a number of activities to assess Member needs including HEDIS and 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.

5. PLANS FOR COORDINATION AND CONTINUITY OF CARE

A. Coordination and continuity of care to specialty providers

RMHP offers formal Case Management Programs in the following areas:

- Oncology Case Management: A specially trained nurse provides support and coordinates services that help Members understand treatment plans.
- Special Needs Case Management: Nurse Case Managers help Members manage the health care system by improving continuity of and promote communication.
- Catastrophic Case Management: Nurse Case Managers work with providers and Members during a catastrophic health event to develop comprehensive and coordinated approach to the Members care.
- Transplant Case Management: Program focused on educating and helping Members become active and responsible in managing their own health care.

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 Statewide Health HMO 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 Customer Service with any questions, concerns or to provide assistance 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 (30) calendar days of the termination to Members who have been undergoing treatment or have been seen at least once in the last twelve 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.

RMHPs 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 days of such an event. RMHP participating providers will continue to provide benefits to covered persons through the date of termination of RMHPs 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.

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: the RMHP EEO Officer. You can file a grievance in person or by phone, mail, fax, or email.

- Phone: 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643
- Mail: ATTN: EEO Officer, Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600
- Fax: ATTN: EEO Officer, 970-244-7909
- Email: eeoofficer@rmhp.org

If you need help filing a grievance, the RMHP EEO Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Multi-Language Insert

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付 費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم المجاني على غلاف هذا الدليل.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر به فارسی صحبت می کنید ، خدمات کمک به زبان رایگان در دسترس است. با شماره تلفن رایگان روی جلد این راهنما تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो नि: शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। इस गाइड के कवर पर टोल-फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកឥតគិតថ្លៃ បានកត់ទៅខាងមុខនៃកូនសៀវភៅនេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.