PROVIDERS

GENERAL CHANGES WITH ACC 2.0

QUESTION: WHAT IS THE GOAL OF ACC 2.0?

Answer: The goal of ACC 2.0 is to combine physical health and behavioral health into one entity. This will strengthen coordination of services and improve health outcomes for members.
Source: colorado.gov/pacific/sites/default/files/ACC%20Phase%20II%20Overview%20Fact%20Sheet%20February%202018.pdf

QUESTION: HOW WILL MEMBERS BE INFORMED/EDUCATED ON ALL OF THE CHANGES, INCLUDING ATTRIBUTION?

Answer: The state will send a letter notifying members of their PCMP assignment, how to change their PCMP, and what RAE they are in based on their PCMP assignment. The state will also be offering a member handbook at healthfirstcolorado.com. Colorado Access will also be sending a member kit with info specific to Colorado Access.
Source: Jean Barker

PHYSICAL HEALTH

QUESTION: WHAT MUST PHYSICAL HEALTH PROVIDERS DO TO HAVE MEMBERS ATTRIBUTED?

Answer: They must have a contract with each RAE where they have a site located, have a Medicaid site ID, and bill HCPF with that site ID.
Source: Jean Barker

BEHAVIORAL HEALTH

QUESTION: WHAT MUST BEHAVIORAL HEALTH PROVIDERS DO TO HAVE MEMBERS ATTRIBUTED TO THEM?

Answer: Members will not be attributed to behavioral health providers. Members will be attributed to the region in which their PCMP is located, which will determine their RAE. The behavioral health provider will need to be contracted with the members' RAE to be reimbursed by the RAE.
Source: Jean Barker

QUESTION: DO MEMBERS NEED A REFERRAL TO RECEIVE BEHAVIORAL HEALTH CARE?

Answer: No. The only exceptions to this would be bed-based care (inpatient, residential, ATU, IOP).
Source: Jean Barker

QUESTION: WHAT CHANGES ARE BEING MADE TO THE BEHAVIORAL HEALTH ORGANIZATIONS?

Answer: The Department will contract with one administrative entity in each region of the state to be responsible for the duties traditionally performed by the Regional Care Collaborative Organizations (RCCO) and Behavioral

Health Organizations (BHO). This change will improve the client experience by creating one point of contact and clear accountability for whole person care.
Source: HCPF

QUESTION: I AM A BEHAVIORAL HEALTH PROVIDER. SHOULD I CONTRACT WITH EVERY RAE REGION?

Answer: In order to be reimbursed for your services from a RAE, you must have contracts with regions in which your patients are assigned.
Source: Jean Barker

QUESTION: WILL REGIONAL ACCOUNTABLE ENTITIES (RAES) BE RESPONSIBLE FOR THE UTILIZATION MANAGEMENT FOR THE CORE BEHAVIORAL HEALTH SERVICES?

Answer: Yes, the RAE will be responsible for the utilization management of core behavioral health services and will authorize services. You can call us at 800-511-5010 and choose option 2, then option 1, then option 5.
Source: coaccess.com/provider-frequently-asked-questions

QUESTION: I'M PART OF REGION 2. WHY WOULD I WANT TO KEEP AN ACTIVE BEHAVIORAL HEALTH CONTRACT WITH COLORADO ACCESS AFTER WE EXIT THE REGION?

Answer: You may have patients who see PCMPs in regions 3 or 5. If so, you may bill Colorado Access for care rendered to those patients
Source: Jean Barker

QUESTION: HOW DOES THE SHORT TERM BEHAVIORAL HEALTH 6-VISIT MAX IN A PRIMARY CARE SETTING WORK?

Answer: Effective July 1, there is a new HCPF billing requirement for behavioral health services provided in primary care clinics, FQHCs, RHC, Indian Health Center and on-physician practitioner groups as follows:

1. The first 6 behavioral health visits provided in a primary care setting must be billed directly to Health First Colorado (Colorado's Medicaid Program).
2. The following CPT codes are included in this new billing requirement: 90791, 90792, 90832, 90834, 90837, 90846, and 90847.
3. Claims for these CPT codes that go beyond 6 visits billed to HCPF require a prior authorization from Colorado Access.

Source: Rebecca Lynn

QUESTION: WILL THE DEPARTMENT PROVIDE A REPORT THAT IDENTIFIES PROVIDERS OR MEMBERS WHO HAVE REACHED THE 6-VISIT MAXIMUM, OR WILL EACH RAE NEED TO RUN THEIR OWN REPORTS BASED ON FFS CLAIMS RAES RECEIVE?

Answer: The Department does not plan to run such a report.
Source: HCPF FAQ

QUESTION: WHAT IS THE DEFINITION OF AN EPISODE?

Answer: Episode is currently defined as a 12-month period beginning with the first date of service.

Source: HCPF FAQ

QUESTION: ARE THE VISITS COUNTED BY THE PROVIDER OR MEMBER?

Answer: Per member.
Source: HCPF FAQ

QUESTION: DOES THE SHORT-TERM BEHAVIORAL HEALTH POLICY ALLOW UP TO 6 SESSIONS IN A BEHAVIORAL HEALTH SETTING WITHOUT A COVERED DIAGNOSIS?

Answer: These sessions will be available in a primary care setting without a covered diagnosis. Sessions provided and billed by a behavioral health practitioner can also be provided without a covered diagnosis, they will be billed to Colorado Access.
Source: HCPF FAQ

QUESTION: WHEN DO THE SHORT-TERM BEHAVIORAL HEALTH BILLING CHANGES GO INTO EFFECT?

Answer: Effective July 1, HCPF's billing requirement for behavioral health services provided in primary care clinics, federally qualified health centers, rural health centers, Indian Health Center, and/or a non-physician practitioner groups will go into effect.
Source: Elise Cooper

QUESTION: WHAT CODES CAN IMPACTED BY CHANGES TO SHORT-TERM BEHAVIORAL HEALTH BILLING?

Answer: The impacted codes include 90791, 90792, 90832, 90834, 90837, 90846, and 90847.
Source: Elise Cooper

QUESTION: WHAT PROVIDER TYPES CAN BILL FOR SHORT-TERM BEHAVIORAL HEALTH SERVICES?

Answer: The following provider types can bill short-term behavioral health codes: primary care clinic, federally qualified health centers, rural health centers, Indian Health Center, and/or a non-physician practitioner group.
Source: Elise Cooper

QUESTION: WHAT IS THE POLICY FOR BILLING SHORT-TERM BEHAVIORAL HEALTH SERVICES IN A PRIMARY CARE?

Answer: Applicable provider types can bill 6 sessions using applicable codes within a 12-month period without a covered diagnosis. They must meet medical necessity, be provided by a Medicaid enrolled masters level or higher licensed behavioral health provider, follow CPT coding practices and documentation requirements, and be available in a primary care setting.
Source: Elise Cooper

QUESTION: MY CLINIC IS ALREADY DOING INTEGRATED CARE. WHAT CHANGES FOR US?

Answer: For applicable provider groups doing integrated care, the first 6 sessions billed using short-term behavioral health codes (90791, 90792, 90832, 90834, 90837, 90846, and 90847) will now be sent to Health First

Colorado as fee-for-service claims instead of the being sent to the Behavioral Health Organization (BHO) for payment. After six sessions, providers must receive a prior authorization from their Regional Accountable Entity (RAE) to have additional short-term behavioral health services paid under the capitated behavioral health benefit.
Source: Elise Cooper

QUESTION: I WORK IN AN INTEGRATED CLINIC AND BILL CODES THAT ARE NOT INCLUDED IN HCPFs LIST OF SHORT-TERM BEHAVIORAL HEALTH CODES. CAN I STILL BILL THOSE CODES?

Answer: Yes. Claims using codes not included in the list of short-term behavioral health codes should be sent to the RAE for payment. Please refer to the Billing and Coding manual for guidance on CPT/HCPCS coding practices and documentation requirements
Source: Elise Cooper

ATTRIBUTION

QUESTIONS: HOW ARE MEMBER ATTRIBUTED TO A SPECIFIC PRACTICE LOCATION?

Answer: In ACC Phase II, members will be attributed to the brick and mortar service location, rather than the group Medicaid billing ID. This means that all PCMPs must ensure they are billing HCPF utilizing site IDs and that each site is contracted with their RAE. All claims submissions must adhere to Colorado Medicaid billing guidelines as outlined in the Billing Manuals. Specifically, claims must be submitted using the proper service location ID and address where services are rendered. For guidance see the Multiple Service Locations fact sheet.
The state will use four different methodologies to ensure all members are attributed to a PCMP site location.

- **Member selection:** ACC member have the option of choosing a different PCMP at any time by calling the state's enrollment broker.
- **Claims history:** If an ACC member has a demonstrated claims history with a practice over the last 18 months, the system will automatically attribute the member to that location. The system first looks at paid Evaluation and Management (E&M) claims, then other types of claims are considered.
- **Family connections:** If member has no utilization with a PCMP in the past 18 months, the system will attribute the member to the PCMP with which a family member is attributed. This occurs only if the PCMP is appropriate.
    - Ex: a parent will not be attributed to a child's PCMP if that PCMP is a pediatrician.

Family relationships will be assumed when a member shares last name, street address, city, ZIP code

- **Proximity:** If neither a member nor a family member has a utilization history with a PCMP, the system will determine the closest appropriate PCMP within the member's region and attribute to that location.

Source: colorado.gov/pacific/sites/default/files/Phase%20II%20Attribution%20FAQ%2003.06.2018.pdf

QUESTION: ONCE ATTRIBUTED TO A PARTICULAR SITE, WITH THE MEMBER'S ABILITY TO SEEK CARE FROM OTHER PROVIDERS OR LOCATIONS BE RESTRICTED?

Answer: No changes have been made to restrict a member's ability to seek care from another provider. Providers with multiple sites should note that patient attribution will be to the site they most frequently utilize for primary care but the patient is not required to only receive care from their attributed site.
Source: colorado.gov/pacific/sites/default/files/Phase%20II%20Attribution%20FAQ%2003.06.2018.pdf

QUESTION: CAN ANY PROVIDER RECEIVE ATTRIBUTIONS?

Answer: No. Providers must be contracted as a PCMP in the ACC program before they can receive attributions. Providers must meet specific criteria to be considered for PCMP contracting and have a signed agreement with the RAE serving their region. For more information, see our Primary Care Medical Provider Contracting Guidance Fact Sheet on CO.gov/HCPF/ACCPhase2.
Source: colorado.gov/pacific/sites/default/files/Phase%20II%20Attribution%20FAQ%2003.06.2018.pdf

QUESTION: WILL PROVIDERS WHO HAVE MISSED THE CONTRACTING DEADLINE FOR THE MASS ATTRIBUTION BE ABLE TO RECEIVE ATTRIBUTIONS AFTER JULY 1?

Answer: Yes, the RAEs will continue to contract as necessary and providers who become PCMPs after the mass attribution will be able to receive attributions of new members each month. For more information, see our Primary Care Medical Provider Contracting Guidance Fact Sheet on CO.gov/HCPF/ACCPhase2.
Source: colorado.gov/pacific/sites/default/files/Phase%20II%20Attribution%20FAQ%2003.06.2018.pdf

QUESTION: IF I HAVE MULTIPLE SITE LOCATIONS AND A MEMBER IS ATTRIBUTED TO A CERTAIN SITE, CAN THEY GO TO THE OTHER LOCATIONS AS WELL?

Answer: Yes
Source: Jean Barker

CONTRACTING

QUESTION: HOW LONG IS IT GOING TO TAKE TO CONTRACT WITH THE NEW RAE?

Answer: If the provider is validated with the state for Medicaid, contracting and credentialing would take a total of approximately 8-10 weeks.
Source: Rebecca Lynn

QUESTION: I'M HAVING ISSUES WITH THE CONTRACT. WHO CAN I TALK TO OR WHAT CAN I DO?

Answer: Please contact your Provider Relations Representative or emails us at pns@coaccess.com.
Source: Provider FAQ

VALIDATION

QUESTION: WHAT IS VALIDATION?

Answer: Federal regulations by the Centers for Medicare & Medicaid Services (CMS) require that all Medicare, Medicaid and CHP+ providers undergo enhanced screening and revalidation.
Source: Provider FAQ

QUESTION: HOW DOES VALIDATION AFFECT ME?

Answer: In accordance with the Department of Health Care Policy and Financing, if a provider is not enrolled or validated with the state, reimbursement for any services rendered to CHP+ and/or Medicaid members may be denied.
Source: Provider FAQ

QUESTION: DO ALL PROVIDERS HAVE TO GO THROUGH THE CREDENTIALING PROCESS? HOW IS CREDENTIALING DIFFERENT THAN VALIDATION?

Answer: Behavioral health providers must go through the credentialing process with Colorado Access. CHP+ HMO providers must also go through the Colorado Access credentialing process. All providers, including behavioral health providers and PCMPs must be validated by the Department and enrolled as a Medicaid provider. Providers that successfully revalidated do not need to do so again. More information see our Primary Care Medical Provider Contracting Guidance Fact Sheet and Behavioral Health Provider Contracting Guidance Fact Sheet on CO.gov/HCPF/ACCPhase2.

PAYMENT/BILLING/CLAIMS

QUESTION: HOW DO I BECOME A PROVIDER?

Answer: Please visit coaccess.com/become-a-colorado-access-provider for specific information on how to become a Colorado Access provider.
Source: Jean Barker

QUESTION: HOW WILL I BE PAID STARTING JULY 1?

Answer: Physical health claims will continue to be paid by the state. PCMPs that receive medical home payments by contracting with us will be receiving those PMPM payments from Colorado Access instead of the state, via our claims processing vendor, Change Health. Behavioral health providers will be paid by submitting their claims to the RAE to which their member is assigned.
Source: Jean Barker

QUESTION: HOW DO I CHANGE THE WAY I'M RECEIVING MY PAYMENTS FROM COLORADO ACCESS?

Answer: The default payment method is via a Virtual Credit Card (VCC). Click here for information on other payment options and how to request a change to how you receive payments from Colorado Access.
Source: coaccess.com/provider-frequently-asked-questions

QUESTION: HOW DO I FILE A CLAIM?

Answer: Behavioral health and CHP+ providers can submit claims electronically through a number of clearinghouses. For more information about EDI claims, click here. All physical health claims will be submitted to the state.

Behavioral health and CHP+ paper claims can also be mailed to:

Colorado Access Claims
PO Box 17470
Denver, CO 80217-0470

Source: Michelle Tomsche

QUESTION: WHERE CAN I CHECK THE STATUS OF A CLAIM?

Answer: The status of a behavioral health or CHP+ claim can be checked at our provider portal providers.coaccess.com/ClaimStatus/security/userLogin.jsf or feel free to contact customer service for additional assistance.
Source: Provider FAQ

QUESTION: WHY IS A CLAIM BEING DENIED?

Answer: For behavioral health and CHP+ claim denial reason can be reviewed on our provider portal providers.coaccess.com/ClaimStatus/security/userLogin.jsf if further clarification is needed please contact customer service.
Source: Provider FAQ

QUESTION: I DO NOT AGREE WITH THE DENIAL CLAIM. SHOULD I RESUBMIT THE CLAIM?

Answer: For behavioral health and CHP+ claims, providers should submit a claim appeal (provider carrier dispute) in writing when they disagree with the way Colorado Access has processed a claim. Information may be submitted in a brief letter or on our claim appeal form.
Source: Provider FAQ

QUESTION: HOW DO I GET PAID FOR THE PATIENTS I SEE?

Answer: After a claim has been submitted and processed the default payment method is via a Virtual Credit Card (VCC). Click here for information on other payment options and how to request a change to how you receive payments from Colorado Access or you can contact 1-855-886-3863.
Source: Provider FAQ

QUESTION: WHY CAN'T I BILL A MEDICAID PATIENT TO GET PAID?

Answer: State statute prohibits providers (Medicaid or non-Medicaid) from billing Medicaid and CHP+ members for covered services. Providers who do this may be reported to HCPF's Program Integrity Unit.
Source: Provider FAQ

UM/PRIOR AUTHORIZATIONS

QUESTION: WHEN WILL COLORADO ACCESS 24/7 COVERAGE GO LIVE?

Answer: Colorado Access began their 24/7 coverage on May 1st, 2018.
Source: Lindsay Cowee

QUESTION: HOW IS THE 24/7 COVERAGE DIFFERENT THAN WHAT I AM USED TO?

Answer: The Colorado Access phone number for authorization used to be forwarded to BHI to manage on our behalf from 5pm-8am. Now, a Colorado Access staff member will be answering those calls and managing authorizations.
Source: Lindsay Cowee

QUESTION: ARE THERE MORE UM STAFF FOR THE TRANSITION FOR 24/7 AND FOR REGION 3?

Answer: Yes. The UM team has doubled the number of behavioral health UM coordinators during the day. We have also added a new rotating/night shift team to manage all of the additional coverage time.
Source: Lindsay Cowee

QUESTION: WILL ANY OF THE PROCEDURES FOR PRIOR AUTHORIZATIONS REQUESTS FOR IOP SUD TREATMENT CHANGES?

Answer: All procedures for prior authorization (including procedures for SUD IOP) will remain the same. Providers can complete the prior authorization request form and fax the form, plus all relevant clinical information, to the fax number listed on the prior authorization form.
Source: Lindsay Cowee

QUESTION: WHERE CAN I GO TO FIND OUT IF A PRIOR AUTHORIZATION IS NECESSARY?

Answer: To determine whether a code requires prior authorization for either RAE or CHP+ members, please consult the Colorado Access Master Authorizations List found on the Colorado Access website: coaccess.com/documents/MasterAuthorizationList.pdf
Source: Lindsay Cowee

ELIGIBILITY

QUESTION: HOW DO I CHECK ELIGIBILITY FOR A PATIENT?

Answer: Eligibility can be checked at the state web portal (colorado-hcp-portal.xco.dcs-usps.com/hcp/provider/Home/tabid/135/Default.aspx *)* or the Colorado Access provider portal (*providers.coaccess.com/ClaimStatus/security/userLogin.jsf*).
Source: Provider FAQ

BENEFITS

QUESTION: WHAT VISION BENEFITS ARE AVAILABLE?

Answer: This is dependent on the type of coverage the member has. For CHP+ SMCN, vision benefits can be located at chpplusproviders.com/pdfs/CHPSMCN_EOC.pdf or you can call Colorado Access customer service. For Colorado Access CHP+ HMO vision benefits can be located at coaccess.com/documents/CHPHMO_EOC.pdf or you can call the child's assigned HMO. Medicaid vision benefits can be located at healthfirstcolorado.com/benefits-services/ or you can contact the member's assigned Accountable Care Collaborative
Source: Provider FAQ

QUESTION: WHAT BENEFITS DO COLORADO ACCESS COVER?

Answer: For CHP+ State Managed Care and CHP+ HMO, Colorado Access administers medical, behavioral, and vision benefits. For Medicaid, Colorado Access administers behavioral and care management benefits.
Source: Provider FAQ