2024 Select Health Network Access Plan

Colorado Service Area

Colorado Individual and Colorado Options Plans

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1. Introduction

1.1. Carrier Name

SelectHealth, Inc. (Select Health)

1.2. Full Name of Network

Select Health Value Network

1.3. Network ID Number

CON001

1.4. General Description

Select Health is a not-for-profit health plan serving more than a million members in Utah, Idaho, Nevada, and Colorado. For nearly 40 years, we've established a reputation for providing access to high-quality care, helping our members stay healthy, and offering superior service to both members and providers. Select Health's mission is helping people live the healthiest lives possible and vision is to be a model health plan by providing extraordinary care and superior service at an affordable cost. Select Health strives to live this vision through our values of integrity, trust, excellence, accountability, and mutual respect and through our inspiration to provide extraordinary care and service in all its dimensions. This also applies to the Colorado Option plan.

The Select Health website***, selecthealth.org***, is an excellent resource of information available to both providers and members. Members can find a plan provider and their demographic information, view member disclosures, compare plan benefits, and use member resources and support. Providers are able to access tools and resources related to providing the best quality of care for members as well as be updated on government programs and regulations.

Select Health members can reach out to Member Services for any questions they may have at 800-538-5038, available weekdays - 7:00 a.m. to 8:00 p.m., Saturdays - 9:00 a.m. to 2:00 p.m., closed Sundays.

1.5. Service Areas

Select Health will be contracting with providers in the following service areas for commercial plans. The Select Health Value Service Area includes the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Larimer, Park, Pueblo, Routt, Teller, and Weld. The Select Health Monument Service Area includes the following counties: Delta and Mesa.

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1.6. Website Information

https://selecthealth.org/

1.7. Contact Information

Care Management 800-442-5305
Member Services 800-538-5038
Provider Development 800-538-5054

2. Network Adequacy and Corrective Action Processes

2.1. Summary of Network Adequacy Standards

Select Health uses the network adequacy standards set forth by the Colorado Division of Insurance. Select Health determines network adequacy by measuring both time and distance standards to provide efficient access to our members. As we will be entering the market in 2024, Select Health currently does not have any measurables for wait times.

2.2. Sufficiency of Network

Select Health will look to monitor the sufficiency of our network to our members. This will be done by running network adequacy monthly, comparing the network to adequacy standards, and determining whether there are any gaps where Select Health does not meet the time or distance standard. If gaps exist, contract representatives will reach out to practitioners and facilities in the service area by specialty type, to potentially fill gaps.

Select Health will use annual wait time surveys, wait time dashboards (for employed Medical Group providers), monitoring of member complaints, special investigations (SIU), monitoring of service approvals/network exceptions, and providers are also required to attest to accepting new members in the online directory. Additional employer-based feedback is considered to measure access as well.

Select Health includes telehealth benefits for its members. This service helps members get services when and where they need them, without having to travel to location onsite for care.

2.3. Factors Used to Build Provider Network

Select Health uses publicly available data to choose providers that offer both high-quality care and that match the beneficiary patterns of care in the service area. Our network is based around Intermountain Health facilities & providers, complemented by our partnership with UCHealth. In addition to these large health systems, Select Health has partnered with a variety of independent practices not affiliated with a health system in order to meet the needs of our members. Select Health does not use tiered networks in Colorado.

2.4. Quality Assurance Standards

The Select Health Quality Improvement Committee (QIC) is accountable to the Board of Trustees and meets monthly to oversee the Quality Improvement (QI) Program. The QIC assures that the Quality Improvement Program addresses potential problems and reports findings to the Board of Trustees of ways quality might be maintained and improved and takes appropriate actions when indicated. The Select Health QIC coordinates recommendations and actions.

- Oversee the annual development of the QI Program Description, QI Work Plan and QI Evaluation
- Review internal and external sources of service quality indicators related to industry standards and measures including NCQA, CAHPS, QRS, STARs, HOS, ECHO
- Recommend and approve strategies and initiatives to address a broad range of care and service issues
- Review and comment on member and physician interventions that help to ensure the quality of clinical care, patient safety and customer service throughout the organization
- Assist in maintaining a constructive relationship with Select Health providers through oversight of physician appointments, reappointments, and evaluation of removal of network providers for cause
- Report to the Select Health Quality Assurance Sub Committee of the Board and Select Health Board of Trustees regarding quality improvement activities and measures

Select Health seeks to develop a Quality Improvement Program utilizing a population-based approach that:

- Makes use of planned, systematic procedures to objectively assess the quality of care and service provided.
- Implements appropriate actions when problems or opportunities for improvement are identified and that achieve demonstratable improvement.
- Continually improves the quality and safety of patient care and the quality of customer service provided to members.
- Integrates information from all Quality Improvement related activities.
- Meets Select Health commitments for extraordinary service to:
    - Help patients/members feel safe, welcome and at ease.
    - Listen with sensitivity and respond to their needs.

    - Treat patients/members with respect and compassion.
    - Keep patients/members informed and involved.
    - Ensure our team works with patients/members.
    - Take responsibility to solve problems.
- Seeks to demonstrate value and improve quality through the detection and elimination of over, under and misuse of healthcare services.
- Is transparent in nature through public disclosure of quality measures for both the health plan and healthcare providers.
- Seeks mechanisms that encourage practitioners to participate in QI initiatives and recognize healthcare practitioners who excel in providing exceptional quality healthcare and/or customer service.
- Promotes continuity and coordination of medical and behavioral health care.
- Address equity and assess disparities and the racial, cultural, and linguistic needs of plan members and take action to meet those needs through the following:
    - Identifying target populations based on population and census analysis, respondents to CAHPS Survey.
    - Matching health care provider resources with member needs.
    - Producing member plan education and health education materials for target populations.
    - Modifying member outreach programs to include the ability to access the outreach materials via different methods and in target population languages.
    - Provide information, training and tools for staff and practitioners to support culturally competent communication and reduce disparities.
- Is based on current standards of medical practice.
- Collects data from health care providers and vendors that supplements claim data for quality improvement measurement and monitors the integrity of the data, including that the data is reliable and complete.
- Develops methods of identifying enrollees with multiple or sufficiently severe chronic conditions with complex health needs that would benefit from participating in a chronic care improvement program, and develop mechanisms for monitoring enrollees that are participating in the chronic care improvement program through the following:
    - Provide care management programs.
    - Improve access to primary care and specialty care ensuring that members with complex health conditions receive appropriate services.
    - Identifying and reducing barriers to services for members with complex conditions.

Peer review, as part of the Quality Improvement Program, is carried out by physicians and other health care professionals in the following ways:

- Identification of potential problem areas in the clinical process of care through clinical program activities.

- Development or approval of criteria for assessing the need for, and the delivery of, care.
- Review of quality considerations in individual cases where a question of care exists.
- Participation in decisions regarding appropriate corrective action and/or participation in implementing those actions.
- Analyses of patterns of care based on collected data.
- Assessing effectiveness of action taken.

Physicians and health care professionals perform peer reviews as part of their membership on the following committees:

- Select Health Quality Improvement Committee
- Intermountain Hospital Medical Executive Committees
- Select Health Pharmacy and Therapeutic Committee
- Intermountain Clinical Program Workgroups and Development Teams
- Intermountain Behavioral Health Network Quality Improvement Committee
- Select Health Credentials Committee

Please refer to the ***Quality Improvement Charter*** and ***Quality Improvement Program Description***, displaying the quality assurance standards to identify, evaluate, and remedy issues relating to access, continuity, and quality of care within Select Health.

2.5. Corrective Action Processes

The Select Health Quality Improvement Committee (QIC) is responsible to identify areas where corrective action needs to be taken including but not limited to issues identified through surveillance of clinical care, complaints and appeals and sees that there is a correction of all problems that are identified.

The Office of the Chief Medical Officer is responsible and authorized, in harmony with the Grievance Process, to initiate action to correct any Quality Improvement deficiencies as identified by the Quality Improvement Committee. Such actions may include:

- Change in Plan policy and/or procedure.
- Education and counseling of practitioners and/or members.
- Modification or restriction in provider panel status or member enrollment status.
- Practitioner financial penalties as allowed by the provider contract.

Removal of a participating practitioner from the Select Health provider panel(s) for cause may only be initiated under the authority of the Quality Improvement Committee (refer to the Practitioner Panel Termination Grievance and Appeals Policy, the participating Provider Services Agreement, the Practitioner Grievance Procedure, and the Master Group Contract).

Corrective action will be initiated as soon as a problem has been identified and documented. In the event of non-compliance, increasingly severe corrective action measures will be applied.

Re-evaluation for effectiveness of action

- Monitoring relative to the corrective action will be continued in an ongoing fashion until such time as it is determined that a problem no longer exists.
- In some instances, monitoring may be continued indefinitely to show continual improvement/compliance.
- Timely follow- up to quality improvement corrective action processes will be presented to the QIC by the assigned corrective action representative.

2.6. Inadequate Network Process

See ***3.3 Out-of-Network Services*** section under Network Access Plan Procedures for Referrals.

2.7. Covered Benefits

If a member needs to go out of network for services not available in-network, then a review is conducted in the Healthy Connections (UM) department of Select Health to determine failed access. If indeed there is failed access and the clinical needs meet criteria, the member can be approved to go OON, and a Single Case Agreement will be negotiated with the OON provider to pay at in-network benefits, at rates that are similar to an in-network equivalent provider of the same type.

2.8. Monitoring Access to In-Network Physician Specialist Services

Select Health has mechanisms in place to identify and pay QPA rates for NSA-eligible claims in the event a member went to a PAR or non-PAR facility, or urgent or emergent care, and was treated by a non-PAR facility specialist such as anesthesia, radiology, hospitalist, pathologist, etc., at in-network benefits.

3. Network Access Plan Procedures for Referrals

3.1. Provider Directory

Select Health' s online directory can be found at ***Selecthealth.org/find-a-doctor.*** If members want to request a hard copy version they can call, chat, or email member services team to order a copy for member.

Changes to the directory will be made within 48 hours. Providers are requested to update their information at least quarterly or as their demographics change. If the provider information on the directory is still current, no changes are needed; however, if information needs to be updated, it can be changed upon request from the provider or the health plan. Providers are asked to review and update their demographic and directory information each quarter via attestations. Printed directories are done on

demand and reflect the most up-to-date information available at the time of print. The provider directory is updated nightly.

The provider directory is available in English and Spanish.

3.2. Description of Referral Process

Select Health does not require referrals.

3.3. Out-of-Network Services

The member and or the provider can call or submit a request for in-network benefits for any out-of-network provider. The request is then reviewed against the Select Health network policy and distance guidelines. If a provider leaves Select Health network while the member is still active on the plan the member can call and request in-network benefits, this is granted for 90 days.

4. Network Access Plan Disclosures and Notices

4.1. Grievance Process

The Appeals and Grievances Department is available to provide reasonable assistance with the written complaint process when a member or their authorized representative is unable to submit a written complaint on their own. The Appeals and Grievances Department reviews each written complaint to determine if it involves an Adverse Benefit Determination, service provided by Select Health, the quality of care the member received, a clinically urgent situation, and/or if the complaint involved any of the criteria that would necessitate an office site visit.

A complaint expressing dissatisfaction about any matter other than an Adverse Benefit Determination is classified as a grievance. Grievances are tracked and reported under one of the following categories: Quality of Care, Access, Attitude and Service, Billing and Financial Issues, Quality of Provider Office, and Discrimination. Upon receipt of receiving grievance, the received date, originator of the grievance, name of the member, and the subject of the grievance is documented.

The Appeals and Grievances Department fully investigates the substance of each grievance and documents the findings and any action taken in the case file. The investigation of a grievance may include interviewing the member and/or their representative, obtaining relevant medical records, interviewing Select Health staff with potential knowledge of the situation, researching applicable laws, regulations, policies, and procedures, and identifying measures, including those already taken, to resolve the issue.

Review of the grievance considers all comments, documents, records, and other information submitted by the member and/or their representative. Prompt and appropriate action is taken, and the final disposition is tracked in the Appeals application in Facets and the member is notified of the resolution. Within 90 days of the receipt of

the written grievance, Select Health sends the member a letter informing him/her the outcome of the review. To find these disclosures related to grievances, please refer to the applicable Certificate of Coverage*, Appeals and Complaints Section, found at ***selecthealth.org/document-lookup.***

****This specific disclosure is standard language for all members, in all service areas, for each state. Certificates of Coverage for Colorado will be available upon approval of forms by the Division of Insurance when coverage is effective.***

If the Appeals and Grievances Department or any other Select Health department identifies a complaint that involves a clinically urgent situation, the member's care manager is notified. The care manager contacts the member and the provider/facility in question to obtain additional information. If a clinically urgent situation exists, the care manager immediately intercedes on behalf of the member, coordinating with other departments within Select Health and Intermountain Healthcare to identify an interim solution to remove the member from harm. Clinically urgent situations are resolved within 72 hours from time of receipt of the complaint. If the complaint is found not to be clinically urgent in nature, the standard complaint resolution process is followed.

4.2. Availability of Specialty Medical Services

Select Health provides disclosures to covered persons regarding the extent to which specialty medical services are available. To find these disclosures related to grievances, please refer to the applicable Certificate of Coverage*, found at ***selecthealth.org/document-lookup***.

****This specific disclosure is standard language for all members, in all service areas, for each state. Certificates of Coverage for Colorado will be available upon approval of forms by the Division of Insurance when coverage is effective.***

4.3. Process for Providing and Approving Emergency and Non-Emergency Medical Care

In-network providers and facilities should request preauthorization on behalf of members. Select Health does not require pre-authorization for emergency care; however, if hospitalized for emergency, Select Health should be contacted once the member has been stabilized or as soon as reasonably possible. A member may be asked to transfer to an in-network facility to receive in-network benefits. To find these disclosures related to providing and approving emergency and urgent benefits, please refer to the applicable Certificate of Coverage* and to disclosures regarding Preauthorization, Section 11, please find at ***selecthealth.org/document-lookup***.

*This specific disclosure is standard language for all members, in all service areas, for each state. Currently there is not a Certificate of Coverage for Colorado, now in progress.

4.4. Process for Choosing and Changing Network Providers

Select Health does not require referrals or any other kind of permissions for members to see providers of their choice, as long as they are in-network.

4.5. Process of Accessibility to Services

Select Health obeys federal civil rights laws. We do not treat members differently because of race, color, ethnic background, age, physical and/or mental disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

Select Health will provide free aid to those with disabilities, including sign language interpreters or information in other formats (large print, audio, electronic). Select Health will provide help to those whose first language is not English, such as interpreters or member materials in other languages.

Members who need help with these services please contact Member Services at 800-538-5038. If members feel like they been treated unfairly, please call Select Health 504/Civil Rights Coordinator at 1-844-208-9012, Compliance Hotline at 1-800-442-4845, or the Office for Civil Rights at 1-800-368-1019. Additional information may be found at ***selecthealth.org/non-discrimination.***

4.6. Process to Identify Potential Needs of Special Populations

Member experience is regularly measured by responses to surveys collected after interactions within the healthcare system as well as through a Relationship Survey distributed regularly to a randomized selection of all members.

Select Health teams meet regularly to discuss improving Member Experience when they are seeking providers who they may feel comfortable working with or who have undergone specific training, such as for gender affirmation care. A cross-sector ad hoc committee has also been working to understand and eliminate barriers for members who speak a language other than English. The groups are as follows:

- Understanding and eliminating language barriers
- Enhancing the Provider Directory
- Trans Health Providers
- Equity Communications

4.7. Process for Assessing Health Care Needs of Covered Persons

Select Health works to understand the communities it serves within specific local areas where the caregivers, patients, and members live. This is based on population level data which indicates health disparities for entire areas and/or populations within those communities. To make an impact to better serve those communities, Select Health's Community Relations team works in alignment with Intermountain Health's Community Health (Benefit) team to invest in efforts aimed at eliminating community level

disparities. Some examples of this work include providing donations, sponsorships, and volunteers for community-based organizations and cultural celebrations.

In 2023, Select Health's leadership team prioritized the identification of and ability to address member outcome disparities as an organizational goal. This goal aligns with the ongoing efforts to improve data collection, analysis, and utilization, and it helps Select Health optimize the infrastructure to improve member experiences and outcomes. Additionally, it was determined that the organization would pursue NCQA Health Equity Accreditation in 2023 to help bolster this work.

As an enterprise, Intermountain Health and Select Health have been working together to understand how to collect, analyze, and address disparities in health outcomes. In 2022, the equity leads recommended the creation of an internal index to monitor how the health system is successfully addressing disparities. Numerous metrics were evaluated with a focus on elements that are routinely required such as Healthcare Effectiveness Data and Information Set (HEDIS) to ensure alignment with already occurring work rather than creating additional metrics.

5. Plans for Coordination and Continuity of Care

5.1. Continuity of Care for Covered Persons referred to Specialty Providers

Select Health members periodically require medical services which may not be available using in-network providers or facilities. These services may involve specific provider expertise or specific technologies, such as specialized procedures, specialized laboratory testing, or advanced imaging services. In these instances, the involved providers or members may request coverage of services by providers not contracted to provide services with Select Health, to be paid at their in-network level of benefits. Criteria for allowing In-Network Secondary Care Coverage with an Out-Of-Network Provider (#1 must be met before #2 is applied):

- #1 ALL the following information is provided in the submitted documentation from an in-network specialist familiar with the member's medical needs:
    - All in-network resources have been exhausted and documentation has been submitted that in-network providers cannot perform the services required
    - Specific services/providers to whom the member is being referred are identified (Letter from PCP or other provider not directly involved in the management of the member's condition is not acceptable, as these providers are not in-network specialists; and letter from the out-of-network provider to whom the member is being referred is inadequate alone to allow failed access, as it does not assure that in-network services have been exhausted, though, it may provide specific information necessary to meet criterion.)
    - Specific services that the provider can offer that are not available in-network

- Specific services requested must be covered, must meet any preauthorization criteria, and not be considered experimental/investigational.

- #2 Distance Guidelines must be met for Sub-Specialists: The entire plan service area is considered the distance limitation for applying service approval criteria. Distance guidelines do not apply to sub-specialty providers. A sub-specialist is defined as: Highly specialized and expertise care for complicated or rare conditions that is not easily available or accessible in most areas. (The following specialties qualify as sub-specialists:
    - Gynecologic Oncology
    - Infectious Diseases (AIDS)
    - Medical Genetics, Nephrologists,
    - Neurosurgeons
    - Neuro-Ophthalmologists
    - Neuro-Otologists
    - Oculoplastic Surgeons,
    - Pediatric Specialists
    - Radiation Oncologists
    - Reproductive Endocrinologists,
    - Rheumatology (except Medicare)
    - Spine Surgeons
    - Sub-Specialty Orthopedists (i.e., hand, foot, etc.)
    - Special Clinics for Rare Conditions
    - Transplant Surgeons
    - Vascular Surgeons (excluding treatment of varicose veins)
    - Oral Appliance Dentists

5.2. Continuity of Care for Covered Persons using Ancillary Services

See ***5.1. Continuity of Care for Covered Persons referred to Specialty Providers*** section under Plans for Coordination and Continuity of Care.

5.3. Discharge Planning

Select Health works to ensure its members have a safe discharge plan in place after an inpatient stay. The Care Manager or designee can work with a member to ensure follow-up connections are in place, medications and discharge orders are understood, home needs are met, and member support is identified. These actions can help ensure a safe and effective transition to home and decrease the risk of a readmission and harm to the member. Readmission costs are significantly more than the first admission. Ensuring a member gets home safely and avoids readmission improves outcomes and reduces cost.

5.4. Changing of Primary Care Provider

Select Health currently has no restrictions for members wanting to change in-network primary care providers. After selecting a primary care provider, members can note the selection through their online Select Health account.

5.5. Process for Providing Continuity of Care in Event of Provider Contract Termination

When a Provider is terminated, Select Health notifies impacted members 30 days prior to provider termination via letter. The Select Health process also involves having an Intake Coordinator route an authorization from Advocates to the appropriate work group. A Utilization Reviewer then approves the services with the terminated provider for 90 days from the termination date for members in the middle of an episode of care. Or a Utilization Reviewer could approve services with a terminated provider through the end of the member's postpartum period for members in their 2nd or 3rd trimester of pregnancy. Continued access authorizations for terminated providers, which meet the requirements above, can be approved without physician review, given all other applicable criteria are met.

5.6. Hold Harmless Provision in Provider Contracts

Select Health has language in provider contracts prohibiting contracted providers from balance-billing covered persons in the event of the carrier's insolvency or other inability to continue operations.