# COLORADO CHOICE HEALTH PLANS

# NETWORK ACCESS PLAN

**May 2016**

**NETWORK ACCESS PLAN - 2016**

Colorado Choice Health Plans' Network Access Plan describes the process used to develop and assure adequate access to our Provider network on behalf of our Members. The plan is organized under the following headings and subheadings:

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## Overview of Colorado Choice Health Plans

### Who we are

Serving Colorado for over 40 years, Colorado Choice Health Plans utilizes a community-focused model. We work hand in hand with local Providers to provide access to the full range of health services covered under contract, improve access to care, and meet the diverse needs of rural populations.

We are well known in our communities for understanding rural and underserved health care needs. However, with the Company's move over the last few years into additional non-rural counties, we have not lost the values from our rural roots. Our focus continues to be on community and the feeling of responsibility that comes when our Members are our neighbors, friends and families. We believe in personalized customer service delivered by real people.

### Communities Served

Colorado Choice Health Plans is a not-for-profit corporation licensed as a Health Maintenance Organization (HMO) in the State of Colorado that specializes in serving rural and underserved counties in south central Colorado and on the eastern plains. Colorado Choice is licensed in the following 30 counties: Alamosa, Baca, Bent, Chaffee, Cheyenne, Costilla, Conejos, Crowley, Custer, El Paso, Elbert, Fremont, Huerfano, Kiowa, Kit Carson, Larimer, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Weld and Yuma.

### Products and Services

Colorado Choice currently offers coverage for individuals and small and large employer groups on a fully-insured basis, and third-party administrative (TPA) services for larger self-funded employers across our entire service area. We also provide Medicare coverage under a federal cost contract, and Children's Health Plan (CHP+) coverage for the State of Colorado. CO Choice began offering its Qualified Health Plans through Connect for Health Colorado (the state's health insurance exchange) during the first open enrollment period for plan year 2014.

### Access to Care

We believe that our Members have the right to receive quality health care services as close to home as possible, but know the pathways to care require networks that include Providers located in the rural communities as well as across the Front Range and into Denver, Colorado Springs, Pueblo, Greeley and Fort Collins. As such, we have established relationships with an extensive network reflecting the pathways to care for these communities. Our Providers appreciate our commitment to effective problem resolution and fast claims payment.

### Accreditation

URAC has granted Colorado Choice Health Plans full accreditation.

### Network Access Plan

This Network Access Plan is designed to meet the criteria outlined in C.R.S. §10-16-704(9) for fully-insured commercial business and the State of Colorado Children's Health Plan contract. This Plan is also intended to address 42 CFR §422.112 Access to Services for the Medicare Cost contract. Additionally, as a Qualified Health Plan (QHP) offering health benefit plans on the Connect for Health Colorado health insurance exchange, CO Choice is subject to the Patient Protection and Affordable Care Act regulations, including §156.230 (network adequacy standards) and section 2702(c) of the Public Health Service Act, as they relate to the types of providers that must be accessible to health benefit plan enrollees. This Plan is also intended to address the URAC standards including but not limited to Core 34 and P-NM-2.

**Adequacy of Participating Provider and Facility Network**

Colorado Choice Health Plans (CO Choice) maintains a network of Providers and facilities sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible given the rural nature of the service area. Our contracting strategy is broad-based and personalized at the same time, meaning that we make every attempt to contract with every facility and every provider located in the communities we serve, while also working with employers and brokers to identify and address individual needs in underserved areas.

Standards of Participation and Non-Discrimination of Providers

All Participating Providers must be credentialed, qualified, properly licensed and maintain appropriate levels of malpractice insurance in accordance with CO Choice requirements and NCQA standards. CO Choice maintains current credentialing documentation on CO Choice's Participating Providers in support of application processing for Licensed Independent Practitioners in a non-discriminatory manner consistent with state and federal laws and regulations.

CO Choice will not discriminate based on an individual's gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin, or any other such prejudicial policies when determining Provider participation in the CO Choice network.

Network Adequacy Management

CO Choice employs a number of means to ensure network adequacy to meet the needs of CO Choice Members. CO Choice uses reasonable criteria including, but not limited to:

- Ratio of Primary Care Providers (PCPs) to Members;
- Ratio of Key Specialty Providers (KSPs) to Members;
- Geographic accessibility including proximity of acute care hospitals;
- Waiting times for appointments;
- Hours of operation; and
- Volume of technological and specialty services available to serve the needs of Members.

As part of the new group onboarding process, a Provider network disruption analysis is conducted for certain large group clients to determine if there are any significant gaps in the network. If gaps in the network are identified, CO Choice makes every effort to retain a direct contract with those Providers or facilities. Alternatively, CO Choice has relationships with supplemental Provider networks that can be used to wrap around CO Choice's direct-contracted network, and to provide expanded access to care for Members needing to receive services out-of-network in urgent or emergency situations.

In addition, CO Choice conducts a periodic claims review to identify trends in claims payments. If it is noted that CO Choice has been receiving a significant volume or amount of claims from a non-Participating Provider, every effort is made to retain a direct contract with that Provider or facility.

CO Choice retains the right to exclude a Provider of a covered service from participation if that Provider does not meet CO Choice's established standards for participation, including credentialing standards.

Acute Care Hospital Services

In rural service areas, CO Choice makes a good faith effort to contract with all acute care general hospitals in the service area and maintain contracts with an adequate number of hospitals offering specialty care in the most accessible urban areas. For urban service areas,

CO Choice will ensure that the standards specified in the Monitoring section are met or exceeded.

The same holds true for free-standing ambulatory surgical centers (ASCs) and imaging centers.

Primary Care Providers

In rural service areas, CO Choice makes a good faith effort to maintain contracts with all Primary Care Providers (PCPs), including family and general medicine physicians, internists, pediatricians, and mid-level practitioners (nurse practitioners and physician assistants) in the service area. For urban service areas, CO Choice will ensure that the standards specified in the Monitoring section are met or exceeded.

Essential Community Providers

In rural service areas, CO Choice will make a good faith effort to maintain contracts with all locally-based Essential Community Providers (ECPs), such as FQHCs, rural health clinics and Ryan White-funded clinics in the service area. For urban service areas, CO Choice will ensure that the standards specified in the Monitoring section are met or exceeded.

Specialty and Subspecialty Providers

In rural service areas, CO Choice makes a good faith effort to maintain contracts with all Specialty Care Providers in the service area and maintain contracts with an adequate number of specialists and subspecialists in the most accessible urban areas and nearby counties. For urban service areas, CO Choice will ensure that the standards specified in the Monitoring section for Key Specialty Providers (KSPs) are met or exceeded. Female Members may obtain routine and preventive reproductive or gynecological care from Participating obstetricians, gynecologists, or certified nurse midwives without a Referral for the office visit. Members with vision coverage may obtain eye care from a Participating optometrist or ophthalmologist without a Referral for the office visit.

Geographic Accessibility

Because of the rural and sparsely populated regions in some service areas, some Members may choose a PCP who practices in a county other than the one where the Member resides. If specialty care is needed that is not available within the service area, the Member may have to travel to the closest urban area. Whenever possible, CO Choice will offer Members several options so they can select the most convenient location. CO Choice standards for Geographic Accessibility are further delineated in the Monitoring section of this Plan.

Pharmacy Services

In rural service areas, CO Choice makes a good faith effort to maintain contracts with all pharmacies in the service area. For urban service areas, CO Choice will ensure that the standards specified in the Monitoring section are met or exceeded. Mail order service is also available.

Currently, CO Choice's pharmacy network is comprised of the majority of the independent and chain pharmacies located throughout its service area. Contracts with the City Market, Safeway, Wal-Mart, K-Mart, King Soopers and Walgreens pharmacies are valid throughout Colorado.

Covered drugs include medically necessary legend drugs (may require prior Authorization), oral contraceptives, injectable insulin by prescription only, and any other drug which, under law, may only be dispensed by written prescription of a duly licensed Provider (i.e. Physician, Dentist, etc.).

Copies of the current Colorado Choice formulary will be provided to a Provider or Member upon request. Because pharmacy coverage may be purchased separately from the medical benefit, not all Members have a prescription drug benefit. Providers are encouraged to verify the prescription drug coverage available to each specific Member.

Other Licensed Ancillary Providers

In rural service areas, CO Choice makes a good faith effort to maintain contracts with all other licensed health care Providers of covered services. This applies, but is not limited to, mental health professionals, physical therapists, speech therapists, and occupational therapists. Mental health professionals may include licensed psychiatrists, licensed psychologists, licensed social workers, licensed professional counselors, and substance abuse counselors. If necessary to meet Member needs, other licensed mental health professionals may be included in the network. For urban service areas, CO Choice will ensure that the standards specified in the Monitoring section are met or exceeded. The extent to which services delivered by these providers are considered covered benefits is described in the Member's schedule of benefits received at enrollment and annually at renewal if changes are made.

Out-of-Network Care

In the rare case where no Participating Provider or facility provides a covered service (e.g., if necessary to accommodate independent living of homebound members with disabilities), CO Choice will arrange for a Referral to a Provider or facility with the necessary expertise and ensure that the Member obtains the covered benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility. To maintain continuity of care and obtain the lowest out-of-pocket costs for the Member, every attempt is made to secure a single-case agreement with the specific Provider or facility.

**Choice of Providers and Facilities**

In-Network Care

For services that do not require a Referral (such as preventive screenings), Members may choose which Provider or facility to utilize and access services directly. Members have access to a wide range of Specialty Providers through a Referral process. Referrals are offered to any network Provider qualified to provide the covered specialty service. However, CO Choice may offer variable deductibles or copayments to encourage the use of selected Providers. If variable deductibles or copayments are offered, the amount of same will be reflected on the Member's ID card or schedule of benefits.

When obtaining approval for hospitalization or surgery outside of the service area, the PCP should consult with CO Choice. CO Choice retains the right to encourage the use of specialty care pathways and consider negotiated rates when approving such care.

Out-of-Network Care

Under the terms of the Evidence of Coverage or Member Handbook, urgent care received outside of the service area is covered if received from a Provider other than a hospital or emergency room; emergency medical care outside of the service area is also covered worldwide. In an effort to provide for a standard of care that ensures the provision of quality care, facilitates optimal coordination of care and serves to reduce re-admission rates, notice to CO Choice is recommended for emergency care received from a non-Participating Provider the first business day after admission or as soon as medically possible.

Emergency Services In- and Out-of Network

Emergency care may be sought at the nearest emergency department if the Member perceives that he or she is experiencing an emergency medical condition. Prior Authorization is not

required, regardless of whether the emergency services facility or Provider is a Participating facility or Provider, or is considered out-of-network. CO Choice will ensure that the Member obtains the covered emergency services benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.

### No Participating Provider Available

In the rare case where no Participating Provider or facility provides a covered and medically necessary service within the service area, CO Choice will arrange for a Referral to a Provider or facility with the required expertise, following the prevalent pathway to care for that particular community. Selection of Provider and facility will be coordinated by CO Choice in concert with the referring physician and the Member.

### Right to Refuse Referral

In general, Members have the right to refuse Referral to specific Providers or facilities. However, if the Member refuses Referrals to all network Providers and wishes to voluntarily obtain services out-of-network despite the fact that there are adequate network Providers available to provide the covered service, the Member or the Provider must show good cause for the need to obtain services out-of-network. If good cause is not established, the Member may be financially responsible for the cost of medical care.

### Selection of PCP

As described in the Evidence of Coverage or Member Handbook, each Member must select a PCP within 30 days after coverage is effective. Members may select any PCP who participates in the CO Choice network (family practice, general practice, internal medicine, pediatrics) and who is available to accept the Member as a patient. A Member may select a pediatrician as a PCP for enrolled children. Members and Providers may contact the CO Choice Customer Service department at 719-589-3696 or 800-475-8466, visit www.cochoice.com, or log into our secure Member/Provider portal if they need information on how to select a Primary Care Physician or to obtain a list of Participating PCPs.

In the event that a subscriber does not make a PCP selection(s) at enrollment or within a reasonable period of time, CO Choice may designate a PCP or clinic for the purposes of coordinating care and facilitating the Referral process. If a PCP is assigned, CO Choice will notify the Member or subscriber in writing.

Groups may purchase an open access rider allowing employees and their enrolled dependents direct access to in-network PCPs and specialty Providers without a Referral. The open access feature is also a standard provision of all fully-insured individual and small group plans sold with an effective date of 01/01/2014 or after. A PCP must still be selected by Members with the open access benefit. Providers may verify whether the Member has the Open Access benefit by looking at the top section of the Member's ID Card for the acronym "OA" or by calling Customer Service at 719-589-3696 or 800-475-8466.

### Change of PCP

A Member may change his or her Primary Care Physician by calling Customer Service at 719-589-3696 or 800-475-8466, or by logging into their account on CHOICE*Connect* (our secure member portal). The new selection will become effective the first day of the month following the change. To ensure a quality physician-patient relationship, a Member's Primary Care Physician may be changed at the Member's request no more than three times in any calendar year.

### Termination of Providers

When any Primary Care Provider's contract is terminated for voluntary or involuntary reasons, CO Choice makes a good faith effort to provide written notification of the change to Members

who are patients of that Provider in writing at least thirty (30) calendar days before the Provider actually leaves the network, or no later than forty-five (45) calendar days following notification that the Provider has left the network. In the case of a PCP termination, Members will be asked to select a new PCP, and provided information about accessing customer support for assistance with the selection process. In the case of a Specialist termination, CO Choice will work with Members, the specialist who is terminating, and the Member's PCP to identify a new specialist to whom to transfer care.

On an involuntary basis if, in the judgment of the CO Choice Medical Director, the immediate health and safety of any Member is in imminent danger – usually due to quality of care or quality of service concerns - the Medical Director is authorized to summarily suspend the authority of any practitioner to participate in the care of CO Choice Members. A communication plan to Members will be developed on a case-by-case basis in this situation.

Cessation of Operations

In the unlikely event that CO Choice ceases operations, CO Choice will notify Members and comply with all state regulations designed to assist with transition to another insurer. Members would not be responsible for any unpaid claims for services that had already been approved or did not require prior approval. In fact, CO Choice's Professional Services Agreement and Hospital Services Agreement contains a "hold harmless" provision that prevents a Provider from billing a Member or subscriber group for any amount owed by the Plan in the event the Plan fails to pay such obligation.

**Preauthorization and Referral Procedures**

As noted in the CO Choice Evidence of Coverage or Member Handbook provided to Members, to qualify as covered benefits, all services and supplies must be expressly set forth as benefits in the Evidence of Coverage or Member Handbook and must be performed by the Primary Care Physician or by another Provider via a written Referral, which requires prior Authorization signed and approved by the Medical Director except for:

- ✓ visits to a Participating Physician or Participating certified nurse midwife for an annual gynecological examination;
- ✓ visits to a physician covering in the absence of a Primary Care Physician;
- ✓ emergency medical care;
- ✓ urgent care;
- ✓ routine laboratory or x-ray tests performed by a Participating Provider;
- ✓ Visit to an in-network specialist for a consult only.

Members receive information regarding prior Authorization and the Referral process upon enrollment, annually if there has been a change in benefits or other plan provisions at renewal, and upon request. In general, specialty care outside of the service area, planned inpatient care, therapy, outpatient surgery and high-cost outpatient procedures require a Referral from the Member's PCP before the service is received. Once a Referral for services or treatment is approved, the approval will not be denied or changed except in cases of fraud or abuse.

Precertification is obtained through the submission of a written request to CO Choice, by regular mail, fax, or secure Provider portal. For Providers, instructions for submitting the CO Choice "Request for Authorization" Referral form and a list of the most commonly ordered services and tests subject to precertification are found in Colorado Choice Health Plans' Provider Manual. Requests for Authorizations are approved or denied within 14 days of request. Requests that meet the criteria for expedited review will be reviewed and responded to within 72 hours of receipt by CO Choice.

CO Choice contracts with OptumRx, a Pharmacy Benefits Manager, to coordinate and monitor a prior Authorization program which includes injectables. Certain types of drugs or drug categories require prior Authorization. For Providers, instructions for submitting the "Medication Prior Authorization Request Form" to OptumRx are found in Colorado Choice Health Plans' Provider Manual.

CO Choice has procedures in place to assure that services provided to plan Members are covered benefits that are medically necessary, appropriate, and applicable to the diagnosis or condition being treated. These procedures are followed in a timely, consistent, and impartial manner in accordance with any applicable state or federal statutes and regulations.

Participating Providers and Facilities

A comprehensive list of all Participating Providers and facilities is accessible to Members and Providers by contacting the Customer Service department at 719-589-3696 or 800-475-8466, visiting www.cochoice.com, or logging into our secure Member/Provider portal.

Timeliness of Referrals

CO Choice's procedures for processing Authorizations and Referrals require that we process and return clean requests for services within three working days whenever possible. Requests requiring more information are held until all appropriate material is received, and are then processed within three (3) working days. Requests must be completed or extended within fourteen (14) days, regardless of whether all information has been received. Urgent care requests will be processed as quickly as possible and always within 72 hours of receipt.

For Authorizations, written approvals are sent to the Member, the admitting physician and the facility. For Referrals, written approvals are sent to the Member, the Provider who submitted the request and the Referral specialist or facility. Denials are mailed or faxed the same day or within one (1) business day. For urgent care requests, the Provider is notified by telephone as well as by mail or fax.

Expedited Referrals

A decision on expedited Referrals will be made as soon as possible but in no event longer than 72 hours after the request is received. A Referral will be expedited if the timeframe for handling a standard Referral could a) seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; b) for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently; or c) in the opinion of a physician with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. In determining whether a request is to be expedited, CO Choice shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

Case Management

CO Choice promotes the provision of cost-effective, quality care by identifying Members for Case Management (CM) and establishing and implementing care plans for those Members. Case Management activities may include, but are not limited to, helping Members in the CM program access care and services and ensuring coordination and integration of services.

Following the initial assessment, Members enrolled in the CM program will be assigned a CM level used to guide frequency, duration, and intensity of CM activities. Severity levels will be assigned as minimal- or no-risk, low-risk, moderate-risk, or high-risk/complex. The Case Manager will develop a care plan based on the assessment completed with the Member. Care plans are Member- and family-centered, and include attainable, measurable, and timely long

term and short-term goals. The Care Manager will reassess and adjust the care plan and its goals, as needed.

Members are identified as candidates for Case Management through a variety of means:

- Identification by Referral
    - Disease Management (DM) Program Referrals;
    - Discharge Planner Referrals;
    - Utilization Management (UM) Referrals;
    - Provider Referrals; and
    - Member self-Referrals.

- Identification by Specific Condition
    - Acute coronary syndrome;
    - AIDS;
    - Cancer (active, serious adult cases and all pediatric cases);
    - Congenital anomalies (serious);
    - Congestive heart failure;
    - Diabetes, uncontrolled;
    - End-stage renal disease;
    - Hepatitis C;
    - High risk pregnancies;
    - Organ transplants;
    - Serious trauma;
    - Spinal injuries or possible spine surgery;
    - Suspected abuse or neglect;
    - Multiple chronic illnesses; and
    - Other conditions resulting in high utilization or high costs.

Members needing special assistance during the discharge planning process or as identified through ongoing evaluation of progress to the treatment plan or, in the event that the Member's health benefits have been exhausted or a specific benefit is excluded, may be referred to social services or other community resources, as appropriate.

Coordination of Care

It is imperative that the Member's care is coordinated. That is why our contracted Providers are required to transmit all necessary information to Providers to whom they refer patients. Likewise, the Provider who receives the Referral is required to transmit relevant information back to the referring Provider.

**Special Needs**

CO Choice strives to ensure that all covered services are available to all enrollees, regardless of sex, race, color, religion, physical/mental disability, sexual orientation, age, marital status, national origin/ancestry, genetic information, health status, status as a Member, or participation in a publicly financed program. CO Choice's Professional Services Agreement, Ancillary Services Agreement, and Hospital Services Agreement contains similar such clauses.

Spanish is the only language other than English commonly spoken in the CO Choice service area; many Providers are either conversant in Spanish or employ office staff who are fluent. Additionally, CO Choice has staff members who are fluent in Spanish and available to assist with translation and communications. However, in the event we need translation services, CO Choice has contracted with Translation Plus to provide interpreter services for Members who do not speak English. These translation services are available during regular business hours.

With respect to the provision of health care services, CO Choice's Office Site Quality Checklist addresses such factors as physical appearance, physical accessibility, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping. Office sites not meeting standards will be revisited, with further action taken on those that continue to fail to correct noted deficiencies.

In the event that a Member is not accommodated as believed necessary, he or she may contact Customer Service at 719-589-3696 or 800-475-8466. TTY functionality is also available at 800-659-2656.

**Member Communications**

In general, Members are provided with written documents that provide details around their coverage, how to access services, and other provisions addressed in the Access Plan upon enrollment (New Member Kit), annually upon renewal if plan provisions or benefits change, and upon request by contacting Customer Service at 719-589-3696 or 800-475-8466. Additional information and self-service features can be found by logging in to the secure Member portal.

Included in the packet of information are:

Instructions for Accessing a Provider and Facility Directory

A comprehensive list of all Participating Providers and facilities is accessible to Members and Providers by contacting Customer Service at 719-589-3696 or 800-475-8466, visiting www.cochoice.com, or logging into our secure Member/Provider portal.

Provision and Authorization of Emergency and Medical Care

Emergency care may be sought at the nearest emergency department if the Member perceives that he or she is experiencing an emergency medical condition. Prior Authorization is not required, regardless of whether the emergency services facility or Provider is a Participating facility or Provider, or is considered out-of-network. CO Choice will ensure that the Member obtains the covered emergency services benefit at no greater cost to the Member than if the benefit had been obtained through a Participating Provider or facility.

Additionally, CO Choice's outbound customer service queue messaging as well as after-hours outbound messaging notifies Members to "hang up and dial 911 or go to the nearest emergency department" if they are experiencing an emergency medical condition. For less urgent health care questions and treatment, Members are directed to contact their Primary Care Physician.

Coordination and Continuity of Care

Members are made aware upon enrollment and annually at renewal through their Evidence of Coverage of the process by which CO Choice ensures coordination and continuity of care between PCPs and Specialty Providers. This includes a description of the process that occurs when CO Choice terminates a contract with a provider or the HMO ceases operations.

Grievance and Appeal Procedures

CO Choice has procedures and processes in place that provide a mechanism for fair and prompt utilization review, payment of claims and resolution of Member complaints, appeals and grievances, including an expedited process for appeals and grievances when indicated as required by state and federal laws and regulations.

Network Access Plan

Members are made aware upon enrollment through their Evidence of Coverage or Member Handbook that CO Choice's Network Access Plan is available upon request by mail and at the Plan's business office, 700 Main Street, Suite 100, Alamosa, CO 81101.

**Monitoring – Network Adequacy**

CO Choice will monitor the sufficiency and quality of its Provider network through several means including, but not limited to, those described below. Sufficiency will be established while developing a network and monitored at least annually thereafter.

Access Standards – Wait Times

Colorado Choice strives to ensure that its Members have adequate access to services within a reasonable length of time. It is the policy of CO Choice that Participating Providers adopt the following access standards in their appointment scheduling practices:

| **Visit:** | **Wait Time:** |
|---|---|
| | |
| Preventive Care - non-urgent, non-symptomatic | Within thirty (30) days |
| Routine Primary Care - non-urgent, symptomatic | Within seven (7) days |
| Specialty Care – non-urgent | Within sixty (60) days |
| Prenatal Care | Within seven (7) days |
| Behavioral Health, Mental Health and Substance Abuse Care – Routine, non-urgent, non-emergency | Within seven (7) days |
| Urgent Care (medical, mental health, substance abuse) | Within twenty-four (24) hours, at a physician's office<br>Immediately, at an Urgent Care Facility or Emergency Services Department |
| Emergency Care (medical, mental health, substance abuse) | 24 hours a day, 7 days a week |
| Wait Time for Scheduled Appointments | No longer than thirty (30) minutes |
| On-call Coverage | Twenty-four (24) hours a day; seven (7) days a week |

The Provider's office will need to provide information to Colorado Choice Members on how medical care may be accessed when a physician or other Provider is not available (i.e., vacation, lunch, after hours). This communication may be made through an answering service or other appropriate method.

Provider to Member Caseload Standards

| | |
|---|---|
| Ratio of PCPs to Members: | 1:2000 |
| Ratio of KSPs to Members: | |
| OB/GYNs | 1:4000 |
| General Surgeons | 1:15,000 |
| Orthopedic Surgeons | 1: 20,000 |

Availability Standards – Geographic Accessibility

| Provider Type: | CEAC[1] | Rural: [2] | Urban/Suburban:[3] |
|---|---|---|---|
| PCP | 60 miles | 30 miles | 20 miles |
| OB/GYN | 60 miles | 30 miles | 20 miles |
| ECP | 85 miles | 60 miles | 30 miles |
| Specialist | 85 miles | 60 miles | 30 miles |
| Acute Care Hospital | 100 miles | 60 miles | 30 miles |
| Pharmacies | 60 miles | 30 miles | 15 miles |

In addition to the access standards described above, network sufficiency is also identified through:

- Routine monitoring of complaints and grievances related to access,
- Routine monitoring of coordination of care and quality of care as part of the Quality Management process,
- Periodic claims review to identify trends in claims payments, and
- Customer satisfaction data.

**Monitoring – Network Quality**

Quality assessment and improvement is a continuous process. CO Choice maintains a Quality Assurance Committee (QAC) that has the authority and responsibility for the overall Quality Management program. The QAC meets on a regular basis and reviews issues related to the following:

- Quality Improvement;
- Utilization Management;
- Credentialing Management;
- Grievance and Appeals, and
- Provider Issues, including quality of care issues identified by the Provider Advisory Committee (PAC).

Specific to network quality, the QAC has the following responsibilities:

- Annual review and approval of the Network Access Plan;
- Routine monitoring of complaints or grievances related to access;
- Routine monitoring of coordination of care as part of the quality management process;
- Analysis of customer satisfaction data;
- Analysis of office site review and routine chart review outcomes of all providers within the service area;
- Condition-triggered review of care within the entire network;
- Corrective actions when deemed necessary in response to any of the above;
- Credentialing and contracting procedures;
- Quality improvement projects selected for the potential to provide improved outcomes for Members; and
- Provider materials and education regarding quality, coordination, and continuity of care.

[1] Counties with Extreme Access Considerations (CEAC) are those with any populations less than 10,000 and density less than 10 square miles.

[2] Defined as a population density less than 1000 per square mile within a given ZIP code. Please note that, in some rural areas where there are no licensed providers, these accessibility standards may not be achievable.

[3] Defined as a population density of at least 1000 per square mile within a given ZIP code.

The QAC evaluates the effectiveness of the Network Access Plan at least annually. The CEO will provide an annual report to the CO Choice Board of Directors of the QAC evaluation. The annual evaluation includes an assessment of the achievement of Network Access Plan goals and objectives and, when indicated, revisions to the Network Access Plan.

**Definitions**

**Authorization:** Refers to a request for inpatient or observation services.
**Clean precertification request**: A request for service that has all appropriate information and documentation included with the Referral. This Referral is then ready for review by the Medical Director or designee.
**Designee:** A person appointed by the CO Choice Chief Medical Director (CMD) who may authorize services.
**Licensed Independent Practitioner:** Any individual permitted by law to provide patient care services without supervision.
**Participating Provider:** A physician or other clinical Provider, institution or vendor who provides medical services or supplies to CO Choice Members and who participates in or contracts with CO Choice.
**Peer Review:** One aspect of quality management consisting of evaluation of a provider's inpatient and outpatient records by providers with similar backgrounds. The primary purpose of peer review is to assess and evaluate coordination of care, documentation issues, quality of care, and appropriateness of treatment.
**Quality Improvement (QI):** Procedures that monitor the quality of care provided by the plan and its health care providers; identifies problems, chooses and examines solutions to those problems; regularly monitors the solutions implemented; and refines solutions as needed for continued improvement.
**Referral:** Refers to request for outpatient or emergency department services.
**Urgent care request:** (1) a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination: (a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or for persons with a physical or mental disability, create an imminent and substantial limitation of their existing ability to live independently, or (b) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. (2) any request that a physician with knowledge of the Member's medical condition determines and states is an urgent care request within the meaning of (1).
**Written precertification request:** Request for services using established CO Choice format; specifies Member identification information, diagnosis, requested service, facility, requested provider, procedure dates or requested length of stay, time, and billing codes, as applicable.

**Reference Documents**
Colorado Choice Health Plans' Service Area Map
Colorado Choice Health Plans' Provider Directory
Colorado Choice Health Plans' Provider Manual
Evidence of Coverage, Individual Plans (on- and off-exchange)
Evidence of Coverage, Small Employer Group Plans (on- and off-exchange)
Evidence of Coverage, Large Employer Group Plans
Colorado Large Group Medical and Hospital Services Agreement
After Hours and Customer Service ACD Telephone Scripts
New Member Welcome Kit