Denver Health Medical Plan, Inc.
Elevate Health Plans
2025 Access Plan

INTRODUCTION

Every year the Denver Health Medical Plan, Inc. (DHMP) evaluates the Elevate Health Plans network of providers which encompasses our Bronze HDHP and Colorado Option Standardized Plans. The Elevate Health Plans Network ID is (CONOO1). The Elevate Health Plans network is the same as, and no more restrictive than, the "non-standard" network and available to eligible enrollees residing in the following counties: Adams, Arapahoe, Archuleta, Denver, Dolores, Grand, Jefferson, La Plata, Lake, Montezuma, Park, San Juan, Summit, Larimer, Weld, and Morgan.

The network is measured against established standards to ensure DHMP members have appropriate access to healthcare services from physicians, hospitals, pharmacies and other healthcare providers. Any access insufficiencies identified during this evaluation are corrected with changes to the DHMP network. This Access Plan is in accordance with C.R.S. 10-16-704 Network Adequacy rules-legislation declaration.

This Access Plan is available online at https://www.denverhealthmedicalplan.org/elevate-exchange-access-care. DHMP shall also make available this Access Plan on its business premises and shall provide it to DHMP members and any interested party upon request. DHMP members may call Health Plan Services at 303-602-2090 or 1-855-823-8872 to arrange an appointment to review the DHMP Access Plan onsite at the DHMP office or to request a printed copy. All health benefit plans, and marketing materials shall clearly disclose the existence and availability of this Access Plan. C.R.S. 24-72-204 (3)

I. DHMP NETWORK OF PRIMARY CARE, SPECIALISTS, BEHAVIORAL HEALTH, HOSPITALS AND PHARMACY PROVIDERS

Definitions:

PCP (Primary Care Provider): A provider who performs routine care of individuals with common health problems and chronic illnesses that can be managed on an outpatient basis. PCPs include physicians designated to practice in Family Medicine, Internal Medicine, General

Medicine, Pediatrics, and Geriatrics; and may include Advanced Practice Nurse Practitioners and Physician Assistants providing primary care in the outpatient setting within the scope of their license. Obstetrics and Infectious Disease Specialists may also be considered PCP's if they perform primary care for Obstetrics and Infectious Disease patients.

SPC (Specialty Care Provider): A provider who is licensed and has appropriate education, training, and clinical practice in a particular medical specialty area other than the primary care disciplines (stated above.) Some examples of Specialists include Cardiologists, Gastroenterologists, General Surgeons, ENT, OB/GYNs, Orthopedics, and Ophthalmologists.

BHP (Behavioral Health Practitioners): A practitioner who is licensed and has appropriate education, training in the evaluation and treatment of psychological and substance abuse disorders. High-volume status is determined during DHMP's annual member encounter data review. Behavioral Health Practitioners may include Psychiatrists, Psychologists, Addiction Medicine Specialists; state licensed or certified master's level Clinical Social Workers, or Clinical Nurse Specialists, and Therapists.

The DHMP Elevate Health Plans Contracted Network consists of the following providers:

Basic Provider Network
PCPs: 6,912
Specialists: 7,450
Behavioral Health Practitioners: 875
Hospitals: 102 Including: Denver Health Medical Center (DHMC), CommonSpirit, Banner Health
Pharmacies: 64,000+ 12 Denver Health out-patient pharmacies located at the neighborhood clinics and on the DHMC main campus.

II. PROVIDER AVAILABILITY STANDARDS

DHMP has established standards to ensure the availability of primary care and specialty providers, behavioral health practitioners, hospitals and pharmacies to meet the healthcare needs of members. DHMP follows NCQA and state guidelines in establishing the availability standards. Annually DHMP performs an analysis of its Elevate Health Plans Network to ensure these standards are met. The Elevate Health Plans Network (CONOO1) applies to our Bronze HDHP and Colorado Option Standardized Plans.

Pursuant to the requirements set forth by the Division of Insurance for the Colorado Option, DHMP has contracted with Clinica Family Health and Salud Family Health locations within the Denver Metro Area, as well as health navigators and care coordinators employed by DHHA, to assist members in overcoming barriers to care in the Denver Metro Area. We are also expanding our service area and provider network to include providers in the mountain and southwestern areas of the state of Colorado.

DHMP employs several Care Coordinators to assist members with their healthcare needs. DHMP network providers including Clinica Family Health, Salud Family Health, and Denver Health Hospital Authority all employ Health/Patient Navigators, however, DHMP does not have a complete count of the number of people employed in these positions.

Provider Availability Standards:

- At least one adult primary care provider for each 1,000 members
- At least one pediatric primary care provider for each 1,000 members
- At least one high volume specialty provider for each 1,000 members (high volume, specialty provider is defined as; Cardiology, OB/GYN Orthopedics, Dermatology, ENT, General Surgery, Ophthalmology, Gastroenterology.
- At least one psychiatrist for each 1,000 members
- At least one psychologist for each 1,000 members
- At least one master level clinicians for each 1,000 members

Provider Availability Projected for Elevate Health Plans Network

Provider	Standard	Results*
Adult Primary Care Providers	1:1,000	1:27.4
Pediatricians	1:1,000	1:80.7
Medical Specialties:		
Cardiology	1:1,000	1:526.2
Dermatology	1:1,000	1:877.1
ENT	1:1,000	1:611.9
General Surgery	1:1,000	1:222.9
OB/GYN	1:1,000	1:144.5
Orthopedics	1:1,000	1:355.6
Gastroenterology	1:1,000	1:398.7
Ophthalmology	1:1,000	1:239.2

Behavior Health Practitioners:		
Psychologist	1:1,000	1:59.6
Psychiatrists	1:1,000	1:36.9
Master Level Clinicians	1:1,000	No data available

*Provider Availability Taken from NCQA 2024 Report

*Projected Total Member Count for 2025: 26,313

III. PROVIDER GEOGRAPHICAL ACCESS STANDARDS

DHMP has established standards for geographical distribution of providers. The standard for each category is for 90% of the membership. Geographical access standards are developed based on NCQA and state guidelines. Annually Elevate Health Plans performs a Geo access analysis of Elevate Health Plans network of providers, including certified nurse midwives, to ensure these standards are met.

Definitions:

Urban Area: A Zip Code population density being greater than 3,000 persons per square mile.
Suburban Area: A Zip Code population density being between 1,000 and 3,000 persons per square mile.
Rural Area: A Zip Code population density being less than 1,000 persons per square mile.

IV. APPOINTMENT AVAILABILITY STANDARDS

STANDARDS	PCP	Specialty	Behavioral Health	Hospital	Pharmacy Access
Urban	2 PCPs within 8-10 miles	1 SPC within 15 miles	1 BHP within 15 miles	1 Hospital within 10 miles	1 Pharmacy every 1 miles
Suburban	2 PCPs within 15 miles	1 SPC within 15 miles	1 BHP within 15 miles	1 Hospital within 15 miles	1 Pharmacy every 5 miles
Rural	1-2 PCPs Within 30 miles	1 SPC within 30 miles	1 BHP within 30 miles	1 Hospital within 30 miles	1 Pharmacy every 15 miles

DHMP has established the following appointment availability standards for emergency, urgent, primary care, specialty, and behavior health. Appointment standards are based on NCQA guidelines.

Appointment Standards	Time Frame
Emergency Care	24 hours a day, 7 days a week
Emergency Care - Behavioral Health non-threatening treatments	Within 6 hours
Urgent Care - Medical and Behavioral	Within 24 hours
Routine Primary Care-symptoms non-urgent	Within 5 business days, 7 calendar days
Primary Care Access to afterhours care	Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician
Specialty Care-non urgent	Within 60 calendar days
Routine Behavioral health care	Within 10 business days
Preventative visit/well visits	Within 30 calendar days

Comments:

- Minimum requirements for appointment availability for primary care, specialty and behavioral health will be met 90% of the time.
- If a specialty appointment is not available in network within the time frame the member is given the option to see an out of network specialist.
- Emergency services are available to covered members 24 hours a day / 7 days a week.
- Denver Health nurse line is available 24 hours a day / 7 days a week for health advice, with immediate access to the provider on call system at Denver Health

v. AVAILABILITY AND APPOINTMENT ACCESS

Annual Evaluation of Provider Networks

The following information applies to DHMP Elevate Health Plans (Bronze HDHP and Colorado Option Standardized Plans) which consist of the following provider network: Elevate Health Plans Network (CONO001)

Quality Improvement staff establishes, monitors and implements improvement processes (if necessary) to ensure compliance with NCQA, state network adequacy, availability of service, appointment access and guidelines. Annually DHMP evaluates its networks of providers for:

- Geographic distribution
- Provider/member ratio for PCPs

- Provider/member ratios for high-volume behavioral health practitioners and specialists
- Provider/member ratios for high-impact specialty care providers

Changing the Primary Care Provider

If a member decides to select a new primary care provider, there is no need to notify DHMP. DHMP members may change their selection at any time. In addition, when a PCP leaves the Denver Health network, a notification is sent to all members who recently received care from the provider. The DHMP website provides the most up-to-date information on providers that participate in the Elevate network. Providers are advised to call Health Plan Services at 303-602-2090 for more information

Open Shopper Surveys

Open Shopper Surveys are performed to monitor appointment quality access:

A.) The Health Plan Services team evaluates the process a member would undertake to reach a live representative to schedule an appointment and/or speak with a provider. Primary Care, Specialty, Behavioral Health, and Pharmacies in the Elevate Basic Network are called and measured on the following:

- Number of prompts required
- Duplicate prompts (if applicable)
- Spanish option offered
- Department identified (live or in voicemail)
- Voice-mail ability (if live person is not available)
- Target date and time for return call (only voicemail)
- After-hours services

B.) Primary Care Appointment Availability-PCPs are contacted to determine the first available appointment against the performance standards for access to:

- Regular and routine care appointments
- Urgent Care appointments
- After hours care
- Behavioral Health Appointment Availability-Behavioral Health Practitioners are contacted to determine available appointments against the performance standards for access to:
- Care for non-life-threatening emergency
- Urgent Care appointments
- Routine Office appointments

The results of these Open Shopper Surveys are evaluated and presented to the DHMP Quality Management Committee. Providers found to be routinely deficient are contacted to discuss an improvement plan.

Evaluation of Member Satisfaction

Member satisfaction regarding access and availability of healthcare services is measured annually

using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey. Survey results are trended and compared to previous survey results and industry benchmark data. Results are reported to the DHMP Quality Management Committee. DHMP will act on identified opportunities to improve access to health care services as appropriate.

Evaluation of Member Issues

The DHMP Quality Management Committee monitors, collects, evaluates trends from the following data: member appeals and grievances, provider availability and accessibility, quality of care issues, appropriateness of care for persons with special needs and member disenrollment data. This information is evaluated by the Quality Management Committee and Access Committee. If necessary, opportunities for improvement are identified and action plans are developed and implemented.

Perinatal, Primary Care, and Behavioral Health Care Services

The Network Management Committee is tasked with establishing, maintaining and reviewing network standards and operational processes as required by National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), Colorado Department of Health Care Policy and Financing (HCPF), and the Colorado Division of Insurance (DOI). The scope of responsibility includes 1) network development and procurement, 2) provider contract management, including oversight, and 3) periodic assessment of network capacity. Additional capacity for Behavioral Health Care Services is provided through the Amwell Behavioral Health Telemedicine Network.

Telehealth Services

Telehealth services allows DHMP members to access additional providers that may not be located near or within their service area, or in close proximity to their home. Furthermore, DHMP has expended resources to support the response to the COVID-19 pandemic. Websites have been developed to provide detailed information and resources to assist both providers and members with their care and options. The pandemic has required healthcare providers to rethink the way patients are seen and cared for, particularly in the outpatient setting. As a result, DHMP providers are capable of conducting most outpatient visits over the phone. Denver Health continues to leverage current resources and the appointment center to enhance telehealth capabilities. The platform does not require additional downloads or special equipment; anybody with a telephone can access and utilize this option. DHMP has increased its capacity for video visits that can be conducted on a smartphone, tablet or computer with a camera. DHMP has expanded the MyChart application/online system to allow for telehealth video visits and consultations when appropriate. DHMP increased the telehealth capabilities within the MyChart system to allow for tele-urgent care visits. Members with MyChart accounts can schedule an urgent care visit to performed via the video capabilities of the system.

VI. STANDARDIZED PLAN NETWORK PROVIDER AND COVERED PERSON DEMOGRAPHIC DATA

Please find below the voluntarily reported demographic data that was collected in 2023 for network providers and members. The percentage of network providers who submitted race and ethnicity data was 44.89% and gender identity was 100%. For sexual orientation, sex at birth, and ability status, there was no data collected. This data was received from MD Staff via the credentialing data management system and since these data points have not traditionally been relevant to credentialling, they have not been historically collected, but we are exploring other avenues for data collection. A request for provider demographic data was sent via an e-mail survey, however no responses were received back from the providers. For covered person demographics, a data collection was also requested via an e-mail survey that resulted in a very low response rate. Of the member responses received back, 1.28% submitted race and ethnicity, sexual orientation, gender identity, sex at birth, and ability status.

This collected data will be confidential, de-identified, and used to improve racial health equity, reduce health disparities for covered persons who experience higher rates of health disparities and inequities and provide aggregate information regarding the demographic diversity of Elevate Health Plans' provider network and covered population.

In our effort to create a culturally responsive network, DHMP will continue to identify and rectify gaps in the network provider demographic data and covered person demographic data collected annually.

NETWORK PROVIDER DEMOGRAPHIC DATA

Race and Ethnicity Data		
Number of Providers in Standardized Plan Network	**Number of Network Providers who Submitted Race & Ethnicity Data**	**Percent Complete**
3564	1600	44.89%
Race Data	**Provider Count (#)**	**Percent of Total Respondents**
American Indian or Alaska Native	4	0.25%
Asian	50	3.13%
Black or African American	18	1.13%
Hispanic or Latino	16	1.00%
Native Hawaiian or Other Pacific Islander	1	0.06%
White, Not Hispanic or Latino	508	31.75%
Two or more races	9	0.56%
Prefer not to answer	994	62.13%
Total	1600	

Sexual Orientation & Gender Identity Data

Number of Providers in Standardized Plan Network	Number of Network Providers who Submitted Sexual Orientation Data	Percent Complete
3564	0	0.00%

Sexual Orientation	Provider Count (#)	Percent of Total Respondents
Straight	0	0.00%
Lesbian	0	0.00%
Gay	0	0.00%
Bisexual	0	0.00%
Pansexual	0	0.00%
Queer	0	0.00%
Asexual	0	0.00%
A sexual orientation not listed here	0	0.00%
Prefer not to answer	0	0.00%
Total	0	

Number of Providers in Standardized Plan Network	Number of Network Providers who Submitted Gender Identity Data	Percent Complete
3564	3564	100.00%

Gender Identity	Provider Count (#)	Percent of Total Respondents
Female	2201	61.76%
Male	1347	37.79%
Transgender Female/Transgender Women	0	0.00%
Transgender Male/Transgender Man	0	0.00%
Non-Binary	0	0.00%
Two-spirit	0	0.00%
Intersex	0	0.00%
Gender Queer/Gender Fluid	0	0.00%
A gender identity not listed here	0	0.00%
Prefer not to answer	16	0.45%
Total	3564	

Number of Providers in Standardized Plan Network	Number of Network Providers who Submitted Sex at Birth Data	Percent Complete
3564	0	0.00%

Sex at Birth	Provider Count (#)	Percent of Total Respondents
Female	0	0.00%
Male	0	0.00%
Not Designated on Birth Certificate	0	0.00%
Prefer not to answer	0	0.00%
Total	0	

Ability Status Data

Number of Providers in Standardized Plan Network	Number of Network Providers who Submitted Ability Status Data	Percent Complete
3564	0	0.00%

Do you have a disability?	Provider Count (#)	Percent of Total Respondents
Yes	0	0.00%
No	0	0.00%
Prefer not to answer	0	0.00%
Total	0	

COVERED PERSON DEMOGRAPHICS

Race and Ethnicity Data		
Number of Enrollees who Submitted Race & Ethnicity Data	**Number of Enrollees in Standardized Plan Network**	**Percent Complete**
119	9288	1.28%

Race Data	**Enrollee Count (#)**	**Percent of Total Respondents**
American Indian or Alaska Native	1	0.01%
Asian	2	0.02%
Black or African American	2	0.02%
Hispanic or Latino	22	0.24%
Native Hawaiian or Other Pacific Islander	1	0.01%
White, Not Hispanic or Latino	80	0.86%
Two or more races	9	0.10%
Prefer not to answer	2	0.02%
Total	119	

Sexual Orientation & Gender Identity Data		
Number of Enrollees who Submitted Sexual Orientation Data	**Number of Enrollees in Standardized Plan Network**	**Percent Complete**
119	9288	1.28%

Sexual Orientation	**Enrollee Count (#)**	**Percent of Total Respondents**
Straight	84	0.90%
Lesbian	5	0.05%
Gay	6	0.06%
Bisexual	9	0.10%
Pansexual	3	0.03%
Queer	2	0.02%
Asexual	2	0.02%
A sexual orientation not listed here	3	0.03%
Prefer not to answer	5	0.05%
Total	119	

Number of Enrollees who Submitted Gender Identity Data	Number of Enrollees in Standardized Plan Network	Percent Complete
119	9288	1.28%

Gender Identity	Enrollee Count (#)	Percent of Total Respondents
Female	65	0.70%
Male	46	0.50%
Transgender Female/Transgender Women	1	0.01%
Transgender Male/Transgender Man	1	0.01%
Non-Binary	3	0.03%
Two-spirit	1	0.01%
Intersex	0	0.00%
Gender Queer/Gender Fluid	0	0.00%
A gender identity not listed here	1	0.01%
Prefer not to answer	1	0.01%
Total	119	

Number of Enrollees who Submitted Sex at Birth Data	Number of Enrollees in Standardized Plan Network	Percent Complete
119	9288	-1.28%

Sex at Birth	Enrollee Count (#)	Percent of Total Respondents
Female	67	0.72%
Male	52	0.56%
Not Designated on Birth Certificate	0	0.00%
Prefer not to answer	0	0.00%
Total	119	

Ability Status Data

Number of Enrollees who Submitted Ability Status Data	Number of Enrollees in Standardized Plan Network	Percent Complete
119	9288	1.28%

Do you have a disability?	Enrollee Count (#)	Percent of Total Respondents
Yes	8	0.09%
No	106	1.14%
Prefer not to answer	5	0.05%
Total	119	

VII. CONTINUITY AND COORDINATION OF CARE

Continuity of Care Program (COC)

The Continuity of Care Program is available to all DHMP Members and is designed to ensure members have access to out of network (OON) providers due to Transition of Care New Enrollments, Continuity of Care Provider Termination, Network Adequacy or due to a State of Emergency. Care Management and Utilization Management work collaboratively to ensure members have access to care for new members in active treatment with an OON provider at the time DHMP membership becomes effective; continued care is authorized for a defined transitional period as need to minimize disruption of care. Care Managers assist members in choosing an in-network provider. DHMP also provides coordination of care for members based on network adequacy issues for a defined period of time until a safe transfer of care can be arranged to an in-network provider. Ongoing services are reviewed, and efforts are made to redirect care when able.

Care coordination activities provided by COC program include but are not limited to:

- In-network PCP coordination if not already established
- Appointment reminders – Ensuring timely physician follow-up care
- DME
- Home Health
- Reviewing mediation regimen
- Disease Management
- Education on health conditions and potential "red flags" for readmission
- Transportation
- Connecting members with helpful community resources

The goal of the Utilization Management Department is to ensure that members receive the right care in the right setting. Staff assists members with the following:

- Approve in network referrals, (if required by member's plan). Primary and specialty care referrals do not require an authorization. Only limited services need authorization (document is located at https://www.denverhealthmedicalplan.org/services-requiring-prior-authorization: Services Requiring Prior Authorization)
- Facilitate out of network referrals if the needed service is not available within the DHMP network, at in-network rates.
- Review and approve medical services that require prior authorizations. See link provided above which gives care specific details*.
- Facilitate transition of care across the continuum such as: from hospital to home, hospital to skilled nursing facility. This is a collaborative effort between DHMP Utilization Management and DHMP Care Management Teams.
- Facilitate and coordinate care between primary care and specialty care. Care Management is available if assistance is needed to obtain appointments. Care within network does not require authorization.
- Facilitate and coordinate care between physical health and behavioral health. Members can self-refer to any in-network behavioral health provider for most care. Health Plan Services can

provide a directory of providers if needed.

- Assist with discharge planning. Utilization Management Inpatient nurses notify the Care Management of all discharges to assist with any additional needs upon discharge including provider appointments, community resources, etc. Home Health Care and DME equipment is processed via Utilization Management when needed. Any DME less than 500 dollars does not require an authorization if provided by a contracted network provider. Prior authorization is not required for the first 30 days with a contracted home health care provider for the first instance each calendar year.

* Authorization requests are considered "urgent" and will be expedited when a delay in authorization could seriously jeopardize the life or health of the member or ability of the covered person to regain maximum function; or for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently. An authorization request may also be expedited when, in the opinion or a physician with knowledge of the covered person's medical condition, a delay would subject the covered person to sever pain that cannot be adequately managed without health care service or treatment that is the subject of the request.

Termination of Plan Provider

DHMP has a rigorous process to notify members affected by the termination of a practitioner or practice group, at least (60) calendar days upon receipt of notification. Upon receiving notice that a provider is leaving the DHMP Network or prior to terminating a provider, DHMP Provider Relations implements the following process.

- The Credentialing team identifies corresponding Provider ID in the Claims System and enters the appropriate term date and term reason code.
- A Data query against DHMP Claims and Membership system is run to identify the name, subscriber ID, and address of all members receiving active treatment from the terminating practitioner during the past 18 months from the PCP termination date.
- Provider Relations then sends termination letters to each DHMP member identified in the data query report notifying them that their PCP or Specialist is leaving the Network along with the following information and instructions:
  - Asking the members to reply within five days of receiving a termination notice
  - The practitioner's name and the effective termination date
  - Procedures for selecting another practitioner
- Instructions for contacting the DHMP Utilization Management Department to obtain authorization for continuity of care
- Provider Relations sends a copy of the data query report to DHMP Utilization Management team to assist with outreach for continuity of care issues.

If circumstances permit, DHMP allows affected members continued access to terminating practitioners, as follows:

- Continuation of treatment through the current period of active treatment, or for up to 90 calendar days beyond the termination date, whichever is less, for members undergoing treatment for a chronic or acute medical condition.

- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

Insolvency of DHMP

In the event of DHMP insolvency contracted providers are required to continue to provide services for ninety (90) days or in the case of an inpatient stay until the member is discharged. Future providers have the following provision in their contracts, which prohibits them from seeking reimbursement for services from the member:

"Provider hereby agrees that in no event, including but not limited to, non-payment by HMO, HMO insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Member, or persons other than HMO acting on their behalf for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or Co-payment, coinsurance and/or deductible amounts in accordance with the terms of the Member Agreement between HMO or Payor and Members.

Provider further agrees that (i) this Article V shall survive the termination of this Agreement regardless of the cause giving rise to termination, shall be construed to be for the benefit of the Member, and shall apply to all authorized Covered Services rendered prior to the termination of the Agreement, and that (ii) this Section 5.1 supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf."

Complex Health Needs

Denver Health Medical Plan, Inc. (DHMP) has a Complex Case Management (CCM) Program designed to provide intensive, personalized case management services for members who have complex medical and social needs and require a wide variety of resources. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions and severe mental illness. The goal of the program is to help members regain optimum health or improved functionality capacity in the right setting, utilizing the right providers, in the right time frame and in a cost-effective manner.

Complex Case Managers have expertise in training in a variety of approaches in the management of health including case management concepts, principles and strategies, insurance benefits, cost containment and savings strategies, transitional care, cognitive behavioral and strengths perspective in order to provide patient-centered, whole person care.

The program is designed to achieve the following objectives:

- Assist members in regaining an optimal health status
- Improved functional status of chronic conditions
- Proactively identify and engage members for the program
- Develop effective case management care plans that meet member health needs with timely, evidence-based care and service
- Provide interventions to positively impact the target population
- Identify and refer to community resources to maximize support
- Improve and increase access to care

- In addition to the CCM program, there are additional programs and resources available to members with complex needs who may/may not be enrolled in the program. Those include but are not limited to:

Behavioral Health and Substance Use Disorders

Denver Health Medical Center offers outpatient behavioral health services with access to care 24/7. Outpatient setting includes individual counseling, group counseling, and intensive outpatient treatment. Services are offered in-person, telehealth, and video-health counseling options. OBHS programs offered for Opioid treatment, MAT, Addiction Recovery, women and family services and substance treatment education programs. Denver Health Medical Plan also offers members access to myStrength™. The myStrength™ website is a self-management tool for members to help manage emotional well-being and motivation. This evidence-based website offers emotional health modules directed at mindfulness, spirituality, managing depression, controlling anxiety, improving sleep, drug or alcohol recovery, managing chronic pain, opioid recovery, LGBTQ+ resources, and pregnancy and early parenting. Tools directed at physical well-being include weight management, eating well, physical fitness, getting active and quitting smoking. Additional topics include attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), bipolar disorder, schizophrenia and spirituality.

Clinical Social Workers

Denver Health Medical Center employs graduate-level clinical social workers to provide services to the population served at Denver Health. Social workers are employed across the continuum of care and work in various settings including community health, public health, school-based clinics, managed care, acute, and primary care. Members with complex needs are often referred to a social worker for intervention. Social work services include but are not limited to assessment of need, counseling, case management and/or care coordination and provision of community resources.

Community Health Worker

Denver Health Medical Plan assists members who experience higher rates of disparities and inequities using community health workers in the counties they reside. Our community health workers are advocates for our members, our Essential Community Provider (ECP) template has the following number of community health workers in the counties we serve in Adams-87, Arapahoe-18, Denver-359, Jefferson-35, Park-0; Grand-0, Summit-7, Lake-0, Archuleta-0, Montezuma-0, Dolores-0, San Juan-0, La Plata-0, Larimer-0, Weld-0, and Morgan-0. DHMP also partners with many community organizations to provide care management services.

Intensive Outpatient Clinic (IOC)

The intensive outpatient clinic provides a multi-disciplinary, comprehensive team approach to addressing the needs of patients who are identified as high risk (e.g., high utilizers, frequent ED/hospital admissions and readmissions, multiple chronic conditions and/or presence of MH/substance abuse). The team consists of primary care physicians, nurses, social worker, psychologist, psychiatrist, CAC (certified addictions counselor), navigator and pharmacist. Their clinic location provides a ‘one-stop’ approach for members at most risk.

VIII. PRODECURES FOR MAKING REFERRALS

Comprehensive Listing of Providers

All DHMP members are sent a new member enrollment packet that contains information on how to obtain a Directory of Participating Providers. This directory is available online at the Elevate website to both members and PCPs and provides network information regarding PCPs, specialists, behavioral health practitioners, clinics, hospitals, pharmacies and other ancillary providers. All DHMP providers in the Basic Network, including primary care and specialists have open panels.

In Network Plan Services

DHMP members are not required to select a PCP but are encouraged to establish a relationship with a PCP as their medical home; the provider can assist you to maintain and monitor your health and access services of specialists. However, referrals may be made by any in network provider. A referral to an in-network specialist in the Basic Network is required. DHMP Members have direct access (no referral needed) to the following in network specialists: Women's health specialist (OB/GYN) for routine well woman care and prenatal care, behavioral health services, chiropractic services, and eye exams. The member must be eligible to receive services through DHMP at the time services are provided and the services that the member receives must be covered services as specified in the DHMP Member Handbook.

Out of Network/Out of Plan Services

Members can be directed to out of network providers if network providers are unavailable or inadequate to meet a member's medical needs. DHMP will arrange for authorization of services from a provider with the necessary expertise and provide a benefit as if the benefit were obtained from an in-network provider. All requests must be approved in advance by DHMP prior to the member obtaining health care services. In the instance where the provider refers the member out of network, benefits (cost share) will apply as if the member is being seen in network. Out of network services will be provided at no greater cost to members than if the services had been obtained from in network providers. DHMP will authorize out of network health care services in the following circumstances:

- DHMP has no contracted providers who can provide a specific, medically necessary covered service.
- A member does not have reasonable access, to a contracted provider due to distance or travel time; or
- A member who is severely ill or impaired (verified by physician) will not be required to travel a reasonable distance to receive services; or
- Continuity of care when a new member is receiving frequent and current care from a non-contracted provider for a special condition, such as high-risk pregnancy or pregnancy beyond the first trimester.
- Approved requests for health care services which DHMP members are eligible to receive are not retrospectively denied except for instances of fraud or abuse by the subscriber or Member.

Emergency and Urgent Care Services

Emergency and urgently needed services do not require a prior authorization. In the case of an emergency, members are informed to go to the nearest facility or call 9-1-1. For urgent care, members are allowed to receive care from any urgent care facility in or out of the service area.

DHMP has contracted with Walgreens Take Care Clinics and members are encouraged to seek care at one of these locations for low acuity conditions, such as ear infections, sore throats, minor cuts and abrasions.

IX. CULTURAL LINGUSITIC APPROPRIATE SERVICES (CLAS)

Cultural and Linguistic Appropriate Services (CLAS)

The QI Program incorporates ongoing monitoring of the cultural and linguistic needs of its membership including but not limited to the following:

- Identify language needs and cultural background of members, including prevalent languages and cultural groups using enrollment data
- Identify languages and cultural background of practitioners in provider network to assess whether or not they meet members' language needs and cultural preferences
- Take action to adjust the provider network if the current network does not meet members' language needs and cultural preferences
- Develop, implement, and evaluate the culturally- and linguistically appropriate services in collaboration with DHMP staff and other departments and staff, as needed
- Ensure interpreter and translation services and auxiliary communication devices will be available to the member at no cost
- Document and forward member needs identified during member contacts or upon receipt of the member questionnaire to the Health Plan Medical Management Department, as needed
- Evaluate CAHPS questions that relate to interpretation and health literacy satisfaction to identify areas for improvement, and implement action plans, as needed
- Monitor HEDIS measures health disparities and conduct a yearly analysis of the data is to assist in the development of targeted health prevention and education programs that address, identify and reduce health disparities based on available data
- Identify annually, using aggregated member Race/Ethnicity/Language (R/E/L) data, languages that must be used in patient materials for quality improvement and marketing activities
- Assess annually aggregated provider R/E/L data to ensure all materials, including translated materials meet the cultural competency and grade level appropriate for the population
- All members written materials for prevalent populations ($\geq$500 members) are translated and made available to members in the respective languages
- These materials appear at a 6th-grade reading level and are available, upon request in braille, large print, audio tape format, or other applicable formats to meet member needs
- Maintain a library of culturally sensitive health prevention and education materials to be used in member mailings
- Participate in DHHA initiatives for reducing health disparities for Plan membership and community

Annually, staff diversity training is provided to:

- Support the linguistic needs of Denver Health members and the surrounding community by providing Health Literacy Trainings on-demand to Denver Health and community stakeholder staff and/or providers
- Support the cultural needs of Denver Health members and the surrounding community by providing cultural competency and responsiveness training to Denver Health and community stakeholder staff and/or providers
- Include annual diversity, equity and inclusion web course required for all employees

Interpretation and Translation Services

DHMP is committed to meeting our plan members' needs. DHMP contracts with an interpreter service: CERTIFIED LANGUAGES INTERNATIONAL, phone number 800-362-3241. If members need an interpreter during their provider visit or call, they can make this request through their provider or Health Plan Services. DHMP contracts with certified translation services at no cost to our plan members. Members that need plan materials translated can also contact Health Plan Services at 303-602-2090.

HEARING IMPAIRED

Members have access to American Sign Language Interpreters as necessary. Members can contact Health Plan Services at 303-602-2090 during regular business hours to schedule an American Sign Language Interpreter.

In addition, a TTY is located in each Denver Health Community Health Service facility and in the Emergency Department. Staff or Patients may use these devices. A TTY is also located in the Nursing Supervisor's office and is available to the hospitalized Patients.

Hearing-impaired Patients also have access to TTY located at the Rocky Mountain Poison Center, Nurse Line, Clinical Social Work Department, Managed Care, and the Patient Representative's Office.

A TTY is also located in the Health Plan Services area and that telephone number is 711.

X. MEMBER EDUCATION/ PLAN COMMUNICATION

All new DHMP members receive the new member packet upon enrollment. This enrollment packet includes a Quick Reference Guide which contains the following information:

- Summary of Benefits indicating copays, coinsurance, and deductibles
- Provider directory information
- How to access, and make PCP and specialty appointments, etc.
- Prior authorization requirements
- Information on obtaining emergency and urgent care
- Health Plan Services contact information and DHMP website information
- Member grievance and appeal process
- Member rights and responsibilities
- Instructions on how to obtain the Member Handbook, which contains more detailed information on plan benefits, services and requirements.

Additionally, the member receives information on health and wellness programs and pharmacy information. Each member receives an ID card which indicates copays, deductible and coinsurance information. Periodically members receive newsletters which contain important information such as benefit updates, upcoming health events, health tips and other information. All member materials can be found at the DHMP website, www.denverhealthmedicalplan.org. Members are encouraged to contact Health Plan Services Department for any questions, issues or concerns.