



NETWORK ACCESS PLAN

January 2020

NETWORK ACCESS PLAN - 2020

Friday 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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1. Overview of Friday Health Plans

Who we are

Serving Colorado for over 40 years, Friday Health Plans (formerly 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 members.

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

Friday Health Plans is licensed as a Health Maintenance Organization (HMO) in the State of Colorado. Friday Health Plans is serving the following counties: Adams, Alamosa, Arapahoe, Archuleta, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Costilla, Conejos, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Huerfano, Jefferson, Kiowa, Kit Carson, Larimer, La Plata, Las Animas, Lincoln, Mesa, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, Summit, and Weld.

Products and Services

Friday Health 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.

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, and Pueblo. 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.

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, Friday Health 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.

2. Adequacy of Participating Provider and Facility Network

Friday Health Plans maintains a network of Providers and facilities sufficient to assure that all covered benefits are available to Members without unreasonable delay as is possible.

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 Friday Health requirements and URAC standards. Friday Health maintains current credentialing documentation on Friday Health'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.

Friday Health 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 Friday Health Network.

Network Adequacy Management

Friday Health employs a number of means to ensure network adequacy to meet the needs of Friday Health Members. Friday Health 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, Friday Health makes every effort to retain a direct contract with those Providers or facilities. Alternatively, Friday Health has relationships with supplemental Provider networks that can be used to wrap around Friday Health'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, Friday Health conducts a periodic claims review to identify trends in claims payments. If it is noted that Friday Health 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.

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

Selection of Network Providers

Friday Health Plans maintains one network. Friday Health Plans network of providers has been designed with a range of specialties and locations to fulfill geographic access standards.

Acute Care Hospital Services

In rural service areas, Friday Health 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,

Friday Health 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, Friday Health 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, Friday Health will ensure that the standards specified in the Monitoring section are met or exceeded.

Essential Community Providers

In rural service areas, Friday Health 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, Friday Health will ensure that the standards specified in the Monitoring section are met or exceeded.

Specialty and Subspecialty Providers

In rural service areas, Friday Health 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, Friday Health 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. Friday Health makes all Providers in its network available to all Members regardless of geographic location. Friday Health standards for Geographic Accessibility are further delineated in the Monitoring section of this Plan.

Pharmacy Services

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

Currently, Friday Health'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 Friday Health 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, Friday Health 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, Friday Health 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.

Telehealth

Friday Health will cover Telehealth services. The plan will reimburse the treating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the member delivered through telehealth on the same basis that the plan is responsible for reimbursing provider for the provision of the same service through in-person consultation or contact by that provider. A member's coinsurance/copay/deductible shall apply in the same manner as it would for an in-person like service.

Friday Health will include a reasonable compensation to the originating site for the transmission cost incurred through telehealth delivered by a contracted participating provider, except that, the originating site does not include a private residence at which the member is located when he or she receives health care services through telehealth.

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), Friday Health 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.

3. Preauthorization and Referral Procedures

As noted in the Friday Health 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 Friday Health, by regular mail, fax, or secure Provider portal. For Providers, instructions for submitting the Friday Health "Request for Authorization" Referral form and a list of the most commonly ordered services and tests subject to precertification are found in Friday 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 Friday Health.

Friday Health contracts with Magellan, 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 Magellan are found in Friday Health Plans' Provider Manual.

Friday Health 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.fridayhealthplans.com, or logging into our secure Member/Provider portal.

Timeliness of Referrals

Friday Health'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, Friday Health shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

Case Management

Friday Health 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.

4. 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, Friday Health 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 Friday Health. Friday Health 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 Friday Health 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. Friday Health 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, Friday Health 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 Friday Health 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

Members are not required to select a PCP. If a Member chooses to select a PCP, they may select any PCP who participates in the Friday Health 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 Friday Health Customer Service department at 719-589-3696 or 800-475-8466, visit www.fridayhealthplans.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.

Termination of Providers

When any Primary Care Provider's contract is terminated for voluntary or involuntary reasons, Friday Health 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, Friday Health 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 Friday Health 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 Friday Health 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 Friday Health ceases operations, Friday Health 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, Friday Health'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.

5. Special Needs

Friday Health 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. Friday Health’s Professional Services Agreement, Ancillary Services Agreement, and Hospital Services Agreement contains similar such clauses.

Friday Health has staff members who are fluent in Spanish and available to assist with translation and communications. In the event we need additional translation services, Friday Health 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, Friday Health’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.

6. 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.fridayhealthplans.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. Friday Health 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, Friday Health'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 Friday Health ensures coordination and continuity of care between PCPs and Specialty Providers. A member would gain access to continuity of care if a provider is no longer in network by contacting Friday Health Plan's medical department. A care manager would be assigned to work with the member to determine if continuity of care was required and then help facilitate the member's ongoing access to the provider as necessary.

Grievance and Appeal Procedures

Friday Health 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. Members can find information on grievances and appeals procedures in the Evidence of Coverage, the member portal, on any adverse determination letter or explanation of benefits, or by calling customer service.

Network Access Plan

Members are made aware upon enrollment through their Evidence of Coverage or Member Handbook that Friday Health'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.

7. Monitoring – Network Adequacy

Friday Health 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

Friday Health Plans strives to ensure that its Members have adequate access to services within a reasonable length of time. It is the policy of Friday Health 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 symptoms	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 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 Friday Health 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:	1:1000
Ratio of OB/GYNs to Members:	1:1000
Ratio of Mental Health Providers to Members	1:1000

Availability Standards – Geographic Accessibility

Provider Type:	CEAC¹	Rural: ²	Micro	Metro
PCP	60 miles	30 miles	20 miles	10 miles
OB/GYN	60 miles	30 miles	20 miles	10 miles
Specialist	85 miles	60 miles	35 miles	20 miles
Acute Care Hospital	100 miles	60 miles	60 miles	30 miles
Pharmacies	60 miles	30 miles	20 miles	10 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.

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.

8. Monitoring – Network Quality

Quality assessment and improvement is a continuous process. Friday Health 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.

The QAC evaluates the effectiveness of the Network Access Plan at least annually. The CEO will provide an annual report to the Friday Health 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.

9. 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 Friday Health 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 Friday Health Members and who participates in or contracts with Friday Health.

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.

Telehealth: A mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a member's health care while the member is located at an originating site and the provider is located a distant site. Telehealth does not include delivery of health care services via telephone, facsimile machine, or electronic mail systems.

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 Friday Health 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

Friday Health Plans' Service Area Map

Friday Health Plans' Provider Directory

Friday 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