COLORADO COMMUNITY HEALTH ALLIANCE

Provider Manual

Physical Health

Primary Care Providers

Last Revised: December 2024

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This provider manual pertains to Health First Colorado (Colorado's Medicaid program) and is specific to physical health primary care medical providers (PCMPs). Please see the definition below.

Primary care medical provider (PCMP): A primary care provider who serves as a Patient-Centered Medical Home (PCMH) for members and may be a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), School-based Health Center (SBHC), clinic or other group practice that provides the majority of a member's comprehensive, preventive and sick care. It can include individual PCMPs or a multi-disciplinary team of physicians, advanced practice nurses or physician assistants focusing on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

PCMPs agree to:

- Participate in all Colorado Community Health Alliance (CCHA) care coordination, health improvement and population health framework initiatives per the practice's PCMP agreement and as clinical and administrative capabilities allow.
- Collaborate with the Regional Accountable Entity (RAE) to create and provide medical homes for assigned members and accept all eligible members that the Department of Health Care Policy and Financing (HCPF) assigns in the order in which they are assigned without restriction. HCPF will assign members to the RAE and PCMP based on HCPF attribution and assignment policies and procedures.

How to Apply for Participation
If you are interested in participating in the CCHA network, please visit CCHAcares.com, contact us at CCHAcares.com/contact > I am a Provider, or call **1-855-627-4685**.

CCHA retains the right to add to, delete from and otherwise modify this provider manual, and the material in this provider manual is subject to change. Contracted providers must comply with this manual and acknowledge it and any other written materials provided by CCHA as proprietary and confidential.

Please visit CCHAcares.com/for-providers/primary-care-provider-resources > Manuals and Resources for the most up-to-date version and information. To request a hard copy of the provider manual and/or provider directory at no cost, contact us at CCHAcares.com/contact > I am a Provider, or call **1-855-627-4685**.

CHAPTER 1: INTRODUCTION

Welcome

Welcome to the Colorado Community Health Alliance (CCHA) network provider family! CCHA is pleased you have joined our network, which consists of some of the finest health care providers in the state.

CCHA is a Regional Accountable Entity (RAE) for the Health First Colorado (Colorado's Medicaid program) Accountable Care Collaborative (ACC). In 2011, Health First Colorado launched the ACC as its primary health plan. The goals of the ACC are to improve member health and reduce costs through coordinated, patient-centered care via the medical home model, where each member is attributed to a primary care medical provider (PCMP). CCHA administers health care services for ACC members who are attributed to a PCMP in Region 6 (Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties) or Region 7 (El Paso, Park and Teller counties).

CCHA's collaborative partnership brings an influential blend of PCMPs, specialists, hospitals, behavioral health services and medical/behavioral health management services to drive innovation within the Medicaid delivery system. This united entity strives to provide members with access to seamless, integrated care that is patient- and family-centered, quality-focused, and cost-efficient. CCHA builds and maintains a network of PCMPs and behavioral health providers committed to delivering integrated, coordinated care for ACC members. All network providers are contracted with CCHA through an agreement.

CCHA is also responsible for promoting collaborative relationships between providers, community services and other community support to address all aspects of a member's health and well-being, called a health neighborhood. The overall goal of this health neighborhood is to support a coordinated model of care that will better serve the needs of the Health First Colorado population, improve health and life outcomes, and optimize resources to avoid duplication of services and reduce the costs of care. PCMPs have access to the health neighborhood for referrals and should share information as applicable with providers involved in the patient's care.

Health First Colorado covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged and individuals with disabilities.

CCHA believes hospitals, physicians and other providers play a pivotal role in managed care, so we can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is important to us and essential to maintaining a stable, high-quality provider network. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for CCHA members — your patients.

About This Manual

This provider manual is for contracted CCHA physical health primary care medical providers. CCHA's goal is to provide a useful reference guide to aid you in providing the most reliable, responsible, timely, cost-effective and quality health care.

Accessing Information, Forms and Tools on the CCHA Website

Throughout this manual, there is reference to the CCHA website at CCHAcares.com, which contains tools, information and forms for the CCHA provider network. CCHA offers the provider manual online and in hard copy upon request, at no cost.

Third-party Websites

The CCHA website (CCHAcares.com) and this manual may contain links and references to internet sites owned and maintained by third parties. Neither CCHA nor its related or affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services and related materials are provided as is, without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. CCHA disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. CCHA does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise. CCHA does not, by way of this manual's links to other websites, endorse or recommend products, positions or statements taken by parties controlling the other websites.

Alternative Formats and Translation Resources

CCHA provides tools and resources to help reduce language and cultural barriers. Written translations are available in each prevalent non-English language. Interpretation services, including oral interpretation in all languages and auxiliary aids such as Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD) and American Sign Language, are available to each CCHA member free of charge. For more information, including how to request assistance with interpretation services, see Interpreter Services within this manual.

Written materials for CCHA members, especially materials critical to accessing services, adhere to the following standards:

- Easily understood language and format
- Font size no smaller than 12 points
- Alternative formats and auxiliary aids and services that consider the special needs of CCHA members with disabilities or limited English proficiency
- Inclusion of a large print tagline and information on how to request auxiliary aids and services, including alternative formats

CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Proprietary Information

The information contained in this manual is proprietary. By working with CCHA, providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services to CCHA members
- To protect and hold the manual's information as confidential
- Not to disclose the information contained in this manual

Updates and Changes

The provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the provider agreement between you or your practice and CCHA, the provider agreement governs. **Providers are responsible for remaining updated on CCHA communications.** Provider manual revisions occur as needed and at least annually. Provider memos or bulletins are sent by email, standard U.S. mail or fax and may serve to amend or update the information in this manual between editions. When enacting any changes to this manual, CCHA will also post on the CCHA website, CCHAcares.com.

The manual is not intended to be a complete statement of all CCHA policies or procedures. Other policies and procedures not included in this manual may be posted on the CCHA website or published in specially targeted communications as referenced above. This manual does not contain legal, tax or medical advice, and information within should not be construed as such. Please consult your own advisors for such guidance.

Emergency Notifications

CCHA strives to communicate promptly and effectively with members and providers during an emergency or service disruption. Depending on the nature of the disruption and its impact on members and providers, notification methods may include:

- **Member and provider websites** - CCHA maintains ongoing emergency procedures on its websites, and CCHA may post alerts there notifying members and providers of a service disruption and how it impacts their ability to access services.
- **Automated calls, text messages and email messages** - CCHA can generate automated phone calls, text messages and emails to communicate information to members and providers.
- **Personal calls** - CCHA employees may make personal phone calls to vulnerable members, including those in case management.
- **Call center** - CCHA member and provider call center employees will provide up-to-date information to callers on continuing to access services.
- **Local media** - Local radio and television can be used to disseminate emergency information to CCHA members and providers.

Nondiscrimination Statement

CCHA does not engage in, aid or perpetuate discrimination, nor does it provide assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. CCHA complies with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendment of 1972, and Section 1557 of the Affordable Care Act. CCHA does not utilize or

administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. CCHA does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Discrimination Act of 1975 (Age Act) and Section 504 of the Rehabilitation Act of 1973, CCHA may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. CCHA provides services to members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, sexual orientation, physical or mental disability, type of illness or condition, or medical history.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a CCHA representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and may receive assistance from CCHA in this accounting if requested. CCHA documents, tracks and trends all alleged acts of discrimination.

Members may also be advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR Complaint Portal
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 1-800-368-1019 (TTY 1-800-537-7697)

Complaint forms are available on the OCR website.

CCHA provides free tools and services to people with disabilities to communicate effectively with us. CCHA also provides free language services to people whose primary language is not English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling CCHA Member Support Services at 1-877-254-3660.

If you or your patient believe CCHA failed to provide these services or discriminated in any way on the basis of race, color, national origin, sexual orientation, age, disability, gender or gender identity, or any other federally protected class, you can file a grievance via:

- Mail: Colorado Community Health Alliance, Grievances, PO Box 13406, Denver, CO 80202
    - Phone: 1-855-627-4685 (TTY 711)
- Contact us at CCHAcares.com/contact > I am a Provider

Equal Program Access on the Basis of Gender

CCHA provides individuals with equal access to health programs and activities without discriminating on the basis of gender. CCHA must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, sexual orientation, gender, gender identity, age or disability).

CCHA may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender to a transgender individual based on the fact that a different gender was assigned at birth or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

CHAPTER 3: CONTACTS AND COMMUNICATIONS

Contacts

Getting in Touch with CCHA

Below are contacts for you and your office staff to use for CCHA services and support.

	Contact Information	Helpful Information Regarding
CCHA Primary Administrative Office	Colorado Community Health Alliance Provider Support Services 999 17th Street, Suite 500 Denver, CO 80202	• Written communications to CCHA
Physical Health Provider Support	Contact us at CCHAcares.com/contact > I am a Provider Phone: 1-855-627-4685	• Contractual issues • New provider orientation • Provider office orientation and training • Tax ID change • Complaint and grievance reporting • Policies and procedures • Eligibility issues • HCPF provider portal questions and training
PCMP Portal Support	Portal@CCHAcares.com	• Inquire about portal access • Report technical issues
Behavioral Health Provider Support	Contact us at CCHAcares.com/contact > I am a Provider Phone: 1-855-627-4685	• Claims payment • Provider credentialing and contracting • Complaint and grievance reporting • Benefit questions • Provider support
Care Coordination and Member Support	***Phone Numbers & Contact Hours*** Toll Free: 1-877-254-3660 Region 6 (local): 303-256-1717 Region 7 (local): 719-598-1540 Hearing/speech assistance: 711 (TTY) Full-services Mon – Fri, 8 am – 5 pm Limited-services 24/7 ***CCHA Care Coordination Referral Form*** Visit CCHAcares.com/referral	Member coordination including: • Disease education and self-management • Transitions of care • Pregnancy and family planning • General medical guidance • Discharge planning • Connecting to community resources such as housing, childcare, food, etc. • Navigating plan benefits • Comprehensive care coordination for high-risk members with multiple or chronic needs

	Contact Information	Helpful Information Regarding
Quality of Care Concerns (QOC)	***CCHA QOC Notification Form*** *Visit* CCHAcares.com/providertools or click here ***Email Completed QOC Notification Form*** HealthTeam@CCHAcares.com	QOC concerns or critical incidents such as: • Delay of care • Preventable injury • Service issues • Prescription errors • Professional conduct concerns
Practice Transformation	PracticeTransformation@CCHAcares.com	• Quality improvement initiatives such as Primary Care First (PCF), Making Care Primary (MCP), etc. • Support for improving key performance indicator (KPI) measures, access and other outcome measures • Data analytics • Clinical practice guidelines • Population health management
Compliance	Compliance@CCHAcares.com	• Please notify CCHA of any compliance concerns and/or possible Health Insurance Portability and Accountability Act (HIPAA) breaches as a result of data accessed through the CCHA PCMP Portal.

Getting in Touch with HCPF
Contact information for ACC providers can be found on the Department of Health Care Policy and Financing (HCPF) website. Visit Colorado.gov/hcpf/provider-help.

Health First Colorado Enrollment
Health First Colorado Enrollment is a state program that helps Health First Colorado members choose which health plan will provide their services. Health First Colorado Enrollment sends letters to all newly enrolled Health First Colorado members, letting them know about their health plan options. They can also assist a member in changing their assigned PCMP.

Health First Colorado Enrollment can be reached through either of the following methods:

- Visit Enroll.healthfirstcolorado.com
- Call 303-839-2120 or 1-888-367-6557 (for members who live outside of Denver), Monday through Friday, 8 am to 5 pm; State Relay 711 for callers with hearing or speech disabilities

RAEs cannot change a member's assigned PCMP but are available to support the member in choosing a new PCMP and connecting with Health First Colorado Enrollment.

CCHA Communications

Providers are responsible for reading and remaining updated on CCHA communications.

Monthly Newsletter

CCHA sends a monthly update communication via email to CCHA providers and office staff. Topics may include new quality or other program updates, clarification of CCHA contract provisions, provider staff trainings or new CCHA key contacts you might encounter. Review the newsletter library at CCHAcares.com/newsletters and sign up here to receive newsletters.

Provider Town Hall Meetings

Information of a broader nature is communicated through in-person and virtual Provider Town Hall meetings. It is expected that CCHA providers participate in these meetings when scheduled. CCHA will present training programs for PCMPs and behavioral health providers on topics related to the coordination of behavioral health and physical health care. These training events may include the opportunity for providers to obtain continuing medical education (CME)/continuing education unit (CEU) credit for participation. Provider town hall meetings will be announced via the monthly newsletter and on CCHAcares.com/providertools.

New Provider Orientation and Training

Orientation

In coordination with the contracting process, CCHA Provider Relations staff schedule new provider orientation visits with the practice. Provider orientation will be scheduled, whenever possible, before the provider's CCHA contract start date. The agenda will include, at a minimum, an overview of the following topics:

- Health First Colorado and the ACC
- CCHA and provider resources
- Per member per month (PMPM) payments
- Quality improvement initiatives
- CCHA Population Management Plan
- Care coordination services

Provider Staff Training

CCHA must monitor and ensure all participating providers who deliver physical health services provide relevant staff with training in accordance with HCPF requirements. As a CCHA contracted provider, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements. Additionally, CCHA will implement measures to monitor compliance with training requirements. CCHA will periodically provide newsletter articles and links to the CCHA website or external websites with information and training on a variety of subjects.

Behavioral Health Consultations for Primary Care Medical Providers

CCHA can connect contracted PCMPs with the CCHA network of behavioral health specialists. For more information about this and other behavioral health consultation resources, Contact us at CCHAcares.com/contact > I am a Provider.

Data Systems and Technology Support

CCHA will provide information and support for data reports and utilizing health information technology (IT) systems, including education on the practical use of available reports as requested by providers. The following are some of the reports available for providers:

- **Member Roster** – A snapshot of the members assigned to a PCMP on the first day of the month, usually available the second week of the month.
- **PMPM Summary** – A monthly report showing the PCMP's total per member per month payment amount, including a breakdown of attribution and payment amount for each of the following payment categories: complex priority members, engaged members, and non-utilizers.
- **KPI Reports** – Key performance indicators for quality improvement activities. This information is also available on the Health First Colorado Data Analytics Portal (DAP). Contact us at CCHAcares.com/contact > I am a Provider for application and provisioning.
- **My Members** – A report showing the current members assigned to a PCMP on a given day. Available on the DAP. Contact us at CCHAcares.com/contact > I am a Provider for application and provisioning.
- **Ad hoc requests** – Available by request through CCHA Practice Transformation or CCHAcares.com/contact > I am a Provider.

Websites, Portals and Tools

Click on the links below for information and assistance:

- CCHA PCMP Provider Portal – The CCHA Provider Portal is a secure, consistent method for CCHA to share data and resources with PCMPs. This may include financial reports, patient reports, electronic forms, patient education materials and CCHA contact lists. The CCHA Provider Portal does **not** take the place of the DAP, The Colorado interChange (Medicaid Management Information System (MMIS)) or the Behavioral Health Availity Claims Portal. Contact Portal@CCHAcares.com or visit CCHAcares.com/portal to get started.
- Health First Colorado Data Analytics Portal (DAP) – Hosted by IBM Watson Health, this data analytics tool allows providers to access information on their members, KPI performance and lists of members who are eligible for an annual wellness exam or other services. Contact us at CCHAcares.com/contact > I am a Provider for application and provisioning.
    - **NOTE:** Managers must immediately notify the HCPF Information Security Unit to terminate DAP account access for any user no longer authorized to perform required obligations and responsibilities within the system**.** Any questions should be directed to the HCPF Information Security Unit at hcpfsecurity@state.co.us.
- The Colorado interChange (MMIS) – The HCPF provider portal allows providers to manage contact information, maintain and update provider information and check member eligibility and benefits, along with provider and RAE assignment.
- Health First Colorado Member Portal – The HCPF member portal allows members to select a new PCMP online.
- Colorado PEAK website – Colorado.gov/PEAK is an online service for Coloradans to screen and apply for medical, food, cash and early childhood assistance programs.
- PEAK*Health* mobile app – You must be a current Health First Colorado or CHP+ member to use the secure PEAK*Health* mobile app. The app allows Health First Colorado members to view their medical card, update their income and contact information, view benefit information and more.
- Contexture – Contexture (formerly CORHIO (The Colorado Regional Health Information Exchange) allows providers to access member digital health records regardless of care history.

CHAPTER 4: OVERVIEW OF CCHA

Physical Health at CCHA

CCHA's mission is to coordinate members' physical and behavioral health care, offering a continuum of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for CCHA members. CCHA works collaboratively with health care providers, including individual behavioral health practitioners, community mental health centers (CMHCs), substance use disorder (SUD) providers, and a variety of community agencies and resources to meet members' needs.

Goals

The goals of CCHA are to:

- Assist members and providers in utilizing the most appropriate, least restrictive medical and behavioral health care in the right place at the right time
- Ensure timely access to necessary care and support resources while containing costs and improving health outcomes
- Promote the integration of the management and delivery of physical and behavioral health services to members
- Achieve the CCHA quality initiatives, including those related to the Healthcare Effectiveness Data and Information Set (HEDIS®), the National Committee for Quality Assurance (NCQA), and HCPF performance requirements
- Work with members, providers and community supports to provide tools and an environment that supports members toward their recovery and resiliency goals

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Values and Principles

The following values are incorporated into CCHA policies and practices:

- Respect for member choice and family inclusion in member-centered care
- A belief in member dignity and self-determination
- Empowering patients in their health care relationships
- The elimination of stigma and discrimination

CCHA adheres to the following principles related to the delivery of physical health services:

- Members can choose their health care professional(s) to the fullest extent possible and appropriate. CCHA has resources to connect members to an appropriate provider based on their preferences, location and health needs. HCPF and CCHA expect that network providers adhere to the principle of patient choice and facilitate upon request.
- CCHA supports the member's involvement, and those significant in the member's life as appropriate, in decisions about services provided to meet the member's health needs.
- CCHA establishes and promotes strategies to engage members who may have histories of inconsistent involvement in treatment.
- For adult members who have a serious mental illness and child members with a severe emotional disturbance (SED), services focus on helping the member maintain their home environment, education and employment, and on promoting their recovery and resiliency.

- Mental health services for children are most appropriately directed toward helping a child and the child's family develop resiliency and maintain a stable and safe family environment.
- CCHA is committed to exploring the use of emerging technology (e.g., telemedicine) to expand access to services and extend the reach of physical health, mental health and substance use disorder service professionals, particularly in rural areas of the state. For more information on telemedicine, please refer to the Telemedicine Billing Manual.
- CCHA facilitates the coordination of services to eliminate gaps in service and duplication of services.
- CCHA promotes quality improvement initiatives and monitors outcomes such as member satisfaction, health status, clinical improvement and service utilization.

Objectives

The objectives of CCHA are to:

- Work with providers to ensure the provision of medically necessary and appropriate care and services to members at the least restrictive level of care, including inpatient care, alternative care settings and outpatient care, both in and out of network
- Provide high-quality care coordination services designed to identify member needs and address them in a person-centered, holistic manner
- Promote continuity and coordination of care among physical and behavioral health care practitioners
- Maintain compliance with local, state and federal requirements
- Utilize evidence-based guidelines and clinical criteria and promote their use in the provider community
- Enhance member satisfaction by working with members in need of services to implement an individually tailored, holistic support and care plan that helps achieve their recovery and resiliency goals
- Enhance provider satisfaction and success by working to develop collaborative and supportive provider relationships built on mutually agreed-upon goals, outcomes and incentives
- Encourage all health care partners to work together to achieve quality and recovery goals through education, technological supports and the promotion of recovery ideals
- Initiate quality improvement activities with the Plan-Do-Study-Act (PDSA) method
- Establish systems to monitor and track outcomes annually

CCHA supports contracted providers in delivering physical health, behavioral health and SUD services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by HCPF.

CCHA Commitment to Providers

CCHA is committed to helping providers deliver effective and successful care to their patients. We are committed to supporting and working with qualified providers to jointly meet quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery

- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person

CHAPTER 5: MEMBER INFORMATION

How to Verify Member Eligibility

Real-time member enrollment and eligibility verification for Health First Colorado is available by calling the hotline or using the website to determine the member's specific benefit plan and coverage:

- Automated voice response: 1-844-235-2387 (24/7)
- HCPF website
- Resource guide for verifying member eligibility

It is important to **verify member eligibility on the same day you provide services**, as HCPF will only cover services for members actively enrolled in Health First Colorado.

Health First Colorado members cannot be billed for services covered by Health First Colorado. Refer to Billing Medicaid Members for Services Policy.

Federal and state policies **prohibit** charging Medicaid members for missed or canceled appointments. Similarly, providers cannot bill Medicaid members for scheduling appointments or ask members to sign forms accepting financial liability for missed appointments. Refer to the Charging Members for Missed Appointments Policy. Providers are encouraged to work with the CCHA practice transformation coach to track and implement interventions to improve missed appointment rates.

Member Information

ACC Member Attribution Summary

Information about ACC member attribution can be found on the HCPF website. For more information on available reports, see Data Systems and Technology Support within this manual.

Member Rights and Responsibilities

CCHA complies with any applicable federal and state laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights.

CCHA is committed to ensuring members are free to exercise their rights. A member cannot be treated adversely in any way by CCHA or a contracted provider for exercising their member rights. If a member feels they are not free to exercise their member rights or are treated adversely because they exercised their rights, the member can file a grievance. CCHA will work with the member to resolve their grievance quickly and prevent future adverse treatment.

The following member rights and responsibilities are defined by the state of Colorado and appear in the Health First Colorado Member Handbook.

Member Rights

CCHA honors civil rights and provides covered services to all eligible members regardless of:

- Age
- Color
- Disability

- Marital status
- National origin
- Race
- Religion
- Gender
- Gender identity
- Sexual orientation
- Military service
- Arrest or conviction record

All medically necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with CCHA, or who refer or suggest services to members, will do so in the same way for all members. Translation or interpretation services are offered free of charge to members who need assistance.

CCHA members have the right to:

- Quality medical care
- Be treated with respect and due consideration for their dignity and privacy
- Use their rights without fear of being treated poorly
- Receive information on available medically necessary treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand
- Participate in decisions regarding their health care, including the right to refuse treatment
- Get a second opinion about their care from a network provider, or have arranged to obtain a second opinion outside the provider network, at no cost to the member
- Freely exercise their choice of provider
- Be referred to a non-network provider if CCHA does not have an appropriately trained in-network provider
- Be involved in all decisions about their health care and say “no” to any treatment offered
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Be free from discrimination based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability or health status
- Ask CCHA for help if their provider does not offer a service they need because of moral or religious reasons (CCHA does not deny access to service due to moral or religious reasons)
- Obtain available and accessible services covered under the contract
- Freely exercise their rights without CCHA, its network providers, or HCPF treating the member adversely
- Have health care services provided in accordance with the requirement for timely access and medically necessary care

- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment, or if they simply want someone else to speak for them
- Have access to emergency care 24 hours a day, 365 days a year for emergency services
- Choose a PCMP, choose a new PCMP, and have privacy during a visit with a health care provider
- Get needed medical services within a reasonable amount of time
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraint
- Receive information on the continuation of certain existing services for new members in accordance with the HCPF Transition of Care policy
- Be provided a toll-free number to contact CCHA for assistance
- Make recommendations regarding the CCHA Member Rights and Responsibilities Policy
- Request and obtain information about advance directives at any frequency requested by a member (see CCHA Advance Directives Policy for more information)
- The right to file a Grievance or Appeal
- Members have the right to understand and have available CCHA's grievance and appeals process, including:
    - The ability to express dissatisfaction about any matter except an Adverse Benefit Determination using CCHA's grievance process
    - The right to receive assistance in completing grievance forms and other procedural steps related to the process, including interpreter services, toll-free numbers and State Relay/TTY/TTD capability at no cost to the member
    - The understanding that no member or provider will be penalized for filing a complaint or grievance. At no time will CCHA cease medically necessary care pending a complaint or grievance investigation.
    - Access to provision of language services for the complaint/grievance process that includes:
        - Interpretation of documents that are written in English into a member's preferred language
        - Member notification that documents are available in languages other than English

The right to a State Fair Hearing includes:

- The method for obtaining a State Fair Hearing
- Rules that govern representation at the State Fair Hearing
- Understanding that benefits will continue, when requested by the member, if the member files a timely Appeal or State Fair Hearing request and if the action is upheld, the member may be liable for the cost of any continued benefits
- Any Appeal rights the State makes available to providers to challenge the failure of CCHA to cover a service

Privacy and medical records

- CCHA's Privacy Policy with information on their rights regarding their protected health information (PHI), CCHA's responsibility to protect this information, and how to obtain a hard copy of the policy is included on the CCHA website. This policy includes the members' right to know how CCHA handles, uses and gives out their PHI.
- Members have the ability to request and receive a copy of their medical records and request an amendment or correction, as specified in 45 Code of Federal Regulations (CFR) sections (§§)

164.524 and 164.526 (if the privacy rule, as set forth in 45 CFR Parts 160 and 164, Subparts A and E, applies).
- Members can look at and get a copy of their enrollment, claims, payment and case management information.
- Members can have their medical record and information protected in accordance with HIPAA and all other applicable privacy laws (see CCHA Privacy Policy for more information).
- Members can request and receive a copy of their medical records and request that the record be amended or corrected.
- Members can receive information in accordance with information requirements in 42 CFR 438.10.
- Members have the right to ask that their PHI not be used or restricted.

Member Responsibilities

CCHA members have the responsibility to:

- Work with their PCMP to guard and improve their health
- Find out how their health benefits work and follow the plans and instructions for care that they have agreed to with their practitioner
- Listen to their PCMP's advice and ask questions when in doubt to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- Call or go back to their PCMP if they do not get better, or ask for a second opinion
- Treat health care staff with the respect members expect themselves
- Tell CCHA if they have problems with any health care staff and to call the Colorado Ombudsman for Health First Colorado Managed Care at 303-830-3560 or 1-877-435-7123 (State Relay 711)
- Keep their appointments; if they must cancel, call as soon as they can
- Use the emergency room only for real emergencies
- Call their PCMP when they need medical care, even if it is after-hours
- Supply information, to the extent possible, that CCHA and its practitioners and providers need to provide care

Disputes, Grievances and Appeals

Overview

CCHA encourages providers and members to seek resolution of issues through the grievance process. Verbal complaints and written grievances are tracked and trended, resolved within established time frames and referred to peer review when needed. The CCHA grievance process meets all state requirements, NCQA standards and federal laws. The member, or member's authorized representative with written consent, has a right to be informed about:

- How to obtain a hearing and the representation rules involved
- Filing grievances and the requirements and time frames for filing
- Assistance available with filing grievances
- The toll-free number to file oral grievances

The building blocks of this resolution process are the grievances. The member, or the member's authorized representative (including a provider with the member's written consent) can file a grievance.

CCHA does not discriminate against providers for filing a grievance on the member's behalf. In addition, providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Grievance

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination. Examples include, but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues with how CCHA conducts business
- The member is unhappy with the quality of the care
- The provider the member wants to see does not have a contract with CCHA to provide services to the member
- The member is not able to receive culturally competent care
- The member got a bill from a provider for a service that Health First Colorado should cover
- Rights and/or dignity were not respected
- The member is recommending changes in policies and services
- Any other access to care issues

The term is also used to refer to the overall system of grievances handled by CCHA and access to the state fair hearing process.

The member may file a grievance at any time. Grievances must be submitted to CCHA by phone or in writing. Members have the right to file a grievance regarding any aspect of CCHA services. An urgent grievance is for urgent or emergency care services.

Filing a Grievance

CCHA's goal is to resolve verbal and written grievances in a timely and equitable manner and in accordance with state, NCQA and federal regulations. Members are encouraged to discuss their concerns with a CCHA Member Support Services representative who can help the member submit a grievance. The representative interviews the member and records details in the Member Support Services tracking system.

The member may file a grievance in any of the following ways:

1. Online at CCHAcares.com/for-members/member-benefits-services/grievance-form
2. Verbally with CCHA Member Support Services at 1-877-254-3660
3. Submit a written grievance at any time with as much information as possible, including:
    - Who is part of the grievance?
    - What happened?
    - When did the incident happen?
    - Where did the incident happen?
    - Why was the member unhappy with the health care services?

The member may attach documents that will help us investigate the problem and should mail the written grievance to:

Colorado Community Health Alliance
Grievances
PO Box 13406
Denver, CO 80202

The following processes apply to grievances:

- CCHA may request medical records or an explanation from the provider(s) involved in the case.
- CCHA may notify providers of the need for additional information in writing or by phone. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the grievance cannot be resolved within 15 business days of receipt, CCHA will notify the member in writing and explain the reason for the delay. This may extend the case up to an additional 14 days for members. For any extension not requested by the member, CCHA will give the member written notice within two calendar days of the reason for the delay. If a member is dissatisfied with the disposition of a grievance, the member may file the unresolved grievance with HCPF.

The following are available at no cost to support members with the grievance process:

- Interpreter services
- Translation of materials into non-English languages and alternative formats
- Toll-free numbers with TTY/TDD capabilities to assist members who are hearing impaired

Grievance Resolution, Notice and Confidentiality

CCHA investigates the member's grievance to develop a resolution in a non-discriminatory manner. After CCHA makes a determination, a resolution letter is sent to the member outlining the findings within 15 business days of receipt of the grievance. Members are notified of the grievance process on the CCHA website and in the Health First Colorado Member Handbook. Members may request a translated version in languages other than English by calling **1-8-77-254-3660 (TTY 711)**.

All grievances are handled in a confidential manner, and CCHA does not discriminate against a member for filing a grievance or requesting a state fair hearing.

Appeals

An **appeal** is a request for a review of an adverse benefit determination. It is a clear expression by the member, or the member's authorized representative with written consent, following a decision that the member wants the decision reconsidered or reviewed. CCHA does not pay claims for physical health services. Therefore, any provider appeals or requests for reconsideration should be directed to HCPF and its fiscal agent, Gainwell Technologies, formerly DXC Technology. If claim filing requirements are not met because of circumstances beyond the provider's control, the provider can contact the fiscal agent. The fiscal agent will forward the request to HCPF for review. The Request for Reconsideration Form can be found on the HCPF website.

If a member wants to appeal a decision, the Health First Colorado Member Handbook provides more information about member rights to file a complaint or an appeal. If a member has a question about

anything included in the Member Handbook, the member can contact CCHA Member Support Services at 1-855-627-4685.

For behavioral health appeals, please reference the behavioral health appeals section in the CCHA Behavioral Health Provider Manual.

CHAPTER 6: COMPLIANCE

Fraud, Waste and Abuse and False Claims Act

Fraud, Waste and Abuse Reporting Policy

The Department of Health Care Policy and Financing's (HCPF) policy on reporting suspected Fraud, Waste and Abuse can be found on the HCPF website.

First Line of Defense Against Fraud

CCHA is committed to protecting the integrity of its health care program and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it – or any other person. The attempt itself is fraud regardless of whether or not it is successful.
- **Waste:** Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When health care providers or suppliers do not follow good medical practices, resulting in unnecessary or excessive costs, incorrect payment, misuse of codes or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud.

Provider Fraud, Waste and Abuse

Examples of provider fraud, waste and abuse include:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures that should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

Member Fraud, Waste and Abuse

Examples of member fraud, waste and abuse include:

- Forging, altering or selling prescriptions
- Letting someone else use the member's identification card
- Obtaining controlled substances from multiple providers
- Relocating to an out-of-service plan area
- Using someone else's identification card

Reporting Fraud, Waste and Abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

You can report your concerns by contacting HCPF. Refer to the contact info on the HCPF website.

CCHA takes any reports of fraud, waste or abuse seriously. Any potential reports of fraud, waste or abuse may be referred to the Department of Human Services and/or to the State Medicaid Fraud Control Unit. CCHA has provisions for the suspension of payments to a network provider for which the state determines there is a credible allegation of fraud (in accordance with 42 CFR 455.23).

CCHA will not take any kind of recovery action or initiate any kind of activity against a network provider when fraud is suspected without the approval of the state.

False Claims Act

CCHA is committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains *qui tam* or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under *qui tam* provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least $5 million (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies, detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse. Include in any employee handbook a specific

discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse.

Privacy Laws

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability for health care fraud and simplifies the administration of health insurance.

- CCHA recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, privacy regulations allow the transfer or sharing of member information. CCHA may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to CCHA, verify that the receiving fax number is correct, notify the appropriate staff at CCHA, and verify that the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, PO Box or department at CCHA.
- The CCHA voicemail system is secure and password-protected. When leaving messages for any CCHA associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting CCHA, please be prepared to verify the provider's name, address and TIN or member's provider number.

SUD Information

CCHA reminds you of your obligation to comply with applicable law, including all federal confidentiality rules, pursuant to your Service Agreement and Business Associate Agreement. This Notice serves to remind you of these obligations and CCHA's expectations regarding 42 CFR Part 2.

As a business partner of CCHA, you may receive information from certain federally assisted programs regulated under 42 CFR Part 2 that could identify an individual as having or having had substance use disorder ("SUD Information").

SUD Information may be disclosed to you from records protected by 42 CFR Part 2, which prohibits you from making any further disclosures of the SUD information without written consent from the member. The authorization requirements can be found under 42 CFR § 2.31.

CHAPTER 7: PROVIDER INFORMATION

Physical Health Network Requirements

Provider Participation and Eligibility Requirements

CCHA offers a PCMP agreement to any willing provider who meets all requirements to serve Medicaid members as a Medical Home in the Accountable Care Collaborative Program, including those who are:

- Currently enrolled as a Colorado Medicaid provider
- Licensed and able to practice in the state of Colorado
- A practitioner holding an MD, DO or NP provider license
- A practitioner whose taxonomy is documented as one of the following specialties: Pediatrics, Internal Medicine, Family Medicine, Obstetrics and Gynecology, or Geriatrics
- A provider who is not excluded from participating in federal health care programs
- A clinic, a Federally Qualified Health Center (FQHC), or a Rural Health Clinic (RHC)
- Acting as the dedicated source of primary care for members and is capable of delivering the majority of the member's comprehensive primary, preventive and sick medical care

When determining a provider's eligibility to serve as a network provider, CCHA considers the provider's ability to offer appointments outside typical workday hours and a provider's ability to provide phone coverage with access to a clinician who can triage a member's health needs 24 hours/day, 7 days/week. These standards are further outlined in CCHA provider agreements.

Provider Application Process

New practices seeking to become PCMP providers must be currently enrolled as Health First Colorado providers. For Health First Colorado enrollment information, go to the provider section of the HCPF website.

The application for CCHA network enrollment can be found at CCHAcares.com/for-providers/primary-care-provider-resources under Network Applications and Forms. Once the application process is approved, each provider will sign a contract or participation agreement with CCHA. This contract will document the requirements for each provider. The determination to add practices to CCHA is based on a review of the completed application, provider credentials and details, and the need for additional PCMP providers. If an application is denied, a letter is sent to the applying practice, indicating the reason for the denial.

CCHA does not employ or contract with providers or other individuals or entities excluded from participation in federal health care programs under either Section 1128 or 1128A of the Social Security Act. CCHA performs monthly monitoring against The U.S. Department of Health & Human Services Office of Inspector General (HHS OIG) List of Excluded Individuals. CCHA does not employ or contract with providers or other individuals or entities who are disbarred, suspended or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. CCHA will terminate any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under title XIX, title XVIII, or title XXI from participating as a provider in the CCHA network.

CCHA does not discriminate against providers for the participation, reimbursement or indemnification of any provider who is acting within the scope of their license or certification under applicable state law,

solely on the basis of that license or certification. CCHA does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment.

Provider Service Exclusions
CCHA, as an organization, does not object to any required services covered by Health First Colorado based on moral or religious reasons. Providers who object to providing a service on moral or religious grounds must furnish information about services it does not cover as follows:

- To the state upon contracting or when adopting the policy during the term of the contract
- To members before and during enrollment
- To members 30 days prior to adopting the policy with respect to any service

Providers must also refer members to CCHA for support in accessing the service(s) to which the provider objects.

New Provider Added to Existing PCMP Practice

New providers must complete the New Provider Application Form and the credentialing process with HCPF before being added to an existing practice.

The application can be found at CCHAcares.com/providertoolsCCHAcares.com/for-providers/provider-resources-training, under Network Applications and Forms.

Updating Practice and Provider Information

Maintaining an updated provider roster is imperative to CCHA's ability to assist members in searching for a provider. Providers are required to notify **both** HCPF and CCHA of practice and provider additions, terminations, and changes as they occur.

Notification to CCHA must occur within 30 days following the effective date of change and prior to the effective date when possible. Reference the Provider Maintenance section of the HCPF Provider Web Portal Quick Guides for HCPF requirements. Providers are required to inform CCHA of material changes to practice and provider roster, such as:

- Change in professional business ownership
- Change in business address
    - Note: changes in business address may be updated in the HCPF Provider Web Portal
- Change in the location where services are provided, including temporary or permanent practice closures that require diverting patients to other service locations or PCMPs for care
- Change in federal 9-digit tax identification number (TIN)
- Change in provider location ID
- Change in National Provider Identifier (NPI)
- Change of specialty
- Languages spoken
- Age limit information
- Gender restriction information
- Change in demographic data
- Change in accessibility information

- Legal or governmental action initiated against a health care professional (This type of action includes, but is not limited to, an action for professional negligence, for violation of the law or against any license or accreditation that, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the provider agreement.)
- Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the provider agreement's care review and grievance resolution procedures
- Notification that the provider is accepting new patients
- Notification that the provider is no longer accepting new patients

To notify CCHA of changes, providers should email Provider Support Services at: CCHAcares.com/contact > I am a Provider.

Practice and/or Provider Termination Process

Practices or participating providers leaving the CCHA, PCMPs must notify CCHA in accordance with their contract and fill out the Practice or Provider Termination Form. CCHA will provide written notice to each member attributed to a practice that closes or opts to leave the CCHA network, per requirements in 42 C.F.R. § 438.10(f)(1).

The termination form can be found at CCHAcares.com/for-providers/primary-care-provider-resources, under Network Application and Forms.

Practice Timely Access Standards

The provider shall comply with the following access requirements, as prescribed and adopted by Health First Colorado:

- Urgent visits: within 24 hours after the initial identification of need
- Outpatient follow-up appointments: within seven days after discharge from an inpatient hospitalization
- Non-urgent, symptomatic care visit: within seven days after the member's request
- Well-care visit: within one month after the member's request, unless an appointment is required sooner to ensure the provision of screenings in accordance with HCPF's accepted Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedules

Nondiscriminatory Hours of Operation

Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against CCHA members enrolled in Health First Colorado.

Americans with Disabilities Act

CCHA providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of members. Providers contracted with CCHA are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers
- Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed
- Providing flexibility in scheduling to accommodate people with disabilities
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider to ensure the individual is fully participating and understands the information
- Making reasonable modifications to policies, practices and procedures

For more information on making changes to a practice to ensure ADA compliance, providers can refer to these additional resources:

- ADA.gov website
- ADA Access to Medical Care for Individuals with Mobility Disabilities

Cultural Diversity and Linguistic Services

CCHA recognizes providing health care services to a diverse population may present challenges. Those challenges arise when providers need to cross a cultural divide to treat members who may have different behaviors, attitudes and beliefs concerning health care, or who speak a different language. Differences in a member's ability to speak or read the same language as their health care providers may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans.

CCHA's cultural competency program helps you and your patients to:

- Acknowledge the importance of culture and language
- Embrace cultural strengths with people and communities
- Assess cross-cultural relations
- Understand cultural and linguistic differences
- Strive to expand your cultural knowledge

CCHA offers cultural competency training online at CCHAcares.com/providertools, periodically at the CCHA Provider Town Hall meetings and in the monthly newsletter.

Additional provider resources are available in the CCHA Caring for Diverse Populations Toolkit.

Interpreter Services

CCHA will ensure members who need interpreter services have access to interpreters 24/7. Services include, but are not limited to, face-to-face assistance during office visits at no cost to the member. Language assistance will be provided at all points of contact, in a timely manner and during all hours of operation. CCHA offers some materials in Spanish. These materials can be found at CCHAcares.com/order.

For those instances when you cannot communicate with a member due to language barriers, telephonic and face-to-face interpreter services are available at no cost to the member. Request telephonic interpreters for members needing language assistance as outlined below:

Providers and members can call CCHA Member Support Services at 1-877-254-3660

To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 48-hour notice.

Take the following steps when requesting an interpreter:

1. Provide the member's ID number
2. Explain the need for an interpreter and state the language required
3. Wait on the line while the connection is made
4. Once connected to the interpreter, the staff member introduces the CCHA member, explains the reason for the call and begins the dialogue

Providers must train their answering services and on-call personnel on how to access these services. CCHA providers should strongly discourage the use of minors, friends and family members acting as interpreters. Providers also must accommodate non-English speaking members by having multilingual messages on answering machines.

In addition, providers must notify members verbally and through written notices about their right to receive the following language assistance services, as well as how to access them:

- Oral interpretation of any language
- Written translation in prevalent languages
- Auxiliary aids and services for members with disabilities (such as TTY/TDD and American Sign Language)

Oral interpretation requirements apply to all non-English languages, not just those the state identifies as prevalent.

Services for Members with Hearing Loss, Visual and/or Speech Impairment

Members with hearing loss or speech impairment can call the designated Colorado state relay number – 711. The Colorado relay service is available 24 hours a day. Members can also request face-to-face sign language interpreters by contacting CCHA Member Support Services. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials by contacting CCHA Member Support Services.

Translation of Materials

Members can request the translation of materials into non-English languages by contacting CCHA Member Support Services.

All required information in this section is sent by CCHA to current and potential members in an easily understood, readily accessible format.

CCHA Find a Provider Tool

CCHA maintains a publicly available tool where members can search for providers who see members enrolled in Health First Colorado, which can be found at CCHAcares.com/findadoc.

Health First Colorado Provider Revalidation

Health First Colorado providers must revalidate participation in the program at least every five years to continue as a provider. Revalidation, a requirement under the Affordable Care Act, includes reconfirming some of the provider's enrollment information so HCPF has accurate information. This is

used to screen providers, ensuring they are eligible to provide services to members. Organization health care providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.

Providers can verify the revalidation due date using the Provider Revalidation Dates Spreadsheet posted to the HCPF website. Providers will also be notified by Gainwell via email approximately six months prior to their revalidation deadline with further instructions. **Attempting to revalidate by completing a new application before being notified will create duplicate enrollments and cause claim processing issues.**

More information on revalidation can be found on the HCPF website.

Implementation of House Bill 18-1282

HB 18-1282 requires newly enrolling and currently enrolled organizational providers to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled in the Colorado interChange. More information can be found on the HCPF website.

Provider Support

CCHA provider support staff are available to provide guidance and support around navigating the Health First Colorado delivery system, including eligibility, benefits, department agencies, contractors, vendors and more. Additional information, resources and key contacts can be found in the provider section of the HCPF website.

Clinical Program and Quality Improvement Initiatives

The provider will work as a partner with CCHA to provide high-quality care to Health First Colorado members. The provider will work with CCHA to improve performance in delivering value-based services through clinical quality outcomes, providing member experience, and reducing the growth in the per capita cost of medical care. CCHA offers practice transformation coaching to assist with:

- Data sharing
- Quality improvement activities such as Plan-Do-Study-Act (PDSA)
- Cooperation with referrals to other providers, community resources and CCHA
- Participation in CCHA and HCPF performance improvement activities and initiatives
- Implementation of technologies, tools, and integrated programs

The provider may be asked to serve as a leader on various Health First Colorado and CCHA committees. The provider agrees to provide feedback and use the data available to the practice from Health First Colorado and CCHA to manage ACC members and their health needs.

The provider agrees to use best efforts to provide CCHA with all member data and access to such data as required to achieve the goals and performance measures of the ACC. Member data will be used to further clinical and quality initiatives and support CCHA quality improvement activities through the use of clinical information systems. The provider agrees to share all data in a manner consistent with HIPAA and 45 CFR to facilitate the exchange of relevant member data for the purposes above.

In the event CCHA is audited by the state or Centers for Medicare and Medicaid Services (CMS), the provider will submit to CCHA all data, including medical records, necessary to characterize the content and purpose of each encounter with a Health First Colorado member. The provider will certify the accuracy, completeness and truthfulness of the encounter data submitted for members, as required by

CMS, including any requirement that the certification be delivered under penalty of perjury. The parties have entered into this agreement as part of a legitimate effort to foster clinical integration, cost savings and quality improvement using a shared electronic health information system and shared member data.

CCHA does 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 their health care, including the right to refuse treatment and to express preferences about future treatment decisions

Medical Records

Documentation Standards

Each provider furnishing services to Health First Colorado members maintains and shares, as appropriate, member health records in accordance with professional standards. CCHA requires providers to maintain medical records in a manner that is current and organized and permits effective and confidential member care and quality review. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- Health care providers are prohibited from disclosing any individually identifiable information regarding a patient's medical history, mental condition, physical condition or treatment without the patient's consent or the consent of their legal representative.
- Records required through a legal instrument may be released without patient or patient representative consent unless prohibited by other regulations.

In the process of coordinating care, each member's privacy must be protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. **Providers must be familiar and in compliance with the security requirements of HIPAA.**

Security

Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration or destruction of the records. Information must be accessible only to authorized personnel within the provider's office, CCHA, HCPF, or to persons authorized through a legal instrument. Records must be made available to CCHA for purposes of quality review, HEDIS and other studies.

Storage and Maintenance

Active medical records should be stored in a central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

What does EPSDT Mean?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for Health First Colorado members aged 20 and under, along with pregnant adults. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.

- **E**arly: Assessing and identifying problems early
- **P**eriodic: Checking children's health at periodic, age-appropriate intervals
- **S**creening: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- **D**iagnostic: Performing diagnostic tests to follow up when a risk is identified
- **T**reatment: Control, correct or ameliorate health problems found

Provider Responsibilities

Providers are responsible for the provision of EPSDT services. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services. EPSDT is made up of the following screening, diagnostic, and treatment services:

Screening Services

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity testing)
- Lead screening (a requirement for all Health First Colorado-eligible children at 12 and 24 months or between the ages of 36 and 72 months, if not previously tested)

Diagnostic Services

- When a screening indicates the need for further evaluation, diagnostic services **must** be provided.

Treatment Services

- Necessary health care services must be made available to treat all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

EPSDT ensures children and youth receive appropriate health care and preventative services, including:

- **Health Education** – Anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention
- **Vision Services** – Diagnosis and treatment for defects in vision, including eyeglasses
- **Dental Services** – Relief of pain and infections, restoration of teeth and maintenance of dental health, including examinations, cleanings and fluoride treatments
- **Hearing Services** – Diagnosis and treatment for defects in hearing, including hearing aids
- **Other Necessary Health Care Services** – Additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered in a

state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis (see Medical Necessity below for more information).

Periodicity Schedule
Colorado has adopted the American Academy of Pediatrics Bright Futures Periodicity schedule.

Who Pays for Which Services?

Physical health services are paid by Health First Colorado. See the Health First Colorado billing manuals for more information. Behavioral health services are paid for by CCHA. See the CCHA Behavioral Health Provider Manual for more information.

Medical Necessity

All Health First Colorado coverable, medically necessary services must be provided even if the service is not normally covered under Health First Colorado. Benefits not listed are not considered to be a state plan benefit and, therefore, are outside of EPSDT coverage and exceptions. No arbitrary limitations on services are allowed (e.g., one pair of eyeglasses or 10 physical therapy visits per year).

Medical necessity is defined by Colorado as a program, good or service that:

- Will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
- Assists the member to achieve or maintain maximum functional capacity
- Is provided in accordance with generally accepted professional standards for health care in the United States
- Is clinically appropriate in terms of type, frequency, extent, site and duration
- Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker or provider
- Is delivered in the most appropriate setting(s) required by the client's condition
- Provides a safe environment or situation for the child
- Is not experimental or investigational
- Is not more costly than other equally effective treatment options

Depending on the service, either the RAE or HCPF's Utilization Management vendor makes the final determination of medical necessity, which is determined on a case-by-case basis. Provider recommendations will be taken into consideration but are not the sole determining factor in coverage. Colorado determines which treatment it will cover among equally effective, available alternative treatments.

How to Request an EPSDT Exception to the State Plan Benefits and Services
The provider simply needs to make a request for services, even if the code for the service is closed in the Medicaid fee schedule. For example, a contracted pediatrician or family medicine provider believes a child needs a circumcision, but circumcisions are not routinely covered by Colorado Medicaid. If the provider believes a child needs one for medical reasons, the provider should make the request through the ColoradoPAR website, which is found at Coloradopar.com. The request will be reviewed based on EPSDT and approved or denied. This process works even though the code for this procedure is closed in the Colorado fee schedule and in Colorado Medicaid provider bulletins.

How CCHA Can Help

CCHA provides EPSDT benefit outreach and education to Health First Colorado members. Additionally, CCHA provides referrals to state health agencies and programs, including:

- Vocational rehabilitation
- Maternal and child health
- Public health, mental health and education programs
- Head Start social services programs
- Women, Infants and Children (WIC) supplemental food program

CCHA can provide information and support with requesting necessary transportation, mileage reimbursement, and scheduling appointments. CCHA provides referral assistance for treatment not covered by the Medicaid fee schedule but found to be needed due to conditions disclosed during screening and diagnosis. If you need help with this process, please contact CCHAcares.com/contact > I am a Provider.

Should barriers exist related to navigating and/or accessing the EPSDT benefit, CCHA provides assistance to providers and members via Member Support Services, Provider Support Services and the Care Coordination teams.

For more EPSDT information, training and materials, please visit the:

- HCPF EPSDT webpage
- CCHA EPSDT webpage
- CCHA EPSDT Recorded Training

Member Dismissal

Reasons for Dismissal

There are occasions when a provider or their practice deems it necessary to terminate a provider-member relationship. The provider may begin the process to dismiss a member from their practice based on one of the reasons listed below:

- There is a documented, ongoing pattern of failure on the part of the member to keep scheduled appointments or meet any other member responsibilities as stated in the practice's policies and procedures and as agreed upon by the member.
- The provider cannot provide the level of care necessary to meet the member's needs.
- The member and/or member's family is abusive to the provider and/or practice staff or poses a serious threat of harm to the provider, staff and/or other patients.

Per 42 CFR § 438.56(b)(2), providers may not dismiss a member based on the following reasons:

- Adverse changes in the member's health status
- Change in the member's utilization of medical services
- Member's diminished mental capacity
- Any behavior of the member resulting from the member's special needs, as determined by HCPF, unless those behaviors seriously impair the provider's ability to furnish services to that member or other members

This dismissal process pertains specifically to member-PCMP-attributed relationships. Further, it is not inclusive of other changes in member circumstances affecting eligibility (e.g., if a member moves out of state).

The provider shall notify CCHA of recurring events that may require action to dismiss a member. Prior to dismissing the member, the provider must make attempts to collaborate with the member to resolve issues impacting the quality and delivery of care, barring circumstances that pose a serious threat of harm.

Process for Dismissal

If the reason for dismissal is met, as listed above, the provider shall notify CCHA of intent to dismiss a member and refer the member to CCHA care coordination. The practice will provide CCHA with the member's name, contact information and reason for dismissal. CCHA care coordinators will outreach the member and attempt to address barriers the member may face. The provider, member and care coordinator shall work collaboratively to attempt to resolve the issue.

If member dismissal is the only solution after attempting to resolve the relationship, the provider must give a verbal warning to the member upon the occurrence of one or more of the events listed above. Upon the second occurrence of the event(s), the provider must send the member a written letter advising that continued behavior can lead to dismissal. Upon the third occurrence, the provider must send a certified written letter dismissing the member.

The member dismissal notice must include:

- Instructions for the member to call Health First Colorado Enrollment to select a new provider and, if possible, referral information for a new provider
- Agreement by the provider to continue provisional coverage of the member's health care needs for up to 45 days while the member obtains a new provider
- Notification that the member's medical records will be sent to the new provider upon receipt of written authorization from the member

The provider must send **a secure email**, subject line *Member Dismissal*, with required dismissal documents to:

- R6Referral@CCHAcares.com for members attributed in Region 6
- R7Referral@CCHAcares.com for members attributed in Region 7

Required dismissal documents include:

- A copy of the written warning sent to the member upon the second occurrence
- A copy of the member dismissal notice
- A completed CCHA Member Dismissal Form, which can be downloaded from CCHAcares.com/for-providers/primary-care-provider-resources

The result of the dismissal request (whether it is approved or denied) will be sent to the provider via email. Upon approval of the dismissal, CCHA will outreach the member and attempt to do a warm handoff to Health First Colorado Enrollment.

Advance Directives

CCHA provides an atmosphere of respect and caring and ensures that each member's ability and right to participate in medical and mental health decision-making is maximized. CCHA follows the Colorado Revised Statute Title 15, Article 18, Colorado Medical Treatment Decision Act (C.R.S. 15-18-101), Colorado Medical Assistance Act – General Medical Assistance, Part 4. Providers-Reimbursement (C.R.S. 25.5-4-413), and the Advance Directives section of the Contract with HCPF.

- Advance directives include any written or oral instructions recognized under state law concerning the making of medical treatment decisions on behalf of, or the provision of medical care for, the person who provided the instructions in the event such person becomes incapacitated.
- Advance directives include, but are not limited to, medical durable power of attorney, durable powers of attorney, or living wills.

Types of advance directives include:

- **Durable Power of Attorney for Health Care (Durable Power)** – Allows the member to name a "patient advocate" to act on behalf of the member.
- **Living Will** – Allows the member to state their wishes in writing but does not name a patient advocate.
- **Health Care Proxy** – An advance medical directive in the form of a legal document that designates another person (a proxy) to make health care decisions in case a person is rendered incapable of making their wishes known. The health care proxy has, in essence, the same rights to request or refuse treatment that the person would have if they were capable of making and communicating decisions.
- **Declaration for Mental Treatment** – Gives instructions about a member's future mental health treatment if they become unable to make those decisions.

Providers are expected to adhere to the following guidelines:

- Discuss the sensitive issues raised by advance directives with patients and their families
- Advise members of their right to change or revoke their advance directive at any time
- Advise members of their right to contact CCHA Member Support Services to request additional information about advance directives
- Document in the member's medical record the discussion about advance directives
- Document, in a prominent and consistent part of the member's medical record, whether the member has executed an advance directive, and include a copy of the directive in the medical record
- Ensure that care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive
- Ensure compliance with State laws regarding advance directives

Providers must comply with all state and federal regulations regarding advance directives, including, but not limited to: The Colorado Medical Treatment Decision Act (Colorado Revised Statutes (CRS) 15-18-101), the Colorado Medical Assistance Act – General Medical Assistance, Part 4 Providers – Reimbursement (CRS 25.5-4-413) and the Behavioral Health Orders for Scope of Treatment (CRS 15-18.7-202).

CCHA provides education to network providers on advance directives through the For Providers section of the CCHA website, in the provider newsletters and meetings, such as provider town halls. This education, at a minimum, includes:

- What constitutes an advance directive
- Information that an advance directive is designed to enhance an incapacitated member's control over medical treatment
- Descriptions of applicable State law concerning advance directives

Additional resources on advance directives can be found on the following websites:

- Colorado Advance Directives Consortium Coloradoadvancedirectives.com
- The Conversation Project Theconversationproject.org
- Colorado Department of Public Health and Environment (CDPHE) Cdphe.colorado.gov/colorado-crisis-standards-of-care/advance-care-planning-tools-for-providers

Complaints concerning noncompliance with advance directives may be filed through CCHA verbally by contacting CCHA Member Support Services or online using the Member Grievance form on the For Members section of the CCHA website.

Complaints concerning noncompliance with advance directives may be filed with the Colorado Department of Public Health and Environment.

Compensation and Network Participation Opportunities

Per Member Per Month Value-based Payment

All physical health providers serving Health First Colorado members are eligible for a per member per month (PMPM) payment.

CCHA uses a tiered payment model to align with HCPF's Population Management Framework. The Population Management Framework is designed to help achieve HCPF and state goals to improve health outcomes, reduce costs, and improve member and provider satisfaction through targeted condition management programs. CCHA invites qualified practices to participate in the CCHA network as follows:

- PCMP practice with Level 1 payments
    - Practice meets general requirements for network participation
- PCMP+ practice with Level 2 payment rates
    - Advanced payment level
    - Advanced contractual responsibilities and reporting
        - One condition management program
- Accountable Care Network (ACN) practice with Level 3 payment rates
    - Advanced payment level
    - Advanced contractual responsibilities and reporting
        - Two condition management programs
        - Comprehensive care coordination staff and services

Ongoing participation in advanced payment levels is assessed annually, dependent upon performance monitoring processes, which may include but are not limited to annual attestation/evaluation of care management services, audits, timeliness and accuracy of report submissions, etc.

CCHA has a value-based payment structure for contracted PCMPs. Providers are incentivized to outreach and engage members using claims data. CCHA has resources to help providers connect to the assigned patient population. In addition, providers may have an opportunity to earn additional dollars for enhanced services and performance. This may include participation in innovations such as achieving the targets for the ACC performance measures, meeting enhanced requirements on the Primary Care Alternative Payment Methodology (APM), and/or participating in state programs.

For more information on the **Primary Care Provider Tiered Payment Methodology Guide**, refer to CCHAcares.com/for-providers/primary-care-provider-resources, under Manuals and Resources.

Electronic Funds Transfer

You may elect to receive your monthly PCMP attribution payment via Electronic Funds Transfer (EFT). Please fill out the EFT form and fax it with a copy of your voided check or bank letter to 303-256-1833.

The form can be found at CCHAcares.com/for-providers/primary-care-provider-resources, under Network Application and Forms.

Provider acknowledges that payments provider receives from CCHA to provide Medicaid-covered services to Health First Colorado members are, in whole or in part, from federal funds. Therefore, the provider and any of their subcontractors are subject to certain laws that apply to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

ACC Performance Measures

The provider shall work to achieve ACC performance measure targets, including but not limited to key performance indicators (KPIs), behavioral health performance measures and other publicly reported measures to earn performance payments. CCHA has a Provider Incentive Program that rewards improvement on all performance measures and provider performance will impact incentive payments. Measures cross over both physical and behavioral health, and all providers should make efforts to impact all of the measures.

Key Performance Indicators

HCPF has established the following KPIs for SFY 24-25:

- Depression screening and follow-up plan
- Oral evaluation, dental services
- Well-child visits in the first thirty months of life (NQF 1392) and child and adolescent well-care visits (NQF 1516)
- Timely prenatal and post-partum care
- Emergency department (ED) visits
- Risk adjusted PMPM

CCHA Provider Incentive Program

CCHA is committed to reinvesting in its contracted practices. Practices that meet performance goals, attend meetings and engage in quality improvement activities may be eligible to receive incentive

payments. Please note that funding for this incentive program is available only if the region meets metrics as a whole. Contact PracticeTransformation@CCHAcares.com for more information.

Publicly Reported Measures

In addition to the KPIs, HCPF will track several other measures to monitor the performance of the program and RAE efforts in each region. The following measures are also eligible for the RAE to earn performance payments. Other measures may be publicly reported and tracked throughout the life of the contract.

Behavioral Health Incentive Measures

- Initiation and engagement in substance use disorder treatment
- Follow-up appointment within seven days of inpatient hospital discharge for a mental health condition
- Follow-up appointment within seven days of emergency department visit for substance use disorder
- Depression screening rate
- Follow-up after a positive depression screen
- Behavioral health screening or assessment for foster care members

Performance Pool Measures

- Members engaged in extended care coordination
- Premature birth rate
- Behavioral health engagement of members releasing from state prisons
- Asthma medication ratio
- Antidepressant medication management
- Contraceptive care for postpartum women

Care Coordination

Reducing Risk to Members through the CCHA Care Coordination Process

CCHA care coordination activities place emphasis on acute, complex and high-risk patients of all ages and ensure active management of high-cost and high-needs patients. This program's goals include improving health, reducing unnecessary utilization, and increasing supportive services related to both physical and behavioral health care through an interdisciplinary approach.

Statement of Integration and Interdisciplinary Approach

To support integration across the full continuum of care, care coordination activities are based on a solid understanding of the CCHA population's medical, behavioral, social and environmental needs. CCHA believes this integrated approach is crucial to improving members' quality of care and health outcomes while proactively managing costs and emphasizing member choice, access, safety, independence and responsibility through active engagement, communication and coordination. The care coordination program supports regular communication between care coordinators and the practitioners delivering services to members.

Members work collaboratively with an assigned lead care coordinator to establish meaningful goals and develop a tailored plan of care to address and prioritize their health-related concerns, their family members/caregivers/significant others and the health team. Care coordinators will address members' needs between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays, and with the services the member receives from any other managed care plan, fee-for-service Health First Colorado, or community and social support providers.

Referrals

CCHA is ultimately responsible for members assigned to a CCHA region, regardless of PCMP attribution. CCHA strives to identify members in need of care coordination support through many sources, including data analytics and HCPF communications. To collaborate with providers around complex member referrals, CCHA provides all PCMPs (including PCMP+ and ACN providers) with a list of their attributed members with indicators for members who are complex based on the region's approved definition.

As the primary source of care for CCHA members, PCMPs often identify member needs before other data sources. If any provider identifies a high-risk member for whom additional support is needed, the provider shall refer the member to CCHA within 48 hours. CCHA will review the referral and coordinate with the provider and/or member to ensure the member's needs are met in a timely manner. Referrals may be submitted to CCHA via:

- **Phone Numbers & Contact Hours**
  - Toll Free: 1-877-254-3660
  - Region 6 (local): 303-256-1717
  - Region 7 (local): 719-598-1540
  - Hearing/speech assistance: 711 (TTY)
  - Full services Mon – Fri, 8 am – 5 pm
  - Limited services 24/7
- **Website Referral Form -** Visit CCHAcares.com/referral
- **Email**
  - Region 6:
    - Click here to download the Region 6 Form
    - Email the completed form to R6Referral@CCHAcares.com
  - Region 7:
    - Click here to download the Region 7 Form
    - Email the completed form to R7Referral@CCHAcares.com

Additional Coordination Activities (Peer Support & Member Support)

In addition to the extended care coordination services described above, CCHA provides peer support specialists with lived experience to assist members when recovery-focused services would be helpful.

The CCHA Member Support Services program provides a range of services to members, including, but not limited to, integrated telephonic care coordination and non-clinical support services for physical and behavioral health needs. This could involve coordinating transportation, attending follow-up appointments or providing appointment reminders, assisting with eligibility and benefits questions, completing paperwork, and communicating with providers and partners. The RAE implements procedures to coordinate services furnished to the member between care settings, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

Client Over-Utilization Lock-In Program (COUP)
The Client Over-Utilization Program (COUP) lock-in seeks to help Health First Colorado (Colorado's Medicaid program) members with a claims history indicating inappropriate benefit utilization through care coordination and management by CCHA and a select team of lock-in providers. CCHA may reach out to providers if an assigned member could benefit from COUP lock-in.

See the COUP Lock-In Program benefits information sheet for more information. Providers may refer members to CCHA for care coordination services, including COUP lock-in.

PCMP+ and Accountable Care Network (ACN) Practices

PCMP+ Practices

At its sole discretion, CCHA contracts with qualified practice site locations in the PCMP+ network based on the condition management programs and services provided to its assigned members. PCMP+ practices are responsible for reporting on members enrolled in their condition management programs.

Practices approved for participation in the PCMP+ network will be evaluated for continued participation. The evaluation may depend upon the practice's compliance with contracted responsibilities and performance and participation in the CCHA Value-based Payment Program.

PCMP+ Reporting Requirements
At a minimum, PCMP+ practices are required to report members engaged in condition management programming on a quarterly basis. A reporting schedule and specifications will be provided to PCMP+ practices annually and when the schedule is updated.

ACN Practices

At its sole discretion, CCHA delegates the responsibility of care coordination and population health management services to qualified provider practices for their attributed ACC members. Additionally, ACN provider practices assume responsibilities related to these services as required by HCPF.

Practices approved for participation in the ACN will be evaluated and may be audited at any time, with a minimum of one audit conducted annually to ensure continued participation. The evaluation will be dependent upon contractor performance and CCHA's value-based payment initiatives.

ACN Population Health and Care Coordination Expectations

- Contacts:
    - Single point of contact for communicating referrals
    - Point of contact for escalating referral or member issues
- Referrals between CCHA and ACN provider:
    - Referrals from CCHA to ACN provider must be acknowledged within five business days.
    - Confirmation to CCHA must include name, phone number and/or email of ACN contact to whom the case is assigned.
    - Referral information shall include but not be limited to:
        - A brief summary of patient information and referral reasoning
        - Primary care medical provider
        - Care coordination needs
        - Summary of any complex needs that require immediate or specialized attention

    - If an ACN provider PCMP identifies a high-risk member for whom additional case or care coordination support is needed, the ACN provider shall contact CCHA for case collaboration within 48 hours. ACN providers may request case collaboration with CCHA at any regularly occurring meeting with CCHA, if timely and appropriate, or by following the referral process outlined for all PCMP providers in the Care Coordination section.
- Care coordination audits conducted by CCHA, including chart audits and site visits as specified in the ACN agreement, which generally include:
    - Comprehensive, member-centered care coordination support including:
        - Process to identify high-risk members that need care coordination services
        - Care plan that supports member's short-term and longitudinal physical, behavioral and social needs
    - Identified lead care coordinator for member
    - Appropriate interventions
    - Support with member referrals, transitions of care, and access to community and health neighborhood resources
    - Collaboration with the member's health neighborhood including, but not limited to: Single Entry Points, Community Centered Boards, behavioral health providers and community resources
    - Coordination to ensure timely access to specialty care and facilitate referrals for behavioral health access after a positive depression screen
    - Outreach to members including Colorado Over-Utilization Program (COUP) ACN members (See Appendix A for a definition of COUP.)
    - Promotion of health and wellness, particularly preventive and healthy behaviors, as outlined in initiatives such as Colorado's 10 Winnable Battles and Colorado's State of Health

ACN Reporting Requirements
HCPF requires specific deliverables for reporting on contracted ACC activities, including care coordination, population health/condition management, quality and performance improvement, member engagement, and engagement with the health neighborhood and community. A schedule of deliverables is provided to ACN providers annually and when the schedule is updated.

ACN Contractor Performance Expectations
Practices approved for participation in the ACN are evaluated annually for continued participation. Evaluation is based on contractor performance and the CCHA Value-based Payment Program.

Contractor performance is discussed and assessed on an ongoing basis and is dependent upon several factors, including but not limited to the following:

- Accurate and timely submission of deliverables
- Coaching and operations meetings and attendance
- Value-based Payment Program
- Care coordination referral and response
- Key performance measures
- Annual audit participation and rating

APPENDIX A: Definitions

Accountable Care Collaborative (ACC) – A program designed to affordably optimize member health, functioning and self-sufficiency. The primary goals for the program are to improve member health and life outcomes and use state resources wisely. RAEs work in collaboration with PCMPs who serve as medical homes, as well as behavioral health and other health providers and members, to optimize the delivery of outcome-based, cost-effective health care services.

Accountable Care Network (ACN) – A network of qualified providers delegated by CCHA to fulfill the responsibilities of care coordination and population health/condition management for its assigned members.

Care Coordination – The deliberate organization of member care activities between two or more participants (including the member and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional long-term services and supports (LTSS), oral health, specialty care and other services. Care coordination may range from deliberate interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a member's health and social needs.

CCHA Provider Incentive Program – A CCHA incentive program designed to reward providers for improving the quality and efficiency of care and containing costs outside of the traditional fee-for-service payment methodology.

Client Overutilization Program (COUP) – A program to assist members who are shown, through development and review of member utilization pattern profiles, to have a history of unnecessary or inappropriate utilization of care services.

Colorado interChange – HCPF's Medicaid Management Information System and supporting services, which includes fiscal agent operations services, provider web portal, online provider enrollment, claims processing and payment, Electronic Data Interchange (EDI), Electronic Document Management System (EDMS), provider call center, help desk, and general information technology functionality and business operations.

Colorado's 10 Winnable Battles – Public health and environmental priorities that have known, effective solutions focusing on healthier air, clean water, infectious disease prevention, injury prevention, mental health and substance use, obesity, oral health, safe food, tobacco and unintended pregnancy. The initiative is overseen by the Colorado Department of Public Health and Environment.

Community Network – A network of entities that provide services and supports that impact member well-being, including health neighborhood providers and organizations that address the spiritual, social, educational, recreational and employment aspects of a member's life.

Condition Management Program – Defined generally as the comprehensive set of protocols used to manage patients' conditions based on diagnosis and individual needs. At minimum, a program should be comprised of member identification/risk stratification, interventions according to risk, member education and specialized staff/materials, health assessments, care planning/navigation/management staff and services, and measurable outcomes/reporting.

Department of Health Care Policy and Financing (HCPF) – The department of the government of the state of Colorado that oversees and operates Health First Colorado and other public health care programs for Coloradans.

Early Periodic Screening, Diagnostic and Treatment (EPSDT) – EPSDT provides a comprehensive array of prevention, diagnostic and treatment services for low-income infants, children and adolescents under

age 21, as specified in Section 1905(r) of the Social Security Act. The EPSDT requirements are defined by 42 CFR § 441.55 to 441.165, 42 CFR § 440.345, 42 U.S.C. 1902(a)(43) and 1905(a)(4)(B), and Medicaid Part V state manual.

Fee-for-Service (FFS) – A payment delivery mechanism based on a unit established for the delivery of that service (e.g., office visit, test, procedure, unit of time).

Grievance – An expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee or failure to respect the member's rights as defined at 42 CFR § 438.400 (b).

Health Neighborhood – A network of Health First Colorado providers ranging from specialists, hospitals, oral health providers, long-term services and supports (LTSS) providers, home health care agencies, ancillary providers, local public health agencies and county social/human services agencies that support members' health and wellness.

HEDIS – The Healthcare Effectiveness Data and Information Set developed by the National Committee for Quality Assurance.

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Key Performance Indicators (KPIs) – Performance measures tied to incentive payments for the Accountable Care Collaborative.

Medical Record – A document, either physical or electronic, that reflects the utilization of health care services and treatment history of the member.

Member – Any individual enrolled in the Health First Colorado ACC program and attributed to a CCHA PCMP.

Monthly Capitation Payment – A payment the state makes on a monthly basis to a contractor on behalf of each member enrolled in its plan under a contract and based on the actuarially sound capitation rate for the provision of services covered under the contract.

Network Provider – Any primary care medical provider or specialty behavioral health provider contracted with the RAE to deliver ACC services to members.

Patient-centered Medical Home – An approach to providing comprehensive primary care that facilitates partnerships between individual members, their providers and, where appropriate, the member's family and community.

PCMP+ Providers – A network of qualified providers designated by CCHA to provide and report on condition management services for its assigned members.

Primary Care Alternative Payment Methodology (Primary Care APM) – A HCPF initiative to transition PCMP reimbursement from a methodology based on volume to a methodology based on value.

Primary Care Medical Provider (PCMP) – A primary care provider who serves as a medical home for members. A PCMP may be a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), clinic or other group practice that provides the majority of a member's comprehensive primary, preventive and sick care. A PCMP may also be an individual or pod of PCMPs that are physicians, advanced practice nurses or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

Provider – Any health care professional or entity that has been accepted as a Health First Colorado provider as determined by HCPF.

Regional Accountable Entity (RAE) – A single regional entity responsible for implementing the ACC within its region.