Access Plan – Cover Sheet

UnitedHealthcare Insurance Company
HIN001, Options Network

1. Standards for Network Composition:

Describe how the issuer establishes standards for the composition of its network to ensure that networks are sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay. Standards must be specific, quantifiable, and measurable based on the anticipated needs of their membership. Common approaches include provider-to-enrollee ratios and time and distance standards. Issuers must also document that their proposed network meets these standards.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented process to establish standards for network composition?	Yes	Pages 4-7
Does the issuer's standard address how the network will be sufficient in number and type of providers, including mental health and substance abuse services?	Yes	Pages 4-7
Is the issuer's standard quantifiable and measurable?	Yes	Pages 4-7
Does the issuer provide documentation or evidence that its proposed network meets its standard?	Yes	Pages 4-7

2. Referral Policy:

Describe the issuer's procedures for making referrals within and outside of its network.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented process for making referrals inside and outside the network?	Yes	Page 8-9
Does the process allow members to access services outside the network when necessary?	Yes	Page 8-9

3. Ongoing Monitoring:

Describe the issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of the population enrolled.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented process for monitoring, on an ongoing basis, the sufficiency of the network to meet the needs of its members?	Yes	Page 9

Does the issuer include a both quantifiable and measurable approach to monitoring ongoing sufficiency of its network?	**Yes**	**Page 9**

4. Needs of Special Populations:

Describe the issuer's efforts to address the needs of covered persons with limited English proficiency and literacy, with diverse cultural or ethnic backgrounds, or with physical and mental disabilities.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented process to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities?	**Yes**	**Page 9-10**
Does the issuer's process identify the potential needs of special populations?	**Yes**	**Page 9-10**
Does the issuer's response describe how its process supports access and accessibility of services for special populations?	**Yes**	**Page 9-10**

5. Health Needs Assessment:

Describe the issuer's methods for assessing the needs of covered persons and their satisfaction with services.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented method for assessing the needs of covered persons?	**Yes**	**Pages 10**
Does the proposed method include a review of quantitative information?	**Yes**	**Pages 10**
Does the proposed method assess needs on an ongoing basis?	**Yes**	**Pages 10**
Does the proposed method assess the needs of diverse populations?	**Yes**	**Pages 10**

6. Communication with Members:

Describe the issuer's method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, it's process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care?	**Yes**	**Page 10-11**
Does the method address the process for choosing or	**Yes**	**Page 10-11**

changing providers and access to emergency or specialty services?		
Does the process describe how it supports member access to care?	**Yes**	**Page 10-11**

7. Coordination Activities:

Describe the issuer's system for ensuring the coordination and continuity of care for covered persons referred to as specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented process for ensuring coordination and continuity of care?	**Yes**	**Pages 11**
Does the proposed process address specialty care referrals; ancillary services, including social services and community resources; and discharge planning?	**Yes**	**Pages 11**
Does the response describe how the process supports member access to care?	**Yes**	**Pages 11**

8. Continuity of Care:

Describe the issuer's proposed plan for providing continuity of care in the event that contract termination between the health issuer and any of its participating providers or in the event of the issuer's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, issuer's insolvency, or other cessation of operations and how they will be transferred to other providers in a timely manner.

Evaluation Criteria	Included In Access Plan	Page Number For Supporting Documentation
Does the issuer have a documented plan for ensuring continuity of care?	**Yes**	**Page 11-12**
Does the issue have a "hold harmless" provision in its provider contracts, prohibiting contracting providers from balance-billing enrollees in the event of the issuer's insolvency or other inability to continue operations?	**Yes**	**Page 11-12**

Standards for Network Composition

UnitedHealthcare maintains standards for the numeric and geographic availability of participating practitioners and providers, adopted from the CMS Medicare Advantage standards for measuring network accessibility. UnitedHealthcare analyzes the networks against these established standards at least annually. At least biennially, UnitedHealthcare conducts an assessment of how well the network meets members' cultural needs and preferences. Interventions related to both analyses are identified and implemented to improve availability when needed. Assessments are conducted in accordance with state, federal and regulatory requirements. Standards and results extracted from the *Availability of Practitioners and Providers* policy are noted in Tables 1 and 3.

Behavioral health services are managed by our sister company, Optum Behavioral Health (formerly known as United Behavioral Health or UBH). OBH is accredited as a Managed Behavioral Health Organization (MBHO) by the National Committee for Quality Assurance (NCQA) and as part of its annual Quality Improvement and Utilization Management Program conducts an assessment of its provider network to ensure it is sufficient in number and type of providers, geographic distribution and cultural/linguistic features to meet the documented needs of our membership. Standards and results extracted from the *Availability of Behavioral Health Clinicians and Facilities* policy are noted in Tables 2 and 4.

In accordance with the standards outlined by CMS, the goal of Essential Community Providers (ECP) contracting efforts is to have a plan network that includes at least 20% of available ECPs and an adequate level of ECP coverage for low-income and medically underserved Marketplace enrollees in the plan's service area. Contracts will be offered to available Indian Health providers and, where available, at least one ECP in each ECP category per county where an ECP in that category is available. We are currently contracted with 30% of the Essential Community Providers in Hawaii.

Additionally, a benefit is provided for **Telehealth** services, however these services are not included in the calculations for demonstrating network adequacy measurements.

Benefits are available for a telehealth consultation between health care providers only if a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider. When behavioral health services are provided through telehealth, a second health care provider is not required to accompany the patient.

Benefits for Covered Health Services provided through telehealth will be the same as Benefits for the same services provided via face-to-face contact between a health care provider and a patient.

"Telehealth" means the use of "telecommunications", including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purposes of delivering enhanced health care services and information to parties separated by distance, establishing a physician-patient relationship, evaluating a patient, or treating a patient.

"Telecommunications" means the offering of transmission between or among points specified by a user, of information of the user's choosing, including voice, data, image, graphics, and video without change in the form or content of the information, as sent and received, by means of electromagnetic transmission, or other similarly capable means of transmission, with or without benefit of any closed transmission medium, and does not include cable service.

Table 1 – Numeric Availability – Medical Services

NUMERIC AVAILABILITY STANDARDS	
Type	**Current Ratio**

Physicians/Practitioners	Standard
Primary Care All Types • Family Practice • General Practice • Internal Medicine • Gerontology • Pediatricians • OB/GYNs (in applicable states)	1:1,000
Allergy/Immunology	1:10,000
Cardiology	1:2,000
Dermatology	1:8,000
ENT	1:4,000
Endocrinology	1:10,000
Gastroenterology	1:4,000
General Surgery	1:2,000
Oncology/Hematology	1:4,000
Neurology	1:4,000
OB/GYN	1:2,000
Ophthalmology	1:2,000
Orthopedics	1:2,000
Pulmonary	1:4,000
Rheumatology	1:10,000
Urology	1:4,000
Hospitals/Ancillary Providers *	
Hospitals	1:2,500
Ambulatory Facilities	1:5,000
Home Health	1:5,000
Laboratory	1:1,200
Outpatient Dialysis	1:2,500
Radiology	1:1,200
Skilled Nursing Facilities	1:2,500
Urgent Care	1:5,000

** Analysis of numeric availability for ancillary providers is not required for all product lines*

NUMERIC AVAILABILITY RESULTS					
Market Description	**PCP 2016**	**PCP 2017**	**HVS 2016**	**HVS 2017**	**Opportunity Details**
HI: UnitedHealthcare Insurance Company	Met	Met	Met	Met	

Table 2 – Geographic Availability-Behavioral Health and Substance Abuse Services

COMMERCIAL DENSITY – OUTPATIENT CLINICS													
Provider Type	**Child & Adolescent (MD &PhD, MA)**			**Psychiatrist & RN with Rx Privileges**			**Doctoral, Master's Level Practitioners**			**Medication Assisted Treatment (MAT)** prescribers with an expertise in buprenorphine or naltrexone injectable			**Opportunity Details**
Goal	**1 : 1,000**			**0.50 : 1,000**			**0.50 : 1,000**			**1 : 20,000**			
Standard	**# Needed**	**# INN**	**Met**	**# Needed**	**# INN**	**Met**	**# Needed**	**# INN**	**Met**	**# Needed**	**# INN**	**Met**	
Results	.90	210	Yes	.45	187	Yes	.45	728	Yes	.04	3	Yes	
COMMERCIAL DENSITY – FACILITIES													

Provider Type	Acute Inpatient Care (MH & SA)			Intermediate Care (MH & SA)			Intensive Outpatient Care (MH & SA)			Medication Assisted Treatment (MAT) methadone clinics, facilities with the methadone level of care			Opportunity Details
Goal	**1 : 20,000**			**1 : 20,000**			**1 : 20,000**			**1 : 20,000**			
Standard	**# Needed**	**# INN**	**Met**	**# Needed**	**# INN**	**Met**	**# Needed**	**# INN**	**Met**	**# Needed**	**# INN**	**Met**	
Results	.04	2	Yes	.04	9	Yes	.04	13	Yes	.04	2	Yes	

Table 3 – Geographic Availability – Medical Services

GEOGRAPHIC AVAILABILITY STANDARDS						
Practitioner/ Provider Type	**Standards**					**Goal**
	Large Metro	**Metro**	**Micro**	**Rural**	**CEAC**	**All Categories**
Primary Care 1 within • Family Practice • General Practice • Internal Medicine • Gerontology • Pediatrics • OB/GYN (in states where applicable)	5 miles	10 miles	20 miles	30 miles	60 miles	90%
Specialty Care Physician 1 within • Cardiology • General Surgery • Ophthalmology • Orthopedics	10 miles	20 miles	35 miles	60 miles	85 miles	90%
• Dermatology • Gastroenterology • Neurology • Oncology/Hematology • Pulmonology • Urology	10 miles	30 miles	45 miles	60 miles	100 miles	90%
• Endocrinology • Infectious Disease • Oncology – Radiation/Radiology • Rheumatology	15 miles	40 miles	75 miles	90 miles	130 miles	90%
• Allergy/Immunology • ENT • OB/GYN	15 miles	30 miles	60 miles	75 miles	110 miles	90%
• Chiropractic		15 miles (Urban)		60 miles		90%
Hospital 1 within	10 miles	30 miles	60 miles	60 miles	100 miles	90%

GEOGRAPHIC AVAILABILITY STANDARDS						
Practitioner/ Provider Type	**Standards**					**Goal**
	Large Metro	**Metro**	**Micro**	**Rural**	**CEAC**	**All Categories**
• Inpatient Psychiatric Facility Services	15 mile	45 miles	75 miles	75 miles	140 miles	90%
Ancillary Providers * 1 within • Laboratory Services	5 miles	10 miles	60 miles	60 miles	100 miles	90%
• Ambulatory Surgical Facilities • Radiology • Urgent Care • Home Health	10 miles	30 miles	60 miles	60 miles	100 miles	90%
• Skilled Nursing Facility	10 miles	30 miles	60 miles	60 miles	85 miles	90%
• Outpatient Dialysis	15 miles	30 miles	60 miles	75 miles	110 miles	90%

** Analysis of geographic availability for ancillary providers is not required for all product lines*

GEOGRAPHIC AVAILABILITY RESULTS							
Market Description	**PCP 2016**	**PCP 2017**	**HVS 2016**	**HVS 2017**	**HIS 2016**	**HIS 2017**	**Opportunity Details**
Hawaii: UnitedHealthcare Insurance Company	Met	Met	Not Met	Met	Met	Met	

Table 4 – Geographic Availability – Behavioral Health and Substance Abuse Services

COMMERCIAL GEOGRAPHIC AVAILABILITY – OUTPATIENT CLINICS									
Provider Type	**Child & Adolescent (MD &PhD, MA)**		**Psychiatrist & RN with Rx Privileges**		**Doctoral, Master's Level Practitioners**		**Medication Assisted Treatment (MAT)** prescribers with an expertise in buprenorphine or naltrexone injectable		**Opportunity Details**
Goal	**90%**		**90%**		**90%**		**90%**		
Designation	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	
Miles Standard	**20**	**60**	**20**	**60**	**20**	**60**	**30**	**75**	
Results	100%	100%	100%	100%	100%	100%	100%	100%	

COMMERCIAL GEOGRAPHIC AVAILABILITY – FACILITIES									
Provider Type	**Acute Inpatient Care (MH & SA)**		**Intermediate Care (MH & SA)**		**Intensive Outpatient Care (MH & SA)**		**Medication Assisted Treatment (MAT)** methadone clinics, facilities with the methadone level of care		**Opportunity Details**
Goal	**90%**		**90%**		**90%**		**90%**		
Designation	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	
Miles Standard	**30**	**75**	**30**	**75**	**30**	**75**	**30**	**75**	
Results	93%	0%	100%	90%	100%	100%	100%	100%	**Acute Inpatient Care:** HHSC is a health system with 4 hospitals on the neighbor islands that have MH IP. Due to small commercial membership numbers and volume of commercial member admissions, they are not interested in contracting at this time. They are contracted currently for Medicare and Medicaid and will continue to accept our commercial members at their facilities.

Referral Policy

These plans do not require PCP selection. Their products are open access for specialty care and have limited notification / prior authorization requirements. UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified.

Out-of-Network Requests and Continuing Care: UnitedHealthcare also has a documented process for providing services, when necessary, outside of the network. Upon receipt of a provider or member's coverage request to begin or continue treatment with an out-of-network provider, the procedures under the utilization management program provide for administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements. If the individual's benefit plan coverage of services is exhausted while the individual still needs care, the organization will offer services, as required, to educate the consumer about alternatives for continuing care and how to obtain care.

The purpose of this process is to provide timely and consistent determinations and notices for all out of network coverage requests and to ensure members have needed information regarding alternatives for continuing care. Examples of Out of Network Coverage Requests include the following:

- **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.
- **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly covered consumer who is receiving ongoing care a transition period before they are required to transfer from an out-of-network provider to an in-network provider and to receive network benefits under the terms of the employer health benefits or government program contract for the transition period.

- **Continuity of Care (CoC):** A request for CoC is based on a benefit which allows a covered consumer to continue to receive in-network benefits for services rendered by a provider who has terminated from the provider network. The consumer is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider under the terms of the employer health benefits or government program contract.

Ongoing Monitoring

In accordance with UnitedHealthcare's *Availability of Practitioners and Providers* policy, we conduct a thorough assessment annually to ensure that the network is sufficient in numbers and types of providers, geographic distribution and cultural/linguistic features to meet the documented needs of our members.

In addition to the annual assessment, UnitedHealthcare monitors the provider network on a monthly basis, in order to appropriately identify any material changes in a timely manner.

Needs of Special Populations

In 2010, the Health Equity Services (HES) program was established to help address health disparities. The HES program helps reduce health disparities by improving our culturally sensitive initiatives that promote health and prevent avoidable health care cost. To accomplish this, the HES program operates with four key focus areas:

- Collecting data to better understand our membership and their cultural characteristics
- Identifying gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language
- Growing multicultural capabilities to enhance the member experience

In 2016 and 2017, we significantly enhanced our HES programs and offerings through:

- Employee training for more insight about providing services to our members from diverse cultural backgrounds
- Customized member outreach and communication
- Enhanced data analytics to address identified health disparities

The Health Equity Services program completed an enterprise compliance assessment of the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and is at industry standard or better for all 15 standards. Despite being at industry standard or better for all CLAS standards, we continue to plan and implement improvements that will further our efforts to reduce identified member health outcome disparities.

Evaluation of members' cultural, ethnic, racial and linguistic needs may be measured using the following data sources:

- CAHPS® data
- Member Satisfaction Survey Data
- U.S. Census Data
- Network Database (NDB)
- Enrollment Data
- Medicare/Medicaid eligibility files
- Focus Groups
- American Community survey

- Other Sources As Required Or Needed

To enable services to be provided in a culturally competent manner and accessible to all members, an assessment of the cultural/linguistic needs of the members is conducted at least biennially. Based on the analysis of this assessment, adjustments may be made to the health plan networks to improve cultural availability. In addition, literacy needs may be measured for Marketplace.

Health Needs Assessment

UnitedHealthcare's *Assessing Member Experience* policy is to assess member experience with its services and programs, at least annually, and identify areas for potential improvement. When opportunities for improvement are identified, actions are taken to improve member experience.

Primary data collection sources include member complaints and appeals, UM consumer concerns, and member experience surveys. Member experience surveys may include, but are not limited to:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS®)
- Key Member Indicators (KMI) Survey
- Member Focus Groups
- Complex Case Management Surveys
- Disease Management Surveys
- State, Federal and Regulatory Surveys

Communication with Members

The *UHC Member Communications* policy is to ensure that members have access to information regarding key topics about their health plan and benefits including but not limited to:

- Member rights and responsibilities
- QI Program activities and accomplishments
- Case management programs
- Disease Management programs
- Financial incentives related to utilization management (UM decisions)
- Benefits coverage, exclusions, restrictions and costs of care
- Pharmacy and UM procedures and benefits
- Notification requirements and medical services
- Evaluation of new technology
- Finding a network physician or hospital
- Obtaining routine, preventive and specialty care; urgent, ER and hospital; after-hours, out of state/area and behavioral care
- Looking up and submitting claims, obtaining and ID card
- How to submit a complaint or appeal
- External appeal processes
- Language assistance and TDD/TYY services
- Notice of Privacy Practices

Methods of communication include, but are not limited to, distribution of the Certificate of Coverage, Welcome Guide, Quick Start Guide, and the annual Rights and Resource Disclosure Booklet (ARRD). Members also have access to myuhc.com, a website with resources for accessing personal health records, finding physicians, and encouraging healthy behaviors.

Coordination Activities

An annual quantitative and qualitative analysis is conducted to review the continuity and coordination of medical care provided to UnitedHealthcare members across settings and or during transitions of care

The scope of activities includes managing and coordinating aspects of medically necessary care between inpatient and various outpatient settings and between primary physicians and specialists through care coordination and providing communications to bridge gaps between treating practitioners and providers. The primary activities may include but are not limited to:

- Prescription of controlled substances
- Member satisfaction with continuity and coordination of medical care
- Provider satisfaction with coordination of medical care
- Steerage to transplant centers of excellence
- Continuity of care between dialysis centers and nephrologist
- Postpartum care
- Transitional Case Management Opportunity
- Monitoring of Quality of Care Complaints

UnitedHealthcare staff partner with OptumHealth and OptumRx to identify gaps and develop strategies to act on opportunities to improve continuity and coordination of medical care.

Continuity of Care

UnitedHealthcare's *Provider Administrative Guide* and provider participation agreements include language that addresses continued access after termination to ensure continuity of care for specific medical conditions. Procedures are in place to ensure that members are notified when any of their active providers terminate participation agreements and that when clinically appropriate, members are allowed continued access to terminated providers at an in-network benefit level. Additionally, provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations.