
# PROVIDER HANDBOOK

***A Guide For Integrated Community Health Partners (ICHP)***

***Participating Providers***

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*Updated May 2015*

# SECTION 1.0 INTRODUCTION TO ICHP

Welcome to the new healthcare world. Integrated Community Health Partners, LLC (ICHP) has been formed by some of the best local Medicaid provider organizations and a national healthcare management organization with offices and experience in Colorado. ICHP was formed to serve as the Regional Care Collaborative Organization (RCCO) for Medicaid members in the communities of southeastern Colorado. ICHP is contracted by the Colorado Department of Health Care Policy and Financing (HCPF), referred to hereafter as the 'Department', to serve in this capacity for the Colorado Accountable Care Collaborative (ACC) Program. We believe ICHP is the ideal care collaborative organization, formally integrating primary care, behavioral healthcare, and sophisticated healthcare management functions. We believe that control of healthcare should be local, that patients are best served through practices organized as patient-centered medical homes, and that medical homes, when given accurate and timely information about their patients, are best positioned to both improve the quality and control the costs of healthcare. It is the Department's goal that eventually most Medicaid members shall receive their primary care through a patient-centered medical home.

# SECTION 2.0 PATIENT-CENTERED MEDICAL HOME

**What is a Medical Home?**

A Medical Home is not a building, house or hospital, but a medical practice that provides high quality and cost-effective healthcare in adherence to patient-centered medical home standards. A Medical Home is a patient and family-centered practice that provides comprehensive, continuous, coordinated, accessible, compassionate, and culturally-competent care. Additionally Medical Home can refer to the actual Primary Care Medical Provider (PCMP). In this document, we will refer to Medical Home in both capacities.

**What services are available through a Medical Home?** Providers enrolled as Medical Homes are responsible for ensuring health maintenance and preventive care; health education; acute and chronic illness care; coordination of medications, specialists and therapies; and 24-hour telephone care.

**What are the components of a Medical Home approach?**

**Comprehensive care** – Families, healthcare professionals, and social service providers identify and provide all medical and non-medical services to help the member.

**Continuity of care** – A process in which the member and his/her healthcare professional are cooperatively involved in ongoing healthcare management toward the goal of high quality, cost-effective care. Additionally, the same healthcare professionals are available from infancy through adolescence, and ensure successful transition to the adult healthcare system.

**Coordinated care** – Families are linked to appropriate educational and community-based services. The provider communicates and collaborates with all service agencies and a centralized record of all relevant information from all service providers is maintained.

**Family-centered care** – The family is recognized as the principal caregiver and center of strength, knowledge, and support for the member. The family voice is valued.

**Accessible care** – Care is provided in the member's community and access to healthcare and advice is available 24 hours a day, seven days a week.

**Compassionate care** – There is a demonstrated concern for the well-being of the patient and family.

**Culturally-competent care** – The cultural background of the member, including beliefs, rituals and customs, is recognized and respected.

**Health Literacy** - The degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions. Medicaid enrollees typically have low health literacy.

## 2.1 Primary Care Medical Provider (PCMP) Standards

In order to participate as a PCMP in the Accountable Care Collaborative ACC Program, the PCMP must:

- Be enrolled as a provider in the Colorado Medicaid program;
- Be any of the following:
  - Certified by the Department as a provider in the Medicaid and Children's Health Plan + Medical Homes for Children program;
  - A Community Health Center (CHC), also known as a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or a clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology; or
  - An individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology;
  - Act as the dedicated source of primary care for members and be capable of delivering the majority of the members' comprehensive primary, preventive, and sick medical care;
  - Be currently licensed by the Colorado Medical Board to practice medicine in the State of Colorado.

# ■ SECTION 3.0 MEDICAID HEALTH PLAN AND PCMP CHOICE

The State of Colorado, Heath Colorado and ICHP work closely together to provide members choice of Medicaid Health Plans and PCMP Choice. Information regarding the State Client Selection Methodology can be found at the following State of Colorado Link:

https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-client-selection-methodology

If you have a patient that has been enrolled in ICHP and they would like to be assigned to your practice please go to the following link and complete the Medicaid Accountable Care Collaborative Program Primary Care Medical Provider (PCMP) Choice Form or call HealthColorado with the patient at 1-303-839-2120 in the Denver Metro Area, or 1-888-367-6557 outside metro Denver to choose their PCP.

The Forms can be found at: http://ichpcolorado.com/providers/pdfs/PCMP-Choice-Form.pdf

If you have any questions regarding this process please call ICHP Customer Service at 1-855-959-7340.

# ■ SECTION 4.0 MEDICAL MANAGEMENT AND CARE COORDINATION

According to one recent estimate, 125 million people in the United States are living with at least *one* chronic illness, and this number may grow to 157 million by 2020. Likewise, the number of people living with *multiple* chronic conditions is growing and may reach over 80 million by the start of the next decade (Hoffman, Catherine & Rice, Dorothy P. *Chronic Care in America: A 21st Century Challenge,* 1996). Providing care for such patients is complex and challenging; individuals with multiple chronic conditions often receive care from numerous healthcare organizations in multiple care settings and may see ten or more different providers in a single year. Patients who attempt to navigate our complex healthcare system and transition from one care setting to another may be unprepared or unable to manage their own care. A number of common, yet avoidable, outcomes may occur. These outcomes include poor follow-up care, medication errors, hospital readmissions, and duplication of services. Care coordination is essential to reduce waste and avoid these unfortunate medical outcomes.

ICHP and its partners recognize that care coordination is a fundamental practice for achieving high-quality and cost-effective healthcare outcomes, particularly for patients with one or more chronic conditions. We believe that care coordination is most effectively delivered in the patient-centered medical home (PCMH). In its essence, care coordination incorporates, “the deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of healthcare

services" (*Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*, Volume 7—Care Coordination. 2007). Optimal care coordination provides timely access to services, enhances continuity of care across providers and care systems, provides support to individual patients and their families, and helps them understand and advocate for necessary services.

ICHP has identified several key strategies that will enhance care coordination for our members and help them obtain the best possible treatment outcomes and overall wellness. One such strategy is to build alliances with community health partners. These alliances begin with patient-centered medical homes, including our community health centers, also referred to as Federally Qualified Health Centers or FQHCs, and mental health center partners. Beyond these initial alliances, ICHP is committed to developing relationships with schools, housing resources, local and regional hospitals, transportation services, child welfare systems, and independent healthcare and behavioral healthcare providers. By developing or strengthening these community connections, ICHP establishes or widens channels for communication about care for our members. A second strategy for improving care coordination is to identify sub-groups of members who are at greatest risk for unfavorable healthcare outcomes. For example, ICHP uses data mining approaches to identify members who are cost outliers, those who have significant medical and psychiatric co-morbidity, and those who have histories of emergency services over-utilization. Identification of these subgroups will continue to evolve as ICHP gathers data about how our members are using healthcare services. A third strategy for improving care is to identify opportunities for preventive care and early intervention. We believe that early care is the best care and that coordinated planning and member education pay dividends in improved healthcare outcomes.

Contracted ICHP providers are expected to participate actively in care coordination for their patients or clients, as defined in provider agreements, ICHP policies and the Medical Management and Care Coordination Plans, which are reviewed and approved annually by the ICHP Board. For those members whose Medical Home is the community health center (CHC), care coordination will be provided by care coordination staff who are directly employed by the CHC. Members will have immediate and continuous access to these staff who are dedicated to providing care coordination services. Likewise, ICHP's behavioral health partners employ care coordinators or case managers whose primary duty is to provide such services. For those members who have other PCMPs, care coordination services will be provided through their PCMP or through the ICHP care coordination team. Care coordinators will meet on a regular basis to review cases, share information about community resources, and combine resources to meet members' needs.

## 4.1 Access to Care

PCMP practices shall provide extended hours on evenings and weekends as effective alternatives for emergency room visits for after-hours urgent care. At a minimum, the

PCMPs will provide twenty-four (24) hour a day availability of information and referral for treatment of emergency medical conditions.

PCMP Appointment Availability standards:

- Within forty-eight (48) hours of a member's request for urgent care.
- Within ten (10) calendar days of a member's request for non-urgent, symptomatic care.

Within forty-five (45) calendar days of a member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with Early Periodic Screening, Diagnosis and Treatment (EPSDT, also known as Healthy Communities) schedules.

In addition, administrative oversight in the form of annual monitorings will be conducted by ICHP administration. PCMP's are required to participate in this annual monitoring process to verify that Members have access to routine, non-urgent/symptomatic, and urgent care within the required timeframes, as noted above.

## 4.2 Referral Process

Integrated Community Health Partners will work with you to ensure that you have a complete understanding of the Department's referral requirements for Medicaid. It is important that all providers are aware of and comply with the referral requirements.

These requirements include referring members to specialty care as appropriate, providing the referring PCMP's Medicaid provider identification number and communicating the reason for the referral.

All ICHP PCMPs are able to refer members to any specialists enrolled in Medicaid or any other Medicaid provider, including those not associated with ICHP or another RCCO.

You are not required to provide a referral when the member receives any of the following services as indicated on the following link:

https://www.colorado.gov/hcpf/colorado-medicaid-benefits-services-overview

As a PCMP in the ICHP network, you must maintain a system for tracking completion of specialty referrals and inclusion of findings and recommendations received from specialty care providers in the member's record. PCMPs must have a process for follow-up and documentation of efforts to reschedule missed specialty appointments or missing specialty care provider reports. In cases where the specialty care provider will be providing ongoing treatment of the patient, PCMPs will document ongoing collaboration with the specialty care provider in the member's record.

## 4.3 Missed Initial Appointments

Integrated Community Health Partners (ICHP) emphasizes the importance of providing care coordination for its members in the most comprehensive, yet efficient and responsible manner possible. As a part of the Department's requirements regarding missed initial appointments, all PCMPs are expected to contact the ICHP member, through a method of the PCMP's choice. This contact should be documented. The PCMP should advise the member of the need to keep future appointments while also assisting the member in resolving any associated barriers to receiving care, such as transportation or day-care issues.

## 4.4 Needs Assessment and Treatment Planning

PCMPs are responsible for completing a comprehensive assessment of members assigned to their care. The required assessment elements will be identified through ICHP policy and will be monitored through an auditing process. Providers will get feedback about their performance and will be directed to complete additional training, if necessary, to achieve compliance with ICHP's standards. Providers will receive training about the Needs Assessment requirements through the onboarding process and through regularly scheduled webinars or other training programs. Providers are also required to document an individualized care coordination or treatment plan that is consistent with the member's needs that were identified during the Needs Assessment process. This documentation is also subject to oversight monitoring from ICHP.

## 4.5 Care Coordination Activities

As part of the initial 'On-Boarding' process, PCMPs will meet with ICHP staff to determine whether care coordination activities will best be provided by the PCMP or ICHP. During this process, discussion will occur around various care coordination activities, documentation requirements, and reporting expectations. Areas of focus include: member stratification, care assessments, care plans, transition of care processes, community resource coordination, discharge planning and other related areas. PCMPs are subject to performance monitoring related to care coordination expectations.

## 4.6 Transitions of Care

Transitions of care from one level of care to another represent a time of particular vulnerability for members with complex medical and/or behavioral health needs. During transitions, patients may be at higher risk for medication errors or for other errors that stem from communication problems. Members who experience poor transitions of care are more likely to return to the emergency room or to inpatient settings, often leading to poorer overall health outcomes. Similar transition problems also can occur when members move from one treatment setting to another (e.g., from clinic based services to nursing home based services) or from one type of program to another (e.g., from child to adult services).

To help reduce transition of care problems, ICHP requires the development of a transition of care plan for members who are receiving active care coordination services. This plan should address the following elements, as appropriate to the particular needs of the member:

- The plan is realistic, comprehensive, timely and concrete;
- The plan is consistent with the recommendations of the treatment team and the preferences of the member;
- Transition from one level of care or program to another is coordinated and as seamless as possible;
- The plan attempts to address continuity of existing medical and therapeutic relationships, as appropriate;
- The provider and/or care manager assists the member to understand the status of the discharge plan and offers the member a copy of the plan;
- Transportation and other needs are addressed, as applicable;
- Pharmacological needs are addressed;
- Collaboration with other medical or behavioral health practitioners has occurred, as necessary;
- The member has timely access to the recommended aftercare services and means of getting to the appointments, including a documented first appointment and the specific time, place, and person who will be conducting that appointment with the member;
- Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated;
- Support systems are outlined;
- Community services and/or self-help groups are recommended.

## 4.6 Cultural Competency Requirements

ICHP requires that all care coordination services are provided in a culturally competent manner. This includes sensitivity to the member's particular language needs and their cultural beliefs and values. As ICHP staff and providers, we are guided by the following principles and expectations:

- We are committed to being sensitive to the needs of all people and cultures and to the communities that ICHP serves. Cultural competence is achieved by integrating knowledge about individuals and groups of people into specific

practices and policies and applied in cultural settings. When professionals are culturally competent, they create positive helping relationships, engage the member, and improve the quality of services they provide.

- We are committed to developing and implementing policies and procedures that will enhance cultural competency.
- We are committed to breaking down barriers to access and utilization that are faced by many minorities when seeking health care. These barriers include relevancy of services and financial, language, transportation and literacy barriers.
- We are committed to broadening multi-cultural participation in our provider network.
- We are committed to promoting the ethic of cultural competence and educating our staff, providers, partners, members and the community about members' right to culturally competent services.
- We are committed to a philosophy of care that is inclusive rather than exclusive and recovery-oriented rather than disability-oriented.
- We are committed to promoting models of communication that give voice to all cultures.

To achieve these principles, PCMPs will be required to participate in a process that assesses cultural competency and language fluency. Providers also will be trained about how to access interpreter and translation services for their patients, when needed.

# SECTION 5.0 PRACTICE SUPPORT

ICHP is committed to providing practice support tools and technical assistance for its contracted providers. The primary goal for practice support is to improve the providers' ability to deliver care that results in improved clinical and cost outcomes. Although many resources are still in development, they include the following:

Clinical practice guidelines, including the 17 clinical guidelines that have already been developed by Health TeamWorks (formerly Colorado Clinical Guidelines Collaborative);

- ICHP website with specific information for members and providers;
- Administrative support related to provider relations, member enrollment, referrals, and billing/claims issues;
- Provider newsletters with updates on policy or procedure changes;
- Provider education forums;
- Toll-free telephonic assistance to providers;
- Data and analytics related to utilization management;
- Database of community resources;
- Clinical toolkits for developing Medical Homes;
- Clinical screening questionnaires and other assessment instruments;
- Updated information on “best practices” in clinical care;
- ValueOptions Achieve Solutions © website, an online resource with more than 200 articles related to healthcare and lifestyle issues.

# SECTION 6.0 STATE/MEDICAID CLAIMS PAYMENT ASSISTANCE

Participation in ICHP does not change the way you bill claims to the Colorado Medical Assistance Program. Affiliated Computer Services (ACS), the fiscal agent for Colorado Medicaid, will continue to process your electronic claims.

The ICHP Provider Relations Support team is available to help PCMPs navigate the Medicaid claims payment system for the Colorado Medical Assistance Program. There are several resources available to providers including: claims billing manuals, onsite courses, and webinars that can help you with the ACS claims process.

Visit https://www.colorado.gov/hcpf/provider-services to access these materials.

Please contact ICHP Provider Relations Support Team at 1-855-959-7340 for assistance or more information.

# ■ SECTION 7.0 NETWORK MANAGEMENT AND ADMINISTRATION

The ICHP to PCMP contracting process includes a multi-level contracting phase that includes both Colorado Medicaid and ICHP contracts. The Colorado Medicaid contract gives providers a financial incentive to participate in the ICHP network by paying a per member per month (PMPM) fee to PCMPs for participation. The contract with ICHP gives PCMPs additional supports and tools to make your Medical Home successful.

If you are interested in joining the ICHP network, please submit a letter of interest to:

Integrated Community Health Partners
Attention: Director of Provider Relations
9925 Federal Drive Suite 100
Colorado Springs, CO 80921

# ■ SECTION 8.0 PERFORMANCE IMPROVEMENT PROGRAM

## 8.1 Performance Standards

ICHP's Performance Improvement Program functions by continually monitoring and improving our ability to achieve desired health outcomes for our members. This is accomplished through the provision of effective, efficient, integrated care. The Performance Improvement Program is administered through the ICHP Performance Advisory Committee (PAC). PAC membership includes ICHP members, PCMPs and other providers, community stakeholders, ICHP staff and others. PCMP input regarding the effectiveness of ICHP systems is essential to the improvement of member health and the overall system of care. PCMPs may be asked to participate in the PAC or provide input on various aspects of ICHP performance, as well as periodic improvement initiatives.

The PAC relies on data and analytics to measure processes, performance and outcomes of care. Aspects of ICHP performance that are monitored include the following:

- Access to healthcare services and appointment availability;
- Care coordination activities and member engagement;
- Member health outcomes;
- Member satisfaction;
- Practice patterns; and
- Service utilization.

ICHP's Performance Improvement Program focuses on a number of performance measures in assessing the effectiveness and efficiency of systems of care. Three

performance outcomes in particular are significant, as these Key Performance Indicators (KPIs) are how all RCCOs across the state are measured on their performance. These KPIs can include incentive payments to the PCMPs, if the KPI has shown improvement – all of which are determined by the Department of Healthcare Policy and Financing.

- Post-Partum Care Rate per 1000 members
- Emergency room visits per 1000 members;
- Well Child Checks (ages 3-9) per 1000 members;

Post-Partum Care is a completeness rate metric that evaluates the percentage of eligible members that have had a Post-Partum visit within the last 12 months. Well Child Check is also a completeness rate metric that evaluates the percentage of eligible members, aged 3 to 9 that have had a Well Child Check within the last 12 months. Emergency Room Visits is a budget/ baseline performance measure which evaluates emergency room utilization rates by eligible members against pre-determined budget values.

PCMPs may be required to meet performance standards related to the performance areas listed above.

The Performance Improvement Program will initiate at least two targeted performance improvement activities annually across the ICHP region. As part of these activities, or other quality review initiatives, you may be asked to provide medical records for review via mail or as part of an onsite visit. When documenting in the medical record, it is important to include any activities that would show evidence of care coordination on behalf of the member, as this may be a focus area and could be targeted for review.

The Performance Improvement Program monitors activities for improvement by a quarterly review of the Care Coordination Metric. Metrics are provided by the practice providers and may include information on: total number of members identified in the practice or which in particular tier level, number of members receiving care coordination services, number of members with completed health/risk assessments, number of members identified as high ER utilizers, number of members receiving transition of care services, number of members with referrals to community resources or specialty care providers, and number of members with missed initial appointments.

## 8.2 Compliance

### Regulatory Compliance

ICHP complies with all laws governing its operation. Regulatory compliance is monitored through the ICHP Compliance Committee. This committee also evaluates and implements processes to ensure adherence to new regulations or changes to existing regulations. PCMP practices will be notified of regulatory changes and new regulations impacting the

ICHP contract that may also impact PCMP practices. ICHP will provide education and training as needed.

**ICHP Compliance Committee**
As a part of the overall goal of monitoring regulatory compliance, this committee oversees the prevention, detection, and reporting of fraudulent, abusive, and wasteful practices within the ICHP program.

**Fraud/Abuse Hotline: To report potential fraud or abuse, please call:**

**1-855-899-7148**

# SECTION 9.0 SYSTEMS INTEGRATION

There are many reasons to focus on effectively integrating services. Some of these include the complex array of service organizations with differing missions, rules and limitations, the changing healthcare environment, and member needs crossing boundaries. Members may experience complex medical and physical needs, traumatic brain injuries, developmental disabilities, homelessness, substance abuse, long-term care placements, and involvement with the judicial system. ICHP will focus on systems integration of local and state agencies and coordinating educational needs and community resources for specialty populations. Helping members navigate through the process of accessing services will ensure they receive optimal healthcare coordination. ICHP staff working with community agencies will coordinate these resources for smoother care transitions and the most efficient use of diverse sources of assistance to our members. The systems integration mission is self-evident: *to ensure the healthcare system is fully integrated into the larger human services system and vice versa.*

Please contact ICHP for assistance with:

1) Problem-solving systems issues where there are multiple agencies involved, leading to resolution and smoother delivery of services;
2) Obtaining additional resources for specialty populations;
3) Encouraging collaboration among systems;
4) Working toward optimal system service integration for the purpose of coordination of services between agencies to meet the member's needs.

For questions or more information about systems integration efforts, please call (toll-free) 1-**855-959-7340** and ask to speak to a Systems Integration representative**.**

# SECTION 10.0 MEMBER SERVICES

**Call Center:**
ICHP has a Member Services department that helps members and families in a variety of ways. Member Services can be reached by calling the ICHP Call Center at 1-855-959-7340.

**The Call Center:**
- Takes calls from 8 a.m. to 5 p.m.; Monday through Friday.
- Transfers callers directly (warm transfer) to providers, HealthColorado (the Colorado Medicaid enrollment broker), the Ombudsman program, and the Nurse Advice Line.
- Is available in English and Spanish.

**Staff at the Call Center:**
- Answer member questions about the ACC program, including:
  - Benefits and eligibility,
  - Participating providers,
  - Services available through care coordination.

- Help members transition between providers
  - Help members locate a provider who can offer a Second Opinion.
  - Provide members/families with information about community resources that will help them achieve better outcomes.
  - Help members and families have a voice in the healthcare system by participating in committees and advisory boards.
  - Health literacy – our staff is trained in developing materials for people at a low grade reading level. Because health literacy is so important to a member's treatment success, our staff can review materials for readability, or provide training to your staff in health literacy.

**Rights and Responsibilities -** The ICHP Member Services Department is responsible for assuring that member rights and responsibilities are being upheld. The department:
- Ensures that members are aware of their rights and responsibilities. ICHP has processes in place to educate member and providers about member rights.
- Handle complaints/grievances including assisting members with filing complaints/ grievances, investigating and resolving complaints, and advocating for members.

ICHP providers must be aware of and uphold Medicaid member's rights. Medicaid rules and ICHP policies, require providers to:
- Prominently post member rights statements in waiting areas or hand each Medicaid client a copy at intake.
- Prominently post information about the Ombudsman for Medicaid Managed Care.
- Post information about the member's right to file a grievance.
- Provide ICHP member information in Spanish.

- Offer interpreter services for members who are Deaf, speak a language other than English or have other communication disabilities. If you have a member who is Deaf or does not speak English, our contract requires that interpreter services be provided. Please contact the ICHP member services department and let them know that you need an interpreter for a patient or family member or assistance with a referral to a provider who is fluent in the member's language.
- Ensure that ICHP members are not discriminated against based on race, national origin, color, creed, religion, sex, age, disability, veteran status, sexual orientation, gender identity, or associational preference.

The ICHP Member Services department can provide you with Member Rights materials in English and Spanish.

**MEMBER COMPLAINTS**

The complaint/grievance process is available to members who wish to file a complaint about their services or their experience with their PCMP. Examples of member complaints/grievances include:

- Customer Service complaints
- Failure to respect a member's rights
- Financial/Billing issues

Members can file complaints/grievances over the phone, in person, or in writing, within 30 calendar days of the precipitating event. Any interested party can file a grievance on behalf of the member, including the member's legal guardian, an independent advocate or a provider. Anyone acting on behalf of a Medicaid member in the grievance process acts as a designated client representative (DCR). In order for a person to be a DCR, the member must give ICHP written permission for the person to act as a DCR. ICHP has a DCR form that can be obtained by contacting ICHP member services.

If ICHP does not have a DCR form on file and a grievance is filed by someone other than the member or legal guardian, ICHP will contact the member or legal guardian to obtain written permission to investigate and resolve the grievance, sign a DCR form, and sign other releases of information.

ICHP Member Affairs can assist the member in the grievance process. Member Services staff:

- Explain the grievance and resolution process.
- Investigate the grievance by contacting agencies and others to gather information.
- Provide a resolution to the grievance.
- Provide support to the member during the process.

Filing a grievance will not restrict or compromise the member's access to services.

## COMPLIMENTS

Our providers and staff also want to know what we are doing well. If you have a compliment, please contact the ICHP Call Center. The compliment will be forwarded to the appropriate provider or staff member and will be logged in our data base.

## MEMBER AND FAMILY INPUT

ICHP seeks member and family input into the design of our programs and services. Members and family members have an opportunity to:

- Participate in focus groups and member surveys,
- Serve on stakeholder advisory committees.

Any ICHP member is eligible to participate. Providers should refer interested members to the Member Services line at 855-959-7340.

## OMBUDSMAN FOR MEDICAID MANAGED CARE

The Ombudsman for Medicaid Managed Care is an independent program that provides assistance with grievances for Medicaid eligible members who are enrolled in the ACC program. Anyone who has filed a grievance on behalf of a member can get help with any portion of the grievance process. The Ombudsman can be reached by calling:

The Ombudsman for Medicaid Managed Care
877-435-7123 or 303-830-3560

Providers are required to post information about the Ombudsman for Medicaid Managed Care or to give it to the member at intake. Posters in English and Spanish can be obtained from our Call Center.

## CONTACTING ICHP MEMBER SERVICES

To get answers to your questions about the member grievance process, get copies of educational or member materials, or learn how a member can participate on an advisory committee: ICHP Member Services - 855-959-7340.