Select Health

2025 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 non-profit health plan in Utah, Idaho, Nevada, and Colorado, with more than one million members across the United States. We are committed to helping our members and everyone in our communities stay healthy. For the 40 years we've been in business, we continually strive to be a part of improving healthcare, from cost to quality. Our integration with key clinical partners and hospital systems across our geographies help us ensure high-quality healthcare at the lowest possible cost for our members and the community. Select Health's mission is helping people live the healthiest lives possible, and our vision is to be a model health plan by providing high-value health benefits and superior service at an affordable cost. 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 contact 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

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 Health Service Area includes the following counties: Delta and Mesa.

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 2025, 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 for our members by:

- Running monthly network adequacy evaluations
- Comparing the network to adequacy standards
- Determining whether there are any opportunities to improve performance for time and distance standards. If opportunities exist, contract representatives will contact practitioners and facilities in the service area by specialty type.

Select Health uses 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 provider-required attestations for accepting new members in the online directory. We consider additional employer-based feedback 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 an onsite location 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 to meet member needs. 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 as well as:

- Overseeing the annual development of the QI Program Description, QI Work Plan and QI Evaluation
- Reviewing internal and external sources of service quality indicators related to industry standards and measures including NCQA, CAHPS, QRS, STARs, HOS, ECHO
- Recommending and approving strategies and initiatives to address a broad range of care and service issues
- Reviewing and commenting on member and physician interventions that help to ensure the quality of clinical care, patient safety, and customer service throughout the organization
- Assisting in maintaining a constructive relationship with Select Health providers through oversight of physician appointments, reappointments, and evaluation of removal of network providers for cause
- Reporting to the Select Health Quality Integration 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 to make things easy and simple
    - 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 quality measure public disclosure for both the health plan and healthcare providers
- Seeks mechanisms that encourage practitioners to participate in QI initiatives and recognizes healthcare practitioners who excel in providing exceptional quality healthcare and/or customer service
- Promotes continuity and coordination of medical and behavioral healthcare

- Identifies and addresses disparities in experience and outcome by analyzing the racial, ethnic, cultural, linguistic, and other 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 experience surveys, enrollment data, and annual HEDIS disparity analysis.
    - 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.
    - Providing 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 healthcare providers and vendors that supplement claim data for quality improvement measurement and monitors the data integrity, 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 develops mechanisms for monitoring participating enrollees by:
    - Providing care management programs
    - Improving 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 healthcare professionals through:

- 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 care patterns based on collected data
- Effectiveness assessment of action taken

Physicians and healthcare professionals perform peer reviews as part of their membership on:

- 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 Credentialing Committee

Please refer to the ***Select Health Quality Improvement Committee Charter*** and ***Select Health Quality Improvement Program Description*** for 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 identified problems.

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 is 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 involves:

- Monitoring relative to the corrective action is 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.
- Presenting timely follow up to quality improvement corrective action processes 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 the Healthy Connections (UM) department of Select Health conducts a review to determine failed access.

If indeed there is failed access and the clinical needs meet criteria, the member can be approved to go out of network (OON), and a single-case agreement is 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.

Select Health members periodically require medical services that may not be available using in-network providers or facilities. These services may involve specific provider expertise or 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 with Select Health to be paid at their in-network level of benefits. Criteria for allowing in-network secondary care coverage with an OON provider as follows (#1 must be met before #2 is applied):

1. The following information is included in the submitted documentation from an in-network specialist familiar with the member's medical needs:
    - 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
      NOTE: Inadequate/unacceptable documentation would include a letter from:
        - The primary care provider (PCP) or other provider not directly involved in the management of the member's condition, as these providers are not in-network specialists.
        - The out-of-network provider to whom the member is being referred (inadequate alone to allow failed access as it does not assure that in-network services have been exhausted); however, the letter may provide specific information necessary to meet criterion.
    - Specific services that the provider can offer that are not available from in-network providers.
    - Specific services requested are covered, must meet any preauthorization criteria, and cannot 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 a provider who offers: Highly specialized and expertise care for complicated or rare conditions that is not easily available or accessible in most areas.

2.8. Monitoring Access to In-Network Physician Specialist Services

Select Health has mechanisms in place to identify and pay Qualifying Payment Amount (QPA) rates for No Surprises Act (NSA)-eligible claims in the event a member went to a participating or non-participating facility, or urgent or emergent care, and was treated by a non-participating facility specialist (e.g., anesthesiologist, radiologist, 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 https://selecthealth.org/find-care**.** If members want to request a hard copy version, they can call, chat, or email the member services team to order a copy.

Changes to the directory are made within 48 hours. Providers should 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 should 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, which are 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 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 Equity Concern (discrimination, language barrier, race/ethnicity issue). When Select Health receives grievance, we document received date, grievance originator, member name, and grievance subject.

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 grievance investigation 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
- Identifying measures, including those already taken, to resolve the issue

Grievance review considers all comments, documents, records, and other information submitted by the member and/or their representative. Issues involving clinical care are reviewed by a medical director or other designated clinician. Because our findings are considered peer review and confidential in nature, members are not notified of the specific findings of our investigation. Select Health takes prompt and appropriate action and tracks the final disposition in the Appeals application in Facets and notifies the member of the resolution. Within 90 days of the receipt of the written grievance, Select Health sends the member a letter informing them of 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***.**

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 Health 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***.**

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, at selecthealth.org/document-lookup.

*This specific disclosure is standard language for all members, in all service areas, for each state.

4.4. Process for Choosing and Changing Network Providers

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

* 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.

4.5. 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 (e.g., interpreters, member materials in other languages).

Members who need help with these services should contact Member Services at **800-538-5038**. If members feel like they have been treated unfairly, they should call Select Health 504/Civil Rights Coordinator at **844-208-9012**, the Compliance Hotline at **800-442-4845**, or the Office for Civil Rights at **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 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 target:

- Understanding and eliminating language barriers
- Enhancing the Provider Directory
- Trans health providers
- Equity communications

4.7. Process for Assessing Healthcare 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 that indicates health disparities for entire areas and/or populations within those communities. 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 identifying and addressing 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, the organization will seek to renew NCQA Health Equity Accreditation in 2025 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 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. The process of analyzing HEDIS outcomes occurs annually.

5. Plans for Coordination and Continuity of Care

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

Continuity of care is provided with transitional coverage for our members who are new to our plan.

Select Health has a process that involves having an intake coordinator route an authorization from advocates to the appropriate work group. A utilization reviewer then approves the services with the out-of-network provider for 90 days from the plan start date for members in the middle of an episode of care. A utilization reviewer could also approve services with a provider through the end of the member's postpartum period for members in their 2nd or 3rd trimester of pregnancy. Continued access authorizations for out-of-network providers, which meet the requirements above, can be approved without physician review, given all other applicable criteria are met.

5.2. Continuity of Care for Covered Persons using Ancillary Services

See ***2.7 Covered Benefits*** section under Network Adequacy and Corrective Action Processes.

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 that they:

- Have follow-up connections in place
- Understand their medications and discharge orders
- Will have home needs met
- Have identified member support

These actions can help ensure a safe and effective transition to home and decrease the risk of readmission and member harm. 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 Member 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. A utilization reviewer could also 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.