Rocky Mountain Health Plans

2017

RMHP CHP+ NETWORK ACCESS PLAN

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This document is a comprehensive presentation of Rocky Mountain Health Plans' (RMHP) approach to meeting the requirements under its contract with the Department of Health Care Policy and Financing (the Department).

The *Provider Network Strategic Plan and Access Plan* (Access Plan) should be used in conjunction with RMHP policies and procedures and with network reports supplied to the Department.

According to the contract between the Department and RMHP, this plan along with supporting documents shall reflect current and future network planning and will include at a minimum:

- Geographic access standards;
- Provider network standards;
- Population demographics; and
- Other requirements as directed by the Department.

This RMHP CHP+ Network Access Plan contains information regarding the RMHP provider network and certain policies and procedures. The Access Plan is not, and in no event shall be construed as, a contract between RMHP and Members covered under RMHP CHP+ plans, nor does it grant any rights, privileges, or benefits to any person. Rights and responsibilities of RMHP CHP+ Members covered under RMHP plans are governed by RMHP's contract with Health First Colorado whether such provisions are also specified or referred to in this Access Plan.

Definitions

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

Ancillary Service Providers: Providers who provide or perform the following types of services including any related technical services: Podiatry, Physical Therapy (Including Manipulative Therapy, Sports Medicine), Occupational Therapy, Clinical Radiology, Clinical Pathology, Speech Therapy, Audiology, Dieticians, Certified Nurse Midwives, and Other Miscellaneous Ancillary Providers.

Behavioral health, mental health, and substance abuse disorder care: Health care services for a range of common mental or behavioral health conditions, or substance abuse disorders provided by a physician or non-physician professionals. (For the purposes of network adequacy measurements, includes the following behavioral health, mental health, and substance abuse disorder care providers: psychiatrists, psychologists, psychotherapists, Licensed clinical social workers, psychiatric practice nurses, Licensed addiction counselors, Licensed marriage and family counselors, and Licensed professional counselors.)

Counties with Extreme Access Considerations (CEAC) : As defined by U.S. Centers for Medicare & Medicaid Services (CMS), with a population density of Less than ten (10) people per square mile, based on U.S. Census Bureau population and density estimates (calendar year 2013).

Emergency services: A medical or mental health screening examination that is within the capability of the emergency department of a hospital or freestanding emergency room, including ancillary services routinely available to the emergency department to evaluate the emergency medical or mental health condition; and within the capabilities of the staff and facilities available at the hospital, further medical or mental health examination and treatment as required to

stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition.

Essential Community Providers (ECP): Includes those providers who demonstrate that they have historically served medically needy or medically indigent patients and demonstrate a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serve the medically indigent patients within its medical capability. These providers also waive charges or charge for services on a sliding scale based on income and do not restrict access or services because of a client's financial limitations. It is RMHP's policy to contract with any ECP that meets quality and credentialing standards, provides services that are a covered benefit, and is willing to contract at a reasonable rate. Of note, ECPs are included in all of the above categories.

Primary Care Physician (PCP): A participating physician designated by the Member to provide routine and primary care services. PCPs are defined by the Department as Family Practice or General Medicine specialties. The Department defines the following specialties under General Medicine: Internal Medicine, Pediatrics, Geriatrics, Obstetrics/Gynecology, Nurse Practitioners, and Physician Assistants.

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

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.

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.

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 our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members. To achieve this, in the RMHP CHP+ service area, RMHP contracts with all available acute care hospitals, primary care physicians (PCPs), specialists and sub-specialists who meet RMHP's credentialing and quality standards.

RMHP offers a network of participating pharmacies throughout its service area. RMHP's 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. RMHP 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 our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

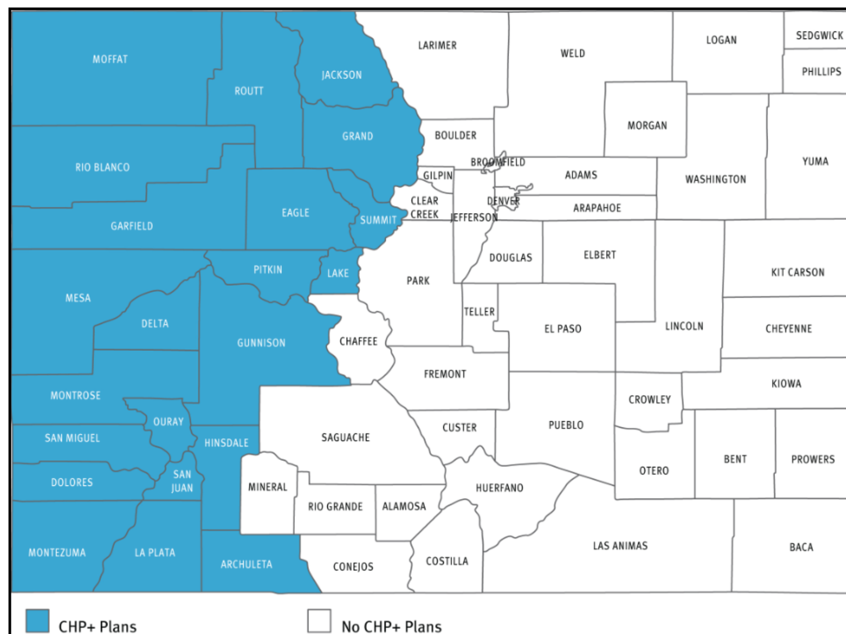
Counties included in RMHP CHP+ Service area (also see map on following page):

Archuleta	Jackson	Pitkin
Delta	La Plata	Rio Blanco
Dolores	Lake	Routt
Eagle	Mesa	San Juan
Garfield	Moffat	San Miguel
Grand	Montezuma	Summit
Gunnison	Montrose	
Hinsdale	Ouray	

The RMHP CHP+ network currently consists of the following participating providers:

447	PCPs
760	Specialists
440	Behavioral Health Providers
799	Ancillary Service Providers (DME, Therapists, etc.)
727	Family Planning Services providers (FP, Ob/Gyn, Gyn, FQHC)
92	Institutional Providers
98	Pharmacy Providers

Map of RMHP CHP+ Network 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 via the internet on RMHP's website. The online directory is updated weekly and the printed directory is updated annually. These directories are available to providers for their use in directing RMHP specialty care, and for Members who wish to see which providers are in RMHP's network.

In-Network Services

All Members are encouraged to establish a relationship with a PCP. RMHP Customer Service assists Members who need assistance selecting a PCP. Members of RMHP CHP+ are able to obtain consultation and treatment from in-network specialist physicians and mid-level providers without a referral from their PCP. The Member must be eligible to receive services through RMHP CHP+ at the time services are provided and the services that the Member receives must be covered services as specified in the *RMHP CHP+ Benefits Booklet*.

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

Members may obtain covered services from out-of-network/out-of-plan providers at the in-network benefit level, subject to obtaining RMHP's approval prior to receiving services. Such approval shall be in a timely manner relative to the member's condition. Such services include those in which:

- RMHP has no participating providers who can provide a specific, medically-necessary covered service;
- Members do not have reasonable access to a participating provider due to distance or travel time;
- Continuity of care when a new member is receiving frequent and current care from a non-participating provider for a special condition, such as chemotherapy, high risk pregnancy or pregnancy beyond the first trimester. In each of these cases, RMHP will arrange for authorization of services from a provider with the necessary expertise and ensure that the member obtains the same benefit level as if the benefit was obtained from a plan provider. Refer to the Continuity of Care section for specific parameters. Any such requests must be approved in advance by RMHP prior to the Member obtaining the health care services.
- Any authorized care is subject to the conditions and restrictions of the authorization.

Timeliness of Preauthorization for Out-of-Network Specialty Care

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

Retrospective Denial of Out-Of-Network Requests

Approved requests for health care services which RMHP CHP+ 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 CHP+ Managed Care Plan

In many communities, and particularly in rural areas, RMHP's philosophy is to contract with all available physicians, pharmacies, Essential Community Providers (ECP), 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.

In areas where most available physicians, hospitals, pharmacies, ECPs 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 to all service areas.

The need for additional access to physicians, ancillary providers 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 CHP+ Network service area;
- 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 be replaced to ensure accessibility and range of services.

Access to Care

The objective of RMHP's access committee is to monitor, measure, and take actions on identified opportunities to improve Member 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 participation by a standing, interdepartmental committee. The Access Committee may make recommendations or suggestions for resolution to any issues that are identified. Recommendations may include contracting with certain providers where practicable, encouraging providers to travel to certain areas, providing transportation alternatives to Members, and use of telemedicine.

Target Provider to Member Ratio:

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

Availability (Timeliness) and Access (Geographic Distribution):

RMHP maintains criteria regarding access to appropriate practitioner care, subject to Members meeting all contractual requirements. The following are geographic and temporal goals used to evaluate access to care:

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

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.

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.

Emergency/Urgent Care Appointment:

- Immediate access to emergency/life and limb-threatening medical and behavioral health care 24 hours a day, 7 days a week.
- Access to urgent medical care appointments within 48 hours of request made to the provider.

Non-Emergent, Non-Urgent Care Appointment:

- Access to Non-Emergent, Non-Urgent Care within 30 days of request

Non-Urgent Symptomatic Care Appointmen:

- Access to non-urgent symptomatic (acute) care within 30 days of request.

Non-Symptomatic Routine and Preventive Well-Care Appointment:

- Access for adult non-symptomatic well care physical examinations within 30 days of request.

Behavioral Health Care Appointment:

- Diagnosis and treatment of a non-emergent, non-urgent substance abuse disorder within 14 calendar days.
- Diagnosis and treatment of a non-emergent, non-urgent mental health condition within 14 calendar days.

Office Wait Time:

- The average office wait time for primary care providers should not exceed 30 minutes for scheduled appointments.

After-Hours Care:

- Access to healthcare provider via telephone/answering service 24 hours per day, 7 days per week
- Access to healthcare provider back up covering all specialties via telephone/answering service 24 hours per day, 7 days per week. (As required in provider contracts and assessed by RMHP survey of provider offices.)
- RMHP ensures that the network provides for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care.
- RMHP requires providers to offer hours of operation for CHP+ members that are comparable to all other lines of business.

RMHP provides Members with information on how to access the care they need. Directions on how to obtain primary care, specialty care, after-hours and emergency care, ancillary and hospital services is explained in the Provider Directory, the RMHP CHP+ Benefits Booklet and Member newsletters.

Female members have access, without referral, to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health care specialist. New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of post-partum care directly related to the delivery only if the practitioner agrees to terms as specified in Section 25.5-5-406(g)(II), C.R.S. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with RMHP toward a transition.

New enrollees with special needs may continue to see a non-plan provider for sixty (60) days from the date of enrollment in RMHP CHP+ if the enrollee is in an ongoing course of treatment with a previous provider and only if the previous provider agrees to terms as specified in Section 25.5-5-406(g)(I), C.R.S. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with RMHP CHP+ toward a transition. Persons with special health care needs who use specialists frequently for their health care may maintain these types of Specialists as their PCP or will be allowed access without referral to Specialists for the needed care.

Quality Improvement Program

The 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 CHP+ 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, Claims, Health Promotions, Home Health, Member Benefit Administration, Marketing, Information Technologies, and effective professional peer review. Pertinent activities from all of these processes are reported and integrated into the QI Program.

Scope of Quality Improvement 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

RMHP's Care Management Department performs care coordination and care management services and reviews inpatient admissions to ensure appropriate discharge planning and identify the need for specialty care.

If a new RMHP CHP+ 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, RMHP upon request may approve continued care for the Member by that non-participating provider if RMHP determines it to be necessary to ensure appropriate and timely care.

Continuity and coordination of our Members' care is evaluated in part through the office review process monitored by the Quality Improvement Department. The primary focus of office reviews is to ensure care delivered conforms to established standards for preventive health care screening, health maintenance, appropriateness of treatment, and medical record documentation.

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.

Additionally, RMHP arranges to provide written interpretations of any documents requested for any foreign language. Member materials are translated into Spanish as required under our contract with the Department. Spanish speaking Customer Service Representatives are available to assist Spanish-speaking Members either by phone or in person. For low-literacy Members, materials are written at an appropriate reading level.

Members with Complex Medical and Social Needs

RMHP addresses the needs of Members with complex medical, behavioral and social needs in a number of ways. RMHP Customer Service Representatives attempt outbound welcome calls to all new CHP+ Members, at which time they inquire about special needs or chronic conditions. If the Member indicates a need, the Representative will refer the member to Care Management for

further assessment of needs and care coordination. Additionally, RMHP Care Management staff receives referrals from providers and other community organizations. RMHP receives hospital admission, discharge and emergency room (ER) visit information and follows up on every known admission and ER visit to ensure that Members have the information and resources needed for a smooth transition of care. RMHP has implemented a care management software platform that allows for shared documentation among care coordinators, as well as scheduled follow-up for members in active care management.

RMHP instructs Members who are hearing-impaired to dial 711 to access Relay Colorado services. RMHP has also adopted standards for transacting business with incapacitated persons. Appropriate family Members or legal guardians are identified and included in Member enrollment and care decisions.

All RMHP buildings meet accessibility standards for people with disability such as parking spaces, ramps, doorways, elevator accessibility to all floors in our offices, and Braille signs. RMHP also monitors physical access for people with disabilities at our PCP provider locations through office assessments.

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

RMHP has a variety of mechanisms in place to assess and track our Members' needs, including case management services, individual health appraisals, Care Management (CM), Quality Improvement (QI), and participation in the HEDIS performance tool (as described under the Quality of Care section).

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 QI team evaluates claims data to determine areas for quality improvement studies. However, they also investigate potential quality of care concerns, Member inquiries and member appeals and grievances, and provider feedback to identify other areas in need of quality improvement attention.

RMHP also voluntarily compiles and submits HEDIS (Health Effectiveness Data and Information Set) data. This nationally recognized and standardized tool reveals much about how well services are being provided to Members and how Members rate care and services received from contracted providers. Based on this Membership data, we learn about our strengths, our Members' needs, and areas in which health care services delivered by contracted providers can improve.

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

Grievance and Appeal Procedures

RMHP informs covered persons of grievance and appeal procedures in several ways. Upon enrollment, all Members receive the *RMHP CHP+ Benefits Booklet*, which explains Members' grievance/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 explanation of benefits form. For prospective service and concurrent service denials, appeal procedures are included in direct written correspondence to the Member.

Availability of Specialty Medical Services

Availability of specialty medical services including the availability of Physical Therapy, Occupational Therapy and Rehabilitation Services, is addressed in the *RMHP CHP+ Benefits Booklet* provided to Members during the enrollment process, as well as the RMHP CHP+ provider directory.

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 online directory as necessary.

Procedure for Providing Urgent and 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 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.

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.

RMHP's procedures for obtaining urgent and emergent medical care are contained in the *RMHP CHP+ Benefits Booklet* and provider directories. Members may also obtain help with benefit and service questions through direct or phone contact with RMHP Customer Service representatives. RMHP CHP+ Member Identification Cards also contain instructions on how to access emergency care.

Accessing Services Not Covered by RMHP

Enrollees will be directed to other sources to access services that are not offered by RMHP. Enrollees in need of medical or medically related services provided by the county of residence, are instructed to contact their provider or any of the numbers listed below for more information. Services not covered by RMHP CHP+ and Health First Colorado must be paid for by enrollees. This information is also explained in the *RMHP CHP+ Benefits Booklet*.

The county health department has information on programs such as transportation, supplemental feeding programs for children and pregnant women, and dental care. These services are not covered by RMHP, but providers or Members can find out more about them by calling their local County Department of Human Services.

RMHP Customer Service:
970-244-7960 or 855-830-1563
Email: customer_service@rmhp.org

Colorado's CHP+ Customer Service

800-359-1991.

Enrollee's Right to a Second Opinion

RMHP CHP+ enrollees are entitled to a second opinion per medical condition at no cost to the member. No referral is needed to see another doctor for a second opinion.

Ensuring Coordination, Continuity of Care: 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 Members' care with specialty providers. Requests for assistance may be directed to RMHP's Care Management staff who identify services that may be provided by ancillary providers, including social services or other community resources.

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 from non-participating providers before treatment is continued.

Process for Changing Primary Care Physicians

RMHP's process for enabling covered persons to change primary care physicians is addressed in the *RMHP CHP+ Benefits Booklet*. Members may change their PCP at any time. 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 fourteen (14) working days of the termination. Such notifications will describe how services provided by the provider will be replaced and will inform the Member of disenrollment procedures. If the contract termination involves a PCP, all Members who are patients of that PCP will be notified within fifteen (15) calendar days of the notice of termination. Members will be instructed on how to choose a new PCP. In case a Member is not given proper notice of their provider's contract termination, he/she will be able to continue receiving care from that provider for sixty days from the date of the provider's termination.

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 RMHP's contract with the State to provide Medicaid services, and will continue care for members confined in an inpatient facility until their discharge. RMHP providers cannot seek reimbursement from RMHP CHP+ Members for covered services received during this period, except for any applicable copayments, coinsurance, or deductibles.

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

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