Provider Manual

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Provider Manual

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1: INTRODUCTION

Welcome! We are glad to have you in our network. This Provider Manual is part of your contract and your guide for our partnership.

We retain the right to modify the Provider Manual. It is updated frequently and replaces all previous versions in its entirety. For the most current version, refer to the online version, available at coaccess.com/providers/resources/.

1.1 Keep Your Information Updated

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.

Regular publications, including updates to this Provider Manual and periodic provider newsletters, facilitate a better understanding of the requirements for network providers, as noted below in the next section. You can also contact our customer service team for general information and policy clarification at 800-511-5010 or your provider network representative.

1.2 Colorado Access Contact Information

Colorado Access is a local health plan that has been transforming the health care landscape in Colorado for more than 30 years. We prioritize the total health of our members and the communities we all live in. Our mission is to partner with communities and empower people through access to quality, equitable, and affordable care.

We are committed to being accessible and attentive to your concerns and needs. Below is important contact information for Colorado Access.

Question or Issue	Contact
Questions about benefits, claim disputes, and general questions about policies	Customer Service: 800-511-5010 or customer.service@coaccess.com Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday
Provider contracting and credentialing	**Contracting**: provider.contracting@coaccess.com **Credentialing**: credentialing@coaccess.com. Submit credentialing documentation through the CAQH ProView data portal.
Provider support and training; questions about provider responsibilities	Provider Network Services: 720-744-5667 or providernetworkservices@coaccess.com

Question or Issue	Contact
Adding a new provider to your existing contract	Complete a Clinical Staff Update Form at coaccess.com.
Provider portal help	providerportal.support@coaccess.com To log in, go to coaccess.com and select "Provider Portal"
Utilization management; prior authorizations	Utilization Management: 844-833-5717
Claims submission	Submit claims electronically through clearinghouses or direct batch file submissions in the HIPAA5010 version of the 837 file format. For questions about electronic claim submissions, email edi_coordinator@coaccess.com. Mail paper claims to: Colorado Access Claims P.O. Box 240389 Apple Valley, MN 55124 Instead of mailing a paper claim, you can use the direct data entry (DDE) portal: portal.smartdatastream.us.
Claims status	Check the Colorado Access Provider Portal or call Customer Services at 800-511-5010.
Member eligibility and enrollment	Verify eligibility through the Colorado Access Provider Portal or the state's eligibility portal. To help members with the application process, contact Access Medical Enrollment Services: • Phone: 303-755-4138 or 855-221-4138 (toll-free) • Fax: 720-744-5227 • accessenrollment.org • 4643 South Ulster Street, Suite 700, Denver, CO 80237 Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday
Care coordination	To refer a member to care coordination, submit a referral at carecoordinationreferral.coaccess.com or call 866-833-5717.
To report privacy concerns or violations	Privacy Official: 877-363-3065 or compliance@coaccess.com. Colorado Access Attention: Privacy Official 4643 South Ulster Street, Suite 700 Denver, CO 80237

Question or Issue	Contact
To report fraud, waste, and abuse	Call the anonymous and confidential compliance hotline at 877-363-3065 or email compliance@coaccess.com
Quality of care and critical incident questions and reporting	qoc@coaccess.com
Mental health crisis services	Call or text 988 for free, immediate, human support 24/7.

2: LEGAL AND COMPLIANCE

2.1 Your Contract Documents and the Provider Manual

Your contract documents consist of your Provider Agreement and all documents and addenda attached to the Agreement. Your contract documents also include the terms, conditions, rights, and obligations in this Provider Manual.

This Provider Manual is intended to supplement and further explain your rights and obligations. If there is a conflict between the Provider Manual and your Provider Agreement and addenda, the Agreement and addenda supersede.

Providers and facilities must acknowledge this Provider Manual and any other written materials provided by Colorado Access as proprietary and confidential.

2.2 Nondiscrimination Policy

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 that discriminates against a member on such basis.

2.3 Language Assistance and Auxiliary Aids

Colorado Access and our providers must take all 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's office. If you do not have this assistance available, contact our customer service team for assistance.

Providers may request language interpretation services for office appointments by completing the Interpretation Request Form on the General Forms page or calling our customer service team at 800-511-5010. Customer service will assist if you have questions or need assistance in providing aids or services for members. Examples of aids and services include:

- Multilingual staff members
- TTY/TDD or Relay Colorado
- Interpreter services (over the phone and in person)
- Information and materials translated into the member's primary language
- Notices prepared in large print
- Audio options for notices for members who are blind or low vision, or have low literacy levels (reading aloud, documents accessible by screen readers, etc.)
- Braille

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

2.4 Privacy

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 & Financing (HCPF) regarding payment of substance use disorder services. If you submit claims to Colorado Access that are protected by 42 CFR Part 2, you must obtain the necessary consent authorizing this disclosure and keep the original signed copy in the member's records.

If you have questions about our privacy policies, please contact our privacy officer at 855-879-8286 or by email at compliance@coaccess.com. You can find more information at coaccess.com/about/compliance.

2.5 Medical Records

Providers are responsible for maintaining confidential medical records that are current, detailed, organized, and that promote continuity of care for each member. Records should be legible, comprehensive, and meet documentation standards. Providers must maintain a record for each encounter with a member.

Well-documented records facilitate communication, coordination, continuity of care, and effective treatment. Colorado Access patient records standards are based on state and federal requirements, 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.

2.6 Fraud, Waste, and Abuse

We support the efforts of federal and state authorities in identifying fraud and abuse and have mechanisms in place to prevent, detect, investigate, report, and correct them. Our fraud and abuse policy is located online at coaccess.com/about/compliance.

- **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. 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 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 and Billing section of this manual for further instructions on how to return an overpayment.

Federal Fraud Statutes (False Claims, Anti-Kickback, Stark)

The table below 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.

	False Claims Act 31 USC § 3729-3733	**Anti-Kickback Statute 42 USC § 1320a-7b(b)**	**Stark Law 42 USC § 1395nn**
Summary	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	Prohibits a physician from referring Medicare or Medicaid patients for designated health services to an entity

	False Claims Act 31 USC § 3729-3733	Anti-Kickback Statute 42 USC § 1320a-7b(b)	Stark Law 42 USC § 1395nn
		generate federal health care program business.	with which the physician or immediate family member has a financial relationship.
Referrals	Referrals from anyone	Referrals from anyone	Referrals from a physician
Items/Services	Any	Any	Designated health services defined by 42 C.F.R. § 411.351
Intent	Must be proven, but on a relaxed standard.	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 and $500,000 for a corporation Per occurrence **Civil**: Civil penalty of no less than $13,508 and no more than $27,018, plus three times the amount of damages the government sustains because of the action; subject to inflationary adjustments 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

Member 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.

3: PROVIDER ENROLLMENT AND CREDENTIALING

3.1 Credentialing

Colorado Access follows the National Committee for Quality Assurance (NCQA) credentialing standards. After enrolling with Health First Colorado, new providers/groups must first notify our contracting team at provider.contracting@coaccess.com. Once a contract is initiated, Colorado Access credentials licensed practitioners who provide services in an outpatient setting. To add a new provider to an already contracted group, complete a Practitioner Update Form 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 organizational assessment prior to contracting. Organizations that 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

Providers must participate with Colorado Access credentialing standards and requirements set forth in our policies and procedures.

The provider agrees to voluntarily provide and disclose, as part of the credentialing process, all documents or materials we request, and recognizes a continuing duty to disclose information that is relevant to the credentialing process. Providers shall not begin to perform contracted services until the application has been approved by Colorado Access. Provider further warrants and represents that it shall supplement their application for credentials in a timely manner, provide any further information we request, and further notify us of any and all actions or events that materially affect the application or approval for credentials. If the Colorado Access Credentialing Committee takes disciplinary action against a provider for quality reasons, the provider will be offered a formal appeals process by our legal team.

Practitioner Rights

All providers have the right to review information submitted to support their credentialing application, including information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards). Colorado Access is not required to make available references, recommendations, or peer-review protected information. Providers have the right to correct erroneous information such as actions against your license, malpractice claims history, or board certification status. When correcting erroneous information is identified through the

verification process, credentialing staff sends up to three email attempts over 21 business days. The provider will be asked to provide the missing information within seven business days. Requested information may be sent back to the individual who made the initial outreach, or responses and documentation may be sent to the credentialing@coaccess.com email. All documentation and communication are saved in the provider's electronic credentialing folder. Colorado Access is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.

All providers have the right to receive the status of their credentialing or recredentialing application upon request. These requests can be sent to credentialing@coaccess.com. We will email a response within two business days. The information we share with practitioners could include an approval/effective date, the date the provider became an applicant if not yet completed, or information still needed to successfully complete the approval process (e.g., DEA, insurance face sheet, re-attestation of the CAQH profile). Submit the missing information within seven business days.

Credentialing Applications

Colorado Access uses CAQH ProView, a web-based tool that enables providers to enter credentialing information online to give access to multiple health care organizations. 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 so we can process your files in a timely fashion. For additional information, please contact our credentialing team by email at credentialing@coaccess.com.

3.2 Out-of-Network Care and Single Case Agreements

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 paper claims to our claims address for processing: Colorado Access Claims, P.O. Box 240389, Apple Valley, MN 55124.

Colorado Access may enter into single case agreements with some providers to foster continuity of care for members. These agreements are primarily for providers outside our network who offer specialized services required for necessary and timely care for one of our members.

3.3 Enhanced Rate for Outpatient Behavioral Health Delivered in a Language Other Than English

Eligible outpatient providers may receive a 10% enhanced reimbursement rate for direct outpatient behavioral health services delivered in a member's identified language without the use of an interpreter. Federally qualified health centers, community mental health centers, residential or bed-based services, and inpatient hospitals are not eligible for this incentive. This incentive acknowledges the additional effort, training, and expertise required to provide culturally and linguistically appropriate care.

This program is exclusive to Colorado Access and does not apply to services delivered through other Regional Accountable Entities (RAEs), including services that involve the use of an interpreter. Participation is limited to contracted outpatient behavioral health service providers. To see if you are eligible, contact your assigned provider network manager.

3.4 Provider Directory

Our provider directory is available to help members identify a provider for the mental health services they need. The provider directory can be found on our website by selecting "Find a Provider" at the top.

Members and their advocates rely on the provider directory to help them find care. Please keep your information updated in the Provider Portal so the directory remains accurate for our members.

3.5 Becoming an Essential Community Provider

We encourage all of our contracted providers to become designated as essential community providers (ECP) with 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 law (25.5-5-403 (2) C.R.S.) 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 ECPs, which can be accessed from the same website. The website offers supplemental information regarding this designation as well as other resources, such as FAQs.

4: COVERED SERVICES

4.1 Health First Colorado (Medicaid) Benefits

Summary of Medicaid Benefits and Services

Health First Colorado (Colorado's Medicaid program), hereto referred to as Medicaid, provides the member handbook at healthfirstcolorado.com/benefits-services. The handbook contains a list of covered services.

Behavioral Health Benefits

Many behavioral health care services are covered for individuals and families, and we can help members 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 Care

All behavioral health services must be in compliance with the state behavioral health services billing manual: hcpf.colorado.gov/sbhs-billing-manual.

Early and Periodic Screening, Diagnostic and Treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provides comprehensive and preventive health services for Medicaid members ages 20 and younger, along with administrative case management for pregnant adults. Services may be covered under EPSDT even if the service is not usually a Health First Colorado (Medicaid) benefit or has service limits.

EPSDT Services

- 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, including glasses and contact lenses
- Dental services
- Hearing services, including hearing aids

Provider Role in EPSDT

We expect you to facilitate and promote the availability of EPSDT services for both behavioral and physical health. This includes:

- 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 families about the availability of services
- Inquiring about utilization of 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 EPSDT training and reviewing EPSDT materials provided by the Department of Health Care Policy & Financing (HCPF)
- Referring Medicaid members to care coordination services so they can access EPSDT services: carecoordinationreferral.coaccess.com or 866-833-5717

For more information about EPSDT, please visit hcpf.colorado.gov/epsdt.

Behavioral Health Services for Children and Youth

Some behavioral health services for children and youth are covered under the capitated behavioral health benefit, and some 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 also 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

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. They must also connect members with clinically appropriate services discovered by any screening or diagnostic procedure. Most EPSDT services do not require prior authorization; however, any EPSDT service is subject to medical record review to ensure the following minimum requirements:

- Accommodate any request for mental/behavioral health screening or assessment. Any provider unable to complete a requested screening or assessment must contact Colorado Access for assistance.
- 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.
- Perform all screenings and services in a culturally and linguistically sensitive manner.
- Record results of all screenings in the child's medical record.
- Refer the member to their primary care provider, Colorado Access, or other provider for services not available at the provider's office.

Colorado System of Care: Intensive Behavioral Health Services for Children and Youth

The Colorado System of Care (CO-SOC) includes intensive in-home and community-based mental health services, intensive care coordination, with planned expansion to include mobile crisis intervention, and stabilization services for members under age 21 for whom these services are medically necessary.

For provider enrollment and billing guidance, see https://hcpf.colorado.gov/co-soc.

CO-SOC Services

The following services are covered regardless of diagnosis as long as the member meets program criteria and are medically necessary:

- Enhanced Standardized Assessment (ESA)

- Enhanced Multi-Systemic Therapy (EMST)
- Enhanced Functional Family Therapy (EFFT)
- Enhanced High Fidelity Wraparound (EHFW)

Instructions for Enhanced Standardized Assessment Providers

The enhanced standardized assessment (ESA) is a comprehensive clinical assessment to determine the appropriate treatment or services for children, youth, and families. Below are instructions for providers completing the assessment:

1. Report your assessment capacity for the week.
2. Colorado Access will send you an assessment referral.
3. Complete the assessment.
4. Submit the assessment.

For detailed instructions on how to complete the ESA, please go to https://hcpf.colorado.gov/bh-policies. For questions, contact behavioral.health@coaccess.com.

Medicaid Member Billing and Copays

Providers may not require a copay for covered services rendered to Medicaid members. **Providers may not bill Medicaid members for covered services, including balance billing and voluntary private pay agreements**.

4.2 Child Health Plan *Plus* (CHP+) Benefits

Summary of CHP+ Benefits and Services

All CHP+ members in Colorado are enrolled into a managed care organization (MCO). Colorado Access is one of the CHP+ MCOs. All CHP+ MCOs in Colorado cover the following services:

- Primary Care
- Emergency Care and Urgent Care
- Hospital Services
- Dental Care
- Prescriptions
- Immunizations
- Maternity Care (prenatal, delivery and postpartum care)
- Mental/Behavioral Health Care (excludes Pediatric Behavioral Therapy, PBT)
- Vision Services

Additional Benefits for CHP+ by Colorado Access

In addition to standard, statewide benefits, CHP+ by Colorado Access offers the following:

- 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.

For a detailed list of all CHP+ by Colorado Access benefits and exclusions, see the member handbook at coaccess.com/members/chp/.

Dental Care for CHP+ Members

DentaQuest provides most dental benefits to CHP+ members. For more information, see the state's CHP+ Dental Care web page: hcpf.colorado.gov/child-health-plan-plus-dental-care. Benefits include preventive and diagnostic services, restorative services, endodontic, periodontic, prosthodontic, oral surgery, and limited orthodontic services. For questions about CHP+ dental benefits, call DentaQuest at 888-307-6561, State Relay 711.

Fluoride varnish can be provided by a dentist or in the primary care setting for CHP+ children ages 0 to 4 who are identified as moderate to high caries risk. When provided by participating PCPs:

- 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.
- 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: 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.

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, or for services not covered by CHP+. 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. To learn more about CYMHTA services, call us at 800-511- 5010 or visit bha.colorado.gov/behavioral-health/cymhta.

CHP+ Member Billing and Copays

Providers may charge Colorado Access CHP+ members copays according to the CHP+ copay schedule: coaccess.com/members/chp/. In-network providers may not bill CHP+ members for any other costs for covered services, including balance billing.

4.3 Behavioral Health in Primary Care Settings

Starting July 1, 2025, the Colorado Department of Health Care Policy & Financing (HCPF) implemented the Integrated Care Sustainability Policy, which allows primary care practices to deliver certain behavioral health services and bill them fee-for-service (FFS). These include:

- Health Behavior Assessment & Intervention (HBAI): **Medicaid only**
- Collaborative Care Model (CoCM): **Medicaid only**
- Select Behavioral Health Integration (BHI) codes (as outlined in the Integrated Care Sustainability Policy): **Medicaid and CHP+**

These services are billed directly to HCPF fee-for-service and are not part of the capitated behavioral health benefit. PCPs may also contract with Colorado Access to deliver behavioral health services covered under the capitated behavioral health benefit.

For the most current billing requirements, refer to the HCPF billing manuals at hcpf.colorado.gov/billing-manuals.

For details on the Integrated Care Sustainability Policy, see hcpf.colorado.gov/integrated-care-sustainability-policy.

If your practice provides other services (e.g., behavioral health 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. These services must be billed to Colorado Access and 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 behavioral health fee-for-service billing, visit hcpf.colorado.gov/behavioral-health-ffs-manual.

Documentation for Integrated Care

Because interventions/treatment episodes are brief and solution-focused, integrated practices must incorporate treatment needs/plans into the body of the documentation (e.g., in the "P" section of a DAP note).

"Integrated care practices" are 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.

Please reference the Outpatient Behavioral Health Documentation Standards, which outline minimum documentation requirements.

4.4 Transportation Benefits

Ambulance Services

Medicaid and CHP+ cover ambulance services for emergencies without prior authorization. Prior authorization is only required when it is non-emergent, such as a transfer to a new hospital.

Non-Emergent Medical Transportation: Medicaid Only

Medicaid covers non-emergent medical transportation (NEMT) to help members access the care they need. Members who need transportation to health services should contact their NEMT provider, based on region (hcpf.colorado.gov/nemtlist). If a member is experiencing barriers to accessing transportation services, direct them to our customer service team. **NEMT is not covered for CHP+ members**.

Behavioral Health Secure Transportation

Behavioral Health Secure Transportation (BHST) is a benefit for all Colorado Access members experiencing a behavioral health crisis and requiring urgent transportation for behavioral health stabilization and treatment.

The service covers voluntary and involuntary transportation from the site of the behavioral health crisis to the closest, most appropriate facility. It includes transportation between the following types of facilities:

- An emergency medical services facility, which means a licensed or certified facility that provides emergency medical services, including but not limited to hospitals, hospital units as defined at Section 25-3-101, C.R.S.; freestanding emergency departments as defined at Section 25-1.5114, C.R.S.; psychiatric hospitals; community clinics; behavioral health entities; and community mental health centers, crisis stabilization units, or acute treatment units.
- A facility designated for involuntary treatment and evaluation as defined in 27-65 et seq. C.R.S. This is a "27-65 designation."
- A licensed and approved substance use disorder treatment facility, as defined in 27-81-106, C.R.S.
- A walk-in crisis center that operates as part of the behavioral health crisis response system.
- A behavioral health entity licensed with a current 24-hour endorsement under 25-27.6-106, C.R.S.

A member is eligible for BHST if they are in a behavioral health crisis, which can include both mental health and substance-related issues, as established by one of the following professionals:

- An intervening professional as defined in 27-65-102(20), C.R.S.
- Skilled professional as defined in 2 C.C.R. 502-1
- Independent professional person as defined in 27-65-102(19), C.R.S.
- Certified peace officer as defined in 4 C.C.R. 901-1, Rule 1(k), Section 21.400.1
- An emergency medical service (EMS) provider as defined in 6 C.C.R. 1015-3:1, 2.22

Colorado Access members must interact with one of these professionals to establish the need for BHST. Members cannot request BHST directly.

Prior authorization is not required for BHST, unless the provider is not in our network. You must be enrolled as a Medicaid provider to provide BHST services to a Colorado Access member. **Submit claims for BHST to Colorado Access** as professional claims (837P/CMS1500).

Billing members for covered services, including balance billing, is strictly prohibited.

The following services are **not** reimbursable:

- Waiting time
- Cancellations, including response calls to locations when no transportation is needed or provided
- Charges when the member is not in the vehicle
- Non-benefit services provided at the scene when transportation is not necessary
- Transportation covered by another entity
- Transportation of a member who has been pronounced deceased at the time that the transportation service arrives
- Pick up or delivery of prescriptions and/or supplies
- A member-directed request for BHST
- Transportation arranged for a member's convenience when the member is not in a behavioral health crisis
- Transportation when the member is chemically restrained
- Transportation when the member requires medical treatment, or active or ongoing medical monitoring
- Transportation provided by law enforcement
- Transportation where restraints were used within the context of voluntary transport
- Transportation services provided by the DHS Office of Civil and Forensic Mental Health (OCFMH) to clients in CDHS custody
- Transportation provided by emergency service patrols established pursuant to Section 27-81-115, C.R.S.
- Transportation after discharge from a hospital, which should be provided by a non-emergency medical transportation provider

BHST providers must retain records of all reimbursed BHST trips and make them available to Colorado Access upon request. You must maintain all records of restraint usage and all relevant documentation surrounding any restraints used during BHST we reimburse.

Refer to the State Behavioral Health Services Billing Manual for more information about how to bill for BHST.

4.5 Telehealth

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and health-related information across distance. This policy applies to covered telehealth services for Medicaid and CHP+ members, consistent with guidance issued by the Colorado Department of Health Care Policy & Financing (HCPF).

Services that are not otherwise covered by Colorado Access under the applicable benefit are not covered when delivered via telehealth. Providers may bill Colorado Access only those procedure codes for which they are contracted with us.

Place of Service Codes

- POS 02 – Telehealth Provided Other than in the Member's Home
- POS 10 – Telehealth Provided in the Member's Home

General Telehealth Requirements

- All telehealth services must be delivered synchronously (real-time interaction).
- Health benefits provided through telehealth must meet the same standard of care as services delivered in person.
- The availability of services through telehealth does not alter a provider's scope of practice and does not authorize the delivery of health care services in a setting or manner not otherwise permitted by law.

Audio-Only (Telephone) Services

- Services may be delivered by telephone (audio only) only when it is clinically appropriate, no other form of service delivery is possible, and the reason is documented in the member's clinical record.
- When a service is provided via audio-only telephone, modifier FQ must be appended in the first available position on the claim.

Member Eligibility, Treatment Planning, and Consent

- Members who are new to a provider must contact the provider to initiate telehealth services.

- Telehealth services for established members must be consistent with the member's documented treatment plan.
- Providers must document the member's consent, either verbal or written, to receive services via telehealth.

Documentation, Privacy, and Confidentiality

Record keeping and member privacy standards must comply with HIPAA and 42 CFR Part 2 regulations.

4.6 Providing Care

Primary Care Provider Role

Primary care medical providers (PCMPs) for Health First Colorado (Colorado's Medicaid program) members should **see Section 10 of this manual** for more details about your role.

CHP+ primary care providers are responsible for the following:

- Provide care and services for eligible members
- Ensure that coverage is available 24 hours a day, seven days a week. Access to a qualified health care provider by phone, either onsite, call sharing, or answering service, is appropriate. 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 for the prior authorization process
- Offer hours of operation not 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 offer provisions for special needs
- Educate members about healthy lifestyles and the prevention of serious illness
- Advise 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)
- 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 and keep proof of verification of the date of service

- Refer members to our participating providers
- Adhere to the professional code of conduct

CHP+ Primary Care Panels

A CHP+ 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 your practice facilitator. To close the panel to new members, the provider must give us 60-day advance written notice.

Opening a panel to new members will become effective on the date the notification is received. Upon receipt of the notice, we will send written notice to the provider, indicating an effective date for the requested panel status change.

Specialty Care Provider Role

Colorado Access does not require a primary care referral for members seeking in-network specialty care, but we encourage primary care providers to direct care for specialty office-based care through clinical referrals. A clinical referral is communication between the primary care and specialty provider for the purposes of care continuity and treatment planning.

Some specialty services may require prior authorization. See the Prior Authorization section for a list of such services.

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 primary care provider or Colorado Access, as necessary
- Obtain appropriate authorization from Colorado Access before treating a member
- Coordinate the member's care with their primary care provider
- Provide a written consultation report to the primary care provider 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

Coordination with Other Providers

All behavioral and physical health providers should coordinate care with the member's primary care provider and other care team members, after obtaining any authorization 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)
- When medications are prescribed or changed

Coordination with Colorado Access care coordination may also be necessary to support a member's whole health. Communicate with our care coordinators promptly when such coordination is needed.

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 outside of regular business hours. For additional information on Access to Care standards, please see Section 3: Quality Management of this manual.

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.

5: CLAIMS AND BILLING

5.1 Payer and Provider Responsibilities

Colorado Access has the following responsibilities with respect to provider claims:

- 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 an 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.

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

5.2 Check Member Eligibility and Identity

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 and keep their eligibility confirmations, as eligibility status is subject to change. Determination of a member's enrollment with Colorado Access may be verified by the following means:

- 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.
- Use our provider portal at coaccess.com.
- 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. Per federal and state laws and regulations, each patient setting must have measures for identification, detection,

prevention, and mitigation of identity theft. We will not pay claims for services provided to anyone who is not a Colorado Access member.

5.3 Billing and Coding

Billing Manuals

Billing manuals for Medicaid services may be found at https://hcpf.colorado.gov/billing-manuals. A separate billing manual for CHP+ services is forthcoming in 2026.

Codes

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 services 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 CMS Healthcare Common Procedure Coding System (HCPCS) to identify services provided to eligible recipients. HCPCS codes (Level 1) include CPT codes. 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.

Modifiers

All billed Medicaid services must have an applicable modifier. 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 prior authorization from Colorado Access utilization management. Please visit coaccess.com/providers/resources/um/ for a list of codes. MODIFIERS ARE NOT REQUIRED FOR CHP+.

Billing Guidance for Specific Services

Anesthesia

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.

Behavioral Health Secure Transport

Behavioral Health Secure Transport claims submitted are professional claims only (837P/CMS1500). A diagnosis is required on all claims. Use the appropriate ICD-10 code that aligns with the established behavioral health crisis. If you do not have a diagnosis from a behavioral health provider, enter code "R69, diagnosis unspecified." Do not fill unused spaces

with zeros. The diagnosis must be referenced to each detail line by placing an "A" in the diagnosis indicator field.

Dates of Service: Each detail line includes space to enter two dates of service: a “From” Date of Service (FDOS) and a “To” Date of Service (TDOS). Both dates must be completed on the electronic record and must be the same date that the transportation took place because “span billing” is not allowed. For services rendered on a single date, complete the FDOS and the TDOS with the same date.

Span billing is not allowed for transportation services. Each detail on the claim must be for a single date of service.

Place of Service Codes: Refer to Appendix K: Place of Service Codes located in the State Behavioral Health Services Billing Manual: hcpf.colorado.gov/sbhs-billing-manual. Use the appropriate place of service code where the member was picked up by secure transportation.

5.4 Claims Submission

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. 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)

Claim Format

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 provider billing manuals.

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, on the UB04 or appropriate electronic format.

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

Inpatient claims will be denied if the POA indicator is not submitted on the claim. 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.

How to Submit Claims

Electronic Submission Through Clearinghouses or Direct Batch File

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.

We prefer to use clearinghouses because 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.

Our EDI front-end validation process ensures that inbound claims meet the standard HIPAA validation rules and increases adjudication auto rates. The process will validate WEDI SNIP Level 1-7. Claims that fail the SNIP levels will be rejected, and the provider will be notified via 277/999.

Paper Claims and Direct Data Entry (DDE)

Paper claims may be mailed to:

Colorado Access Claims
P.O. Box 240389
Apple Valley, MN 55124

Instead of mailing a paper claim, we have a direct data entry (DDE) portal where providers can key in claims, which are then sent electronically. Enroll in DDE at portal.smartdatastream.us.

Timely Filing

- When Colorado Access is the primary payer, timely filing is 365 calendar days from the date of service for claim dates of service in 2026 and after. For claim dates of service **before 2026**, timely filing is 120 calendar days from the date of service or the contractual time limit, whichever is shorter.
- When Colorado Access is the secondary payer, timely filing is 120 days from the date of the primary payer's explanation of payment.
- Corrected claims must be submitted 120 days from the date of Colorado Access' explanation of payment.
- Provider-carrier disputes must be filed 60 days from the date of Colorado Access' explanation of payment on which the disputed claim appears.

Multiple Occurrences of the Same Procedure

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.

Statements and superbills are not accepted.

Locum Tenens Claims

Locum tenens physicians (MD or DO only) who provide services under a locum tenens agreement must enroll in Health First Colorado. 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 2 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 still be considered a member of the group until a permanent replacement is obtained.

Non-Clean Claims

In accordance with CRS 10-16-106.5, if a submitted claim requires 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.

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 *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," and 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.
- Mail corrected paper claims to our claims address.

Resubmitted Claims for 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.

Checking Claim Status

Check the status of your claim on our provider portal. If you do not have a provider portal account, request one by submitting the form located at coaccess.com/providers/forms.

Our customer service team can also answer questions regarding benefits, eligibility, claim disputes, claim status, and general questions about our policies. Call 800-511-5010 Monday through Friday from 8:00 a.m. to 5:00 p.m.

We aim to pay claims in a timely manner. 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 timely. No legal action or lawsuit may be taken against Colorado Access due to a delay caused by any of these events.

5.5 Coordination of Benefits

Filing a Claim for Members with Other Insurance (Third-Party Liability)

Medicaid is the payer of last resort. If members have other insurance, that insurance should be used first. In most cases, CHP+ members should not have other insurance.

- 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.
- 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 third-party payer's denial date or processing date.

Claims Pending for Missing Primary Evidence of Payment

If a claim is submitted as an original submission for a member with other active health insurance, the claim will pend for missing primary Explanation of Payment (EOP).

- The provider has 30 calendar days from the date of the request to submit the missing primary EOP. **The EOP must include all relevant denial reason statements. If the EOP applies to multiple claims, it must be submitted for each claim.**
- If we do not receive the requested information within 30 days, the claim will be denied.
- To request reconsideration of payment, the provider must submit a formal corrected claim. Refer to the Corrected Claims section of this manual for instructions on submitting corrected claims.

Secondary Benefit Calculation

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.

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.

Prior Authorization and Coordination of Benefits

If Colorado Access is the secondary payer, we do not require prior authorization 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, including:

- 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 be denied for no authorization. We will perform a retrospective review for medical necessity if the claim is resubmitted on appeal.

5.6 Member Billing/Balance Billing

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

5.7 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 different 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
- Payments made in excess of amounts due in instances of third-party liability and/or coordination of benefits

These errors are typically discovered through the provider's self-disclosure 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.

If there is an outstanding negative balance as a result of claims adjustments or nonpayment after a reasonable period of time, we may issue you a demand for repayment, 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 the 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.

5.8 Provider-Carrier Disputes

A provider-carrier dispute is a claim dispute between a participating provider and Colorado Access.

Provider-carrier disputes **are not** for utilization review decisions, including a denial of benefits for services that are not medically necessary or not covered. A provider-carrier dispute is also not for issues with credentialing, a claim validation audit, or routine provider inquiries that Colorado Access resolves in a timely fashion through existing informal processes.

To appeal a utilization management decision on a member's behalf, go to coaccess.com/members/services/appeals. To submit an appeal on a member's behalf, you will need to provide Colorado Access with permission from the member to be the member's Designated Client Representative and follow the member appeal process.

Provider-Carrier Dispute Definitions

Routine provider inquiries: Provider questions or requests for information that Colorado Access resolves in a timely fashion through existing informal processes. Examples of routine provider inquiries include 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.

Submitting a Provider-Carrier Dispute

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 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.
- You may also 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:

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

Provider-Carrier Dispute 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. If 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 to provide the requested additional information. If the provider does not respond with 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.

6: UTILIZATION MANAGEMENT

6.1 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
- Providing access to or copies of clinical records or other documents, as requested by Colorado Access

We authorize some behavioral health services as a Health First Colorado (Medicaid) regional organization and a Child Health Plan Plus (CHP+) HMO. Our utilization management service coordinators are available 24 hours a day, 7 days a week to take behavioral health authorization requests.

We authorize some physical health services for the CHP+ 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.

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 our website. For criteria specific to Medicaid Early and Periodic Screening, Diagnosis, and Treatment services, please reference the policy UM104 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) on our website. EPSDT is applicable for Medicaid only.

Services Requiring Authorization

In general, services rendered by non-participating providers require prior authorization for payment except where specifically noted.

Below are tables summarizing the types of services that require prior authorization for participating providers. The Master Authorization List, a comprehensive list of procedure codes and corresponding prior authorization requirements, is on our website at coaccess.com/providers/forms/. Specific services are listed below.

Medicaid Behavioral Health Services

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 Treatment	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+) Services

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 Treatment	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 CHP+ covered benefit *Reimbursement for ABA might be an option through the Children & Youth Mental Health Treatment Act (CYMHTA)
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

Exempt from Authorization

Services Already Rendered

We do not review requests for prior authorization for services that have already been rendered. If you provide services without 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.

Primary Care Services

Services provided by participating primary care providers (PCPs) do not require prior authorization.

Emergency and Urgent 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.

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 (4-2-17 C.R.S.).

Post-stabilization services are 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.

Downstream Providers

A downstream provider is 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.

Concurrent Review and Reauthorization for Continued Services

All requests for ongoing services beyond the initial authorization require reauthorization. Providers who have access to the Authorization portal can submit their reauthorization requests online. Providers who do not use the Authorization portal can submit reauthorization requests via email, or fax, as indicated above 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.

6.2 Continuity of Care for New and Existing Members

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.

Existing Members

At the time we are notified of a network transition (e.g., provider group termination or vendor contract termination), we will prepare a plan 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.

To ensure timely coordination of care and appropriate follow-up, all IMD facilities are required to notify the Colorado Access utilization management team of a member's discharge **on the day of discharge, and no later than 24 hours after the discharge occurs**.

This prompt notification is essential to support continuity of care, facilitate transitions, and meet contract performance standards.

After-Hours Discharge Planning Needs

For after-hours discharge planning needs (to initiate home health, DME, oxygen supplies), such as on holiday or weekends, the provider 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 must initiate a procedure authorization.

6.3 To Submit Prior 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 member's health condition requires and within the specific line of business requirements, which are within seven 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.

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 HCPF eligibility portal.
2. Colorado Access provides a secure authorization portal for providers that do not use third-party billers. This allows providers to submit initial authorization requests, concurrent reviews, and discharge information. Alternatively, providers can complete a Prior Authorization Request (PAR) form and email or fax the form with appropriate clinical documentation 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 authorization forms for different services in the Utilization Management and Pharmacy section of the forms page on our website: coaccess.com/providers/forms/:
3. You will be notified if additional information is needed, if the service is authorized, or if the service will not be authorized.

If you have questions, please call us at 800-511-5010.

6.4 Determinations

Our utilization review process complies with state and federal guidelines. For additional information about our utilization review, please reference the policy UM102 Utilization Review Determinations at coaccess.com/providers/resources/um/.

A prior authorization request will result in one of these determinations:

- **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.
- **Adverse Benefit Determination**: The authorization request was denied.
- **Administrative Denial**: The authorization request was denied because the provider did not follow contractual requirements and/or established procedures regarding authorization requirements (out of timely notification, failure to submit necessary information, etc.).

6.5 Peer Review Process

When a Colorado Access medical director has issued a denial, the Colorado Access utilization management reviewer will wait to process 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 can request a peer review with a Colorado Access medical director. During a peer review, a facility physician/prescriber can discuss the case with a Colorado Access medical director (this may not always be the same medical director who issued 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 Colorado Access peer review process, please reference the policy UM105 Peer Review Process on our website.

6.6 Appeals and Independent Reviews

Health Plan Appeal

Colorado Access has a process available to members to appeal denials of care or payment for care. 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. During the appeal process, Medicaid members may also request continuation of benefits.

Continuation of benefits is not available to CHP+ members.

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 team at 800-511-5010 if they have questions or want assistance with appeals.

State Fair Hearing

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

Second Review for Substance Use Disorder Services

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 Colorado PAR portal at 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 hcpf.colorado.gov/secondary-medical-necessity-sud-reviews.

Children and Youth Mental Health Treatment Act

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.

7: MEMBER POLICIES, SERVICES, AND EXPERIENCE

7.1 Member Eligibility and Enrollment

Eligibility for Health Benefits

Medicaid and CHP+ members must apply for health benefits through the state before becoming members of Colorado Access. Members can apply through their county human services office, the PEAK website, or at an application assistance site.

Access Medical Enrollment Services

Our application assistance site, Access Medical Enrollment Services, accepts and processes applications for CHP+ and all Medicaid programs. Services:

- Answer questions regarding all medical assistance programs, including CHP+, Health First Colorado (Colorado's Medicaid program), Long-Term Care Services, Medicare Savings Programs, and Medicaid Buy-In programs.
- Process medical assistance applications.
- Provide support in completing the paper medical assistance application in-person, through appointments or walk-in services.
- Support families in gathering and submitting all required documentation, such as income, citizenship, and identification, with their applications.
- Help complete the Disability Application for state vendors when a disability determination is required, in conjunction with the medical assistance application.
- Provide guidance and assistance with the PEAK online platform.

accessenrollment.org
Phone: 303-755-4138; 855-221-4138 (toll-free)
Fax: 720-744-5227
4643 South Ulster Street, Suite 700, Denver, CO 80237
Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday

7.2 Member Enrollment in Colorado Access

Medicaid and CHP+ members enroll in Colorado Access after they apply for state benefits and are found eligible for Medicaid or CHP+.

Health First Colorado (Medicaid)

Colorado Access is the regional organization for Region 4 of Health First Colorado (Colorado's Medicaid program), which includes Adams, Arapahoe, Denver, and Douglas counties.

Medicaid members are attributed to a primary care medical provider (PCMP) based on utilization history or selection of a PCMP. These members are assigned to Colorado Access as their regional organization if their PCMP is a Colorado Access PCMP. Members who do not have a PCMP but live in our region are also assigned to Colorado Access.

A Medicaid member (or parent/guardian) can choose a PCMP at any time by calling Health First Colorado Enrollment at 888-367-6557 or going to enroll.healthfirstcolorado.com/en.

Medicaid members can access their ID card through PEAK. They can request a physical card by calling the Health First Colorado Member Contact Center at 800-237-0757.

CHP+

As the state's largest CHP+ managed care organization (MCO), Colorado Access serves eligible children and pregnant people who live in the following 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.

Children and pregnant people eligible for CHP+ are passively enrolled into an MCO. If more than one MCO is available in their county, the member (or parent/guardian) has 90 days to choose a different MCO by calling Health First Colorado Enrollment at 888-367-6557 or going to enroll.healthfirstcolorado.com/en.

Once enrolled, the member receives a Colorado Access CHP+ ID card.

Pre-MCO Enrollment Period

There is a period of time after members have been determined eligible for CHP+ but are not yet enrolled with an MCO. Any services provided during this pre-enrollment period must be billed fee-for-service (FFS). FFS claims must be submitted to the Colorado Interchange and pharmacy claims must be submitted to MedImpact Healthcare Systems. Please visit the Provider Resource Page for more information at hcpf.colorado.gov/our-providers. Any services provided after the start date of a member's enrollment into Colorado Access must be billed to Colorado Access.

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 member is inpatient in a hospital at 11:59 p.m. the day before his or her enrollment into Colorado Access is scheduled to take effect, enrollment is postponed. Within 14 calendar days

of discovering the member's hospital admission, Colorado Access will notify HCPF that the enrollment will be delayed. The new effective date of member's enrollment will be the first day of the month following the month of discharge.

Disenrollment

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

- The child turns 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 member's residence to an area not in the Colorado Access service area. Disenrollment will be effective the first day of the month following the confirmation of the move outside of the 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 disenroll for good cause reasons or at the time of renewal. Good cause reasons include:

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

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 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 disenrollment, the disenrollment is approved.

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.

Primary Care Provider Assignment

CHP+ members are assigned to a primary care provider (PCP) effective the first date of enrollment. If the member does not contact us, the member will be assigned to a PCP based on their home address.

Members (or parents/guardians) can change their PCP any time and may see any participating PCP in our network. PCP changes may be requested verbally or in writing. We will issue the member a new ID card with the name of the new PCP within 7 to 10 business days.

If you are assisting a member with a PCP change, please contact the customer service team or make the change on our provider portal. PCP changes will be made effective on the date of the request.

7.3 Member Experience

Member Rights and Responsibilities

Members have the right to:

- Receive information about COA, COA's services, practitioners and providers, member benefits, and member rights and responsibilities, in the member's language and in a way the member can easily understand.
- Be treated with respect and recognition of their dignity and right to privacy. A member's personal information will only be released to others when the member gives permission or when allowed by law.
- Participate in decisions about their care, including the decision to refuse or stop treatment, except as provided by law.
- Receive clear information and have candid discussions about their condition and appropriate or medically necessary treatment options and alternatives, regardless of cost or benefit coverage, presented in a manner appropriate to the Member's condition and ability to understand.
- Select or request a change to any primary care provider in COA's network.
- Receive family planning services and family planning-related services directly from any licensed or certified provider, without referral.
- Receive services from a provider that provides reasonable accommodation and equipment, in their language or with free interpretation services.
- Access to care within timely appointment standards.
- Receive care for emergency conditions from any provider, in- or out-of-network, 24 hours a day, seven days a week.

- Get a second opinion on their diagnosis or treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive written notice of any decision COA makes to deny or limit services.
- File complaints or appeals about COA, care it provides, its practitioners and providers, or decisions about the Member's care.
- Request and receive a copy of their medical records and request that they be corrected.
- Freely use their rights without adverse treatment by COA or its providers.
- Recommend changes to our member rights and responsibilities.
- Exercise all other rights guaranteed by law.
- Get care that is medically necessary from an adequate network of providers.

Member responsibilities:

- Use providers in COA's network, except in an emergency.
- Follow COA's rules and the rules described in the member handbook.
- Tell COA if they have other health coverage, including Medicare. This also includes coverage from a claim or action against a third party responsible for your illness or injury.
- Work with their providers and be respectful to providers and COA staff.
- Pay any copays.
- Keep their personal information updated.
- Keep scheduled appointments and reschedule or cancel if they cannot make the appointment.
- Give COA and their practitioners and providers any information needed to provide care, to the best of their ability.
- Follow the plans and instructions for care that the Member has agreed to with their provider.
- Understand their health problems and participate in creating mutually agreed-upon treatment goals, to the best of their ability.

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 and provide procedures for providers to inform the client about implementing the advance medical directive.

You must document prominently in the member's medical record if the individual has 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 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 advanced 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).

Right to a Second Opinion

Members have a right to a second opinion. If a member needs assistance arranging a second opinion or getting an appointment, please call our customer service team at 800-511-5010 and ask to speak to a care coordinator.

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 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

Missed Appointments

Providers are responsible for actively promoting the continuation of services for 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, are 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.

Providers should attempt to reengage members who unexpectedly miss appointments to determine if there are concerns or barriers that contribute to the missed appointments and attempt to find a solution. Our care coordinators are available to assist in promoting and continuing services. Providers and members can submit a referral for care coordination at carecoordination.coaccess.com. Members and providers can also call 866-833-5717 (toll-free) to speak to a care coordinator.

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.

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 team at 800-511-5010 if they have questions or want assistance with grievances.

Providers are expected to cooperate fully with Colorado Access in the review and resolution of member grievances involving their services, regardless of whether the concern is substantiated. Each provider organization must designate a staff member responsible for receiving, investigating, and responding to grievance requests.

When notified of a grievance, providers are required to review the concern, gather relevant information, and submit a response, including findings and any corrective actions taken (if applicable), within five calendar days of notification. Timely provider participation is necessary to support required member response timeframes under applicable regulatory standards. If you do not respond promptly, it affects grievance resolution timelines and may result in follow-up requests from Colorado Access.

Member Dismissals

The provider may request a member's dismissal 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

Considering Member Dismissal

If a provider is considering member dismissal, 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.

Dismissal 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. The written notice must also be mailed to: Colorado Department of Health Care Policy & 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 to Colorado Access, Attn: Grievance, P.O. Box 17950, Denver, CO 80217-0950.

The written notice of dismissal 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, information about new providers for the member.

- 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 medical records should be included in the notice of dismissal, 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.

Behavioral Health Ombudsman for Access to Care

The office of the Ombudsman for Behavioral Health Access to Care acts as a neutral party to help members and health care providers address issues related to behavioral health access to care. Colorado Access will work with the Ombudsman to resolve member issues with accessing and finding care. You may contact the Ombudsman at 303-866-2789 (State Relay 711) or ombuds@bhoco.org.

Member Advisory Council

The Colorado Access 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 monthly. For more information, please visit www.coaccess.com/partnering/members/.

7.4 Care Coordination Services and Health Programs

Colorado Access care coordinators connect, support, and empower members to reach their health goals. Care coordinators are trained professionals who have expertise in many health conditions and can help members find care, transition from inpatient settings, and facilitate communication among care teams. Care coordinators work with a member's providers (PCP, specialists, subspecialists) and community resources (facilities and agencies, ancillary or nonmedical services) to help the member access the care and other services that they need and prevent service duplication.

Health Risk Assessments

Medicaid and CHP+ members both receive a health risk assessment (HRA). HCPF administers the Medicaid HRA, and Colorado Access administers the CHP+ HRA within 90 days of enrollment. Based on the results of the HRA, the care coordination team will contact the member to discuss individual needs and connect the member to appropriate care and resources. Members identified with special health care needs will be reassessed annually.

Care coordinators contact these members directly to discuss their health care needs. The care coordinator's priority is to ensure that the member has an ongoing source of primary care and is connected to appropriate specialists who can monitor the needs of the member.

Care Plans and Care Plan Changes

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 coordinator will engage the member by asking them to establish goals in their care plan that contribute to effective management of the special health care needs. The goal-setting process includes steps that the member will take toward reaching goals and what interventions the care coordinator will take to help the member successfully reach their goals.

Care coordinators work to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Care coordinators 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.

Through the care coordination process, care coordinators work in conjunction with the treating provider to determine the most appropriate, medically necessary services at the least restrictive level of care. 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.

Complex Case Management

Colorado Access offers Complex Case Management to members who have serious or long-term health problems and need more support. Members may be identified for the program through available health records or by referral. Members may be referred to the program by internal and external medical management programs, discharge planner, member, or caregiver. Providers can also refer members into the program by completing a referral form available at carecoordinationreferral.coaccess.com/https://www.coaccess.com/document/colorado-access-care-management-referral-form/. If the member is not eligible for the program, Colorado Access will help connect them to an alternative care coordination program.

Health Programs

Colorado Access offers programs to help members navigate care and tools and resources to help manage members manage their day-to-day health. More information about these programs is available at coaccess.com/members/health-programs, including how members become eligible to participate, how to use programs and services, and how to opt in or out of the programs.

8: QUALITY MANAGEMENT

8.1 Quality Assessment and Performance Improvement Program

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 updates and member 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.

8.2 Cooperation with Quality Improvement Activities and Performance Data

Providers and practitioners are required to cooperate with Colorado Access's quality improvement activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in Colorado Access's quality improvement programs. In addition, provider agrees that Colorado Access may use provider performance data for quality improvement activities

8.3 Access 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 team at 800-511-5010 for assistance in finding services within the required timeframes.

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

Access to Care Standards

Type of Care	Timeliness Standard
Emergency: physical health	24 hours a day availability of information, referral, and treatment of emergency medical conditions
Emergency: behavioral health in person	Urban/suburban areas: within one hour of contact

	Rural/frontier areas: within two hours of contact
Emergency: behavioral health by phone	Within 15 minutes after initial contact, including TTY accessibility
Urgent Care *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.*	Within 24 hours of initial identification of need
Outpatient follow-up after hospitalization or residential treatment	Within seven days after discharge
Routine, non-symptomatic well-care physical examinations, preventive care	Within 30 days after request, unless required sooner by AAP Bright Futures schedule
Routine, non-urgent symptomatic primary care or behavioral health care *Administrative or group intake processes and placement are not appointments for non-urgent, symptomatic behavioral health care.*	Within seven days after request
High-Fidelity Wraparound services for children and youth	Initiate within 30 calendar days of contractor's referral of the member to a High-Fidelity Wraparound provider.
Psychiatry/psychiatric medication management, urgent	Within seven days after request
Psychiatry/psychiatric medication management, ongoing	Within 30 days after request
Medication assisted treatment (MAT)	Within 72 hours after request
Substance use disorder (SUD) residential care	Screen for level-of-care needs within seven days of request. If admission to the needed level of care is not available, refer the member 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.
SUD residential care for priority populations as identified by Behavioral Health Administration, in order: • People who are pregnant and using drugs by injection • People who are pregnant • People who use drugs by injection • People with dependent children • People who are involuntarily committed to treatment	Screen a member for level-of-care needs within two days of request. If admission to the needed level of care is not available, refer the person 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.

Phone Standards

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.

Compliance with Access to Care Standards

We monitor provider compliance with appointment standards through a variety of mechanisms, including:

- 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
- 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 team at 800-511-5010 for assistance in finding services within the required timeframes. Providers must contact the provider network services team 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.

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 it is reasonable to members to avoid long waits. All providers must develop a mechanism to document appointment time and actual time seen.

8.4 Quality of Care Concerns and Critical Incidents

A quality of care grievance (QOCG) is a process through which members may express and report dissatisfaction about any matter other than benefit determinations. QOCGs may be filed if members' care did not meet professionally recognized standards or there is evidence of harm. Members may express dissatisfaction about any matter, including misdiagnoses, not receiving appropriate treatment, receiving care that adversely impacts health, or receiving poor quality care from the health plan or provider. Additional examples include, but are not limited to, prescribing a member the wrong medication, or discharging them prematurely. A general QOCG review or beneficiary complaint review may cover a single or multiple concerns.

A critical incident is defined as a patient safety event with a more severe threshold that is not primarily related to the natural course of the patient's illness or condition 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, or being operated on the wrong side or site during surgery.

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 quality of care 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 investigation. QOCGs 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 your provider agreement for details. If you have additional questions, please email qoc@coaccess.com.

8.5 Clinical Practice Guidelines

Colorado Access uses current, evidence-based, and 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 annually by medical professionals to ensure relevance. Copies of the approved clinical practice guidelines and other retired guidelines are also available upon request, free of charge.

8.6 Member Satisfaction Surveys

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.

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 update.

In addition to administering an internal member satisfaction survey in collaboration with the customer service team, Colorado Access administers these satisfaction surveys every year:

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

- The Experience of Care and Health Outcomes (ECHO) Survey for behavioral health services for CHP+ and Health First Colorado members

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 the 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 meets 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.

The ECHO survey is administered by an independent company, Press Ganey.

If asked, 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.

9: PROVIDER TOOLS, SUPPORT, AND TRAINING

9.1 Provider Network Services

Provider Network Services provides quick responses to your questions and concerns. Email providernetworkservices@coaccess.com or call 800-511-5010 to contact them.

9.2 Provider Portal

We maintain a provider portal that gives you access to member eligibility, member roster, claim status, prior authorization requests and remittance advice information. To register for the portal, please send an email to providerportal.support@coaccess.com. Include your TIN, NPI and contact information. 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 coaccess.com. Select Provider Portal. At the top.

9.3 Required Provider Training

Providers are required to complete trainings required 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.

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 responsiveness 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. We believe it is essential to achieve these high standards and well worth the effort.

9.4 Provider Information and Updates

We send a monthly Provider Update to keep you informed. Sign up for our Provider Update emails: coaccess.com/providers/.

10: HEALTH FIRST COLORADO PRIMARY CARE MEDICAL PROVIDERS

We have contracted with the Colorado Department of Health Care Policy & Financing (HCPF) to serve as the Regional Accountable Entity (RAE) (regional organization), to be responsible for, and to promote, physical and behavioral health for Region 4. As a regional organization, 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 Region 4 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 regional organization network PCMP.

Some PCMPs have been designated as care coordination partners (CCPs), and some will have additional clinical requirements for their practice as specified in their CCP contract addendum. These additional requirements are detailed below.

10.1 PCMP Qualifications

To qualify as a primary care medical provider (PCMP) under the RAE, provider must meet the following requirements:

1. Enrolled as a Colorado Medicaid provider.
2. Licensed and able to practice in the State of Colorado.
3. A properly licensed and credentialed M.D., D.O. or N.P. and practice in one or more of the following specialties: internal medicine, family practice, pediatrics, obstetrics and gynecology, and geriatrics. Community mental health centers (CMHCs) and HIV/Infectious Disease (HIV/ID) practitioners may qualify as PCMPs upon approval of Colorado Access and provided they meet all other PCMP criteria.
4. A practice, agency, or individual provider, as applicable, that renders services utilizing one of the following Medicaid provider types:
    - Physician (Code 05)
    - Osteopath (Code 26)
    - Federally Qualified Health Center (Code 32)
    - Rural Health Clinic (Code 45)
    - School Health Clinic (Code 51)
    - Family/Pediatric Nurse Practitioner (Code 41)
    - Clinic-Practitioner Group (Code 16)
    - Non-physician Practitioner Group (Code 25)

10.2 PCMP Obligations

A primary care medical provider (PCMP) has the following responsibilities:

1. Provide care coordination.
2. Provide 24/7 phone coverage with access to a clinician that can triage the member's health need.
3. Adopt and regularly use universal screening tools including behavioral health screenings, uniform protocols, and guidelines/decision trees/algorithms to support members in accessing necessary treatments.
4. Track the status of referrals to specialty care clinicians and provides the clinical reason for the referral along with pertinent clinical information.
5. Have weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (Monday–Friday, 7:30 a.m.–5:30 p.m.) or school hours for School-Based Health Clinics.
6. Use available data (e.g., Department of Health Care Policy and Financing claims data, clinical information) to identify special member populations who may require extra services and support for health or social reasons. The PCMP must also have procedures to proactively address the identified health needs.
7. Collaborate with the member, family, or caregiver to develop an individual care plan for members with complex needs.
8. Use an electronic health record or work with Colorado Access to share data with the state.
9. Assure outpatient follow-up appointments are within seven calendar days after member's discharge from a hospitalization.
10. Assure routine primary care for non-urgent symptoms is available within seven business days after the request.
11. Assures well care visit are available within 30 calendar days after the member's request unless an appointment is required sooner to ensure the provision of screenings in accordance with the Bright Futures schedule.
12. Avoid placing members on a wait list without their consent.
13. Ensure, to the extent possible, that members eligible for EPSDT benefits receive regularly scheduled examinations of physical and mental health, growth, development, and nutritional status in accordance with the Bright Futures schedule.
14. Improve referral processes to ensure that the tracking of outgoing referrals to specialty care providers, the clinical reason along with the pertinent clinical information for the referral, and the results of the referral service are documented with appropriate Member follow-up.

15. Participate in provider-to-provider communication and consultations, including the use of e-consults.
16. Work with Colorado Access to ensure that members receive programming and/or services not available within the site.
17. Participate in Colorado Access-sponsored forums/training/best practice sharing pertaining to clinical and non- clinical topics that impact members.
18. Engage and collaborate with practice support to achieve regional performance measures.
19. Participate in and provide timely responses to any practice assessments and on-going/spot audits.
20. Work with Colorado Access to develop a practice-specific mechanism for engaging with the RAE in care coordination for transitions of care including:
    - Transition of members from physical or behavioral health in-patient hospital stays to the community.
    - Other populations identified through risk stratification or HCPF initiatives.
21. Collaborate with medical and non-medical providers (individuals without formal medical training that provide care or assistance) who regularly see members.
22. Submit all required vaccination data to the Colorado Immunization Information System (CIIS).

10.4 Care Coordination Responsibilities for All PCMPs

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 regional organization.

Collaboration with Medical and Non-Medical Providers

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. Care compact agreements 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.

Data and 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.

Data Set Changes

The PCMP understands and agrees that the regional organization content focus and areas of study may evolve and change over time. Therefore, data requirements from the PCMP may also change or evolve. The regional organization 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 regional organization, 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.

10.5 Responsibilities for Care Coordination Partners

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

As a CCP, you will ensure that all employees performing services or activities as a CCP or on behalf of a CCP (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 regional organization and the Accountable Care Collaborative (ACC). These topics include the RAE program, the medical home model principles, the CCP care coordination categories and related services, and how this Provider Manual relates to each employee's position or role.

The CCP 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 CCP contract addendum.

Population Management

CCPs 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.

Targeted Populations

CCPs 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

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

Risk Stratification

CCPs must design and implement a population management strategy that offers prevention and wellness services, and utilize risk stratification to identify different categories of membership for clinical care, care coordination, and member engagement. The CCP may utilize its own established risk methodologies but should be capable of incorporating high-risk members as identified by the regional organization. The CCP should also be able to identify the following members: non-engaged members, members who need chronic disease management, special populations (criminal justice and child welfare), members with high emergency department utilization, and members with complex needs.

CCPs must have the ability to create clinical registries based on risk criteria and know how to identify short-term and long-term care coordination efforts.

High Acuity (Tier 3) Management

In addition to care coordination for the general member population, there are additional requirements for the highest acuity (also known as Tier 3) members as defined by the regional organization. Upon member consent to care coordination, care plans for Tier 3 members must be established within 90 days and these plans must be updated at least twice per year for as long as the member remains actively engaged in Tier 3 care management. Regular engagement between the member and their care coordinator or care team at a minimum of one time per month should also be documented.

Comprehensive care plans for Tier 3 members must include at a minimum:

- Measurable, time-bound, relevant member-identified goals for whole-person care

- A list of all entities and individuals involved in the member's care with the identification of the lead care coordinator. The lead care coordinator may be a care coordinator/case manager from another entity that provides support around the member's identified primary needs and serves as the member's primary point of contact
- An agreed upon frequency of engagements with the member and/or their care team
- Member-specific criteria for successful discharge from care coordination.

Care Coordination

CCPs must use the activities in this section to coordinate care for members. CCPs are also encouraged to use population management and care coordination activities in addition to the ones described below to maximize their outcomes for members

Deliberate Care Coordination Interventions (Short Term)

The CCP is 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 CCP 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.
- Members 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

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

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 identified as the member's desired intention.

Face-To-Face Activity

The CCP must offer face-to-face interventions. This type of activity may be reserved for members who meet the CCP'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 CCP site's discretion.

Transitions of Care

CCPs 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.

Cost Containment

Identify and Collaborate

The CCP shall identify system utilization/cost issues and collaborate within the regional organization 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

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

Value-Based Initiatives

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

Alignment With Colorado and Federal Programs

The CCP 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 CCP 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.

Data and Reporting

Timely Reporting

The CCP 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 CCP which may result in delayed or reduced payment to the CCP, and/or termination of the CCP agreement in accordance with the terms of the Professional Provider Agreement and Addendum 2. If data delivery to Colorado Access by a CCP is late due to a delay in data from Colorado Access and/or Truven, the CCP will submit the required data to Colorado Access within ten calendar days of having access to such required data. Colorado Access-mandated changes must be implemented within 45 calendar days.

Data Management

The CCP 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 CCPs within this Provider Manual.

Care Coordination Activity Report

The CCP 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:

- Quantitative data reporting: deliberate interventions
- Connection to Medical Care
- Connection to Community Resource
- General Check-In
- Transportation
- Quantitative data reporting: extended care coordination
- Care Planning
- Care Transitions
- Screening/Assessment

Financial Accountability Report

The CCP will report on use of CCP 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.

Patient-Centered Medical Home Capabilities

CCPs should strive to reach the highest standards of a patient centered medical home (PCMH) consistently throughout the practice. If a CCP 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 CCP shall submit such certification, recognition, and/or designation to Colorado Access.

Access to Care

The CCP must be able to offer same-day appointments to members who require same-day appointments. In addition, the CCP 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 CCP 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 CCP operations.

Clinical Practice and Quality

Integrated Behavioral Health Care

As a leader in clinical practice, the CCP 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 that will be implemented over time.

Evidence-Based Practices/Promising Practices

The CCP 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 CCP will also provide a meaningful leading role within the region to disseminate and share these practices throughout the provider network at various RAE forums.

RAE Clinical Design

The CCP shall participate in and provide leadership to the clinical design within the Colorado Access designated region. The CCP must participate and contribute in the regional organizations

via organized committees, ad-hoc meetings, learning collaborative meetings, and webinars to facilitate clinical design under the regional organization concepts.

Practice Improvement Activities

The CCP must have active quality improvement programs using proven methodologies that specifically address regional organization-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 CCP will collaborate within its regional organization region, the medical and non-medical communities, as well as across regional organization 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.

Performance Reviews and Audits

Performance-related obligations under this agreement and auditing procedures will be at the sole discretion of Colorado Access. A CCP's performance-related activities will be monitored over the course of the regional organization implementation through different performance measurement mechanisms. Eligibility for care coordination partner payments will be reviewed annually. Care coordination partner practices will participate in biannual audits aligned with NCQA's Complex Case Management standards, specifically focusing on:

- Identification and Assessment: Evaluating processes for identifying eligible members and conducting comprehensive assessments.
- Care Planning: Reviewing the development of individualized care plans that address members' unique needs.
- Care Monitoring: Assessing ongoing monitoring activities to track members' progress and adjusting care plans as necessary.
- Care Coordination: Examining coordination efforts among various care providers to ensure seamless service delivery.

Performance in these audits will directly impact the ongoing eligibility to maintain care coordination partner status. We reserve the right to review a CCP's reports, data, policies and procedures, processes, or status at any mutually agreeable time.

Upon review and determination by Colorado Access, any CCP who does not meet the requirements contained in the Provider Manual or Provider Agreement will undergo a performance evaluation and may be subject to a corrective action plan. Audits may affect PMPM payments or participation eligibility. CCPs may seek additional coaching, training, and/or consulting from Colorado Access or elsewhere, at its sole expense.