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

Section 1. Colorado Access General Information
Section 2. Colorado Access Policies
Section 3. Quality Management
Section 4. Provider Responsibilities
Section 5. Eligibility Verification
Section 6. Claims
Section 7. Coordination of Benefits
Section 8. Provider-Carrier Disputes (Claim Appeals)
Section 9. Utilization Management Program
Section 10. Behavioral Health
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Section 12. General Directive for all PCMPs

- General Directive for all PCMPs
- Specific Directive for Enhanced Clinical Partners (ECPs)
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You can search quickly and easily by using the command Control+F. This will display a search box for you to enter what you want to find.

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

General Directive for all PCMPs

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

The Professional Provider Agreement (PPA) and Addendum 1 and/or Addendum 2 along with this Provider Manual will specify your duties and obligations in connection with your activities and responsibilities as a RAE network PCMP.

Some PCMPs have been designated as enhanced clinical partners (ECPs) and some will have additional clinical requirements for their practice as outlined in their contract Addendum 2. These additional requirements are detailed in a separate portion of this Section 12.

GENERAL DATA AND REPORTING FOR ALL PCMPS

Data Set Changes

The PCMP understands and agrees that the RAE content focus and areas of study may evolve and change over time. Therefore, data we require from the PCMP may also change or evolve. The RAE will act in good faith to coordinate with the PCMP to formulate and agree upon appropriate timelines for these types of changes. However, PCMP acknowledge and agree that as participants under the RAE, these deadlines are often imposed by HCPF. 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 in Addendums 1 and/or 2 and this Provider Manual, including all costs associated with reporting or data set changes.

CARE COORDINATION REQUIREMENTS AND ACTIVITIES

Care Coordination

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

Collaboration with Medical and Non-Medical Providers

The PCMP must devise a short-term and long-term plan to work closely within the medical and non-medical communities that best serve their members.

Reporting

The reporting of care coordination activities will evolve over time and will be coordinated with us once the RAE operations commence. PCMP reporting will occur through the Colorado Access provider portal once it is operational under the RAE. The PCMP will collaborate with us on information sharing and reporting in the format and frequency determined by Colorado Access.

IMPROVE COORDINATION EFFORTS WITH MEDICAL AND NON-MEDICAL PROVIDERS

Specialty Care and Care Compact Agreements

Specialty care and care compact agreements are a designated performance goal under the RAE. This is directly related to the RAE key performance indicators. The PCMP should strive to develop and implement care compacts with medical and non-medical providers using proven tools and methodologies to ensure that specialty operations are in place, with identified point people and/or contacts. The compacts must outline specific communication requirements and relevant timeframes. The PCMP will in good faith adhere to these processes once the compact is in place.

Referral Processes

Specific referral processes must be outlined within individual care compacts. These 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

Provider consults must be outlined within individual care compact agreements. The PCMP must strive to set up specialty consults that not only meet the member’s needs, but also complement the PCMP’s resources and expertise, and ultimately create effectiveness and efficiencies in member care.

Specific Directive for Enhanced Clinical Partners (ECPs)

The enhanced clinical partners (ECPs) are obligated to provide enhanced care coordination and population management services. The responsibilities of an ECP under the RAE encompass broad population management concepts that include, but are not limited to, care coordination. The minimum operational activities and requirements are set forth below:

ADDITIONAL POPULATION MANAGEMENT REQUIREMENTS FOR ECPS

Dedicate Appropriate Resources to Achieve RAE Objectives - Staffing

As an ECP you will ensure that all employees performing services or activities as an ECP or on behalf of an ECP (including, without limitation, medical professionals, front-line staff, and clerical, billing, and office staff), have the requisite education and/or training on topics related to the RAE and the Accountable Care Collaborative (ACC). These topics include, without limitation, the RAE program, the medical home model principles, the

ECP care management categories and related services, and how this Provider Manual relates to each employee's position or role.

Resources

The ECP must possess the organizational resources and commitment necessary to perform the work outlined under the RAE and successfully implement and operate the programs to achieve the desired and designated results.

Access to Care

The ECP must have a methodology in place to offer same-day appointments to members who require same-day appointments. In addition, the ECP must have a methodology to appropriately triage appointments, schedule and staff resources to treat these members.

Team Based Care

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

Patient-Centered Medical Home Capabilities

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

Participate in Regional Gaps

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

ECP Participation as a Leading Provider in Clinical Practice

INTEGRATED BEHAVIORAL HEALTH CARE

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

EVIDENCE-BASED PRACTICES/PROMISING PRACTICES

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

ALIGNMENT WITH COLORADO AND FEDERAL PROGRAMS

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

- Colorado Alternative Payment Model (APM)
- State Innovation Model (SIM)
- Colorado Opportunity Framework
- Comprehensive Primary Care Initiative (CPC+)

CONTRIBUTE TO RAE CLINICAL DESIGN

The ECP shall participate in and provide leadership to the clinical design within regions 3 and 5. The ECP must participate and contribute in the RAEs via organized committees, ad-hoc meetings, learning collaborative meetings, and webinars to facilitate clinical design under the RAE concepts.

PRACTICE IMPROVEMENT ACTIVITIES

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

COLLABORATE ACROSS RAE REGION

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

ECP Obligation to Contain Health Care Costs

IDENTIFY AND COLLABORATE

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

ENGAGE AND IMPLEMENT

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

ECP Population Management and Care Coordination Obligations

DELIBERATE CARE COORDINATION INTERVENTIONS (SHORT TERM)

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

EXTENDED CARE COORDINATION INTERVENTIONS (LONG TERM)

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

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

CARE PLAN

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

A care plan must be based on the needs assessment and other relevant sources. Care plans will establish treatment objectives, treatment follow-up, outcomes monitoring and processes to

ensure the care plan is revised as necessary. The care plan must reflect the member's desires and provide a professionally established, member-focused "road map" of interventions to increase a member's self-management skills, awareness of warning symptoms of disease instability/progression, and to increase the member's understanding and course of her/his chronic condition(s). At least one goal on the care plan should be member identified as the member's desired intention.

CARE PLAN ACTIVITY

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

FACE-TO-FACE ACTIVITY

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

OTHER

ECPs are encouraged to utilize population management/care coordination activities that are not listed within this section to maximize their outcomes for members.

TRANSITIONS OF CARE

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

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

TARGETED POPULATIONS

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

USE OF MEMBER REGISTRIES

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

RISK STRATIFICATION

ECPs must design and implement a population management strategy that utilizes risk stratification to identify different categories of membership for clinical care, care coordination,

and member engagement. The ECP may utilize its own established risk methodologies but should be capable of translating this data into the broad HCPF-established four-quadrant model to address members who have both physical and behavioral health needs. Examples of how risk criteria may be used:

- Identify non-engaged members, members who need prevention and wellness services, chronic disease management, special populations (criminal justice and child welfare), ED utilization, and members who have complex needs.
- Ability to create clinical registries based on risk criteria.
- How to identify short term and long term care coordination efforts.

HCPF FOUR QUADRANT RISK MODEL

HCPF requires each RAE region to use a Four Quadrant stratification model. The framework captures both the physical and behavioral health needs of members and allows for further customization by Network Providers and RAEs to effectively meet the unique needs of their assigned members.

ECP Required Data Reporting

TIMELY REPORTING

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

DATA MANAGEMENT

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

CARE COORDINATION ACTIVITY REPORT

The ECP will submit quarterly, as defined below, in a HIPAA-compliant manner that has been approved by Colorado Access. The ECP may initially submit its data through a standardized file format via an established secure FTP site, but will transition to the Colorado Access provider portal, once it is operational under the RAE. The schedule and specific due dates for submitting this report will be:

- October (day TBD)
- January (day TBD)

- April (day TBD)
- July (day TBD)

The care coordination activity report must specify at a minimum:

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

FINANCIAL ACCOUNTABILITY REPORT

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

VALUE BASED INITIATIVES

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

ECP Auditing

PERFORMANCE OBLIGATIONS

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

AD-HOC PERFORMANCE REVIEWS

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

UNDERPERFORMANCE BY AN ECP

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