Provider Manual

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Provider Manual

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- Provider Manual
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Colorado Access General Information

MISSION STATEMENT

Partner with communities and empower people with access to quality, affordable care.

Our employees will work together in an environment that promotes mutual respect and partnering in support of the following commitments:

- We will eliminate barriers to access to high-quality health care for each of our members
- We will facilitate services to support coordinated care for all of our members
- We will develop programs that support continuity of care for the medically underserved
- We will work closely with Providers to develop and administer streamlined managed care principles
- We will support our partner Providers to improve the safety-net system
- We will work with our regulators to ensure the effective movement of medically underserved populations into managed care programs
- We will strive to exceed expectations

THE PROVIDER MANUAL

This manual is part of the Provider contract, is updated frequently, and replaces in its entirety all previous versions. Colorado Access retains the right to add to, delete from, and otherwise modify this Provider Manual. Providers and facilities must acknowledge this Provider Manual and any other written materials provided by Colorado Access as proprietary and confidential. If there is a conflict with the Provider Manual and your Agreement, your Agreement supersedes. We encourage you to contact your provider relations representative whenever you need clarification.

Please note: Material in this Provider Manual is subject to change. Please refer to the online version as it is the most current version. It is available online at coaccess.com/provider-resources.

We will notify you of updates through the provider newsletter and/or our website. The provider newsletter is distributed by email only, so please be sure we have your current email address for our distribution list. You can submit your email information to ProviderNetworkServices@coaccess.com. The most current version is available online at coaccess.com/provider-bulletins-and-updates.

YOUR CONTRACT DOCUMENTS

Your contract documents consist of your Provider Agreement and all documents and Addenda attached to the Agreement. In addition, your contract documents also include the terms, conditions, rights, and obligations set forth in this Provider Manual. For questions about your rights and obligations, you should always start with a careful review of your Provider Agreement and the attached Addenda. This Provider Manual is intended to supplement,

segment and explain the Provider-Colorado Access relationship and further articulate your rights and obligations to and with Colorado Access. If there is a conflict between this Provider Manual and your Provider Agreement and Addenda, the Agreement and Addenda shall apply.

PROVIDER NETWORK SERVICES

We are committed to managing a network that is accessible and attentive to your concerns and needs. We continuously monitor and endeavor to improve our performance in this regard. Regular publications, including updates to this Provider Manual and periodic provider newsletters, facilitate a better understanding of the requirements for network Providers. You can also contact our customer service department for general information and policy clarification at 800-511-5010 or your provider relations representative as noted below in the next section.

We have provider network managers who can assist you with general questions.

FORMS

You can find required forms such as the emergency services notification form and prior authorization request forms on our website at coaccess.com/frequently-used-forms.

IMPORTANT CONTACT INFORMATION AND FREQUENTLY USED PHONE NUMBERS

AREA	PHONE NUMBER(S) AND EMAIL ADDRESS (IF APPLICABLE)
Colorado Access main line	800-511-5010
- Customer Service	800-511-5010 customer.service@coaccess.com
- Provider Network Services	720-744-5667, 844-430-6684 (toll free) ProviderNetworkServices@coaccess.com
- Utilization Management (coordinated clinical services)	844-683-1072
- Care Management (peer services)	866-833-5717
- Claims Research Team	claimsresearch@coaccess.com
- Provider Contracting	Provider.Contracting@coaccess.com
988 Colorado Mental Health Line	988 If the emergency is life-threatening, call 911
TTY/TDD	720-744-5126, 888-803-4494 (toll free)
Access Medical Enrollment Services	303-755-4138, 855-221-4138 (toll free)
Privacy Official	855-879-8286 compliance@coaccess.com

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PROVIDER PORTAL

We maintain a provider portal that gives you access to member eligibility, member roster, claim status, and remittance advice information. To register for the portal, you'll need a provider ID number. Please send an email to ProviderNetworkServices@coaccess.com for assistance. Portal usernames and passwords are confidential and may not be shared. If your username or password has been compromised, contact Colorado Access immediately.

The provider portal is located at https://secure.healthx.com/v3app/publicservice/loginv1/login.aspx?bc=7be2e49e-b678-4291-9a17-699997acb06f&serviceid=3c53cf41-7238-4737-b4f1-c2c1f640ef57.

MEDICAL APPLICATION ASSISTANCE

As an Eligibility Application Assistance site, Access Medical Enrollment Services accepts and process applications for Child Health Plan *Plus* (CHP+) and all Medicaid programs.

Services Provided:

- Full processing of the State of Colorado Medical Assistance application into the State's system to determine Medicaid or CHP+ eligibility.
- Accept applications in person, by fax, or email.
- Assistance in completing the paper Medical Assistance Application for CHP+ and Medicaid, both in person and by telephone.
- Provide guidance and support of the PEAK online resource.
- Assistance with the state vendor Disability Application along with the Medical Assistance application when a disability determination is needed with specific programs.
- Verification of income, citizenship, and identification.
- Assist families to ensure all necessary documentation is submitted along with the application.
- Provide answers to questions about CHP+, Medicaid, which includes long-term care and Medicaid buy in programs.

Contact Information:

- Phone: 303-755-4138, 855-221-4138 (toll free)
- Fax: 720-744-5227
- Website: accessenrollment.org
- Address: 11100 E. Bethany Dr., Aurora, CO 80014
- Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday

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Section 12. General Directives for all PCMPs

- Diversity and Cultural Responsiveness
- Training Program
- Effective Communication and Language
- Assistance
- Non-Discrimination
- Confidentiality of Proprietary Information
- Confidentiality of Member Information
- Fraud, Waste and Abuse
- Member Rights and Responsibilities
- Member Grievances and Appeals
- Alternative Treatment Options
- Moral or Religious Objections
- Advance Directives
- Credentialing Process
- Member's Discharge from Care

If you have any questions, call us at 800-511-5010 (toll free).

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Colorado Access Policies

DIVERSITY AND CULTURAL RESPONSIVENESS TRAINING PROGRAM

We are committed to maintaining an environment that respects the perspectives, beliefs, and differences of our Providers, members, and staff members. To this end, we promote cultural diversity and responsiveness to increase access to care and quality of service.

Cultural responsiveness goes beyond racial bounds to include color, national origin, sex, gender, religion, creed, sexual orientation, mental or physical disability, socioeconomic level, age, and more. It celebrates the numerous strengths that people with different backgrounds bring to an organization.

We live in a world filled with people who come from different places and cultural backgrounds. We believe these differences should be recognized in order for organizations to be more effective. Understanding your patients and coworkers will enhance the services you provide and improve the effectiveness of your workplace.

We assist network Providers in providing culturally sensitive care and services by offering free cultural responsiveness training. Cultural responsiveness training is designed to provide a basic understanding of cultural response in the context of delivering health care services. It serves as a means of strengthening the member-Provider relationship through an increased awareness of cultural and linguistic barriers that exist in accessing needed health care services. Ultimately, the training is intended to equip network Providers with a set of skills, attitudes, and guidelines to draw from while providing care and services to members with cultural differences.

Our cultural responsiveness training program goals are high. Achieving such high standards is not only worth the effort, we believe it is a necessity. For more information, please call us at 800-511-5010.

EFFECTIVE COMMUNICATION AND LANGUAGE ASSISTANCE

Communication with Limited English Proficient & Sensory-Impaired/Speech-Impaired Persons

Colorado Access and our Providers shall take necessary steps to communicate with members, potential members, family members, and their legal and designated representatives in a language or format that they understand, about services, benefits, consent forms, waivers of rights, financial obligations, consent to treatments, and other matters. Language interpreters and auxiliary aids are provided without cost to the individuals being assisted.

Language assistance must be available in the Provider office or the Provider shall contact our customer service department for assistance.

Please call our customer service department at 800-511-5010 if you have questions or need assistance in providing aids or services for members. Aids and services include, but are not limited to, the following:

- Multilingual staff members
- TTY/TDD
- Interpreter services (over the phone and in person)

- Information and materials translated into the member's primary language
- Notices prepared in large print
- Reading the contents of notices aloud for members who are unable to read large print or who have low literacy levels
- Audio tape
- Braille
- Relay Colorado

To obtain written member materials in languages other than English, or an alternative format such as audiotape or large print, please contact our customer service department at 800-511-5010.

NON-DISCRIMINATION

We do not exclude from our network, or deny benefits to, or otherwise discriminate against any person on the grounds of race, color, national origin, gender, sex, religion, creed, sexual orientation, ability, disability, marital status, or age. This includes all of our programs and activities or those provided through a contractor or any other entity with whom we arrange to carry out our programs and activities.

You shall not discriminate against any member on the basis of race, color, national origin, gender, religion, sex, creed, sexual orientation, age, health status, participation in any government program (including Medicaid and Medicare), source of payment, participation in a health plan, marital status, or physical or mental disability. Nor shall you knowingly contract with any person or entity which discriminates against a member on such basis.

CONFIDENTIALITY OF PROPRIETARY INFORMATION

You shall hold all confidential or proprietary information or trade secrets received under your Provider Agreement in trust and confidence and shall use such information only for the purposes necessary to fulfill the terms of the Provider Agreement, and not for any other purpose. Specifically, you shall keep strictly confidential all terms of the Provider Agreement, including but not limited to, compensation rates, except for the method of compensation (e.g., fee-for-service, capitation, shared risk pool, DRG, per diem, etc.), unless otherwise required by state or federal laws.

CONFIDENTIALITY OF MEMBER INFORMATION

We expect you to abide by applicable state and federal rules to protect members' personal information, including name, address, Social Security number, state ID number, and any other information considered to be protected health information by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law requires health care organizations to keep certain sensitive information confidential, such as AIDS or substance use disorder-related information. The laws are not intended to prevent our Providers from accurately and appropriately submitting claims to Colorado Access. Disclosure of clinical record information must be made by all state and federal laws. You can find more information at

coaccess.com/psmi.

Substance Use Information Protected by 42 CFR Part 2

We are required to submit claims data to the Colorado Department of Health Care Policy and Financing regarding payment of substance use disorder services. If you submit claims to Colorado Access that are protected by 42 CFR Part 2, we expect you to obtain the necessary consent authorizing this disclosure and to keep the original signed copy in the member's records. If you have questions about our privacy policies, please contact our privacy official at 855-879-8286, or by email at compliance@coaccess.com. You can find more information at coaccess.com/about/compliance.

FRAUD, WASTE, AND ABUSE

We support the efforts of federal and state authorities in identifying incidents of fraud and abuse and have mechanisms in place to prevent, detect, investigate, report, and correct incidents of fraud and abuse.

- **Fraud:** An intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. This includes any act that constitutes fraud under Medicare and Medicaid, or other applicable federal or state laws.
- **Abuse:** Practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost to Colorado Access or federal health care programs, or in seeking reimbursement for goods or services that are not medically necessary, or that fail to meet professionally recognized standards for health care.
- **Waste:** Incurring unnecessary costs as a result of deficient management, practices, systems, or controls; the overutilization of services not caused by criminally negligent actions; and the misuse of resources.

Please report any possible incidents of fraud, waste, or abuse to our compliance team. We strongly encourage Providers to self-report any known problems with inadequate documentation, Provider license issues, or other issues that could be interpreted as waste or abuse if discovered independently by Colorado Access. Our fraud and abuse policy is located online at coaccess.com/about/compliance.

- Call the anonymous and confidential compliance hotline at 877-363-3065; or
- Email compliance@coaccess.com.

We initiate and perform independent reviews and audits of Provider billing practices based on a number of factors including, but not limited to, compliance or quality reports, claims monitoring, billing practices and trends, and requests of the State. Poor audit findings, including indications of possible fraud, waste, or abuse, can lead to required Provider education; corrective action plans; ongoing monitoring; termination of Provider contract; reporting to state and federal agencies and authorities; and/or repayment of claims. We are required by law to recoup any money that was paid for a claim found to be invalid or not fully supported by the Provider medical records.

The False Claims Act establishes legal liability for offenses related to certain acts, including knowingly presenting false or fraudulent claims to the government for payment, and making a false record or statement that is material to the false or fraudulent claims. Knowingly includes not only actual knowledge but also deliberate ignorance or reckless disregard for the truth or falsity of the information. Examples of potential False Claims Act violations include upcoding, billing for unnecessary services, billing for services or items that were not rendered, and billing for services performed by an excluded individual.

Similarly, Providers are obligated to perform independent reviews and audits of their own billing practices to evaluate and assure that their billing practices are in compliance with applicable federal and state rules and regulations to prevent fraud, abuse, and wasteful practices. In the event of a positive finding of a prohibited practice, the Provider has an affirmative obligation to report the same to Colorado Access and further, to take immediate corrective action.

Overpayments

Providers are required by federal law to report and return any Medicaid overpayment to Colorado Access within 60 days of identification of the overpayment. Failure to return overpayments creates the possibility of legal liability and penalties for committing fraud, waste, and abuse. Overpayments can be returned by filing a corrected or voided claim, or by submitting a written request to our claims department. Please review the Claims section of this manual for further instruction on how to return an overpayment.

Comparison of the False Claims Act, the Anti-Kickback Statute, and the Stark Law

The following table provides a brief overview of the primary federal fraud statutes. This chart is for illustrative purposes only, and is not a substitute for consulting statutes and the applicable regulations.

OVERVIEW	FALSE CLAIMS ACT	ANTI-KICKBACK STATUTE	STARK LAW
Citation	31 USC § 3729-3733	42 USC § 1320a-7b(b)	42 USC § 1395nn
Prohibition	Prohibits false or fictitious claims or demands for medical goods or services	Prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or generate federal health care program business	Prohibits a physician from referring Medicare or Medicaid patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies

OVERVIEW	FALSE CLAIMS ACT	ANTI-KICKBACK STATUTE	STARK LAW
			Prohibits the Designated Health Services entity from submitting claims to Medicare or Medicaid for those services resulting from a prohibited referral
Referrals	Referrals from anyone	Referrals from anyone	Referrals from a physician
Items/Services	Any items or services	Any items or services	Designated Health Services that are defined at 42 C.F.R. § 411.351
Intent	Intent must be proven, but upon a relaxed standard	Intent must be proven (knowing and willful)	No intent standard for overpayment (strict liability) Intent required for civil monetary penalties for knowing violations
Penalties	**Criminal:** • Up to five years imprisonment • Fines up to $250,000 for an individual/$500,000 for a corporation, and is per occurrence **Civil:** • Civil penalty of not less than $13,508, not more than $27,018, plus three times the amount of damages the government sustains because of the action; penalties are subject to inflationary adjustments • Liability is per occurrence	**Criminal:** • Fines up to $25,000 per violation • Up to a five-year prison term per violation **Civil/Administrative:** • False Claims Act liability • Civil monetary penalties and program exclusion • Potential $50,000 Civil Monetary Penalty per violation • Civil assessment of up to three times the amount of the kickback	**Civil:** • Overpayment/refund obligation • False Claims Act liability • Civil monetary penalties and program exclusion for knowing violations • Potential $15,000 Civil Monetary Penalty for each service • Civil assessment of up to three times the amount claimed

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MEMBER RIGHTS AND RESPONSIBILITIES

Detailed information on member rights and responsibilities is found in the applicable program's member handbooks and located on our website at coaccess.com/members/services/rights/.

We encourage you to direct members to our website or to call our customer service department at 800-511-5010 if they have questions or want to request a copy of their member benefits information.

MEMBER GRIEVANCES

Members and their families have the right to express dissatisfaction about any matter other than an adverse benefit determination. We notify members regarding their rights and how to file a grievance. Providers should also inform members of their right to file a grievance. The term "member" refers to the member, the member's parent or legal guardian, authorized representative, or any individual designated to assist in the grievance process. A member's grievance will be addressed without adverse consequences or retaliation. There is no time limit to filing grievances.

Our website contains detailed information for members on grievances at coaccess.com/members/services/grievances/.

Colorado Access is available to assist members in filing grievances. We can take the information over the phone, assist in completing forms, and offer auxiliary aids and interpreter services. We encourage you to direct members to our website or to call our customer service department at 800-511-5010 if they have questions or want assistance with grievances.

MEMBER APPEALS

Colorado Access has an appeal process available to members to appeal denials of care and/or payment for care. The term "member" refers to the member, the member's parent or legal guardian, authorized representative, or any individual designated to assist in the appeal process. We notify members regarding their rights and how to file an appeal. Colorado Access provides a written Notice of Adverse Benefit Determination ("Notice") to members as described in our utilization review policies and procedures. The Notice includes information on the member's right to request an Appeal or State Fair Hearing and how to do so.

Appeals may be filed orally or in writing within 60 calendar days from the date of the Notice. Medicaid members may also request continuation of benefits during the appeal process. Continuation of benefits is not available to CHP+ members.

Additional details about the process and how members may proceed to State Fair Hearing are included in the Notice provided to members. Providers may find information about the process from start to finish in UM106 Member Appeals Process located on our website at coaccess.com/providers/resources/um/.

Colorado Access is available to assist members in filing appeals, including taking the request over the phone, assisting in completing forms, and offering auxiliary aids and interpreter services. Colorado Access will provide the member, free of charge, with the case file, including any medical records or documents and any new or additional documents considered, relied

upon, or generated by Colorado Access in connection with the appeal.

We encourage you to direct members to our website or to call our customer service department at 800-511-5010 if they have questions or want assistance with appeals.

ALTERNATIVE TREATMENT OPTIONS

We do not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the Provider's patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

MORAL OR RELIGIOUS OBJECTIONS

If you object to providing a service on moral or religious grounds, you must notify Colorado Access about the services you do not provide.

ADVANCE DIRECTIVES

An advance directive is a written instruction of care such as a living will or medical durable power of attorney relating to the provision of health care when, or if, the individual is incapacitated. Medical Providers have the responsibility to provide information about advance medical directives and to assist members with completing advance medical directive forms, as appropriate. If the member has an advance medical directive, it is the responsibility of the member to provide medical providers of the facility with a copy.

Hospitals, skilled nursing facilities, and home health agencies must maintain written policies and procedures concerning advance medical directives. These policies must specify how and when a directive can be changed, as well as procedures for providers to give information to the client regarding implementation of the advance medical directive.

You shall document prominently in the member's medical record if the individual has executed an advance medical directive. The presence or absence of an advance medical directive is not a

provision of care and Providers cannot discriminate against an individual based on advance medical directive status. If possible discrimination or coercion is suspected, a member or provider (on behalf of a member) can file a grievance. If you cannot execute or implement an advance medical directive on the basis of conscience, you are to issue a written or other appropriate form of statement of limitation to the member (or the member's representative). To learn more about advance medical directives, please visit our website at coaccess.com/members/services/resources.

CREDENTIALING PROCESS

Colorado Access follows National Committee for Quality Assurance (NCQA) credentialing standards. After enrolling with Health First Colorado (Colorado's Medicaid program), our contracting team needs to be notified first if the Provider/group is new with Colorado Access at Provider.Contracting@coaccess.com. Once a contract is initiated, Colorado Access credentials licensed practitioners who provide services in an outpatient setting. If a new Provider is being added to an already contracted group, a clinical staff update form located on our website needs to be completed. If the Provider falls under the scope of credentialing, they will need to be approved before seeing Colorado Access members. We also perform organization assessment prior to contracting. Organizations who are licensed and regulated by a governing body fall under the scope of credentialing. Re-credentialing occurs at least every three years.

Provider Credentialing Responsibilities

Provider shall participate with the Colorado Access credentialing standards and requirements as set forth in our policies and procedures, and individual Providers shall have a CAQH profile (see below) or, for organizations, submit the Colorado Access Organizational Provider Application and other required attachments, as modified from time to time in accordance with NCQA and Colorado Access standards. Provider agrees to voluntarily provide and discloses, as part of the credentialing process, all such documents or materials we request, and recognizes a continuing duty to disclose such information that is relevant to the credentialing process. Providers shall not begin to perform contracted services until application has been approved by Colorado Access. Provider further warrants and represents that it shall timely supplement the Provider's application for credentials and provide any further information requested by Colorado Access and shall further notify us of any and all actions or events that materially affect the application and/or approval for credentials. All providers have the right to review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing or recredentialing application, upon request.

Credentialing Applications

Colorado Access utilizes CAQH ProView to access credentialing documentation. CAQH is a web-based tool that enables Providers to enter credentialing information online to allow multiple health care organizations access to documents. The service is free for Providers. If you would like more information about registering for the service or completing the CAQH application, please visit proview.caqh.org. If you already participate with CAQH, please designate Colorado Access as an authorized health plan. Please remember to re-attest at least every 120 days and upload the most current documentation (DEA, professional Liability insurance, etc.) so we can process your files in a timely fashion.

For additional information, please contact our credentialing department by email at credentialing@coaccess.com.

MEMBER'S DISCHARGE FROM CARE

Discharge Generally

The Provider may request a member's discharge from the panel and/or the practice for reasons including, but not limited to:

- Documented history of abusive behavior by the member or member's family or other behavior that demonstrates a severe threat of harm to the Provider, staff members, or other patients from continued care
- Non-compliance
- Failure to keep or cancel scheduled appointments
- Inability of Provider to provide the necessary level of care
- Removal from the area by the Provider

If a Provider is considering discharging a member from the panel and/or practice, the Provider must notify the member verbally and in writing by U.S. mail. In the written notification, the Provider must:

- Document the inappropriate behavior.
- Explain the impact on the Provider's ability to provide adequate care to the member.
- Warn the member of possible discharge from service if the behavior is not corrected.

The Provider should send a copy of the written notification to grievance@coaccess.com or PO Box 17950, Denver, CO 80217-0950.

After receipt of the written notification, Colorado Access will contact the member. We maintain a copy of the documentation.

Discharge of Medicaid Members

If a Provider decides to terminate the Provider-patient relationship with a Medicaid member, the Provider must provide a written notice of termination at least 45 days before the termination becomes effective. Such written notice must also be mailed to:

Colorado Department of Health Care Policy and Financing
Attn: Provider Relations Division
303 E 17th Ave
Denver, CO 80203

The provider should send written notification to the Colorado Access grievance team at grievance@coaccess.com or:

Colorado Access
Attn: Grievance
PO Box 17950
Denver, CO 80217-0950

The written notice of termination must include the following:

- Assurance that the Provider will continue provisional coverage of the Medicaid member’s health care needs for up to 45 days while the member obtains a new Provider.
- If possible, referral information to the member regarding possible new Providers.
- Notification that the member’s medical records will be sent to the new provider upon receipt of written authorization from the member.

Generally, an authorization for releasing of medical records should be included in the notice of termination, enabling the member to designate the new provider and sign. Members should be assured that the former Provider will promptly send the first copy of the member’s records at no charge.

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In the Colorado Access Provider Manual, you will find information about:

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- Member Satisfaction
- Accessibility and Availability of Services
- Access to Care Standards
- Support for Timeliness Standards
- Patient Record Documentation
- Quality of Care Concerns and Critical Incidents
- Clinical Practice Guidelines

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If you have any questions, call us at 800-511-5010 (toll free)

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Quality Management

The philosophy of the Colorado Access Quality Assessment and Performance Improvement (QAPI) program is to ensure that members receive access to high-quality care and services in an appropriate, comprehensive, and coordinated manner that meets or exceeds community standards. Emphasis is placed on community-based, individualized, culturally sensitive services designed to enhance self-management and shared decision-making between members, their families, and providers. The Colorado Access QAPI program promotes objectives and systematic measurement, monitoring, and evaluation of services and work processes and implements quality improvement activities based upon the outcomes. The QAPI program uses a continuous measurement and feedback paradigm with equal emphasis on internal and external services affecting the access, appropriateness, and outcomes of care. Performance is measured against specific standards and analyzed to detect trends or patterns that indicate both successes and areas that may need improvement.

The scope of the QAPI program includes but is not limited to the following elements of care and service:

- Accessibility and availability of services
- Over- and under-utilization of services
- Member satisfaction and experience of care
- Quality, safety, and appropriateness of clinical care
- Clinical outcomes and performance measurement
- Service monitoring
- Clinical practice guidelines and evidence-based practices
- Care management
- Performance improvement projects

The operation of a comprehensive, integrated program requires all participating primary care providers, medical groups, specialty providers, behavioral health providers, substance use providers, and other contracted ancillary providers to actively monitor quality of care. The results of program initiatives and studies are used in planning improvements in operational systems and clinical services. Information about the QAPI program and summaries of activities and results are available to providers and members on the Colorado Access website. Information is also published in provider and member bulletins/newsletters.

Providers with results from activities in the QAPI program that are found to not meet Colorado Access quality standards will receive further communication from the quality department about areas of deficiency and remediation opportunities.

Colorado Access quality department supports and promotes correcting any deficiencies using SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) interventions. Colorado Access will review provider materials submitted through a remediation process and give feedback on interventions based on how likely the actions are to offer long-term solutions to the deficient areas. The Colorado Access quality department may conduct additional QAPI program activities after remediation actions and discussion to assess improvement effectiveness and ensure enhancements have been sustained.

MEMBER SATISFACTION

In addition to administering an internal member satisfaction survey in collaboration with the customer service department, Colorado Access also partners with the Colorado Department of Health Care Policy and Financing (HCPF) and the Health Services Advisory Group (HSAG) to administer several satisfaction surveys throughout the year, including:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey for CHP+ members
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey for Health First Colorado members

Member satisfaction with quality of care and services is assessed utilizing a combination of approaches and data sources, including: member surveys, anecdotal information, call center data, and grievance and appeals data. The CAHPS surveys are conducted annually by HCPF and HSAG, who work with a third-party survey vendor, DataStat, to administer the survey and collect the data. Both are designed to evaluate member perception of services received from the health plan and evaluate performance of network physicians and providers in the delivery of care to members. Survey data is used for continuous quality improvement by establishing benchmarks and/or goals for performance and assessing overall levels of satisfaction as an indication of whether the plan is meeting member expectations. These surveys are typically administered January through May. Results from these surveys shared with providers are intended to promote quality improvement within provider practices. CAHPS survey results can be found at hcpf.colorado.gov/client-satisfaction-surveys-cahps.

If inquired, please educate members on the importance of completing member satisfaction surveys and reiterate the value of getting members' voices heard. These surveys provide valuable information on member experience of health care. Colorado Access uses member satisfaction survey results to identify and implement improvement projects within the network.

In addition to the CAHPS survey, Colorado Access also conducts a member satisfaction survey to solicit actionable member feedback on their experience of care. Survey results provide Colorado Access with a valuable opportunity to hear feedback from members and understand their experience in a timely manner. Survey responses are used to improve how Colorado Access interacts with and advocates for members by understanding their experience and satisfaction of care. Member satisfaction survey results are published in the provider newsletter.

ACCESSIBILITY AND AVAILABILITY OF SERVICES

Excessive wait time for appointments is a major cause of member dissatisfaction with health care providers; therefore, it is crucial that all Colorado Access network providers follow contractual state and federal standards for appointment availability. If you are unable to provide an appointment within the required timeframes, please refer the member to the Colorado Access customer service department at 800-511-5010 for assistance in finding member services within the required timeframes.

Providers must have an adequate phone system that allows members to connect with live representatives for treatment inquiries.

- Members must not wait on hold for longer than 15 minutes to speak with a representative at a provider's office.
- Providers must also have a voicemail system or another method to track calls received so that members are getting the communication needed to secure appointments. Calls must be returned to members within one to two business days.
- Voicemails for provider practices must clearly identify the provider reached and provide the member with information on after-hours coverage. Providers' voicemails should also provide information on how members can seek emergency services.
- Providers who serve Health First Colorado or CHP+ members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

Providers are encouraged to offer flexible appointment times or after regular business hours' appointments to members whenever possible. Federal regulations prohibit discrimination against Health First Colorado and CHP+ beneficiaries. Any practice which selectively excludes members from available treatment services and/or appointments may be in violation of those regulations.

ACCESS TO CARE STANDARDS

Physical Health, Behavioral Health and Substance Use	
Type of Care	**Timeliness Standard**
Urgent	Within 24 hours of initial identification of need *Urgent is defined as the existence of conditions that are not life-threatening but require expeditious treatment because of the prospect of the condition worsening without clinical intervention.*
Outpatient follow-up after hospitalization or residential treatment	Within seven days after discharge
Non-urgent, symptomatic*	Within seven days after request

**For behavioral health/substance use disorder (SUD), cannot consider administrative or group intake processes as a treatment appointment for non-urgent, symptomatic care or place members on waiting lists for initial requests*	Behavioral health/SUD **ongoing** outpatient visits: Frequency varies as the member progresses and the type of visit (e.g., therapy session versus medication visit) changes. This should be based on member's acuity and medical necessity.
Physical Health only	
Type of Care	**Timeliness Standard**
Emergency	24 hours a day availability of information, referral, and treatment of emergency medical conditions
Routine (non-symptomatic well-care physical examinations, preventive care)	Within one month after request* **Unless required sooner by AAP Bright Futures schedule*
Behavioral Health (BH) and Substance Use Disorder (SUD) only	
Type of Care	**Timeliness Standard**
Emergency (by phone)	Within 15 minutes after initial contact, including TTY accessibility
Emergency (in-person)	Urban/suburban areas: within one hour of contact Rural/frontier areas: within two hours of contact
Psychiatry/psychiatric medication management- urgent	Within seven days after request
Psychiatry/psychiatric medication management- ongoing	Within 30 days after request
SUD Residential for Priority populations as identified by Office of Behavioral Health in order: • Women who are pregnant and using drugs by injection; • Women who are pregnant; • Persons who use drugs by injection; • Women with dependent children; • Persons who are involuntarily committed to treatment	Screen a member for level of care needs within two days of request. If admission to the needed residential level of care is not available, refer the individual to interim services, which can include outpatient counseling and psychoeducation, as well as early intervention clinical services (through referral or internal services) no later than two days after making the request for admission. These interim outpatient services are intended to provide additional support while waiting for a residential admission.
SUD Residential	Screen a member for level of care needs within seven days of request.

	If admission to the needed residential level of care is not available, refer the individual to interim services, which can include outpatient counseling and psychoeducation, as well as early intervention clinical services (through referral or internal services) no later than seven days after making the request for admission. These interim outpatient services are intended to provide additional support while waiting for a residential admission.

We monitor provider compliance with appointment standards through a variety of mechanisms, including (but not limited to):

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
- Member satisfaction surveys
- Member grievance monitoring
- Quality of care concerns
- Access to care evaluation of appointment availability, including requests to provide Third Next Available Appointment (TNAA) data, Secret Shopper calls, and required quality improvement opportunities
- Behavioral health and substance use disorder medical record reviews
- Provider access to care and medical record review trainings

SUPPORT FOR TIMELINESS STANDARDS

If you are unable to provide an appointment within the required timeframes, please refer the member to the Colorado Access customer service department at 800-511-5010 for assistance in finding services within the required timeframes. Providers must contact the provider network services department at ProviderNetworkServices@coaccess.com or 800-511-5010 if changes are needed for member panel size, closing panels, or acceptance of new patients. Providers must give a 60-day advance written notice for closing the panel to new members. Please contact your provider network services representative for additional details.

PATIENT RECORD DOCUMENTATION

Providers are responsible for maintaining confidential medical records that are current, detailed, organized, and that promote continuity of care for each patient. Well-documented records facilitate communication, coordination, continuity of care, and effective treatment. Colorado Access patient records standards are based on state and federal requirements, Office of Behavioral Health (OBH) standards, Behavioral Health Administration (BHA) standards, the State Behavioral Health Services (SBHS) Billing Manual, National Committee for Quality Assurance (NCQA) guidelines for medical record documentation, and clinical best-practices. We

may perform patient record audits/chart reviews to ensure compliance with these standards.

Providers billing behavioral health and substance use disorder service codes need to review the SBHS Billing Manual for technical documentation requirements and information on correct billing guidelines. Providers are subject to behavioral health and substance use disorder documentation audits and subsequent training and/or remediation based on audit results.

Integrated care practices (defined by the Agency for Healthcare Research and Quality as "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.") are not required to construct a formal, free-standing treatment plan separate from the treatment plans noted in an assessment or therapy note. Because interventions/treatment episodes are brief and solution-focused, integrated practices need to incorporate treatment needs/plans into the body of the documentation (i.e., in the "P" section of a DAP note).

Behavioral Health and Substance Use Disorder Documentation Standards
General Documentation Requirements
Name or Medicaid ID is listed on each document within the record
Identification and demographic information are documented
Documentation is legible
Documentation of consent to participate in services noted by member/guardian
Interpretation, when needed, is documented
Assessment Documentation Requirements
Date of service
Start and end time of service or service duration
Place of service
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held. Assessment is countersigned by the licensed supervisor of a non-credentialed provider.
Assessment is completed timely (outpatient—as soon as is reasonable upon admission and no later than seven (7) business days of admission into services)
Chief complaint/problem statement
Client strengths, skills, abilities, interests
Complete psychosocial history (social history)
Developmental history for clients younger than 18 years old
Cultural/spiritual factors that may impact treatment
Psychiatric/mental health history

Medical history and medical necessity
Prescribed medication(s)
Complete mental status evaluation (MSE)
Substance use/abuse history
Formal risk assessment/screen, including questions about suicide **and** homicide risk; Associated safety plan/crisis plan, if applicable
Behavioral health or SUD diagnoses with supporting evidence
Readiness for treatment/admissions summary
Plan for next contact/care coordination
Treatment Plan Documentation Requirements
Treatment plan is completed timely (outpatient—14 business days after assessment)
Treatment plan is updated/current (outpatient—when there is a change in the client's level of functioning or service needs, and no later than every six months)
Treatment plan is individualized and culturally sensitive
Treatment plan is strength-based
Treatment goals are measurable, specific, objective, and realistic
Treatment interventions include specific types and frequency of services
Risk/harm/SI/HI concerns are addressed in the treatment plan
Discharge criteria is established and discharge summary is present when client is absent from services for more than 30 days
Treatment plan identifies agencies/other providers involved in client's care along with the services they are providing
Child's treatment plan includes how family/guardian(s) will be involved in treatment to address child's issues or reason why their involvement is inappropriate
Client participation in treatment plan
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held. Treatment plan is countersigned by the licensed supervisor of a non-credentialed provider.
Progress Summary Documentation Requirements
Date of service
Start and end time of service or service duration
Place of service
CPT service code
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held. Progress summary is countersigned by the licensed supervisory of a non-credentialed provider.
Progress summary refers to the goals and objectives from the treatment plan
Includes the clinical intervention/treatment modality
Client's response to intervention
Progress towards goal(s)
Plan for next contact/care coordination
Notes address risk/harm/SI/HI, as needed, until risk is resolved
Evidence of documentation of no-show appointments or drop out of services

Coordination of Care Documentation Requirements
For clients 18 years old and older, evidence that provider asked if client has advanced directive and offered educational information (see Health First Colorado Right and Responsibilities form).
Provider assessed for health/services needs other than mental health and made appropriate referrals. Documents follow-up on referrals made.

QUALITY OF CARE CONCERNS AND CRITICAL INCIDENTS

A quality of care concern (QOC) is a concern that care provided did not meet a professionally recognized standard of health care. A general quality of care review or a beneficiary complaint review may cover a single or multiple concerns (See 42 CFR §476.1). QOCs can include complaints made regarding a provider's competence, conduct, and/or care provided that could adversely affect the health or welfare of a member. Examples include, but are not limited to, prescribing a member the wrong medication, or discharging them prematurely.

A critical incident is defined as a patient safety event not primarily related to the natural course of the patient's illness or condition that reaches a patient and results in death, permanent harm, or severe temporary harm. Critical incidents are subject to mandatory reporting under Colorado law as well as your Provider Agreement. Examples include but are not limited to, a suicide attempt requiring prolonged and exceptional medical intervention and being operated on the wrong side or site.

You must report any potential quality of care concerns and critical incidents that you identify during a course of treatment of a member. The identity of any provider reporting a potential concern or incident is confidential.

A Colorado Access medical director will review each concern/incident and score them based on the level of risk/harm to the patient. A facility might receive a letter about the incident that includes education about best practices, remediation opportunities, a formal corrective action plan, referral to a licensing or regulatory agency or could be terminated from our network based on findings from the QOC. Quality of care concerns and critical incidents can be reported by filling out the Quality of Care & Critical Incident Notification form and emailing it to qoc@coaccess.com.

Please note that the reporting of any potential quality of care concerns or critical incidents is required in addition to any mandatory reporting of critical incidents or child abuse reporting as required by law or applicable rules and regulations. Please refer to you provider agreement for details. If you have additional questions, please email qoc@coaccess.com.

CLINICAL PRACTICE GUIDELINES

Colorado Access uses current, evidence-based, nationally recognized resources for standards of care when evaluating and adopting clinical practice guidelines. All approved clinical practice guidelines are available to providers and members on our website at coaccess.com/providers/resources/quality/. Clinical practice guidelines are identified and reviewed by medical professionals to ensure relevance. Copies of the approved clinical practice guidelines are also available upon request, free of charge.

Provider Manual

In the Colorado Access Provider Manual, you will find information about:

Section 1. Colorado Access General information

Section 2. Colorado Access Policies

Section 3. Quality Management

Section 4. Provider Responsibilities

- Communication Expectations
- Primary Care Providers (PCP)
- Specialty Care Providers
- EPSDT Services for Members with
- Medicaid
- Provider Training

Section 5. Eligibility Verification

Section 6. Claims

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

Section 9. Utilization Management Program

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

If you have any questions, call us at 800-511-5010 (toll free).

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Provider Responsibilities

COMMUNICATION EXPECTATIONS

Providers should coordinate with the member's other providers to support care management and continuity of care. This includes sharing information from the medical record as allowed by and in compliance with, applicable law.

Such communications would ideally occur:

- At the outset of care
- When changes in the member's status occur that may impact medical condition(s)
- When medications are prescribed or changed

PRIMARY CARE PROVIDERS (PCPS)

Each member may select, or be assigned to, a participating primary care provider (PCP). The PCP is responsible for managing the member's total health care services. These responsibilities include the following:

- Provide care and services for eligible members
- Be accessible (or have call coverage) to members 24 hours a day, 7 days a week
- Hours of operation must not be less than those offered to members with commercial health plans
- Provide services to members according to the plan's access standards
- Coordinate health care services for members, including referring members to specialists
- Provide preventive health services and offering provisions for special needs
- Educate members about healthy lifestyles and prevention of serious illness
- Counsel members about appropriate emergency department utilization
- Provide culturally appropriate health care
- Maintain confidentiality of medical information in compliance with all state and federal regulatory agencies (including HIPAA and 42 CFR Part 2)
- Maintain legible and comprehensive medical records for each encounter with a member that conform to documentation standards

Administrative Responsibilities Include:

- Participate in our quality management and utilization management programs
- Comply with our credentialing requirements
- Maintain a separate medical record for each of our members

- Report encounter and claim data to Colorado Access, so that we can track service utilization
- Confirm patient's identity at every office encounter to prevent card sharing and patient identity theft
- Verify eligibility and enrollment for every office encounter. Provider should keep proof of verification of the date of service
- Refer members to our participating providers
- Adhere to the professional code of conduct

Practice Capacity and Acceptance of New Patients

A PCP may determine how many members the practice will accept and at what point the panel is open or closed. To request a change in member capacity or an open/closed panel status change, please contact our provider network services department. To close the panel to new members, the Provider must give a 60-day advance written notice to our provider relations department by emailing ProviderNetworkServices@coaccess.com or calling 800-511-5010. Opening a panel to new members will become effective on the date the notification is received. Upon receipt of the notice, provider network services staff members will provide written notice to the Provider, indicating the effective date for the requested panel status change.

The PCP is responsible for the care of members assigned to the PCP from the date of assignment, whether or not the PCP has previously provided care to the patient.

Coverage

- The PCP must ensure that coverage is available 24 hours a day, 7 days a week, for member services. Access to a qualified health care provider by phone either onsite, call sharing, or answering service is appropriate. Please note, a recorded message advising a member to seek emergency care does not constitute after hours coverage.
- The call coverage provider must know and follow the requirements of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

SPECIALTY CARE PROVIDERS

Contracted specialty care providers have the following responsibilities to members:

- Verify member eligibility on the date of service
- Provide specialty care consultation approved by the member's PCP or by Colorado Access, as necessary
- Obtain appropriate authorization from Colorado Access before treating a member
- Coordinate the member's care with his or her PCP
- Provide a written consultation report to the PCP within five days of providing service
- Maintain confidentiality of medical information in compliance with all state and federal requirements

- Maintain a separate medical record for each Colorado Access member
- Maintain legible and comprehensive medical records for each encounter
- Hours of operation must not be less than those offered to members with commercial health plans

Second Opinion

Members have a right to a second opinion. If a member needs assistance arranging a second opinion, or setting an appointment, please call 800-511-5010 and ask to speak to a care manager.

Coverage

- The specialist must assure that coverage is available 24 hours a day, 7 days a week for member services. Access to a qualified health care Provider by phone either onsite, call sharing, or answering service is appropriate.

  Please note: A recorded message advising a member to seek emergency care does not constitute after hours coverage.
- The call coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

If you have questions or concerns regarding the provider responsibilities, please email ProviderNetworkServices@coaccess.com.

ESSENTIAL COMMUNITY PROVIDER

We encourage all of our contracted Providers to become designated as Essential Community Providers (ECP) with the Colorado Department of Health Care Policy and Financing (HCPF). Essential Community Providers are providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of our patient population. The ECP designation will apply to providers participating in Health First Colorado (Colorado's Medicaid program, hereto referred to as Medicaid), Child Health Plan *Plus* (CHP+), and Connect for Health Colorado.

ECPs are currently defined in Colorado state statute 25.5-5-403 (2) as a health care provider that:

- Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and
- Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

To become designated please visit colorado.gov/hcpf/essential-community-providers and complete the application form. If your application is approved, you will be included on the

current list of Essential Community Providers, which can be accessed from the same website. The website offers supplemental information regarding this designation as well as other resources, such as FAQs.

EPSDT SERVICES FOR MEMBERS WITH MEDICAID

For children and adolescents under the age of 21, any medically necessary service to treat any physical, dental, or mental health diagnosis is covered under the member's Medicaid. Services may even be covered if it is not a Health First Colorado (Colorado's Medicaid Program) benefit or has service limits. Services covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services include:

- Well-child visits and teen check-ups
- Developmental evaluations
- Behavioral evaluations and therapies
- Immunizations
- Lab tests, including lead poisoning tests
- Health and education preventive education
- Vision services
- Dental services
- Hearing services

Some of these services are covered under the capitated behavioral health benefit, and some of these services are covered under the physical health fee-for-service benefit, often through primary care (reimbursed through fee-for-service). In addition to traditional state plan services such as individual, group, and family psychotherapy, inpatient hospitalization, we are also able to reimburse for the following behavioral health services through the capitated behavioral health benefit under the EPSDT program:

- Vocational services
- Intensive case management
- Prevention/early intervention activities
- Clubhouse and drop-in centers
- Residential treatment
- Assertive community treatment
- Recovery services
- Respite services

Our provider network is expected to facilitate and promote the availability of EPSDT services, both behavioral health and physical health in nature. This includes, but is not limited to, the following:

- Regular communication and coordination with the member's primary care provider (with the member's permission and release of information)
- Informing and educating members and their families about the availability of these services available to them
- Inquiring about utilization of these benefits (i.e. "with your birthday coming up, have you scheduled your annual checkup?" or "have you gotten your flu shot yet this year?")

- Attending an EPSDT webinar and reviewing EPSDT materials provided by the Colorado Department of Health Care Policy and Financing

Behavioral health providers contracted with us are required to screen and assess members' treatment needs (even those not covered by the capitated behavioral health benefit), and provide the clinically appropriate services discovered by any screening or diagnostic procedure. Most EPSDT services do not require prior authorization (residential treatment is the exception and does require prior authorization); however, any EPSDT service is subject to medical record review to assure the following minimum requirements:

- Any request for mental/behavioral health screening or assessment must be accommodated. Any provider unable to complete a requested screening or assessment must contact Colorado Access for assistance.
- Any screenings and services must be performed by a provider who is qualified to furnish mental health services according to the staff requirements in the State Behavioral Health Services Billing Manual for the relevant service.
- All screenings and services must be performed in a culturally and linguistically sensitive manner.
- Results of all screenings must be recorded in the child's medical record.
- Referrals to the member's primary care provider, Colorado Access, Healthy Communities, or other referral, as appropriate, for services not available at the provider's office.

For more information about EPSDT, please visit https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt. The website includes valuable information and resources such as fact sheets and training videos for both parents and providers, request forms, and regulatory information.

Any member or provider who needs assistance accessing EPSDT services, or is experiencing barriers or problems related to EPSDT services (even physical health services not reimbursed by Colorado Access) can contact care management at 720-744-5124 or 866-833-5717 (toll free). The Healthy Communities family health connectors can also assist with accessing services:

- Adams, Arapahoe, and Elbert counties: Tri-County Health Department 303-873-4404
- Denver County: Denver Health and Hospital Authority 303-602-6770
- Douglas County: Douglas County Health Department 720-643-2400

PROVIDER TRAINING

Providers are required to complete all trainings offered by Colorado Access.

Providers are responsible for ensuring they are updated and current on all available trainings, including any required annual training. These trainings are designed to assist providers in the policies, procedures, and processes of Colorado Access, billing/claims, and other essential areas and frequently asked questions. To learn more about the courses offered on the Learning Management System, or how to sign up, email ProviderNetworkServices@coaccess.com or call 720-744-5667.

Provider Manual

In the Colorado Access Provider Manual, you will find information about:

Section 1. Colorado Access General information

Section 2. Colorado Access Policies

Section 3. Quality Management

Section 4. Provider Responsibilities

Section 5. Eligibility Verification

- Verifying Eligibility
- Eligibility Online Verification Overview
- CHP+ Primary Care Provider (PCP) Assignment

Section 6. Claims

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

Section 9. Utilization Management Program

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

If you have any questions, call us at 800-511-5010 (toll free).

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Eligibility Verification & PCP Assignment

VERIFYING ELIGIBILITY

We will only pay claims for members who are eligible on the date of service. The Provider is responsible for verifying eligibility before rendering services. We strongly recommend that Providers continue to verify eligibility on an ongoing basis, as eligibility status is subject to change. Determination of a member's enrollment with Colorado Access may be verified by the following means:

- Use our provider portal at https://secure.healthx.com/v3app/publicservice/loginv1/login.aspx?bc=7be2e49e-b678-4291-9a17-699997acb06f&serviceid=3c53cf41-7238-4737-b4f1-c2c1f640ef57.
- Use the State's eligibility web portal system at colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx. Obtain a screen print of the eligibility screen on the service date and keep it in the member's record for documentation.
- Call our customer service team at 800-511-5010.
- In addition to verifying eligibility, Providers should verify each member's identity every time services are provided, even if the member is an established patient. Each patient setting must have measures for identification, detection, prevention, and mitigation of identity theft per federal and state laws and regulations. We will not pay claims for services provided to anyone who is not a Colorado Access member.

ELIGIBILITY ONLINE VERIFICATION OVERVIEW

Our provider portal includes an eligibility verification tool and can be used by Providers to verify enrollment in one of our health plans and verify primary care provider (PCP) assignment. If you need assistance to access the provider portal, please contact ProviderNetworkServices@coaccess.com.

CHP+ PRIMARY CARE PROVIDER (PCP) ASSIGNMENT

Initial PCP Assignment

Initial PCP assignments are made effective on the first date of enrollment. If the member does not contact us, the member will be assigned to a PCP located near their listed home address.

Requesting a PCP Change

The member or legal representative may request a PCP change, either verbally or in writing. We will issue the member a new ID card with the name of the new PCP, within approximately 7 to 10 business days.

If a Provider is assisting the member with a PCP change, please contact the customer service department. The change can also be made on our provider portal. PCP changes will be made effective on the date of the request.

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Section 3. Quality Management

Section 4. Provider Responsibilities

Section 5. Eligibility Verification

Section 6. Claims

- Claims Submission
- Timely Filing
- Electronic Claims
- Claim Status
- Provider Responsibilities
- CMS 1500 Claims Specifications
- Present on Admission (POA) Indicator
- Diagnosis Coding
- Procedure Coding
- Anesthesia Billing
- Immunizations
- Multiple Occurrences
- Non-Clean Claims Process
- Locum Tenens
- Out-of-Area Services
- Corrected Claims
- Late or Additional Charges
- Member Billing or Balance Billing
- Missed Appointments
- Overpayments

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

Section 9. Utilization Management Program

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Section 12. General Directives for all PCMPs

Claims

Providers are required to submit complete claims for all services rendered to our members, whether the services are rendered under capitation or fee-for-service. Electronic submission of claims is preferred. However, we will accept paper claims in current CMS 1500 or UB04 formats. In order to process claims in a timely, accurate manner, we ask Providers to observe standard billing requirements.

Providers may also reference the following resources when completing claims submissions:

- CMS 1500 Physician's Manual
- UB04 Billing Manual
- ICD-10-CM Code Book
- AMA Current Procedural Terminology (CPT) code sets
- Healthcare Common Procedure Coding System (HCPCS) code sets
- State Behavioral Health Services Billing Manual (use for Medicaid behavioral health claims)

CLAIMS SUBMISSION:

> **Colorado Access Claims**
> PO Box 240389
> Apple Valley, MN 55124

TIMELY FILING

- Initial and corrected claims must be submitted within 120 calendar days from the date of service or the contractual time limit; whichever is shorter.
- Provider-Carrier Disputes must be submitted within 60 calendar days from the date of the incident on which the Provider-Carrier Dispute is based or the explanation of payment on which the claim in dispute appears.

ELECTRONIC CLAIMS

We accept claims electronically through clearinghouses or through direct batch file submissions in the HIPAA5010 version of the 837 file format. We currently do not accept electronic claims through a web-based application/web portal. If you have questions about electronic claim submissions please email edi_coordinator@coaccess.com.

EDI Clearinghouses

The use of clearinghouses is preferred as they provide quick and efficient submission of electronic/EDI claims that are compliant with current guidelines. We accept electronic/EDI claims from the clearinghouses listed at coaccess.com/providers/resources/claims/.If you use one of these clearinghouses, please advise the clearinghouse to direct your claims to the appropriate payer ID.

EDI Front-End Validation Process

We have an EDI Front-End Validation Process to ensure that inbound claims are meeting the standard HIPAA validation rules and to increase auto-adjudications rates. The process will be validating WEDI SNIP Level 1-7. Claims that fail the SNIP levels will be rejected and the provider will be notified via the 277/999.

CLAIM STATUS

Providers can check the status of a claim in two ways; by using our provider portal or calling our customer service department.

Online Provider Portal

To check the status of your claim on our website, you must register for the provider portal and receive your username and password. If you do not have a provider portal account, you can request one by submitting the form located at coaccess.com/frequently-used-forms.

Customer Service

720-744-5100 (Denver metro area)
800-511-5010 (toll free)

Our customer service team can answer questions regarding benefits, claims, claim appeals, claim status, and general questions about our policies. Customer service representatives are available Monday through Friday from 8 a.m. to 5 p.m., Mountain Time.

COLORADO ACCESS RESPONSIBILITIES

We have the following responsibilities with respect to the Provider:

- Provide information about requirements for filing claims
- Notify new Providers of standard forms, instructions or requirements upon acceptance into the plan
- Determine whether sufficient information has been submitted to allow proper consideration of the claim
- Provide appropriate explanation for denied claims
- Approve, deny, or settle all “clean” paper claims within 45 calendar days of receipt, and clean EDI claims within 30 days
- Apply interest and/or penalties to clean claims paid outside of these guidelines in accordance with Division of Insurance regulations

Note: we will not interpret claim information from provider statements or superbills.

Note: in case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism, or other cause beyond our control, we may be unable to process claims on a timely basis. No legal action or lawsuit may be taken against Colorado Access due to a delay caused by any of these events.

PROVIDER RESPONSIBILITIES

Providers rendering services to our members have the following responsibilities in relation to billing for these services:

- Except in the case of emergencies, verify the member's eligibility and PCP assignment prior to rendering services, screen prints are highly encouraged
- Ensure that the appropriate authorization requirements have been met
- Bill in compliance with any/all applicable HCPF billing/coding manuals
- Verify place of service codes are correct
- Verify that diagnosis and/or procedure codes match the service provided
- Complete all required data elements
- Leave non-required data fields blank (do not enter N/A)
- Use only black or dark red ink on any handwritten paper claims
- Use only good quality toner, typewriter or printer ribbons/cartridges for paper claims
- Do not use highlighters to mark claims or attachments
- Bill original claims within 120 days from the date of service
- Bill third party prior to submitting claims to Colorado Access
- Attach all required documentation to the claim
- If several claims require the same attachment, a photocopy of the attachment must be submitted with each claim
- We will allow interim billing for all bed-based care
- Submit paper claims to the appropriate address
- Provider shall comply with the Colorado Access fraud and abuse program identified in this Manual and shall bill in compliance therewith

CMS 1500 CLAIMS SPECIFICATIONS

Providers must file all claims for professional services, including laboratory services performed by an independent laboratory, on the current CMS 1500 or appropriate electronic claim format. Please reference Health First Colorado (Colorado's Medicaid Program) provider billing manuals.

UB04/CMS 1450 CLAIMS SPECIFICATIONS

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, on the UB04 or appropriate electronic format. Please reference Health First Colorado (Colorado's Medicaid Program) provider billing manuals.

PRESENT ON ADMISSION (POA) INDICATOR

We require a Present on Admission (POA) indicator on all inpatient claims.

Note: inpatient claims will be denied if the POA indicator is not submitted on the claim.

According to state and federal guidelines, all inpatient facility claims should include POA indicators. The Centers for Medicare & Medicaid Services (CMS) defines present on admission as:

> "…present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission."

A POA indicator should be assigned to the principal and secondary diagnoses. According to coding guidelines, the correct POA indicators are:

- Y – Yes
- N – No
- U – Unknown
- W – Clinically undetermined unreported/not used (exempt from POA reporting)

In the event of improper reporting, DRG assignment and reimbursement will be adjusted accordingly.

In some cases, retrospective claim review may occur. We reserve the right to collect any overpayments that are the result of the retrospective review.

DIAGNOSIS CODING

We require Providers to enter the appropriate diagnosis code on each claim submitted. We only accept those codes published in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10 codes). The Provider must enter ICD-10 codes clearly on the claim form and include all digits and characters.

- Some procedures are appropriate only when specific conditions are present.
- We require Providers to ensure the diagnosis entered is appropriate for the services provided and is supported by the patient's medical record.
- We require Providers to submit ICD-10 codes to the highest specificity with all of the required digits (three, four, or five) to completely and accurately describe the disorder or illness, including behavioral health services.

Confidential Diagnosis Coding

Please enter AIDS or AIDS-related diagnosis codes on the claim form as with any other diagnosis or condition. While federal and state statutes provide stringent penalties for failure to keep AIDS-related information confidential, these statutes are not intended to prevent accurate and appropriate submission of claims.

Federal and state statutes prohibit disclosure of information regarding application for or receipt of public assistance. However, this information may be disclosed for purposes of administering a public assistance program. Claims submitted for serviced rendered to our members include information necessary to process claims, calculate costs, and project future funding. In sharing information for these purposes, we do not jeopardize the privacy of the recipient.

PROCEDURE CODING

We use the Centers for Medicare & Medicaid Services' Healthcare Common Procedure Coding System (HCPCS) to identify services provided to eligible recipients. HCPCS codes (Level 1) include CPT codes. In order to ensure that claims are processed promptly and accurately, please follow these guidelines:

- Use the most current CPT/HCPCS code revision, based on date of service.
- Be aware that not all codes are covered benefits under Colorado Access member benefits.
- When we receive billed codes that are considered obsolete, the claim line(s) will be denied and written notification will be sent on a claim voucher.
- Our claims transaction system utilizes the CMS-mandated Correct Coding Initiative (CCI) edits and American Medical Association's (AMA) Current Procedural Terminology (CPT) guidelines to evaluate coding accuracy.

ANESTHESIA BILLING

Anesthesia service codes (procedure codes 00100-01999) must appear in field 24-D. Time units must be entered in field 24-G (1 unit equals 15 minutes). When calculating reimbursement on anesthesia claims, we do pay for time and units. However, we pay for the actual time administered. Please see the example below:

Step 1: Actual time divided by 15 equals X.

Step 2: The Base Factor is added to the X. This total equals Y.

Step 3: The Relative Value is multiplied by Y. This total is the payment amount.

IMMUNIZATIONS

- Please report all immunizations given to Colorado Access members on the CMS 1500 claim form with the vaccine procedure code.
- A separate vaccine code should be listed for each vaccine administered.
- Providers should bill the appropriate vaccine administration code(s) per CPT guidelines. When billing immunization administration fees submit on a single claim line with the appropriate number of units. This will avoid denials for duplicate charges.
- Immunization information may be used for tracking and reporting purposes.

MULTIPLE OCCURRENCES

Report multiple occurrences of the same procedure on the same date on one billing line, using multiple units of service. The charges reported should equal the unit procedure price multiplied by the number of units provided.

- Providers may refer to the CPT or HCPCS Bulletin for more information about unit definitions.
- DME Providers should use the units outlined in the CPT coding manual.

NON-CLEAN CLAIMS PROCESS

In accordance with CRS 10-16-106.5, if a submitted claim required additional information in order to be paid, denied, or settled, the claim will not be considered a clean claim. Such claims will be paid, denied, or settled according to the following:

- Within 30 calendar days of receiving the claim, we will pend the claim and send a Missing Information Notice requesting the missing information.
- If, within 30 calendar days of our request, a Provider fails to submit the additional information, the claim will be denied.
- When all additional information necessary to resolve the outstanding claim has been provided, during the 30 calendar day period, the claim will be processed, absent fraud, within 90 calendar days after the date that we first received the claim.

LOCUM TENENS

Locum Tenens physicians (MD or DO only) who provide services under a locum tenens agreement must enroll in Health First Colorado (Colorado's Medicaid Program). Claims for services by a locum tenens physician must identify the enrolled locum tenens physician as the rendering provider. Hospitals may enter the member's regular physician's Medical Assistance Program provider ID in the Attending ID field if the locum tenens physician is not enrolled in Medicaid.

A member's regular Provider may submit a claim and receive payment for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician if:

- The regular physician is unable to provide the visit services;
- The member has arranged or seeks to receive the services from the regular physician;
- The regular physician pays the locum tenens for his or her services on a per diem or similar fee-for-time basis;
- The substitute physician does not provide the visit services to members over a continuous period of longer than 14 days for a reciprocal billing arrangement, or a continuous period of longer than 90 days for a locum tenens arrangement; and
- The regular physician identifies the patient visit as services provided by a substitute physician meeting the requirements of this section by entering modifier Q5 (service furnished by a locum tenens practitioner) in box 24d of CMS 1500, after the procedure code. Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to Colorado Access upon request.

A continuous period of covered visit services begins with the first day on which the substitute physician provides covered services to the patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

Example: The regular physician goes on vacation on June 30, 2009 and returns to work on September 4, 2009. A substitute physician provides services to patients of the regular physician on July 2, 2009, and at various times thereafter, including August 30, 2009 and September 2, 2009. The continuous period of covered visit services begins on July 2, 2009 and runs through September 2, 2009, a period of 63 days. Since the September 2nd services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive payment for them. The regular physician may, however, bill and receive the payment for the services that the substitute physician provides on his or her behalf in the period of July 2, 2009 through August 30, 2009.

Note: A physician who has left a group, and for whom the group has engaged a locum tenens physician as a temporary replacement, may be still be considered a member of the group until a permanent replacement is obtained.

OUT-OF-AREA SERVICES

We are financially responsible for all emergency services and certain urgent care services provided by out-of-area medical and hospital facilities. Please refer any out-of-area provider contacts regarding a Colorado Access member to us at 800-511-5010 (toll free). Out-of-area providers should submit claims to our claims address for processing.

CORRECTED CLAIMS

Providers must submit corrected claims within 120 calendar days from the date of service or the contractual time limit; whichever is shorter.

Corrected Claim Process

- Corrected electronic claims should be submitted following the guidelines in the HIPAA standard TR3 Implementation Guide, using the frequency code of “7” in Loop 2300, Segment CLM05-3 and the original claim number in Loop 2300, Ref*F8.
- Corrected paper claims should be clearly marked “Corrected” on the face of the newly completed claim form.
    - The resubmission must be newly dated and signed with an authorized signature.
    - Correct the appropriate information clearly and accurately.
    - Adjust total charges to reflect the amount being resubmitted.
    - For a UB04 claim form, change the fourth digit of the bill type to a “7,” the original claim number in Box 64. For example, an initial inpatient claim would be submitted with a bill type of 0111 and a corrected claim would be submitted with a bill type of 0117.
    - For a CMS 1500 claim form, enter a “7” in Box 22 with the original claim number of the corrected claim.
    - Corrected paper claims can be mailed to our claims address (see our addresses located in this section).

LATE OR ADDITIONAL CHARGES

Providers billing late or additional charges for previously submitted claims must resubmit the entire claim. Do not submit the missing lines or additional lines separately. For example, if an inpatient claim was submitted without the laboratory fees, the new/corrected claim must include the laboratory fees AND the original claim lines.

MEMBER BILLING OR BALANCE BILLING

Hold Harmless Clause for Covered Services

According to your contract with Colorado Access and CRS § 25.5-4-301(1)(a)(I),

> Provider agrees that, in no event, including nonpayment by Colorado Access, the insolvency of Colorado Access, or breach of this Agreement by any party, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against members or persons other than Colorado Access. This provision shall not prohibit collection of copayments on Colorado Access' or Payer's behalf in accordance with the terms of the applicable Benefit Program. Provider further agrees that this provision: (a) shall survive the termination of this Agreement regardless of the cause giving rise to termination; (b) shall be construed for the benefit of members; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and members or persons acting on their behalf.
>
> This includes charging members for missed appointment and for failing to follow appointment cancellation policies.

Medicaid members may NOT be changed for Medicaid-covered items or services regardless of whether Colorado Access has actually reimbursed the Provider and regardless of whether the Provider is enrolled in the Colorado medical assistance program.

Circumstances in Which a Member can be Billed for Services

- Any deductible, copayment or coinsurance that is the member's cost share
- A CHP+ member sees a non-participating provider in a non-emergent, non-urgent, outpatient setting without prior authorization (applies to in-state and out-of-state providers).
- A member does not follow the pharmacy rules (member may have to pay for the medication).
- A member receives non-emergent health care services outside of the United States.

MISSED APPOINTMENTS

Per state requirements, members are not subject to missed appointment fees, even if the cancellation occurred within 24 hours of the scheduled appointment time.

OVERPAYMENTS

You should routinely review claims and payments in an effort to determine if you have received any overpayments. Overpayments requiring recoupment from a provider routinely occur in a

number of ways, including, but not limited to:

- Claims paid in error;
- Claims allowed/paid greater than billed;
- Duplicate payments;
- Payments made for services in excess of applicable benefit limitations; or
- Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.

These types of errors are typically discovered through self-disclosure by the Provider or through our claims review and/or audit processes. These are considered overpayments discovered during the normal course of business, and do not include auditing performed or repayments required specific to fraud, waste, and abuse efforts.

When an overpayment is discovered during the normal course of business, you may be directed to either submit a revised claim on a Provider-Carrier Dispute form available at coaccess.com/providers/forms, or submit a check for the overpayment, at our discretion. Any revised claim adjustments will be reflected as a credit balance and are set off against future claims submitted by the Provider.

Repayments for non-participating Providers will be made by check.

In the event that there is an outstanding negative balance as a result of claims adjustments or nonpayment after a reasonable period of time, we may issue a demand for repayment to you, subject to applicable laws and regulations. If you fail to respond and/or provide the amounts demanded within a reasonable period of time, such failure to respond is deemed approval and agreement with the demand for repayment, and we may pursue all available remedies. If you disagree with demand for repayment of an overpayment, you may request in writing that such demand for repayment be reviewed, provided that such review is submitted prior to the due date of the repayment.

Provider Manual

In the Colorado Access Provider Manual, you will find information about:

Section 1. Colorado Access General information

Section 2. Colorado Access Policies

Section 3. Quality Management

Section 4. Provider Responsibilities

Section 5. Eligibility Verification

Section 6. Claims

Section 7. Coordination of Benefits

- Filing a Claim for a Patient with Third Party Liability
- Secondary Benefit Calculation "Lower of Logic"
- Authorization and Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

Section 9. Utilization Management Program

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

Coordination of Benefits

FILING A CLAIM FOR A PATIENT WITH THIRD PARTY LIABILITY

- Electronic claims must be submitted with the appropriate third party liability (TPL) data segments populated per the HIPAA Standard TR3 Implementation Guide.
- Paper claims (CMS 1500 or UB04/CMS 1450) must be submitted with the Explanation of Payment (EOP), denial notice (including all denial reason wording), benefits exhausted statement or a copy of the check/voucher used for claim payment from the other insurance/third party liability (TPL).
- If an EOP applies to more than one claim, the EOP information must be submitted with each claim submission.
- Submit the claim within 120 calendar days from the TPL's denial date or processing date.

SECONDARY BENEFIT CALCULATION "LOWER OF LOGIC"

We calculate secondary benefits in the following manner:

- The Colorado Access benefit allowance is compared to the primary payment.
- If the primary payment is equal to or greater than the Colorado Access benefit allowance, we will not make a payment.
- If the primary payment is less than the Colorado Access benefit allowance, we will pay the difference between the two amounts.
- We do not automatically pay the other insurance's (including Medicare) copayments, coinsurance, and/or deductibles.

Note: you cannot bill clients for the difference between the primary carrier's health insurance payments and their billed charges when we do not make additional payments.

AUTHORIZATION AND COORDINATION OF BENEFITS

If Colorado Access is the secondary payer, no authorization is required to coordinate benefits with the primary payer. Colorado Access authorization rules apply when we are the primary payer or are anticipated to become the primary payer. You should request authorization for services anytime you believe Colorado Access will be responsible for primary payment of services that require prior authorization. This includes:

- When services are not a covered benefit of the primary payer.
- When benefits are exhausted by the primary payer.
- When the primary payer does not have an adequate network to provide the covered service.

If a claim is submitted under the above circumstances and an authorization has not been obtained, the claim may deny for no authorization. We will perform a retrospective review for

medical necessity if the claim is resubmitted on appeal.

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Section 5. Eligibility Verification

Section 6. Claims

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

- Definitions
- Submission Process
- Processing Timeframes

Section 9. Utilization Management Program

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

If you have any questions, call us at 800-511-5010 (toll free).

Provider-Carrier Disputes

A **Provider-Carrier Dispute** is an administrative, payment, or other dispute between a Participating Provider and Colorado Access that **does not** involve Utilization Review analysis, a member appeal of any kind, including a denial of benefits for services that are not medically necessary or covered by the applicable benefits program, credentialing, a claim validation audit, or routine provider inquiries that Colorado Access resolves in a timely fashion through existing informal processes.

If a Participating Provider or provider representative is making an appeal on a member's behalf, please see our website at coaccess.com/members/services/appeals/ and the section titled "Appeals" in the Health First Colorado Member Handbook on the Health First Colorado website for this separate process. To submit an appeal on a member's behalf, you will need to provide Colorado Access with permission (as the Designated Client Representative) from the member and follow the Member Appeal process instead of the Provider-Carrier Dispute process.

DEFINITIONS

Routine provider inquiries: Routine provider questions or requests for information that Colorado Access resolves in a timely fashion through existing informal processes. Examples of routine provider inquiries include, but are not limited to, billing questions, checking claims status, and requests for information on claim denials. Routine provider inquiries are not considered Provider-Carrier Disputes.

Participating Provider: A provider, either within or outside of Colorado that, under a contract with Colorado Access or with its contractor or subcontractor, has agreed to provide health care services to members with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from Colorado Access.

Provider Representative: A person designated by a Participating Provider in writing, including other Participating Providers or an association of Participating Providers, to represent the Participating Provider's interests during the Provider-Carrier Dispute process.

Utilization Review: A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques include, without limitation, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization Review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is a medically necessary service or is considered experimental or investigational in a given circumstance, and reviews of a member's medical circumstances when necessary to determine if an exclusion applies in a given situation. Utilization Reviews are not considered Provider-Carrier Disputes.

SUBMISSION PROCESS

In accordance with Division of Insurance regulations, we require Provider-Carrier Disputes to be submitted in writing. Information may be submitted in a brief letter in the Provider Portal, an email or, for claims appeals, on the Colorado Access Provider-Carrier Dispute form located on our website at coaccess.com/providers/forms.

Provider-Carrier Disputes must be submitted within **60 calendar days** from the date of the incident on which the Provider-Carrier Dispute is based or the explanation of payment on which the claim in dispute appears. Furthermore, Providers may only submit one Provider-Carrier Dispute per each specific administrative, payment, or other dispute at issue.

- The *easiest method* is to use the **Provider Portal**. Once you have identified the claim, select 'File Claim Appeal.' A form will appear, and you attach supporting documentation, or;
- **Email** all necessary information to claimappeals@coaccess.com. You can find a claim appeal form at coaccess.com/wp-content/uploads/2023/06/01-06-102-0623E_Provider-Carrier-Dispute-Form-Fillable.pdf to make the process easier. or;
- **Mail** a letter or Provider-Carrier Dispute form with all necessary information to:

  Provider-Carrier Disputes
P.O. Box 17189
Denver, CO 80217-0189

Each request to resolve a Provider-Carrier Dispute must contain all of the following necessary information:

1. Each date of service, if applicable
2. Member name
3. Colorado Medicaid member number
4. Provider name
5. Provider tax identification number
6. Dollar amount in dispute, if applicable
7. Provider position statement explaining the nature of the dispute
8. Supporting documentation where necessary, e.g., medical records, proof of timely filing, etc.

PROCESSING TIMEFRAMES

Upon receipt of a Provider-Carrier Dispute and all necessary information, we will review, record, investigate, resolve, and provide appropriate and timely notifications in accordance with applicable state and federal rules and regulations.

- We will issue a written confirmation to the Participating Provider or their Provider Representative within 30 calendar days of receiving all necessary information for the Provider-Carrier Dispute. In the instance where the Provider-Carrier Dispute request is resolved within 30 calendar days, the written notification of the outcome will serve as written confirmation of receipt.

- When we do not receive all necessary information to make a determination, we will send a written request any additional information needed. The provider will have 30 calendar days from the date of the written request for to provide the requested additional information. If the provider does not respond and provide the request additional information within the 30 calendar-day timeframe, we will close the request without further review. Further consideration of a closed Provider-Carrier Dispute must begin with a new request by the provider within applicable timeframes.
- We will resolve Provider-Carrier Disputes and issue written notification of the outcome within 45 calendar days of receipt of all necessary information, unless both parties agree to an extension.
- We may choose to use electronic means to send required notifications including email or fax.

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Section 4. Provider Responsibilities

Section 5. Eligibility Verification

Section 6. Claims

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

Section 9. Utilization Management Program

- Urgent and Emergency Care
- Medical Necessity
- Prior Authorization Request Process
- After Hours Discharge Planning Needs
- Downstream Providers
- Peer Review Process
- Continuity of Care for New Members
- Continuity of Care for Existing Members

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

If you have any questions, call us at 800-511-5010 (toll free).

Utilization Management Program

Participation in our utilization management (UM) program is a contractual obligation of every network Provider. This includes:

- Adhering to policies, procedures, and standards;
- Identifying and addressing barriers to the provision of quality care;
- Reporting grievances and/or quality of care concerns;
- Participating in auditing processes; and
- Providing access to or copies of clinical records or other documents, as requested by Colorado Access.

We authorize some behavioral health services under the Health First Colorado (Colorado's Medicaid Program) regional organization contract and the Child Health Plan *Plus* contract. Our utilization management service coordinators are available 24 hours a day, 7 days a week to take authorization requests.

We authorize some physical health services for the Child Health Plan *Plus* HMO contract. Our utilization management service coordinators are available Monday through Friday from 8:00 am to 5:00 pm to receive physical health authorization requests.

Below are tables summarizing the types of services that require prior authorization. The Master Authorization List, a comprehensive list of procedure codes and corresponding prior authorization requirements, is on our website at coaccess.com/providers/forms/.
We don't perform prior authorization review on services that have already been rendered. If you provide services without an authorization, your claim may be denied. Retrospective or post-service requests must be submitted to utilization management within 90 days of admission/start of the service. This summary of our authorization rules does not guarantee coverage.

1. **Participating vs. Non-Participating Providers:** In general, all services rendered by non-participating providers require prior authorization for payment except where specifically noted.
2. **Primary Care:** In general, services provided by participating primary care providers (PCPs) do not require prior authorization.
3. **Specialist Referrals:** Office visits for participating specialty Providers do not require a referral to be submitted to Colorado Access from the member's PCP. We encourage PCPs to direct care for specialty office-based care through clinical referrals. We consider a clinical referral to be communication between the PCP and the specialty Provider for the purposes of care continuity and treatment planning. Certain services, such as visits with physical, occupational, and speech therapists may require authorization.

Contact the utilization management department for more information.

Medicaid Behavioral Health	
Type of Service	**Authorization Rules**
Ambulance	Emergency ground or air ambulance transport does not require prior authorization.
Emergency Care (POS 23)	No prior authorization required
Observation (POS 22)	No prior authorization required
Inpatient	Prior authorization required. Professional services and ancillary services rendered during an inpatient stay are considered downstream and do not require separate authorization for both participating and non-participating providers except as described in the Authorization Categories section under Procedure Authorization.
Crisis Stabilization Unit (CSU)	No prior authorization required
Residential	Prior authorization required
Acute Treatment Unit (ATU)	Prior authorization required
Outpatient – Routine	No authorization required
Outpatient – Higher Levels of Care: • Day treatment • Partial hospitalization program (PHP) • Intensive outpatient program (IOP) • Electroconvulsive therapy (ECT) • Psychological/neuropsychological testing	Prior authorization required
Substance Use Treatment: • Intensive outpatient program (IOP) • Partial hospitalization program (PHP) • Residential treatment	Prior authorization required
Substance use treatment: • Outpatient services	No prior authorization required
Any services from non-participating providers (except emergency department)	Prior authorization required

Child Health Plan *Plus* (CHP+)	
Type of Service	**Authorization Rules**
Emergency Care (POS 23)	No prior authorization required
Urgent Care (POS 20)	No prior authorization required
Observation (POS 22)	No prior authorization required
Inpatient	Prior authorization required. Professional services and ancillary services rendered during an inpatient stay are considered downstream and do not require separate authorization for both participating and non-participating providers except as described in the Authorization Categories section under Procedure Authorization.
Residential	Prior authorization required
Outpatient – office visits (physical/medical)	No prior authorization required
Outpatient medical procedures	May require prior authorization, please check the Master Authorization List
Outpatient physical, occupational, speech therapies	Prior authorization required
Applied behavior analysis (ABA) therapy	Not a covered benefit *Reimbursement for ABA might be an option through CYMHTA (see section 10)
Outpatient – Behavioral Health Higher Levels of Care: • Day treatment • Partial hospitalization program (PHP) • Intensive outpatient program (IOP) • Electroconvulsive therapy (ECT) • Psychological/neuropsychological testing	Prior authorization required
Substance Use Treatment: • Intensive outpatient program (IOP) • Partial hospitalization program (PHP) • Residential treatment	Prior authorization required
Substance use treatment: • Outpatient services	No prior authorization required
Newborns	Coverage of services to a newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother's eligibility alone.
Diagnostic services	Routine laboratory and imaging services do not require prior authorization. Specialized diagnostic procedures may require prior

	authorization, please check the Master Authorization List.
DME	May require prior authorization, please check the Master Authorization List
Home Health	Prior authorization required
Ambulance	Emergency ground or air ambulance transport does not require prior authorization. Non-emergent scheduled requires prior authorization
Any services from non-participating providers (except emergency department)	Prior authorization required

URGENT AND EMERGENCY CARE

Emergency services (place of service 23) and urgent care services (place of service 20), regardless of provider contract status, do not require prior authorization.

Definitions:

An emergency medical condition is defined as a sudden, unexpected onset of a health condition, including pain, which a prudent layperson could reasonably expect to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ/part, if immediate medical attention is not obtained. We cover all emergency department services necessary to screen and stabilize members if a prudent layperson would have reasonably believed that use of a [contracted] provider would result in a delay that would worsen the emergency; or a provision of federal, state, or local law requires the use of a specific provider (DOI Regulation 4-2-17).

Post-stabilization services are those covered services, related to an emergency medical condition, which are furnished by a qualified Provider after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition.

For additional information about emergent, urgent, or post-stabilization services, please reference the policy UM103 Emergency and Post-Stabilization Care on the UM Section of the COA website.

MEDICAL NECESSITY

Colorado Access makes utilization review determinations based on professionally recognized written criteria or established guidelines and specifies the procedures to apply those criteria in an appropriate and consistent manner.

For more information about the criteria utilized, please reference the policy UM 101 Criteria for Utilization Review on the COA website. For criteria specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, please reference the policy UM104 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) on the COA website (applicable for RAE only, not applicable for CHP+).

PRIOR AUTHORIZATION REQUEST PROCESS

Submitting Authorization Requests

It is best to plan ahead and submit an authorization request well in advance of the service being rendered. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function). We will not retrospectively deny benefits for treatments that have been preauthorized except in cases of fraud, abuse, or if the member loses eligibility.

In order to submit a request for prior authorization:

1. Prior to submitting an authorization, please verify the member's eligibility through the Colorado Access website or the Department of Health Care Policy and Financing eligibility portal.
2. Complete a Prior Authorization Request (PAR) form below and email or fax the form with appropriate clinical information to the email or fax number listed on the form. Please complete all required fields – incomplete forms will not be accepted and will be returned to sender. You can find the following forms on our website at coaccess.com/providers/forms/:
    a. Physical Health Prior Authorization Request Form
    b. Home Health or Outpatient Therapy Prior Authorization Request Form
    c. Durable Medical Equipment (DME) Prior Authorization Request Form
    d. Behavioral Health Prior Authorization Request Form
    e. Psychological Testing Authorization Request Form
    f. Pharmacy Injectable Medication (J-Code) Authorization Request Form
    g. Substance Use Prior Authorization Request form, referred to as the Colorado SUD Treatment – Standard Authorization Request Form
3. You will be notified if additional information is needed, if the service is authorized, or if the service will not be authorized.
4. If you have questions, please call us at 800-511-5010.

Types of Utilization Review Determinations

Our utilization review determinations comply with state and federal guidelines. For additional information about our utilization review, please reference the policy UM102 Utilizations Review Determinations on the COA website.

1. **Authorized** – The requested service meets all utilization review criteria including, but not limited to, member eligibility, medical necessity, and if the service is a covered benefit. Authorization is not a guarantee of payment.
2. **Pended** – A determination cannot be made with current information. The case is

pending receipt of additional information and/or documentation requested in the form of an extension letter.

3. **Adverse Benefit Determination ("Denied")** for detailed information about adverse benefit determinations, please reference the policy UM102 Utilization Review Determinations on the COA website
4. **Administrative Denial** – A provider's failure to follow contractual requirements and/or established procedures regarding authorization requirements (i.e., out of timely notification, failure to submit necessary information, etc.) may result in an administrative denial.

Concurrent Review and Reauthorization for Continued Services

All requests for ongoing services beyond the initial authorization require reauthorization. Please complete and submit the appropriate prior authorization form and email or fax as indicated above at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone, fax, or email clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access.

AFTER HOURS DISCHARGE PLANNING NEEDS

For afterhours discharge planning needs (to initiate home health, DME, oxygen supplies), such as on holiday or weekends, the Provider (vendor) must notify Colorado Access on the next working day following discharge from the facility. A review is done to ensure the following: eligible member; covered benefit; medical necessity; and timeliness of notification. For continuing needs, the Provider (vendor) must initiate a procedure authorization.

DOWNSTREAM PROVIDERS

A downstream provider is defined as any Provider who renders services at the direction of other Providers. These Providers are not subject to the prior authorization and/or referral process.

- **Emergency room** (place of service 23) services billed by Providers are considered downstream.
- **Inpatient** (place of service 21) pathology, radiology, anesthesia and all other physician services not on our Master Authorization List are considered downstream.
- **Outpatient** (place of service 22) the following services should be considered downstream:
    - Pathology – all professional laboratory procedures
    - Radiology – all professional radiology procedures
    - Anesthesia – all professional services billed within the procedure code range of (00100-01999)
    - Facility – all outpatient contracted facility services billed with place of service 22 or 24. The use of a non-contracted facility requires prior authorization.

- **Skilled nursing facility** (place of service 31 or 32) physician services for care rendered in a skilled nursing facility. However, podiatrists (DPM) are required to obtain prior authorization.
- Interpretive Services – all services using modifier 26.

PEER REVIEW PROCESS

When a Colorado Access medical director has issued a denial, the Colorado Access utilization management reviewer will hold off on processing the formal denial letter until after the facility/provider has been notified of the decision. During this notification, the facility will be informed of the process by which to request a peer review.

Prior to the issuance of a formal denial, facilities have the ability to request a peer review with a Colorado Access medical director. During a peer review, a facility physician/prescriber has the ability to discuss the case with a Colorado Access medical director (this may not always be the same medical director who rendered the denial), and present any information that may not have been clear in the initial request.

The Colorado Access medical director conducting the peer review will issue a decision at the close of the peer review call. This decision will either uphold the initial denial or overturn the initial denial. If upheld, the denial will be formally issued via the required denial letters. If overturned, the reviewer will proceed with issuing the authorization per the peer review agreement.

For additional information about the COA peer review process, please reference the policy UM105 Peer Review Process on the COA website.

CONTINUITY OF CARE FOR NEW MEMBERS

We will contact new members who have been identified as having potential continuity of care needs so a needs assessment may be completed. If the member is in an ongoing course of treatment with a provider, and the provider agrees to continue the service, the member may continue to receive medically necessary covered services at the level of care received prior to enrollment, for a transition period of up to 60 calendar days.

If the provider is not contracted with Colorado Access and is not willing to do so, and the service is expected to be ongoing, we, as appropriate, will work with the member and provider to have the appropriate services transitioned into the network by the completion of the transition period. Services will be reassessed at the end of the transition period as part of routine authorization to ensure that they continue to be appropriate at the current level of care.

Members who are in their second or third trimester of pregnancy at the time of enrollment may continue to see their obstetrical provider until the completion of postpartum care directly related to the delivery.

If we do not have the direct capacity to provide a medically necessary covered service within the network, arrangements will be made for the continued service to be provided through a single case agreement with an approved, non-participating provider.

CONTINUITY OF CARE FOR EXISTING MEMBERS

At the time we are notified of a network transition (i.e., Provider group termination or vendor contract termination), a plan will be prepared to provide a coordinated approach to the transition. A good faith effort will be made to provide written notice of a Provider termination (with or without cause) within 15 calendar days to members who are patients of that Provider. CHP+ members will be allowed to continue receiving care for 60 calendar days from the date a participating Provider is terminated without cause, unless it is determined by an associate medical director or designee that continued care with the terminated Provider would present undue risk to the member or to Colorado Access.

Provider Manual

In the Colorado Access Provider Manual, you will find information about:

Section 1. Colorado Access General information

Section 2. Colorado Access Policies

Section 3. Quality Management

Section 4. Provider Responsibilities

Section 5. Eligibility Verification

Section 6. Claims

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

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Section 10. Behavioral Health and Substance Use Specific Policies and Standards

- Services Provided
- Billing, Coding and Documentation
- Requirements
- Member Copay
- Communication Expectations
- Waiting Room Guidelines
- Urgent and Emergent Access
- Missed Appointments
- Reduction or Discontinuation of Services
- Arranging Transportation Services
- Member Handbook
- Member and Family Services
- The Ombudsman for Medicaid Managed Care
- EPSDT Services
- Child Mental Health Treatment Act
- Behavioral Health Services in Primary
- Care Setting (Medicaid Only)

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

If you have any questions, call us at 800-511-5010 (toll free).

colorado access

Behavioral Health – Specific Policies and Standards

SERVICES PROVIDED

We have many kinds of behavioral health care services for individuals and families and we can help clients find what works best for them. For more information on services, please visit coaccess.com/members/care/.

Services include:

- Outpatient treatment
- Day treatment
- Psychosocial rehabilitation
- Case management
- Medication management
- Emergency services
- Inpatient services
- Residential services
- Home-based services for children and adolescents
- Evaluations/assessments
- Deaf and hard of hearing services
- Vocational services
- Peer support
- Substance Use Disorders (SUD)
- Intensive outpatient program (IOP)
- Partial hospitalization program (PHP)
- Respite

BILLING, CODING AND DOCUMENTATION REQUIREMENTS

All billed services must have an applicable modifier. Please note that many services can have more than one applicable modifier, and all must be included for the claim to be paid. There are levels of care that require a prior authorization from Colorado Access Utilization Management. Please visit coaccess.com/providers/resources/um/ for a list of codes.

ALL SERVICES MUST BE IN COMPLIANCE WITH THE STATE BEHAVIORAL HEALTH SERVICES BILLING MANUAL FOUND HERE: HCPF.COLORADO.GOV/SBHS-BILLING-MANUAL. PLEASE NOTE, MODIFIERS ARE NOT REQUIRED FOR CHP+.

Providers must meet the Colorado Access quality documentation standards. Please see the Section 3: Quality Management of the provider manual.

MEMBER COPAY

Providers may not require a copay for covered behavioral health services rendered to Health First Colorado members enrolled with Colorado Access. For CHP+ HMO members, providers may not require a copay for outpatient behavioral health services. Copays may be required for emergency care, urgent care, inpatient treatment, and/or some behavioral health prescription medications. Please note that Health First Colorado members may not be billed for covered behavioral health services, including voluntary private pay agreements.

COMMUNICATION EXPECTATIONS

Upon receiving a release of information (ROI), all behavioral and physical health providers should coordinate care with the member's PCP, obtaining any authorizations required to disclose such information. These communications would ideally occur:

- at the onset of care
- when changes in the member's status occur that may impact medical condition(s), or
- when medications are prescribed or changed
- coordination with Colorado Access care management may also be necessary to support a member's whole health. Providers should coordinate care with our care managers promptly, when needed.

WAITING ROOM GUIDELINES

Our expectation of all Providers is that members are seen promptly for outpatient appointments. Members should not be made to wait for long periods of time past their scheduled appointment. We understand that unexpected circumstances arise that may delay appointments or force schedule changes; however, these should be communicated as soon as is reasonable to members to avoid long waits. We will monitor Providers from time to time regarding their adherence to these guidelines. All Providers must develop a mechanism to document appointment time and actual time seen.

URGENT AND EMERGENT ACCESS

During normal business hours, we expect members to be able to receive urgent and emergent access by calling their established Provider. We encourage all Providers to offer walk-in emergency services whenever this service is feasible. All Providers must have the ability to accept or redirect emergency member calls after hours. For additional information on Access to Care standards, please see Section 3: Quality Management of the provider manual.

MISSED APPOINTMENTS

Providers are responsible for actively promoting the continuation of services for those members who unexpectedly miss appointments or discontinue services. In all cases, Providers should contact the member at the time of the missed appointment, assess the reason for the missed appointment and the member's clinical condition, and attempt to reschedule the appointment. Three outreach attempts via two contact methods, including an outreach letter or phone call from the Provider, is necessary when a member has unexpectedly dropped out of treatment. Clinically appropriate intervention is required in urgent or emergent situations and for medium to high acuity members.

Attempts to reengage members who unexpectedly miss appointments will include Provider efforts to determine if there are concerns or barriers that contribute to the missed appointments. When specific problems are identified, Providers should attempt to find a solution. Our care managers are available resources for clinicians and members, to assist in promotion and continuation of services. Please contact our customer service department at 800-511-5010 to be connected to care management resources.

Providers are required to document evidence of their outreach efforts to determine clinical status and presence of barriers that might be remedied, actions taken to promote continuation of needed services, and the member's response, which may include refusal to continue treatment. Providers must document efforts to initiate crisis services, including inpatient care, if indicated, and required in cases involving imminent risk associated with 27-65 criteria.

Please refer to Section 3: Quality Management of the provider manual for appropriate voicemail and after-hours requirements.

REDUCTION OR DISCONTINUATION OF SERVICES

Through the care coordination process, we will work in conjunction with the treating Provider to determine the most appropriate, medically necessary services at the least restrictive level. Treatment plan review may show that a discontinuation or a reduction of service is indicated. The treating Provider will discuss the proposed treatment plan with the member. If the member agrees with the proposed treatment plan, the treatment plan will be implemented.

The member's agreement with the changes in the treatment plan should be documented in the member's clinical record.

Remember: members should be full participants in service planning and treatment decisions. The member has the right to not accept a proposed treatment plan that would result in reduction or discontinuance of services. In a situation where the member disagrees with a Colorado Access decision to reduce or discontinue services, he or she can request an appeal, following receipt of the Notice of Adverse Benefit Determination We will mail the Notice at least 10 days before the effective date of reduced or discontinued services. The notification will contain information regarding the member's right to appeal and an explanation of the process to request review.

Members and providers can ask for a second medical necessity review for residential or inpatient substance use disorder (SUD) services after the member loses an appeal for denied or reduced services.

Providers may request a secondary review by completing the SUD request form on the ColoradoPAR portal: https://hcpf.colorado.gov/par.

Members may also request a review by contacting Health First Colorado directly. They will need a provider to agree to request the secondary review. If a member lists you as their requesting provider, Health First Colorado will contact you directly to confirm your agreement.

For more information, go to https://hcpf.colorado.gov/secondary-medical-necessity-sud-reviews.

MEMBER HANDBOOK

Health First Colorado (Colorado's Medicaid Program, hereto referred to as Medicaid) provides the member handbooks at healthfirstcolorado.com/benefits-services.

ARRANGING TRANSPORTATION SERVICES

Members who need transportation to health services should be given the resource of their applicable NEMT provider (hcpf.colorado.gov/nemtlistColorado). If a member is experiencing barriers to accessing transportation services, members should be directed to Colorado Access so that arrangements can be made for transportation to appointments.

MEMBER AND FAMILY SERVICES

Our provider directory is available to help members identify a provider for the mental health services the need. The provider directory can be found on our website by clicking 'Find a Provider.' If a member is experiencing barriers to finding or accessing services, please refer the member for care management services by submitting a care management referral to us.

The Member Advisory Council provides an opportunity to include the member voice and perspective into member-facing activities and programs. It is designed with intentional representation from different member constituencies and meets on a monthly basis. For more information, please visit coaccess.com/partnering/getinvolved/.

Members are given updates on quality initiatives taking place within Colorado and are given an opportunity to interact with staff members for individual staff members and departments. For more information, call 800-511-5010.

The newsletter is sent to all members on a quarterly basis. The newsletter has useful information about member and family activities, health education materials, the member Partnership meeting schedule and agenda, and other helpful program information.

Training and education on member and family issues, such as cultural or linguistic matters, is a resource that is available free of charge to Providers. For more information, please contact the director of member affairs at 800-511-5010.

THE OMBUDSMAN FOR MEDICAID MANAGED CARE

Colorado Access will work with the Ombudsman for Medicaid Managed Care, and Health First Colorado (Colorado's Medicaid Program) informs members about its services and how to access them in the member handbook. Please contact the Director or Member Affairs for more information. To contact the Ombudsman directly, call 303-830-3560 or 877-435-7123 (toll free). TTY users should call 888-876-8864.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive and preventive health care benefit for Health First Colorado (Colorado's Medicaid program) members ages 20 and younger, including administrative case management for pregnant adults. The EPSDT benefit ensures children and youth receive medically appropriate preventive physical, developmental, dental, mental health, substance use, and specialty services. Services may even be covered if it's not a Health First Colorado benefit or has service limits. Services

covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services include:

- Well-child visits and teen check-ups
- Developmental evaluations
- Behavioral evaluations and therapies
- Immunizations
- Lab tests, including lead poisoning tests
- Health and education preventive education
- Vision services
- Dental services
- Hearing services

Some of these services are covered under the capitated behavioral health benefit, and some of these services are covered under the physical health fee-for service benefit, often through primary care (reimbursed through fee-for-service). In addition to traditional state plan services such as individual, group, and family psychotherapy, inpatient hospitalization, we are also able to reimburse for the following behavioral health services through the capitated behavioral health benefit under the EPSDT program:

- Vocational services
- Intensive case management
- Prevention/early intervention activities
- Clubhouse and drop-in centers
- Residential treatment
- Assertive community treatment
- Recovery services
- Respite services

Our provider network is expected to facilitate and promote the availability of EPSDT services, both behavioral health and physical health in nature. This includes, but is not limited to, the following:

- Regular communication and coordination with the member's primary care provider (with the member's permission and release of information)
- Informing and educating members and their families about the availability of these services available to them (A family-friendly EPSDT fact sheet can be found here)
- Inquiring about utilization of these benefits (e.g., "with your birthday coming up, have you scheduled your annual checkup?" or "have you gotten your flu shot yet this year?")
- Attending an EPSDT webinar and reviewing EPSDT materials provided by the Department of Health Care Policy and Financing here

Behavioral health providers contracted with us are required to screen and assess members' treatment needs (even those not covered by the capitated behavioral health benefit) and provide the clinically appropriate services discovered by any screening or diagnostic procedure. Most EPSDT services to not require prior authorization (residential treatment services do require prior authorization); however, any EPSDT service is subject to medical record review to assure the following minimum requirements:

- Any request for mental/behavioral health screening or assessment must be accommodated. Any provider unable to complete a requested screening or assessment must contact Colorado Access for assistance.
- Any screenings and services must be performed by a provider who is qualified to furnish mental health services according to the staff requirements in the Uniform Service Coding Standards manual for the relevant service.
- All screenings and services must be performed in a culturally and linguistically sensitive manner.
- Results of all screenings must be recorded in the child's medical record.
- Referrals to the member's primary care provider, Colorado Access, Healthy Communities, or other referral, as appropriate, for services not available at the provider's office.

For more information about EPSDT, please visit HCPF's website, which includes valuable information and resources such as fact sheets and training videos for both parents and providers, request forms, and regulatory information.

Any member or provider who needs assistance accessing EPSDT services or is experiencing barriers or problems related to EPSDT services (even physical health services not reimbursed by Colorado access) can contact care management at 720-744-5124 or 866-833-5717 (toll free). The Healthy Communities family health connectors can also assist with accessing services:

- Adams County: Adams County Health Department (303-220-9200)
- Arapahoe County: Arapahoe County Public Health (303-220-9200)
- Douglas County: Douglas County Health Department (720-643-2400)
- Elbert County: Elbert County Health and Environment (303-621-3144)
- Denver County: Denver Department of Public Health and Environment (720-865-5365)

CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT

The Children and Youth Mental Health Treatment Act (CYMHTA) allows families to access some community mental health services, including residential services, for their child or youth when there are no other available funding options, such as private insurance. To be eligible for CYMHTA services, individuals must have a mental health diagnosis, they must be younger than 18 years old, they must be at risk of out-of-home placement, and they must not be eligible for Medicaid. For children and youth with Medicaid, CYMHTA offers an objective third-party clinical review of residential denials. To learn more about CYMHTA services, call us at 800-511-5010 or visit bha.colorado.gov/behavioral-health/cymhta.

BEHAVIORAL HEALTH SERVICES IN PRIMARY CARE SETTING (MEDICAID ONLY)

In order to see the availability of a full continuum of behavioral health services, the Department of Health Care Policy and Financing (HCPF) is promoting the provision of short-term behavioral health services within primary care settings for brief episodic conditions. Providers may bill up to six behavioral health services, with or without a covered behavioral health diagnosis, to Medicaid fee-for-service as you would a medical service. **This process does not apply to CHP+ members.**

This benefit applies to several types of primary care settings, listed below. In order to bill for these services, there must be a Medicaid-enrolled behavioral health clinician on site, employed and/or billed by the primary care provider. If you are part of a co-located arrangement with a behavioral health provider, then whether or not this process applies to you depends on who bills for the services. If the behavioral health provider bills for the services, those claims will always come to Colorado Access to be paid under the Behavioral Health Capitation. If the primary care provider bills for the services, then this process applies to you.

- Primary care clinics
- Federally qualified health centers
- Rural health clinics
- Indian health centers
- Non-physician medical practitioner groups (e.g., nurse practitioners, nurse midwives)

The following procedure codes are included in this benefit.

- 90791
- 90832, 90834, 90837
- 90846 and 90847

All services must be provided by a Medicaid-enrolled behavioral health provider. While a covered behavioral health diagnosis is not required, there must be an appropriate diagnosis that supports medical necessity. All coding practices and documentation requirements must be followed. A link to the State Behavioral Health Services Billing Manual can be found here. These procedure codes may be billed to HCPF fee-for-service in any combination for a total of six visits across all providers. The six-visit count re-starts July 1st of each year. If additional services (beyond the first six) are needed, they may be billed to Colorado Access without prior authorization if the provider is contracted. Non-contracted providers will require prior authorization.

If your practice provides other services (e.g., prevention/early intervention services) in the primary care setting, those services will continue to be reimbursed by Colorado Access through the capitated behavioral health benefit. Those services will not be reimbursed if billed to HCPF fee-for-service. These types of services include (but are not limited to):

- Behavioral health screening: H0002
- Behavioral health outreach: H0023
- Behavioral health: H0025
- Group: 90853, H0005

For more information from HCPF about billing, visit hcpf.colorado.gov/behavioral-health-ffs-manual.

If it is found that services were requested and billed to Colorado Access without billing the first six visits to HCPF fee-for-service, payment for those services may be recouped as overpayment.

Provider Manual

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Section 6. Claims

Section 7. Coordination of Benefits

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Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

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- Background
- Enrollment
- CHP+ Eligibility
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- Pre-HMO Enrollment Period
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- Member ID Cards
- Disenrollment
- Benefits and Copays
- Servicing Members with Special Health Care Needs
- CHP+ Benefits and Copayments
- Child Health Plan *Plus* (CHP+) Claims
- Specific Information

If you have any questions, call us at 800-511-5010 (toll free).

Child Health Plan *Plus* (CHP+) offered by Colorado Access – Specific Policies and Standards

BACKGROUND

Starting in 1998, we began serving low-income children through Child Health Plan *Plus* (CHP+) offered by Colorado Access. As the State's largest CHP+ Managed Care Organization (MCO), the plan currently serves children in 45 counties up and down the Front Range and in the Eastern Plains. Members of CHP+ offered by Colorado Access receive benefits beyond the standard CHP+ benefit package, including additional vision benefits, reduced prescription copayments, coverage of the over-the-counter medication with a doctor's prescription, additional hearing aid benefits, additional PT/OT/ST visits and special health care programs for diseases such as diabetes, depression, and asthma.

Child Health Plan *Plus* (CHP+) is a part of Colorado Access, a nonprofit health plan. We are dedicated to the operation of a competitive health plan designed to improve access to needed health care directly for enrolled members, and indirectly through our partners, to all underserved Coloradans with an emphasis upon primary care and the maintenance of the continuum of care.

ENROLLMENT

To enroll in CHP+ offered by Colorado Access, children and pregnant people must be eligible for CHP+. The state CHP+ program or the county department of human or social services determines eligibility through the Colorado Application for Public Assistance. A copy of this application is located online at colorado.gov/hcpf/how-to-apply. Children and pregnant people with CHP+ will be passively enrolled into a Managed Care Organization (MCO) if there is more than one MCO option in their county. After a member has been determined eligible for CHP+, the member (or parent/guardian) will have 90 days to choose the MCO by calling CHP+ customer service at 888-367-6557 and selecting prompt #2, if they were not placed into their MCO of choice.

CHP+ ELIGIBILITY

To qualify for CHP+, children must:

- Be 18 or younger,
- Be a Colorado resident,
- Not have any other health insurance (except Medicare or stand-alone vision, dental, or COBRA plans); and
- Meet the most current income guidelines for enrollment into CHP+. These can be found at colorado.gov/hcpf/program-snapshots

To qualify for the CHP+ Prenatal Care Program, potential members must:

- Be a pregnant person,

- Not have any other health insurance (except Medicare or stand-alone vision, dental, or COBRA plans); and
- Meet the most current income guidelines for enrollment into CHP+. These can be found at colorado.gov/pacific/hcpf/child-health-plan-plus.

Members who are in their second or third trimester of pregnancy at the time of enrollment may continue to see their obstetrical provider until the completion of postpartum care directly related to the delivery. The provider must agree to accept the Colorado Access fee schedule as payment in full and agree to follow Colorado Access utilization management and quality management policies and procedures.

The Presumptive Eligibility (PE) Health First Colorado or CHP+ program gives temporary medical coverage right away to children under 19 and pregnant people. This coverage can last for up to 60 days while the medical assistance application is processed. If a member applies by mail, it may take up to 45 days for their CHP+ application to be processed. To qualify, a potential member must:

- Be a child under 19 or a pregnant person,
- Appear to qualify for Health First Colorado or CHP+, and
- Apply for medical assistance.

Note: Dental services are not covered for children while in this program.

COLORADO ACCESS SERVICE AREA

CHP+ offered by Colorado Access is available to eligible children and pregnant people who live in the following Colorado counties:

Adams, Alamosa, Arapahoe, Baca, Bent, Boulder, Broomfield, Chafee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Douglas, Eagle, Elbert, El Paso, Fremont, Gilpin, Huerfano, Jefferson, Kit Carson, Kiowa, Larimer, Lincoln, Logan, Las Animas, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Sedgwick, Summit, Teller, Washington, Weld, and Yuma. A service area map can be found at coaccess.com/wp-content/uploads/2022/06/CHP-County-map.png.

PRE-MCO ENROLLMENT PERIOD

There is a period of time when members, as determined eligible for CHP+, are not yet enrolled with their chosen MCO; this is referred to as the pre-MCO enrollment period. If a CHP+ member’s eligibility start date occurs prior to the member’s enrollment with a CHP+ MCO, any services provided during the retro-eligibility period must be billed fee-for-service (FFS). FFS claims must be submitted to the Colorado InterChange and pharmacy claims must be submitted to Prime Therapeutics. Please visit the Provider Resource Page for more information here: hcpf.colorado.gov/our-providers. Any services provided after the start date of a member’s enrollment into an MCO must be submitted to the MCO for reimbursement.

CHP+ NEWBORN ENROLLMENT

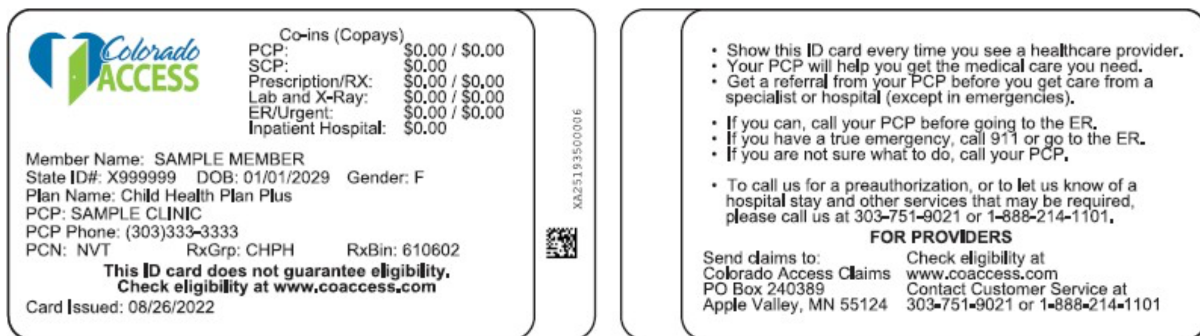
Children born to CHP+ members are covered for the first 30 days of life or until the end of the first full month following birth, whichever is sooner. To ensure continued coverage, members need to call the state CHP+ program at 800-359-1991 to enroll their newborn. Once enrolled, the newborn will be assigned to the same MCO as the mother.

ENROLLMENT POSTPONEMENT DUE TO INPATIENT STAY

If a potential member is an inpatient of a hospital at 11:59 p.m. the day before his or her enrollment into CHP+ offered by Colorado Access is scheduled to take effect, enrollment shall be postponed. Within 14 calendar days of discovering the member's hospital admission, Colorado Access will notify the Colorado Department of Health Care Policy and Financing (HCPF) that the enrollment shall be delayed. The new effective date of member's enrollment will be the first day of the month following the month of discharge.

MEMBER ID CARDS

Once enrolled, we send each CHP+ offered by Colorado Access member an ID card. The following is a sample of the ID card:



DISENROLLMENT

HCPF may disenroll a member from Colorado Access for the following reasons:

- The child becomes 19 years old.
- Members enrolled in the Prenatal Care program will be disenrolled 12 months after their pregnancy ends.
- Administrative error on the part of HCPF, including but not limited to, the enrollment of a person who does not reside in the Colorado Access service area.
- A change in the enrollee's residence to an area not in the Colorado Access service area.
- The child becomes eligible for the Medicaid program or gains other health insurance coverage. Please note the disenrollment may not always take place on the same day the member gains other coverage.
- The child becomes an inmate of a public institution or a patient in an institution for mental diseases.

- Fraud or intentional misconduct, including but not limited to, non-payment of applicable fees by the member, knowing misuse of covered services by a member, knowing misrepresentation of membership status by the member.
- An egregious, ongoing pattern of behavior by the member that is abusive to a provider, staff member, or other patients or disruptive to the extent that our ability to furnish covered services to the other member or patients is impaired.

Members may only change their MCO for good cause reasons or at the time of renewal. Good cause reasons include, but are not limited to:

- Member moved out of the service area
- Data entry error
- Other (must be approved by HCPF)

Effective Dates of Disenrollment

When a member disenrolls from Colorado Access, the effective date of the disenrollment shall be no later than the first day of the second month following the month in which the member requested the disenrollment. If a member requests disenrollment and a decision is not made by HCPF, or its designee, by the first day of the second month following the month in which the member requested the disenrollment, the disenrollment shall be approved.

Disenrollment Postponed Due to Inpatient Stay

If a current member of CHP+ offered by Colorado Access is an inpatient of a hospital at 11:59 p.m. the day before his or her disenrollment is scheduled to take effect, disenrollment shall be postponed until discharged from the hospital. When the member is discharged from the hospital, the new disenrollment date shall be the last day of the month following discharge.

Member Moves Outside of Service Area

Members must notify their county department of human or social services that they have moved. This information will be communicated to HCPF, which will then disenroll the member effective the first day of the month following the confirmation of the move outside of the service area.

Material Incentives Prohibition

Colorado Access and its participating providers are prohibited from providing material incentives unrelated to the provision of service as an inducement to members to enroll or disenroll in the health plan or to use the services of a particular subcontractor.

BENEFITS AND COPAYS

The following services are benefits of CHP+ offered by Colorado Access. This information is for summary purposes only and does not guarantee coverage. See the CHP+ offered by Colorado Access member benefits booklet for covered services and exclusions. The booklet is located on our website coaccess.com/members/.

Additional Colorado Access Benefits

- $150 toward eyeglasses or contact lenses per calendar year
- More than 200 over-the-counter medications like vitamins and Tylenol®, when prescribed by a provider
- A total of 40 outpatient visits per calendar year (combined) for physical, occupational, and speech therapy
- Unlimited physical, occupational, and speech therapy for children ages 0 to 3
- Reduced copayments for prescriptions
- No copays for prescription birth control
- No limit for oxygen and oxygen supplies
- Smoking cessation benefits through the Colorado QuitLine: 800-QUIT-NOW (800-784-8669). Members over the age of 15 can self-refer, identify themselves as a Colorado Access member and provide their ID number to receive services.

Health Risk Assessment & Care Management

All Colorado Access CHP+ members receive an initial Health Risk Assessment (HRA) within 90 days of enrollment to screen for special health care needs such as physical, functional, and behavioral health problems. HRA results are analyzed by the care management team and stratified depending on identified needs. Based on the results of the HRA, the care management team will contact the member to discuss individual needs and link the member to the appropriate licensed health care professionals and community resources. Members with high-intensity physical and/or emotional needs receive priority in assistance with accessing resources and/or needed care. Members identified with special health care needs will be re-assessed annually.

Care managers contact the member and discuss special health care needs. The care manager's priority is to ensure that the member is connected with an ongoing source of primary care and is connected to appropriate specialists who can best monitor the needs of the member. Care managers coordinate with the necessary providers (PCP, specialists, subspecialists) and community resources (facilities and agencies, ancillary or nonmedical services) to help the member access the health care and other services that they need and to prevent duplication of those activities.

If necessary, an individualized care plan is created that addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. The care manager will engage the member by asking them to establish goals in their care plan that contributes to effective management of the special health care need(s). The goal-setting process shall include steps that the member will take toward reaching goals and what interventions the care manager will take to help the member successfully reach their goals. Our medical director may confer with the treating physician(s) as necessary and make suggestions for revision to the care plan.

Care managers work to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Care managers are also asked to document any cultural or linguistic needs that may impact a member's ability to access necessary health care services and community resources.

SERVICING MEMBERS WITH SPECIAL HEALTH CARE NEEDS

CHP+ has an obligation to ensure that appropriate services and accommodations are made available to members with special health care needs. Services must be provided in a manner that promotes independent living and facilitates member participation in the community.

Members with special health care needs may be allowed to have direct access/standing referral to their specialist as needed for their care. If you have a member who may need a longstanding referral, contact Colorado Access for assistance.

FLUORIDE VARNISH PROVIDED IN A PRIMARY CARE SETTING

Fluoride varnish services can be provided to CHP+ children identified as moderate to high caries risk. Fluoride varnish may also be provided by participating PCPs or an in-network dentist. When provided by a dentist, these services are covered by DentaQuest under the routine dental benefit.

Note: this service is not covered for the CHP+ Prenatal Care Program

- Covered services must be provided by the member's assigned, in-network, PCP and does not require prior authorization.
- Benefit covers up to two fluoride varnish treatments in a calendar year for children ages 0 to 4.
- Risk assessments must be performed prior to providing varnish treatment.
- All PCPs providing this service must receive the appropriate training.
- For more information regarding training and risk assessment forms, visit cavityfreeatthree.org or call 303-724-4750.

Medical personnel who can bill directly for these services include MDS, DOS and nurse practitioners. Below are the complete billing procedure instructions:

For children ages 0 to 2:

Medical Practice: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three years of age and counseling with Primary Caregiver) must be billed together.

Federally Qualified Health Centers and Rural Health Clinics: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three years of age and counseling with Primary Caregiver) must be itemized on the claim. ICD 10 codes are: Z01.20 Encounter for dental examination and cleaning without abnormal findings and Z01.21 Encounter for Children with examination and cleaning with abnormal findings.

For children ages 3 and 4:

Medical Practice: D1206 (topical fluoride varnish) and D0190 (dental screening) must be billed together.

Federally Qualified Health Centers and Rural Health Clinics: D1206 (topical fluoride varnish), D0190 (dental screening) and D0999 (dental screening) must be itemized on the claim. ICD 10 codes are: Z01.20 Encounter for dental examination and cleaning without abnormal findings and Z01.21 Encounter for dental examination and cleaning with abnormal findings.

What Dental-Related Services are Covered?

- DentaQuest provides dental benefits to all eligible and enrolled CHP+ child members and to pregnant women.
- These benefits include preventive and diagnostic services, restorative services, endodontic, periodontic, prosthodontic, oral surgery, and limited orthodontic services.
- If you have any questions about CHP+ dental benefits call DentaQuest at 888-307-6561, TTY 711.

CHP+ BENEFITS AND COPAYMENTS

The current copays are available on our website at coaccess.com/members/chp/benefits/ in the section labeled “Your Copays”.

Reminder

When rendering services, please check the state web portal to confirm eligibility.

Provider Manual

In the Colorado Access Provider Manual, you will find information about:

Section 1. Colorado Access General information

Section 2. Colorado Access Policies

Section 3. Quality Management

Section 4. Provider Responsibilities

Section 5. Eligibility Verification

Section 6. Claims

Section 7. Coordination of Benefits

Section 8. Provider-Carrier Disputes (Claim Appeals)

Section 9. Utilization Management Program

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directives for all PCMPs

- General Directive for all PCMPs
- Specific Directive for Enhanced Clinical Partners (ECPs)
- ECP Participation as a Leading Provider in Clinical Practice
- ECP Obligation to Contain Health Care Costs
- ECP Population Management and Care Coordination Obligations
- ECP Required Data Reporting
- ECP Auditing

If you have any questions, call us at 800-511-5010 (toll free).

General Directive for all PCMPs

We have contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to serve as the Regional Accountable Entity (RAE), to be responsible for, and to promote, physical and behavioral health for regions 3 and 5. As the RAE for these regions, we maintain a network of behavioral health providers and primary care medical providers (PCMPs). PCMPs may be medical homes or other providers who qualify as a PCMP. We collaborate with contracted PCMPs on the delivery of outcome based, cost effective health care services for RAE 3 and 5 Medicaid members.

The Professional Provider Agreement (PPA) and its incorporated addendum(s) in conjunction with this Provider Manual will specify your duties and obligations in connection with your activities and responsibilities as a RAE network PCMP.

Some PCMPs have been designated as Enhanced Clinical Partners (ECPs) and some will have additional clinical requirements for their practice as specified in their ECP contract Addendum. These additional requirements are detailed below.

GENERAL DATA AND REPORTING FOR ALL PCMPS

Data Set Changes

The PCMP understands and agrees that the RAE content focus and areas of study may evolve and change over time. Therefore, data requirements from the PCMP may also change or evolve. The RAE will act in good faith to coordinate with the PCMP to formulate and agree upon appropriate timelines for these types of changes. However, PCMPs acknowledge and agree that as participants under the RAE, these deadlines are often imposed by HCPF. Therefore, we may be unable to negotiate timelines under such circumstances.

Costs and Expenses of Reporting

The PCMP will assume all costs and expenses associated with meeting and complying with the reporting requirements as specified in the contract and this Provider Manual, including all costs associated with reporting or data set changes.

CARE COORDINATION REQUIREMENTS AND ACTIVITIES

Care Coordination

We will collaborate with the PCMP to develop a practice specific mechanism for delegating care coordination that is commensurate and in proportion to the size and member population the practice serves under the RAE.

Reporting

PCMP reporting will occur through the Colorado Access provider portal. The PCMP will collaborate with us on information sharing and reporting in the format and frequency determined by Colorado Access.

IMPROVE COORDINATION EFFORTS WITH MEDICAL AND NON-MEDICAL PROVIDERS

Collaboration with Medical and Non-Medical Providers

The PCMP will work closely within the medical and non-medical communities that best serve their members.

Specialty Care and Care Compact Agreements

The PCMP should strive to collaborate with medical and non-medical providers using best practice tools and methodologies to ensure that specialty operations are in place, with identified point people and/or contacts. The compacts must outline specific communication requirements and relevant timeframes.

Referral Processes

Referral processes should strive to achieve "referral to outcome" results where the referring provider receives information about the visit and outcome so it may be documented in the referring provider's medical record. This will allow appropriate member follow-up.

Provider to Provider Consults

The PCMP must strive to set up specialty consults that not only meet the member's needs, but also complement the PCMP's resources and expertise, and ultimately create effectiveness and efficiencies in member care.

Specific Directive for Enhanced Clinical Partners (ECPs)

ECPs are obligated to provide enhanced care coordination and population management services as specified by your current ECP contract addendum. The responsibilities of a RAE ECP encompass broad population management concepts that include, but are not limited to, care coordination. The minimum operational activities and requirements are set forth below:

ADDITIONAL POPULATION MANAGEMENT REQUIREMENTS FOR ECPS

Dedicate Appropriate Resources to Achieve RAE Objectives - Staffing

As an ECP you will ensure that all employees performing services or activities as an ECP or on behalf of an ECP (including, without limitation, medical professionals, front-line staff, and clerical, billing, and office staff), have the requisite education and/or training on topics related to the RAE and the Accountable Care Collaborative (ACC). These topics include, without limitation, the RAE program, the medical home model principles, the ECP care management categories and related services, and how this Provider Manual relates to each employee's position or role.

Resources

The ECP must possess the organizational resources and commitment necessary to successfully implement and operate the programs to achieve the desired and designated results as specified by your current ECP contract addendum.

Access to Care

The ECP must be able to offer same-day appointments to members who require same-day appointments. In addition, the ECP must be able to appropriately triage appointments, schedule appointments within required access to care timeframes, and maintain adequate staff resources to meet the service needs of members.

Team Based Care

The ECP must implement and follow a team-based care model to deliver care to members on a daily basis. The model must include having a multi-disciplinary team in place (i.e., MD, NP, PA, RNs, therapists, MAs, front desk staff, billing, coding, etc.) who can operate at the highest level of their licensure or profession and contribute to the efficiency and effectiveness of member care and ECP operations.

Patient-Centered Medical Home Capabilities

ECPs should strive to reach the highest standards of a patient centered medical home (PCMH) consistently throughout the practice. If an ECP site has been accredited for PCMH via NCQA, URAC, Joint Commission etc.; these certifications may serve as a substitute for some auditing functions required by Colorado Access, provided Colorado Access agrees to such substitution in writing. The ECP shall submit such certification, recognition and/or designation to Colorado Access.

Participate in Regional Gaps

ECPs shall maintain the ability to address gaps in services that pertain to specific populations, and shall participate in quality improvement activities to advance capabilities over time that will meet the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to member preferences.

ECP Participation as a Leading Provider in Clinical Practice

INTEGRATED BEHAVIORAL HEALTH CARE

As a leader in clinical practices, the ECP will offer integrated behavioral health services within the primary care setting. The approach must utilize evidence based/promising practice models to ensure systematic and cost-effective strategies to be implemented over time.

EVIDENCE-BASED PRACTICES/PROMISING PRACTICES

The ECP must be a leader in utilizing evidence-based practices and promising practices models within its own sites and have the ability to report data and outcomes that lead to success. The ECP will also provide a meaningful leading role within the region to disseminate and share these practices throughout the provider network at various RAE forums.

ALIGNMENT WITH COLORADO AND FEDERAL PROGRAMS

The ECP participating in various other state and federal "health care transformation" programs

must align these other activities (when possible) with RAE activities within a site, system, and/or region. The ECP will take steps to facilitate and assist Colorado Access and the RAE in leveraging and utilizing existing programs and infrastructure to remove duplication and waste and increase efficiency in the system. Examples of these programs are:

- Colorado Alternative Payment Model (APM)
- Colorado Opportunity Framework
- Primary Care First

CONTRIBUTE TO RAE CLINICAL DESIGN

The ECP shall participate in and provide leadership to the clinical design within the Colorado Access designated region. The ECP must participate and contribute in the RAEs via organized committees, ad-hoc meetings, learning collaborative meetings, and webinars to facilitate clinical design under the RAE concepts.

PRACTICE IMPROVEMENT ACTIVITIES

The ECP must have active quality improvement programs using proven methodologies that specifically address RAE-related programs and performance metrics. Sites must have identified multidisciplinary quality improvement teams to address these improvements on an ongoing basis.

COLLABORATE ACROSS RAE REGION

The ECP will collaborate within its RAE region, the medical and non-medical communities, as well as across RAE regions. Areas of collaboration must include, but not be limited to, clinical intervention alignment to meet overall performance metrics, assessing and filling gaps within the care delivery system and connecting social determinants of health needs to comprehensive care for members.

ECP Obligation to Contain Health Care Costs

IDENTIFY AND COLLABORATE

The ECP shall identify system utilization/cost issues and collaborate within the RAE region to support the design of regional strategies that will reduce overall costs and will participate in the implementation of these programs once designed.

ENGAGE AND IMPLEMENT

ECPs must engage appropriate representatives within their own organizations as well as additional RAE system partners to design implementation efforts that are consistent with regional common agendas and annual work plans.

ECP Population Management and Care Coordination Obligations

DELIBERATE CARE COORDINATION INTERVENTIONS (SHORT TERM)

The ECP will be required to address members' referrals to the medical and social service communities. This type of member intervention can be delivered by telephonic/digital channels/other contact types.

EXTENDED CARE COORDINATION INTERVENTIONS (LONG TERM)

The ECP must plan to care for members who require longer-term care coordination or members who may have more complex needs. This may include, but is not limited to:

- Members with complex medical needs and treatment regimens.
- Member who need additional assistance in managing their medical care.
- Members having difficulty contacting other physicians or obtaining medical equipment or medications.
- Members who lack adequate social support systems.
- Members with both physical and behavioral health needs.

CARE PLAN

A care plan is a tool that can be used for members who need to be managed over a period of time. It is a complimentary tool to all medical treatment plans that members may have received from an inpatient setting or as part of their ongoing care from a PCMP. A care plan can include, but is not limited to, the following items: member status, member goals, established timelines for ongoing evaluation of status and goals, resources that the member has been advised to access and how the social support system of the member can help carry out the care plan/identify any gaps.

A care plan must be based on the needs assessment and other relevant sources. Care plans will establish treatment objectives, treatment follow-up, outcomes monitoring and processes to ensure the care plan is revised as necessary. The care plan must reflect the member's desires and provide a professionally established, member-focused "road map" of interventions to increase a member's self-management skills, awareness of warning symptoms of disease instability/progression, and to increase the member's understanding and course of her/his chronic condition(s). At least one goal on the care plan should be member identified as the member's desired intention.

CARE PLAN ACTIVITY

The ECP must ensure that members who are receiving extended care coordination have a care plan in place.

FACE-TO-FACE ACTIVITY

The ECP must offer face-to-face interventions. This type of activity may be reserved for members who meet the ECP's appropriate risk criteria to fit into this type of contact intervention. Risk criteria for face-to-face interventions can be based on the individual ECP site's discretion.

OTHER

In addition to the activities listed in this section, ECPs are encouraged to utilize other population management/care coordination activities to maximize their outcomes for members.

TRANSITIONS OF CARE

ECPs are required to support transitions of care for the following transition types:

- Transitions of members from institutional settings to community-based services.
- Transitions of members from inpatient hospital stays to the community.
- Medicaid-eligible members transitioning out of the criminal justice system.
- Children involved with child welfare.
- Transitions of members from one RAE to another RAE.
- Other populations identified through risk stratification or state initiatives.

TARGETED POPULATIONS

ECPs must possess the ability and expertise to identify and implement RAE regional programming to targeted populations that are identified through the regional common agendas and annual work plans.

USE OF MEMBER REGISTRIES

ECPs must possess the knowledge, skills, and abilities to generate and utilize clinical and non-clinical registries to manage identified/targeted populations. ECPs must implement the technology support to track, update, and report ongoing registry work under the RAE.

RISK STRATIFICATION

- ECPs must design and implement a population management strategy that utilizes risk stratification to identify different categories of membership for clinical care, care coordination, and member engagement. The ECP may utilize its own established risk methodologies but should be capable of incorporating high-risk members as identified by the RAE. Identify non-engaged members, members who need prevention and wellness services, chronic disease management, special populations (criminal justice and child welfare), ED utilization, and members who have complex needs.
- Ability to create clinical registries based on risk criteria.
- How to identify short term and long-term care coordination efforts.

ECP Required Data Reporting

TIMELY REPORTING

The ECP will be timely, accurate, and diligent with required reporting to Colorado Access. If data reporting is not properly delivered to Colorado Access within the prescribed periods, we may consider such failure to be a breach of contract by the ECP which may result in delayed or reduced payment to the ECP, and/or termination of the ECP agreement in accordance with the terms of the Professional Provider Agreement and Addendum 2. *If data delivery to Colorado Access by an ECP is late due to a delay in data from Colorado Access and/or Truven, the ECP will*

submit the required data to Colorado Access within ten calendar days of having access to such required data.

DATA MANAGEMENT

The ECP must have software or other dependable mechanisms for documenting applicable population management/care coordination services, including but not limited to the items listed in the section *Specific Guidance for Enhanced Clinical Partners, Additional Population Management Activities for ECPs* within this Provider Manual.

CARE COORDINATION ACTIVITY REPORT

The ECP will submit quarterly reports, as defined below, in a HIPAA-compliant manner that has been approved by Colorado Access. The schedule and specific due dates for submitting this report will be the second Monday following the close of the quarter.

The care coordination activity report must specify at a minimum:

1. Quantitative data reporting: deliberate interventions
    - Referral/Linkage – medical
        - Telephonic/Electronic outreach
        - Other
    - Referral/Linkage – social
        - Telephonic/Electronic outreach
        - Other
2. Quantitative data reporting: extended care coordination
    - Care plan activity
    - Face-to-face activity
    - Extended care coordination
    - Other

FINANCIAL ACCOUNTABILITY REPORT

The ECP will report on use of ECP funds. Specific details on the contents of this report and the cadence of submission will be determined once HCPF provides the specific template to Colorado Access.

VALUE BASED INITIATIVES

ECPs will have the opportunity to participate in value-based initiatives as they evolve under the RAE. ECPs will be held to a high standard of participation and accountability under these programs once they are developed and implemented.

ECP Auditing

PERFORMANCE OBLIGATIONS

Performance-related obligations under this Agreement and auditing procedures will be at the sole discretion of Colorado Access. An ECP's performance-related activities will be monitored over the course of the RAE implementation through different performance measurement

mechanisms.

AD-HOC PERFORMANCE REVIEWS

We reserve the right to review an ECP's reports, data, policies and procedures, processes, or status at any mutually agreeable time.

UNDERPERFORMANCE BY AN ECP

Upon review and determination by Colorado Access, any ECP who is not meeting the requirements contained in the Provider Manual or Provider Agreement will undergo a performance evaluation and may be subject to a corrective action plan. ECPs may seek additional coaching, training, and/or consulting from Colorado Access or elsewhere, at its sole expense.