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

Section 1. Colorado Access General Information

Section 2. Colorado Access Policies

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- Effective Communication and Language Assistance
- Non-Discrimination
- Confidentiality of Proprietary Information
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Section 11. Child Health Plan *Plus* (CHP+) offered by Colorado Access Specific Policies and Standards

Section 12. General Directive for all PCMPs

Search Tip:
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).

Colorado Access Policies

DIVERSITY AND CULTURAL COMPETENCY 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 competency to increase access to care and quality of service.

Cultural competency 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 competency training. Cultural competency training is designed to provide a basic understanding of cultural competence 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 competency training program goals are high. Achieving such high standards is not only worth the effort, we believe it is a necessity. For more information, please call us at 800-511-5010.

EFFECTIVE COMMUNICATION AND LANGUAGE ASSISTANCE

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

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

Language assistance must be available in the Provider office or the Provider shall contact our customer service department for assistance at 800-511-5010. For Providers with 14 or fewer employees, we will pay for oral or other interpretive services in compliance with federal and state rules and regulations and contracts. For Providers with 15 or more employees, we may pay for oral or other interpretive services only where the cost to the Provider is deemed an undue burden.

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

- Multilingual staff members
- TTY/TDD
- Interpreter services (over the phone and in person)
- Information and materials translated into the member's primary language
- Notices prepared in large print
- Reading the contents of notices aloud for members who are unable to read large print or who have low literacy levels
- Audio tape
- Braille
- Relay Colorado

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

NON-DISCRIMINATION

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

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

CONFIDENTIALITY OF PROPRIETARY INFORMATION

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

CONFIDENTIALITY OF MEMBER INFORMATION

We expect you to abide by applicable state and federal rules to protect members' personal information, including name, address, Social Security number, Medicaid/plan 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 in accordance with all state and federal laws. You can find more information at coaccess.com/privacy-security-of-member-information.

Substance Use Information Protected by 42 CFR Part 2

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

FRAUD, WASTE, AND ABUSE

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

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

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

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

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

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

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

Overpayments

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

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

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

OVERVIEW	FALSE CLAIMS ACT	ANTI-KICKBACK STATUTE	STARK LAW
Citation	18 USC § 287	42 USC § 1320a-7b(b)	42 USC § 1395nn
Prohibition	Prohibits false or fictitious claims or demands for medical goods or services	Prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or	Prohibits a physician from referring Medicare or Medicaid patients for designated health services to an entity with

OVERVIEW	FALSE CLAIMS ACT	ANTI-KICKBACK STATUTE	STARK LAW
		generate federal health care program business	which the physician (or immediate family member) has a financial relationship, unless an exception applies Prohibits the Designated Health Services entity from submitting claims to Medicare or Medicaid for those services resulting from a prohibited referral
Referrals	Referrals from anyone	Referrals from anyone	Referrals from a physician
Items/Services	Any items or services	Any items or services	Designated Health Services that are defined at 42 C.F.R. § 411.351
Intent	Intent must be proven, but upon a relaxed standard	Intent must be proven (knowing and willful)	No intent standard for overpayment (strict liability) Intent required for civil monetary penalties for knowing violations
Penalties	**Criminal:** • Up to five years imprisonment • Fines up to $250,000 for an individual/$500,000 for a corporation, and is per occurrence **Civil:** • Civil penalty of not less than $5,000, not more than $10,000, plus three times the amount of damages the government	**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	**Civil:** • Overpayment/refund obligation • False Claims Act liability • Civil monetary penalties and program exclusion for knowing violations • Potential $15,000 CMP for each service • Civil assessment of up to three times the amount claimed

OVERVIEW	FALSE CLAIMS ACT	ANTI-KICKBACK STATUTE	STARK LAW
	sustains because of the action • Liability is per occurrence	• Potential $50,000 CMP per violation • Civil assessment of up to three times the amount of the kickback	

MEMBER RIGHTS AND RESPONSIBILITIES

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

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

MEMBER GRIEVANCES AND APPEALS

Members and their families have the right to the highest quality care. We notify members regarding their rights and how to file a grievance. Providers should also inform members of their right to file a grievance or appeal. The term "member" refers to the member, the member's parent or legal guardian, authorized representative, or designated grievance and appeal representative. Members may designate an individual, including the Provider, to submit a grievance or appeal on behalf of a member. A member's grievance or appeal will be completed without adverse consequences or retaliation. A Provider designated as the member's appeal representative may also request a State Fair Hearing according to the appeals process.

Detailed instructions for filing a member grievance or an appeal are located in the member handbooks and on our website at coaccess.com/general-forms-information.

Clinical Appeals Process

A clinical appeal may be filed by a member (or authorized representative) or a treating provider. The clinical appeal must be received within 60 calendar days from the date of the notice of the adverse benefit determination.

- *Standard Appeals*: A standard appeal is resolved within 10 business days of receipt (this excludes Colorado state holidays) and the appeal requestor is provided an acknowledgement letter within two business days of receipt.
- *Expedited Appeals*: An expedited appeal is resolved within 72 hours of receipt and can be initiated if we determine or the requestor indicates that the time for a standard

resolution would seriously jeopardize the member's life, health, or the ability to maintain or regain maximum function. An acknowledgement letter is not required for an expedited appeal request.

If you have any questions on the clinical appeal process, please call us at 844-683-1072. More information about the clinical appeal process can be found in policy ADM219 Member Appeal Process here.

ALTERNATIVE TREATMENT OPTIONS

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

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

MORAL OR RELIGIOUS OBJECTIONS

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

ADVANCE DIRECTIVES

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

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

You shall document prominently in the member's medical record if the individual has executed an advance medical directive. The presence or absence of an advance medical directive is not a provision of care and Providers cannot discriminate against an individual based on advance medical directive status. If possible discrimination or coercion is suspected, a member or provider (on behalf of a member) can file a grievance. If you cannot execute or implement an

advance medical directive on the basis of conscience, you are to issue a written or other appropriate form of statement of limitation to the member (or the member's representative). To learn more about advance medical directives, please visit our website at coaccess.com/advance-directives.

CREDENTIALING AND CREDENTIALING SCOPE

We credential our contracted Providers and follow National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing and recredentialing. We also credential and recredential hospital-based Providers who provide care in an outpatient setting (such as an anesthesiologist offering pain management or university faculty who have private practices that are, or will be, contracted with us to provide health care services). We perform credentialing of hospitals, home health agencies, skilled nursing facilities, nursing homes and freestanding surgical centers prior to contracting and re-credentialing occurs at least every three years thereafter. Providers that are exempt from the credentialing process are listed below:

- Covering providers and locum tenens;
- Providers who practice exclusively within the inpatient setting or are hospital-based and who provide care to our members only as a result of the member being directed to the hospital or another inpatient setting (i.e., anesthesiologists, pathologists, radiologists, emergency medicine, neonatologists, telemedicine consultants, and hospitalists);
- Providers who practice exclusively within freestanding facilities and who provide care to members only as a result of members being directed to the facility (mammography centers, urgent care, surgery centers, and ambulatory behavioral health facilities);
- Dentists who provide primary dental care only under a dental plan or rider;
- Pharmacists who are contracted with a pharmacy benefit management organization (PBM) who is contracted with Colorado Access; and
- Unlicensed doctoral or master level Providers only when necessary to meet member linguistic/cultural needs, or for service provision in a rural or underserved area.

Provider shall participate with the Colorado Access credentialing standards and requirements as set forth in the Colorado Access policies and procedures and shall submit to Colorado Access, or its designee, the Colorado Health Care Professional Credentials Application or the Colorado Access Organizational Provider Application and other required attachments, as modified from time to time in accordance with NCQA and Colorado Access standards. Provider agrees to voluntarily provide and disclose, as part of the credentialing process, all such documents or materials requested by Colorado Access and recognizes a continuing duty to disclose such information that is relevant to the credentialing process. Provider and its Provider Representatives shall not begin to perform contract services until such application has been approved by Colorado Access. Provider further warrants and represents that it shall timely supplement the Provider's application for credentials and provide any further information requested by Colorado Access and shall further notify Colorado Access of any and all actions or events that materially affect the application and/or approval for credentials.

Credentialing Applications

We participate in the CAQH ProView. CAQH is a web-based tool that enables Providers to enter credentialing information online and avoid the hassles of completing the same paperwork for multiple health care organizations. If you would like more information about registering for this 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.

For additional information, please contact our credentialing department at 720-744-5100 or 800-511-5010, or by email at credentialing@coaccess.com.

MEMBER'S DISCHARGE FROM CARE

Discharge Generally

The Provider may request a member's discharge from 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 serious threat of harm to the Provider, staff members, or other patients from continued care
- Non-compliance
- Failure to keep or cancel scheduled appointments
- Inability of Provider to provide the necessary level of care
- Removal from the area by the Provider

If a Provider is considering discharging a member from the panel, the Provider must notify the member both 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 our grievance and appeals department at customersatisfaction@coaccess.com or PO Box 17950, Denver, CO 80217-0950.

After receipt of the written notification, our grievance and appeals team will contact the member. We maintain a copy of the documentation.

Discharge of Medicaid Members

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

Colorado Department of Health Care Policy and Financing
Attn: Provider Relations Division

1570 Grant St.
Denver, CO 80203

Such written notice of termination if written by the Provider instead of the grievance and appeals team should also be sent to the Colorado Access grievance and appeals team at:

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

The written notice of termination must include the following:

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

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