Rocky Mountain Health Plans

2017

RMHP Medicare Network

ACCESS PLAN

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This Access Plan (Access Plan) contains general information regarding the Rocky Mountain HMO (RMHP) provider network 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 Medicare Evidence of Coverage (EOC), whether such provisions are also specified or referred to in this Access Plan.

Definitions

Primary Care Physician (PCP): A participating physician designated by the Member to provide routine and primary care services. Includes: Family Practice, Internal Medicine, Geriatrics, Primary Care Physician Assistants and Primary Care Nurse Practitioners.

Specialist – Key: A set of physician specialties selected by RMHP for access and availability measurements. Includes: Ophthalmology, Cardiovascular Disease, Orthopedic Surgery, Urology, Pulmonary Disease, Gastroenterology, Surgery, Otolaryngology, Neurology, and Endocrine/Diabetes/Metabolic.

Specialists – Other: A participating physician who is not a Primary Care Physician and whose specialty is not listed under Key Specialist.

Ancillary Product Providers: Companies who provide the following types of products: Durable Medical Equipment (Including Braces and Orthotics), Oxygen, Medical Supplies, and Miscellaneous Ancillary Products.

Ancillary Service Provider: A participating provider who provides or performs the following types of service: Audiology, Certified Nurse Midwives, Clinical Pathology, Clinical Radiology, Dentists, Dietician, Mental Health Therapy, Oral Surgeon, Physical Therapy, Podiatry, and Other Miscellaneous Ancillary Services.

Emergency/Life and Limb-Threatening Medical Care: An event which a prudent layperson would reasonably believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

High-Impact Specialist: Practitioner types who treat conditions that have high mortality and morbidity rates. NCQA defines these specialty types as Oncologists, OB/Gyn, and Gynecology (for Medicare only).

Institutional Providers: Participating facilities limited to Hospitals, Hospices, Home Health, and Skilled Nursing Facilities.

Pharmacy Providers: Pharmacy facility that is registered with the State Board of Pharmacy and has obtained all other required state and or federal licenses or registrations. Includes Retail, Long-Term Healthcare, Home Infusion, Specialty, and Mail-Order Pharmacies.

Urban Area: A ZIP Code population density being greater than 3,000 persons per square mile.

Suburban Area: A ZIP Code population density being between 1,000 and 3,000 persons per square mile.

Rural Area: A ZIP Code population density being less than 1,000 persons per square mile.

Pharmacy (including Medicare Part D):

- **Urban Area:** at least 90% of Medicare beneficiaries, on average, live within 2 miles of network pharmacy.
- **Suburban Area:** at least 90% of Medicare beneficiaries, on average, live within 5 miles of network pharmacy

- **Rural Area:** at least 70% of Medicare beneficiaries, on average, live within 15 miles of network pharmacy

Urgent Care: Medical care needed to treat an injury or illness of a less serious nature than those requiring emergency care, but required in order to prevent serious deterioration of the Member's health.

Network of Acute Care Hospitals, Primary Care Physicians and Specialists

In establishing and maintaining out network of providers, RMHMO endeavors to provide care within a reasonable travel time and distance to Members. To achieve this, RMHMO contracts with most available acute care hospitals, primary care physicians (PCPs), specialists and sub-specialists who meet RMHMO's credentialing and quality standards within the service area.

For those plans with a pharmacy benefit, RMHMO offers a network of participating pharmacies throughout its service area. Our policy is to offer contracts to any willing pharmacy provider who meets our licensure and credentialing standards as defined under Pharmacy Providers, and who is willing to provide services to members at reasonable rates for the services provided. Rocky Mountain Health Plans may also contract with Mail Order Pharmacies whenever access to service is limited or there is no physical location for members to access pharmacy services.

RMHP does not use quality measures, member experience measures, or cost-related measures to select practitioners or facilities. In establishing and maintaining out network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

Counties included in RMHP's Service Area for RMHP Medicare plans

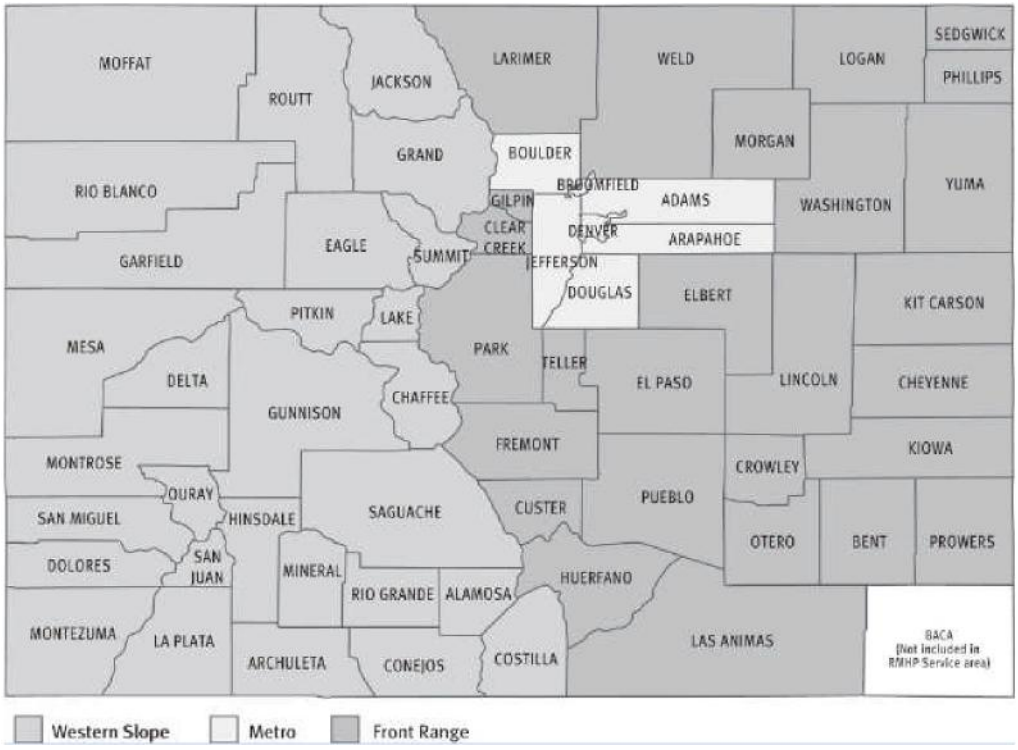
Adams	Costilla	Garfield	Lake	Otero	San Juan
Alamosa	Crowley	Gilpin	Larimer	Ouray	San Miguel
Arapahoe	Custer	Grand	Las Animas	Park	Summit
Archuleta	Delta	Gunnison	Lincoln	Philips	Teller
Bent	Denver	Hinsdale	Logan	Pitkin	Washington
Boulder	Dolores	Huerfano	Mesa	Prowers	Weld
Broomfield	Douglas	Jackson	Mineral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

RMHP's Medicare network currently consists of the following participating providers

2505	PCPs
6567	Specialists
665	High Impact Specialists
2201	Behavioral Health providers
3892	Family Planning Services providers (FP, Ob/Gyn, Gyn, FQHC)
426	Institutional Providers
943	Ancillary Providers
754	Pharmacies

RMHMO also contracts with providers in neighboring states to help serve Colorado Members in border areas who may have trouble accessing Colorado providers due to winter travel limitations or lack of providers in their area.

Map of RMHP Medicare Service Area



Procedures for Making Referrals Within and Outside The RMHP Network

Comprehensive List of Providers

The Directory of Participating Physicians and Contracting Providers is available online at rmhp.org. A paper copy of the Directory is available upon request. The directories list our entire network of PCPs, specialists, hospitals and other institutional and ancillary providers, organized by geographic region. The directory listing is incorporated herein by reference. The directories, both online and hardcopy are updated and available to providers for their use in directing RMHMO specialty care.

In-Network Services

All Members are required to choose a PCP to direct their care. Members of a RMHP Medicare plans 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 RMHP health plan at the time services are provided and the services that the Member receives must be covered services as specified in the Medicare Evidence of Coverage (EOC).

RMHP Medicare allows in-network direct access to influenza vaccines and does not impose cost sharing for influenza vaccines. Direct in-network access to mammographies is also

permitted.

Out-of-Network/Out-of-Plan Services

Medicare Members may choose to access original Medicare benefits instead of RMHP benefits. For services that are covered by original Medicare, Members may use non-participating Providers. In that case, the provider must submit claims directly to original Medicare and the Member must pay original Medicare coinsurance and deductibles. RMHP will not pay any amounts for these services unless the care received was urgent, emergent, or prior authorized.

Except as set forth above, the Medicare EOC stipulates that a Member is restricted to a specific network of providers. Members may be directed to non0participating providers by the PCP, subject to obtaining RMHP's approval, in these circumstances:

- RMHP has no participating providers who can provide a specific, medically-necessary covered service; or
- Members do not have reasonable access to a participating provider due to distance or travel time.
- Any such requests must be approved in advance by RMHP prior to the Member obtaining health care services.
- Any authorized care is subject to the conditions and restrictions of the authorization.

Non-emergent non-urgent-care services that Medicare cost plan enrollees obtain from non-network providers, when not referred, are covered under original Medicare and subject to Medicare Fee-for-Service coinsurance and deductible requirements.

Timeliness of Preauthorization for Out-of-Network Specialty Care

Requests for specialty care requiring preauthorization by RMHMO will be processed within all regulatory timeframes. Preauthorizations may be expedited and processed within all regulatory timeframes if indicated by a member's medical condition if requested by the Member or the Member's PCP.

Timeliness of Out-of-Network Preauthorizations

Requests for out-of-network services to be covered at the in-network benefit level will be processed within all regulatory timeframes.

Retrospective Denial of Out-Of-Network Service

Approved requests for health care services which RMHP Members are eligible to receive are not retrospectively denied except for fraud or abuse by the subscriber or Member. Approved 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.

Process for Monitoring and Assuring Network Sufficiency

Process for Monitoring and Assuring the Sufficiency of the Network to Meet the Health Care Needs of Members Enrolled in RMHP Medicare Plans

In many communities, and particularly in rural areas, RMHP's philosophy is to contract with most available physicians 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 large enough provider base to ensure accessibility and

range of services for all our Members.

In areas where most available physicians, hospitals, and ancillary providers who meet RMHP's credentialing and quality standards are not under contract, the number of such providers contracted in the area is based on Membership size. However, in all areas, RMHP strives to maintain an appropriate number of providers to ensure accessibility and range of services. When feasible, contracts are negotiated with ancillary providers that have multiple statewide locations to ensure coverage in all service areas.

The need for additional access to physicians, ancillaries, and facilities is based on the following factors:

- In response to a specific need identified by RMHP's Utilization and Medical Quality Improvement team;
- In response to requests from Members;
- Due to expansion of RMHP's service area; or
- When RMHP determines more providers are needed for providing enrolled Members and projected enrollment with adequate access to care. If the enrolled Membership size in an area is stable, providers leaving a specified panel will generally be replaced to ensure accessibility and range of service.

Access to Care

The objective of RMHP's access committee is to monitor, measure, and take actions on identified opportunities to improve Member access to health services.

RMHP maintains quality standards to identify, evaluate, and remedy problems relating to access of care. Set forth below are RMHP's targets, which are goals, for provider to Member ratios, availability of appointment, and waiting times in provider offices. For each specific area served, RMHP regularly reviews access to care by Members, considering the relative availability of PCPs, specialists and sub-specialists, and acute care hospitals in the area based on location, number and types of providers, cost and suitability of care, and whether the provider can meet RMHP's credentialing requirements.

RMHP evaluates such access through its Access Committee, with participating by a standing, interdepartmental access committee. If problems are identified, RMHP seeks to remedy access problems in various ways depending on the nature of the problems. Some problems may be remedied by contracting with certain providers were practicable, encouraging providers to travel to certain areas, providing transportation alternatives to Members, and use of telemedicine.

Target Provider to Member Ratios

The geographic distribution of providers and members is based on data from the US Census Bureau population estimates to determine the delineation of a specific county in Colorado as Large Metro, Metro, Micro, Rural, or CEAC (Counties with Extreme Access Considerations) according to the parameters below:

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

95th Percentile of Beneficiaries Served by MA Organizations

The “95th Percentile Base Population Ratio” represents the 95th percentile of MA market penetration rates of Coordinated Care Plan (CCP) and network-based Private Fee for Service (PFFS) Medicare Advantage Organizations (MAO) contracts by county for each county type3 (Large Metro, Metro, Micro, Rural and CEAC); i.e., 95% of CCP and network-based PFFS contracts have county penetration rates equal to or less than the calculated rates.4 Each year CMS updates the 95th percentile based on current enrollment.

Provider Ratios:

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
General Practice					
Family Practice					
Internal Medicine					
Geriatrics					
Primary Care - Physician Assistants					
Primary Care - Nurse Practitioners					
Primary Care	1.67	1.67	1.42	1.42	1.42
Allergy and Immunology	0.05	0.05	0.04	0.04	0.04
Cardiology	0.27	0.27	0.23	0.23	0.23
Chiropractor	0.10	0.10	0.09	0.09	0.09
Dermatology	0.16	0.16	0.14	0.14	0.14
Endocrinology	0.04	0.04	0.03	0.03	0.03
ENT/Otolaryngology	0.06	0.06	0.05	0.05	0.05
Gastroenterology	0.12	0.12	0.10	0.10	0.10
General Surgery	0.28	0.28	0.24	0.24	0.24
Gynecology, OB/GYN	0.04	0.04	0.03	0.03	0.03
Infectious Diseases	0.03	0.03	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
Neurology	0.12	0.12	0.10	0.10	0.10
Neurosurgery	0.01	0.01	0.01	0.01	0.01
Oncology - Medical, Surgical	0.19	0.19	0.16	0.16	0.16
Oncology - Radiation/Radiation Oncology	0.06	0.06	0.05	0.05	0.05
Ophthalmology	0.24	0.24	0.20	0.20	0.20
Orthopedic Surgery	0.20	0.20	0.17	0.17	0.17
Physiatry, Rehabilitative Medicine	0.04	0.04	0.03	0.03	0.03
Plastic Surgery	0.01	0.01	0.01	0.01	0.01
Podiatry	0.19	0.19	0.16	0.16	0.16
Psychiatry	0.14	0.14	0.12	0.12	0.12
Pulmonology	0.13	0.13	0.11	0.11	0.11
Rheumatology	0.07	0.07	0.06	0.06	0.06
Urology	0.12	0.12	0.10	0.10	0.10
Vascular Surgery	0.02	0.02	0.02	0.02	0.02
Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01

Specialty	Geographic Type				
	Large Metro	Metro	Micro	Rural	CEAC
General Practice					
Family Practice					
Internal Medicine					
Geriatrics					
Primary Care - Physician Assistants					
Primary Care - Nurse Practitioners					
Primary Care	1.67	1.67	1.42	1.42	1.42
Allergy and Immunology	0.05	0.05	0.04	0.04	0.04
Cardiology	0.27	0.27	0.23	0.23	0.23
Chiropractor	0.10	0.10	0.09	0.09	0.09
Dermatology	0.16	0.16	0.14	0.14	0.14
Endocrinology	0.04	0.04	0.03	0.03	0.03
ENT/Otolaryngology	0.06	0.06	0.05	0.05	0.05
Gastroenterology	0.12	0.12	0.10	0.10	0.10
General Surgery	0.28	0.28	0.24	0.24	0.24
Gynecology, OB/GYN	0.04	0.04	0.03	0.03	0.03
Infectious Diseases	0.03	0.03	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
Neurology	0.12	0.12	0.10	0.10	0.10
Neurosurgery	0.01	0.01	0.01	0.01	0.01
Oncology - Medical, Surgical	0.19	0.19	0.16	0.16	0.16
Oncology - Radiation/Radiation Oncology	0.06	0.06	0.05	0.05	0.05
Ophthalmology	0.24	0.24	0.20	0.20	0.20
Orthopedic Surgery	0.20	0.20	0.17	0.17	0.17
Physiatry, Rehabilitative Medicine	0.04	0.04	0.03	0.03	0.03
Plastic Surgery	0.01	0.01	0.01	0.01	0.01
Podiatry	0.19	0.19	0.16	0.16	0.16
Psychiatry	0.14	0.14	0.12	0.12	0.12
Pulmonology	0.13	0.13	0.11	0.11	0.11
Rheumatology	0.07	0.07	0.06	0.06	0.06
Urology	0.12	0.12	0.10	0.10	0.10
Vascular Surgery	0.02	0.02	0.02	0.02	0.02
Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01

Drive Time and Distance Standards - Providers:

Specialty	Geographic Type									
	Large Metro		Metro		Micro		Rural		CEAC	
	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)
General Practice										
Family Practice										
Internal Medicine										
Geriatrics										
Primary Care - Physician Assistants										
Primary Care - Nurse Practitioners										
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology - Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation/Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative Medic	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130

Time and Distance Standards – Facility:

Specialty	Geographic Type									
	Large Metro		Metro		Micro		Rural		CEAC	
	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)	Time (minutes)	Distance (miles)
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services – ICU	20	10	45	30	160	120	145	120	155	140
Outpatient Dialysis	20	10	45	30	65	50	55	50	100	90
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Orthotics and Prosthetics	30	15	45	30	160	120	145	120	155	140
Home Health										
Durable Medical Equipment										
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Heart Transplant Program										
Heart/Lung Transplant										
Kidney Transplant Program										
Liver Transplant Program										
Lung Transplant Program										
Pancreas Transplant Program										

Availability (timeliness) and Access (geographic distribution):

RMHP maintains criteria regarding access to appropriate practitioner care, subject to Members meeting all contractual requirements. Medicare uses a general rule of geographic access to be 30 miles or 30 minutes.

RMHP's goal is to provide access to services to the extent such services are relatively available based on location, number and types of providers, cost and suitability of care, RMHP's credentialing requirement and considering usual travel patterns within the community. Each goal, criteria and ratio described herein is only a goal and not a binding standard.

Access to Care-Pharmacy Services-Medicare Part D

Retail Pharmacy network access standards are given in terms of distance only:

- Urban- At least 90% of Medicare beneficiaries, on average, live within 2 miles of network pharmacy
- Suburban- At least 90% of Medicare beneficiaries, on average, live within 5 miles of network pharmacy
- Rural- At least 70% of Medicare beneficiaries, on average, live within 15 miles of a network pharmacy

Additional availability criteria for appointment and wait times are as follows. These goals are monitored through interdepartmental activities which are reviewed and evaluated by the access committee.

Service Type	Time Frame	Time Frame Goal
Emergency Care - Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care - Medical, Behavioral, Mental Health and Substance Abuse	Within 6 hours*	Met 100% of the time
Primary Care - Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care - Routine, non-urgent, non-emergency	Within 7 calendar days	Met ≥ 90% of the time
Prenatal Care	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hrs. / 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care - non urgent	Within 60 calendar days	Met ≥ 90% of the time

RMHP provides Members with information on how to access the care they need. Directions on how to obtain primary care, specialty care, ancillary and hospital services are given in our Provider Directories, our Member Care Guide and Member newsletter, and in the Medicare EOC. After-hours and emergency information is outlined in our Emergency Care brochure, the EOC, Member Care Guide, and on our Member Identification cards.

Quality Improvement Program

The Rocky Mountain Health Plans (RMHP) 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 10-16- 401(4)(m) and 10-16-402(1)(b)(II), C.R.S., and regulations promulgated under such laws.

Goals of Quality Improvement Program

- Improve the quality of all categories of health care, including behavioral health care and chronic illness care, provided to the entire population of RMHP Members.
- Promote clinical care and services that are delivered in a safe, timely, efficient, effective, equitable, and patient-centered manner.
- Respond to the needs and expectations of RMHP internal and external customers by evaluating clinical and service performance relative to meeting those needs and expectations.
- Encourage and engage in effective professional peer review.

- Support and facilitate health care entities in geographically distinct areas in coordinating the collection and utilization of quality improvement information.
- Evaluate and improve the effectiveness of the QI Program by developing action plans based on measured outcomes.
- Report results of quality improvement efforts.
- Ensure compliance with statutory requirements and accreditation standards.

Objective of Quality Improvement Program

The objective of the RMHP 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.

The RMHP QI Program includes but is not limited to the following activities:

- Identify, through multiple mechanisms, important areas of care, safety, and service to be monitored. Initiate and complete necessary activities.
- Promote quality and safety of clinical care by reviewing identified adverse patient outcomes, identifying and evaluating trends, and taking corrective action if deemed warranted.
- Improve Member awareness and engagement in their own health care.
- Review and respond to Member and provider concerns through interdepartmental committee activities. Identify and evaluate related trends. Take corrective action if deemed warranted.
- Monitor and improve Member access to and continuity of care through interdepartmental committee activities.
- Coordinate and facilitate the collection and review of QI data pertinent to services provided to RMHP Members by contracting entities.
- Monitor the cultural and linguistic needs of Members and determine if actions are required in order to serve the diverse needs of the Membership.
- Identify Members with complex health needs and improve coordination of care and
- services for Members receiving care and services from providers and agencies.
- Credential/recredential practitioners.
- Facilitate the development, distribution, and implementation of clinical practice guidelines of importance to the RMHP Membership. Use results of performance measurement to continually improve care delivered to the Membership.
- Monitor and improve practitioner adherence to standards for preventive and chronic illness care.
- Monitor and improve practitioner adherence to standards for medical record documentation.
- Develop continuing medical education (CME) programs based on results of performance measurements and other quality improvement data.
- Report QI activity progress and findings to providers and others, including Members as deemed appropriate.
- Advance the awareness of the QI Program within the organizational structure and

processes.

Continuity of Care

RMHMO's Care Management (CM) Department performs case management services and reviews inpatient admissions to ensure appropriate discharge planning and identify the need for specialty care.

If a new RMHMO Member has been treated by a non-participating provider more than three times in the previous six months as part of the same treatment plan, RMHMO upon request may approve continued care for the Member by that non-participating provider if RMHMO determines it to be necessary to ensure appropriate and timely care.

Addressing the Needs of Members

Addressing the needs of members with limited English proficiency, illiteracy, diverse cultural and ethnic backgrounds, and physical and mental disabilities

Members with Limited English Proficiency and Illiteracy

In an effort to meet non-English speaking Members' needs, RMHP has identified health care providers who speak languages other than English, including American Sign Language. When direct interaction with a bilingual health care provider is not possible, RMHP makes available interpretation services.

RMHP has arrangements to provide written interpretations of requested documents for foreign languages. More commonly used materials are available in Spanish, and Spanish-speaking Customer Service Representatives are available to assist Members either by phone or in person. In addition, language-line interpretive services are available by phone for any non-English speaking Members. For low-literacy Members, effort is made to ensure our materials are written at an appropriate reading level.

Members with Complex Medical and Social Needs

For Members with complex medical and social needs, RMHP case managers promote health and well-being by coordinating services and treatments. RMHP staff, PCPs, or other providers may refer 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.

For hearing-impaired Members, we have access to TDD services. RMHP has also adopted standards for transacting business with incapacitated persons. Appropriate family Members or legal guardians are identified and may be included in Members' enrollment and care decisions in compliance with HIPAA regulations.

All RMHP buildings meet accessibility standards for the disabled, such as handicapped parking spaces, ramps, doorways, elevator accessibility to all floors in our offices, and Braille signs. RMHP also considered physical access for the disabled at PCP provider locations.

Health Care Needs Assessment, Outcomes, and Evaluation

Methods for Determining Members' Health Care Needs, Tracking and Assessing Clinical Outcomes from Network Services, and Evaluating Consumer Satisfaction with Services Provided

Determining Members' Health Care Needs

RMHMO has a variety of mechanisms in place to assess and track our Members' 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 Members' needs.

The Quality Improvement Committees evaluate 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.

Tracking and Assessing Clinical Outcomes from Network Services

RMHP evaluates the clinical outcomes of its Membership populations in each geographic community. Methods used to track and trend clinical outcomes may include concurrent inpatient review, case management, focused quality improvement studies and a series of measurements for targeted chronic diseases. Clinical outcome information is shared with contracted provider networks in each community and needed action is taken with the combination of collective data and Membership feedback.

Evaluating Consumer Satisfaction with Services Provided

RMHP conducts annual Member surveys to determine Member satisfaction. These satisfaction survey results are evaluated for strengths and weaknesses within the organization with comparisons made to previous outcomes. Areas of weakness are reported and corrective action plans are implemented where appropriate.

Informing Members of Plan Services and Features

Method of informing members of plan services and features

Grievance and Appeal Procedures

RMHP informs covered persons of grievance and appeal procedures in several ways. Upon enrollment, all Members receive a Medicare EOC, which explains Members' complaint/appeal rights and responsibilities in detail. When a Member is retrospectively denied payment for services provided, a Right to Appeal notice is provided on the Member's Notice of Denial of Payment form or the Member billing statement. For prospective service and concurrent service denials, appeal procedures are included in direct written correspondence to the Member.

Process for Selecting and Changing Network Providers

In many communities and particularly in rural areas, RMHP contracts with most physicians and hospitals that meet RMHP's credentialing and quality standards. RMHP rarely experiences change due to a provider choosing not to renew their contract with RMHP. However, when such a rare change occurs, members affected by the change are identified and directly informed by letter. The Member is instructed on how to choose a new PCP and is provided with instructions on how to obtain a provider directory or directed to use our on-line directory (www.rmhp.org) as necessary.

Procedure for Providing and Approving Emergency and Medical Care

Emergency/Life and Limb-Threatening Care and Urgent 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 emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHMO to seek emergency services.

When possible, Members should contact their PCP, who can provide guidance for the urgent care needs. Urgent care centers are available for members within certain communities.

Members may obtain emergency care by dialing 911 or going to the nearest hospital emergency room. Treatment of life and limb-threatening emergencies is covered whether received from a participating or non-participating facility. RMHMO Member Identification Cards also contain instructions on how to access emergency care.

Medical Care

RMHP's procedures for obtaining urgent and emergent medical care are contained in the RMHP Medicare Member Handbook and provider directories. Members may also obtain help with benefit and service questions through direct or phone contact with RMHP Customer Service representatives.

Coordination and Continuity of Care, Referrals to Specialty Providers

System for Ensuring the Coordination and Continuity of Care for Covered Persons Referred to Specialty Providers

RMHP supports and encourages primary care physicians to coordinate the Members' care. Requests for assistance are directed to the case manager.

For new Members who are currently involved in a treatment plan, RMHP may consider approving the continued use of non-participating providers. It is important for RMHP to evaluate and approve services by non-participating providers before treatment is continued.

Prescription Services for Medicare/Medicaid

Enrollees covered by both Medicaid and Medicare receive most of their drug coverage under Medicare Part D if they choose to enroll in Medicare prescription drug plan. If such dually eligible Members do not enroll in a Medicare Part D plan, they will only have very limited drug coverage through Medicaid.

RMHP Medicare Members who also have RMHP Medicaid can elect one of RMHP's Medicare plans that include drug coverage or they can select coverage from another Part D plan. The state of Colorado has elected to cover certain Medicare-excluded drugs under its Medicaid program. RMHP provides and integrates coverage of these "wrap around" medications under its Colorado Medicaid contract.

Process For Changing Primary Care Physicians

Members may change their PCP at any time by notifying a RMHP Customer Service representative before receiving health care services from the new PCP. Members should contact the new PCP first to be sure he/she is accepting new patients before the change is requested. The member is provided with the most current Provider Directory if requested and/or directed to use RMHP's online directory.

Continuity of Care in the Event of Contract Termination or Insolvency

Proposed Plan for Providing Continuity of Care in the Event of Contract Termination or Insolvency

If a provider's contract is terminated, every effort will be given to provide Members receiving care on a regular basis from the affected provider written notice within thirty (30) working days of the termination or as soon as reasonably possible. Such notifications will describe how services provided by the subcontractor will be replaced and will inform the Member of their right to disenroll and disenrollment procedures. If the contract termination involves a PCP, all Members who are patients of that PCP will be notified. Members will be instructed on how to choose a new PCP.

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 period for which the Member's premium has been paid and will continue care for Members confirmed in an inpatient facility under 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.

Provisions in the Event of Contract Termination or Insolvency

Provisions to Hold the Member Harmless in the Event of Contract Termination or Insolvency

All Rocky Mountain Health Plans provider contracts contain a provision that in no event, including but not limited to nonpayment by Rocky Mountain Health Plans or Rocky Mountain Health Plans 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.

Exhibit A

Network Adequacy Strategic Plan

Rocky Mountain HMO
Medicaid Network Adequacy Strategic Plan
July 1, 2016 through June 30, 2017

1. Rocky Mountain HMO will continue to use the access standards approved by the Colorado Department of Health Care Policy and Financing (HCPF) as submitted jointly by RMHP, Denver Health and Colorado Access and first used for Medicaid fiscal year 2005-06. The access standards adopt varying distance and travel time criteria according to Urban, Suburban and Rural geographic designations. The definitions and access criteria are shown below:

Urban Area: a ZIP Code population density being greater than 3,000 persons per square mile.
Suburban Area: a ZIP Code population density being between 1,000 and 3,000 persons per square mile.

Rural Area: a ZIP Code population density being less than 1,000 persons per square mile.

	Urban	Suburban	Rural
PCP	30min/30miles	30min/30miles	45min/45miles
Specialist	45min/45miles	60min/60miles	90min/90miles

RMHP will continue to adhere to definitions used by HCPF for PCP and Specialist as shown below. Although RMHP still uses "Key Specialists" for the purpose of reporting, all providers will be included in either PCP or Specialist categories as defined by the Department below:

Primary Care Physician (PCP): A participating physician designated by the Member to provide routine and primary care services. Per the Department, PCPs are defined as Family Practice or General Medicine specialties. Due to RMHMO's system parameters, we classify specialties as those identified by American Board of Medical Specialties (ABMS - for MDs) and/or American Osteopathic Board where there was no corresponding ABMS specialty (AOA - for DOs) as both of these entities are approved by NCQA for Board Certification primary source verification. To remain consistent with the Department's definitions, RMHMO will include the following specialties under the Department's definition of General Medicine category; Internal Medicine, Pediatrics, Geriatrics and Obstetrics/Gynecology

Specialists: A participating physician who is not a primary care physician and is defined by the Department as a specialist. This would include physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.

2. Based on recent GeoAccess studies - including reporting required and submitted to HCPF - and the experience of Rocky Mountain HMO – and barring unforeseen circumstances, geographic criteria and provider network criteria will remain unchanged for the Colorado fiscal year and RMHP contracting period July 1, 2014 through June 30, 2015. The target provider to Member ratio is shown below.

Target Provider to Member Ratio:

The Physician to Member ratio: = 1:2,000 Members.
The Specialist to Member ratio: = 1:2,000 Members.