

State: COLORADO

Citation

Condition or Requirement

SECTION 1: ACCOUNTABLE CARE COLLABORATIVE PROGRAM

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

I. The State will contract with an

- i. MCO
 ii. PCCM (including capitated PCCMs that qualify as PAHPs)
 iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

- i. fee for service;
 ii. capitation;
 iii. a case management fee;
 iv. a bonus/incentive payment;
 v. a supplemental payment, or
 vi. other. (Please provide a description below).

TN No. 13-003

Approval Date MAY 01 2013

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Date:

ATTACHMENT 3.1-F
Section I (ACC), Page 2
OMB No.:0938-0933

State: COLORADO

Citation

Condition or Requirement

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ii. Incentives will be based upon specific activities and targets.
- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

The following conditions apply to incentive payments for PCCMs in the Accountable Care Collaborative program:

- a. **Incentives are based upon measures that are attributable to a reduction in utilization or costs, or improvement in health outcomes. The specific performance targets may change each year. The State determines the measurement areas, performance targets, and incentive amounts for the fiscal year (July-June), and communicates these to the PCCMs, no later than March 1 of each year.**

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b. Prior to the start of each state fiscal year, the State determines the baseline against which performance is measured.

c. The State pays any earned incentive payment to the PCCM on a quarterly basis within 180 days from the last day of the quarter in which the incentive payments was earned. The State calculates the incentive payment separately for each month in a quarter, and the PCCM may receive different amounts for each month within a quarter based on the specific performance targets the PCCM was able to meet during each specific month.

d. The PCCM receives an incentive payment only for those targets the PCCM reaches in a given month. The PCCM does not have to pay PMPM moneys back to the State for adverse results.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (Example: public meeting, advisory groups.)

In 2009, the Department hosted public forums to obtain input and advice about the ACC program. In addition, the Department established four ACC program advisory groups, including one that has representation from ACC members, families, advocates, PCCM providers, other Medicaid providers, the behavioral health community, and community organizations.

1932(a)(1)(A)

5. The state plan program will ___/will not x implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___/ voluntary ___ enrollment will be implemented in the following county/area(s):

- i. county/counties (mandatory) _____
- ii. county/counties (voluntary) _____
- iii. area/areas (mandatory) _____

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iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

- | | |
|---|--|
| 1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1) | 1. <input type="checkbox"/> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met. |
| 1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A) | 2. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met. |
| 1932(a)(1)(A)
42 CFR 438.50(c)(3) | 3. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met. |
| 1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C) | 4. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met. |
| 1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m) | 5. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met. |
| 1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6) | 6. <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. |
| 1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6) | 7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met. |

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Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. None.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. <input checked="" type="checkbox"/> Recipients who are also eligible for Medicare. Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC. If enrollment is voluntary, describe the circumstances of enrollment. (Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. <input checked="" type="checkbox"/> Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian

TN No. 14-004

Approval Date 6/5/14

Supersedes TN No. 13-003

Effective Date July 1, 2014

State: COLORADO

Citation

Condition or Requirement

Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. X Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. X Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. X Children under the age of 19 years who are in foster care or other out-of-the-home placement.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

1932(a)(2)(A)(iv)

vi. X Children under the age of 19 years who are receiving foster care or

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Citation	Condition or Requirement
42 CFR 438.50(3)(iv)	adoption assistance under title IV-E. Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <input checked="" type="checkbox"/> Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.
E. Identification of Mandatory Exempt Groups	
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (Examples: children receiving services at a specific clinic or enrolled in a particular program.) Children who receive services through Colorado's Health Care Program for Children with Special Needs.
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: <input type="checkbox"/> i. program participation, <input type="checkbox"/> ii. special health care needs, or <input checked="" type="checkbox"/> iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. <input checked="" type="checkbox"/> i. yes

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	<p>ii. no</p>
1932(a)(2) exempt 42 CFR 438.50 (d) <i>identification</i>	4. Describe how the state identifies the following groups of children who are from mandatory enrollment: <i>(Examples: eligibility database, self-identification)</i> <ul style="list-style-type: none">i. Children under 19 years of age who are eligible for SSI under title XVI; Eligibility database.ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; Eligibility database.iii. Children under 19 years of age who are in foster care or other out-of-home placement; Eligibility database.iv. Children under 19 years of age who are receiving foster care or adoption assistance. Eligibility database.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i> Not applicable. Enrollment is not mandatory.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system; self-identification)</i>

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Citation

Condition or Requirement

42 CFR 438.50

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
- ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

- i. the existing provider-recipient relationship (as defined in H.1.i).

Clients enrolled in the ACC program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider they already have a relationship with. If that provider is not part of the ACC program, the PCCM (Regional Care Coordination Organization) will request that the provider enroll. The State will initially assign a PCMP based on which provider was the main source of Medicaid care for the client during the previous year.

- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

The Regional Care Collaborative Organizations work with the State to recruit providers that have traditionally served Medicaid recipients to be a part of the ACC program. These providers have been involved as stakeholders since program planning began.

- iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56

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	<p>iv Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.)</p> <p>The letter sent by the State's enrollment broker to notify a client of the State's intent to enroll the client in the ACC program also includes instructions for disenrolling within the first 90 days of the client's enrollment into the program.</p>
	<p>v Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</p> <p>Enrollment is based on geographic service areas. The ACC program enrolls clients receiving fee-for-service Medicaid and will not affect the number of clients passively enrolled into other managed care plans.</p>
	<p>vi Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</p> <p>The state monitors rates of enrollment through monthly reports generated by the enrollment broker.</p>

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

- I The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

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Approval Date 10/9/12

Supersedes TN No. 11-010

Effective Date July 1, 2012

State: COLORADO

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	<p>2. <u>x</u> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities, unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p>3. <u> </u> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p><u>x</u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>4. <u> </u> The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act, and the recipient has a choice of at least two primary care providers within the entity (California only)</p> <p><u>x</u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>5. <u>x</u> The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.</p> <p><u> </u> This provision is not applicable to this 1932 State Plan Amendment.</p>
1932(a)(4) 42 CFR 438.50	<p>J. <u>Disenrollment</u></p> <p>1 The state will <u>x</u> /will not <u> </u> use lock-in for managed care.</p> <p>2 The lock-in will apply for <u>12</u> months (up to 12 months).</p> <p>3 Place a check mark to affirm state compliance.</p> <p><u>x</u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p>4 Describe any additional circumstances of "cause" for disenrollment (if any).</p> <p>a. If the temporary loss of eligibility has caused a client to miss the annual disenrollment opportunity, the client may disenroll upon regaining eligibility.</p> <p>b. Enrollment into the PCCM program, or the choice of or assignment to the provider, was in error.</p>

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Supersedes TN No. 11-010

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- c. There is a lack of access to covered services within the program.
- d. There is a lack of access to providers experienced in dealing with the client's health care needs.
- e. Any other reasons satisfactory to the State.

k. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

 The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

42 CFR 438.10(i) does not apply ("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.

The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CFR 438.10(f) and other applicable requirements of 42 CFR 438.10.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

All Medicaid services are included in the ACC program. All services provided by someone other than the assigned PCCM provider will need a referral from the assigned PCCM provider, except for the following (which are available directly and without referral):

1. Emergency care.
2. EPSDT screening examinations.
3. Emergency and non-emergent county transportation.
4. Anesthesiology services.
5. Dental and vision services including refractions.
6. Family planning services.
7. Behavioral health services.
8. Home and community based services.
9. Services rendered pursuant to a child abuse diagnostic code.
10. Obstetric care.
11. Hospice.

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State: COLORADO

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	<p>M. <u>Selective contracting under a 1932 state plan option</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <ol style="list-style-type: none">The state will <input checked="" type="checkbox"/> /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.<input checked="" type="checkbox"/> The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (<i>Example a limited number of providers and/or enrollees</i>) The State limits the number of PCCM entities that serve as Regional Care Collaborative Organizations (RCCOs). To maximize collaboration, the program is designed to have one RCCO in each area of the state. RCCO selection was done as a competitive procurement. The criteria for selection are extensive, and are included in the Request for Proposals.<input type="checkbox"/> The selective contracting provision is not applicable to this state plan. <p>N. PCCM Contracts:</p> <ol style="list-style-type: none">PCCM contracts for Regional Care Collaborative Organizations and Primary Care Medical Providers set forth all payments (except for fee-for-service reimbursements) to these PCCMs, including the per-member-per-month fee and any incentive payments. These contracts also describe the services rendered in exchange for the payments.The State shall submit all PCCM provider contracts to CMS for review and approval.

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CMS-PM-XX-X
Date:

ATTACHMENT 3.1-F
Section 2 (PCPP), Page 1
OMB No.:0938-0933

State: COLORADO

Citation

Condition or Requirement

SECTION 2: PRIMARY CARE PHYSICIAN PROGRAM (PCPP)

This Section has been deleted effective August 1, 2014.

TN No. 14-032

Approval Date 9/16/14

Supersedes TN No. 13-003

Effective Date August 1, 2014

CMS-PM-XX-X
Date:

ATTACHMENT 3.1-F
Section 3 (CAHI), Page 1
OMB No.:0938-0933

State: COLORADO

Citation

Condition or Requirement

SECTION 3: COLORADO ALLIANCE FOR HEALTH AND INDEPENDENCE (CAHI)

This Section has been deleted effective January 1, 2013.

TN No. 13-003
Supersedes TN No. 11-010

Approval Date May 1, 2013
Effective Date January 1, 2013

State: COLORADO

Citation Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a **voluntary** basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

- i. MCO
 ii. PCCM (including capitated PCCMs that qualify as PAHPs)
 iii. Both

In the Accountable Care Collaborative (ACC) Payment Reform Program (Program), the State will contract with Rocky Mountain Health Plans (RMHP) to implement the Colorado House Bill 12-1281. The Program is comprised of a comprehensive risk-based payment for a subset of the ACC eligible population in 7 counties in RCCO region 1.

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

- i. fee for service;

TN No. 14-002

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SECTION 3: ACC PAYMENT REFORM PROGRAM

- ii. capitation;
- iii. a case management fee;
- iv. a bonus/incentive payment;
- v. a supplemental payment, or
- vi. other. (Please provide a description below).

The State will pay RMHP a comprehensive capitation payment.

1905(i)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

- 3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ii. Incentives will be based upon specific activities and targets.
- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

- 4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (Example: public meeting, advisory groups.)

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Citation

Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

In 2012, HB 12-1281 created a statute that required the Department to accept proposals for innovative ACC payment reform models designed to improve client outcomes while reducing costs. The Department went through an extensive public outreach process, which consisted of stakeholder meetings where drafts of the guidelines for proposal (GFP) were reviewed. The GFP outlined minimum requirements and selection criteria for the proposals. The Department ultimately selected the proposal of RMHP. RMHP collaborated with all of the provider types within its network to develop its payment reform proposal. RMHP has established an advisory group of stakeholders that will meet quarterly to monitor the Program. The State will also solicit feedback from the ACC Program Improvement Advisory Committee (PIAC) throughout the duration of the Program.

1932(a)(1)(A)

5. The state plan program will ___/will not X implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___/ voluntary X enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary) Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield and Rio Blanco.

iii. area/areas (mandatory) _____

iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

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- | | |
|---|--|
| <p>1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)</p> | <p>1. <u> X </u> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p> |
| <p>1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)</p> | <p>2. <u> </u> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 438.50(c)(3)</p> | <p>3. <u> X </u> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)</p> | <p>4. <u> X </u> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)</p> | <p>5. <u> X </u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)</p> | <p>6. <u> X </u> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)</p> | <p>7. <u> </u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.</p> |
| <p>45 CFR 74.40</p> | <p>8. <u> X </u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.</p> |

D. Eligible groups

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- 1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.
- None.**
2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.
- Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
- 1932(a)(2)(B)
42 CFR 438(d)(1) i. Recipients who are also eligible for Medicare.
- If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)
- Medicare eligible recipients who were enrolled in RMHP's PIHP and/or are in a Medicare Advantage program and reside in the ACC Payment Reform Program catchment area will be passively enrolled into the ACC Payment Reform Program. Medicare eligible recipients who opt out of the ACC Demonstration to Integrate Care for Medicare and Medicaid Eligible Beneficiaries may opt into the ACC Payment Reform Program. Beneficiaries will not be enrolled in both programs simultaneously.**
- 1932(a)(2)(C)
when
42 CFR 438(d)(2) ii. Indians who are members of Federally recognized Tribes except
- the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
- 1932(a)(2)(A)(i)
Supplemental
42 CFR 438.50(d)(3)(i) iii. Children under the age of 19 years, who are eligible for Security Income (SSI) under title XVI.

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- Only children who are in this mandatory exempt group and fall into the Aid to the Needy Disabled/Aid to the Blind (AND) eligibility group will be passively enrolled into the ACC Payment Reform Program.**
- 1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii) iv. X Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
- Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**
- 1932(a)(2)(A)(v)
of-
42 CFR 438.50(3)(iii) v. X Children under the age of 19 years who are in foster care or other out-of-home placement.
- Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**
- 1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv) vi. X Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
- Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**
- 1932(a)(2)(A)(ii)
42 CFR 438.50(3)(v)^a vii. X Children under the age of 19 years who are receiving services through family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
- Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**

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E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)

Children who receive services through Colorado's Health Care Program for Children with Special Needs.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

- i. program participation,
- ii. special health care needs, or
- iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

- i. yes
- ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (*Examples: eligibility database, self identification*)

- i. Children under 19 years of age who are eligible for SSI under title XVI;

Eligibility Database

- ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

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cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Not applicable. Enrollment is not mandatory.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Not applicable. Enrollment is not mandatory.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

The following eligibility groups will be permitted to enroll on a voluntary basis within participating counties:

- 1) **Old Age Pension (Age 65+)**
- 2) **Aid to the Needy Disabled/Aid to the Blind - Supplemental Security Income without regard to age**
- 3) **MAGI Parents/Caretakers**
- 4) **MAGI Pregnant Women**
- 5) **MAGI Adults**
- 6) **Working Adults with Disabilities (Adult Buy-In)**

H. Enrollment process.

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1932(a)(4)
42 CFR 438.50

1. Definitions

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
- ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

- i. the existing provider-recipient relationship (as defined in H.1.i).

Clients enrolled in the Program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider with whom they already have a relationship. If that provider is not part of the Program, RMHP will request that the provider enroll.

- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

RMHP works with the State to recruit providers that have traditionally served Medicaid recipients to be a part of the Program. These providers have been involved as stakeholders since program planning began.

- iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)

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The notification letter also describes other options available, including managed care plans, the fee-for-service option, and any other available program.

- iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the Program.

- iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The letter sent by the State's enrollment broker to notify a client of the State's intent to enroll the client in the Program also includes instructions for disenrolling within the first 90 days of the client's enrollment into the program.

- v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

The Program will enroll clients with the appropriate eligibility category and who live in a participating county. The clients are currently in the ACC, in RMHP's PIHP (which is sun setting) or are receiving fee-for-service Medicaid. Enrollment in the Program will not affect clients passively enrolled into other managed care plans. Clients in the participating counties and in the applicable eligibility categories will be enrolled in the Program instead of the standard ACC.

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- vi. Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)

The State monitors rates of enrollment through monthly reports generated by the enrollment broker.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.
2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).
3. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

This provision is not applicable to this 1932 State Plan Amendment.

4. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

This provision is not applicable to this 1932 State Plan Amendment.

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5. The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will /will not use lock-in for managed care.
2. The lock-in will apply for up to 12 months (up to 12 months).
3. Place a check mark to affirm state compliance.

The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).
 - a. **If the temporary loss of eligibility has caused a client to miss the annual disenrollment opportunity, the client may disenroll upon regaining eligibility.**
 - b. **Enrollment into the Program, or the choice of or assignment to the provider, was in error.**
 - c. **There is a lack of access to covered services within the program.**
 - d. **There is a lack of access to providers experienced in dealing with the client's health care needs.**
 - e. **Any other reasons satisfactory to the State.**

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50

The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs

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42 CFR 438.10 operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

42 CFR 438.10(i) does not apply ("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.

The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.

1932(a)(5)(D) L. List all services that are excluded for each model (MCO & PCCM)
1905(t)

All services and benefits including drugs covered in the state plan are included in the MCO program, either as part of the capitation payment or as wrap-around fee-for-service payments.

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will X /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.
2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (Example: a limited number of providers and/or enrollees.)

The State limits the number of contracted entities based upon the competitive selection process established in State House Bill 12-1281. The criteria for selection were extensive, and were included in the GFP.

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4. The selective contracting provision in not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS-10120 (exp. 01/31/2008)

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4:
SECTION 4: DEMONSTRATION TO INTEGRATE CARE FOR MEDICARE AND MEDICAID ELIGIBLE CLIENTS

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—sec.D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

I. The State will contract with an

- i. MCO
- ii. PCCM (including capitated PCCMs that qualify as PAHPs)
- iii. Both

The purpose of this initiative is to establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the State of Colorado (State), Department of Health Care Policy and Financing (Department), to implement the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees (Demonstration), a Managed Fee-for-Service (MFFS) Financial Alignment Model. The Demonstration will coordinate services across Medicare and Medicaid and achieve cost savings for the Federal and the State government. CMS plans to begin this MFFS Financial Alignment Model Demonstration on July 1, 2014, and continue until December 31, 2017, unless terminated or extended pursuant to the terms and conditions of the Final Demonstration Agreement. Key objectives of the Demonstration are to improve beneficiary experience in accessing care, promote person-centered planning, promote independence in the community, improve quality of care, assist beneficiaries in getting the right

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Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p>care at the right time and place, reduce health disparities, improve transitions among care settings, and achieve cost-savings for the Federal and the State government through improvements in health and functional outcomes.</p> <p>2. The payment method to the contracting entity will be:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> i. fee for service; <input type="checkbox"/> ii. capitation; <input checked="" type="checkbox"/> iii. a case management fee; <input type="checkbox"/> iv. a bonus/incentive payment; <input type="checkbox"/> v. a supplemental payment, or <input type="checkbox"/> vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.</p> <p>If applicable to this state plan, place a check mark to affirm the state has met <i>all</i> of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).</p> <ul style="list-style-type: none"> <input type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. <input type="checkbox"/> ii. Incentives will be based upon specific activities and targets. <input type="checkbox"/> iii. Incentives will be based upon a fixed period of time. <input type="checkbox"/> iv. Incentives will not be renewed automatically. <input type="checkbox"/> v. Incentives will be made available to both public and private PCCMs. <input type="checkbox"/> vi. Incentives will not be conditioned on intergovernmental transfer agreements. <input checked="" type="checkbox"/> vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its

Citation

Condition or Requirement

initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (Example: public meeting, advisory groups.)

The Department engaged a wide variety of stakeholders and partners throughout the initial stages of proposal development from June 2011 through May 2012. The collaborative process to solicit input and provide opportunities for feedback included six statewide stakeholder meetings with toll-free call-in options; five recurring workgroups devoted to Communication (Outreach and Information), Care Coordination, Behavioral Health, Developmental Disabilities, and Financing Strategies and Quality Medical Outcomes; nine area stakeholder meetings across the state; 58 presentations to and conversations with individual stakeholders and specific organizations; Tribal Consultation; a dedicated web page on the Department's Web site; and a toll-free question/comment hot line. The Department continued its engagement with stakeholders through focused interviews with Medicare/Medicaid enrollees and focus groups for caregivers.

As part of the Demonstration, CMS and the State require mechanisms to ensure meaningful beneficiary input processes and the involvement of beneficiaries in planning and process improvements. In addition, the State provides avenues for ongoing beneficiary input into the Demonstration model, including beneficiary participation through the Colorado Medicare-Medicaid Enrollees Advisory Subcommittee, the ACC Program Improvement Advisory Committee and its standing subcommittees.

The State is developing input processes and systems to monitor and measure the level of care provided to Medicare/Medicaid enrollees in the Demonstration. Moreover, the State the beneficiary rights and protections alliance may provide additional beneficiary input and feedback throughout the Demonstration's planning processes, implementation, and operation. All activities needed to fulfill the Department's commitment to collaborative process, multi-perspective evaluation, and continuous improvement will continue after implementation.

1932(a)(1)(A)

- 5. The state plan program will ___/will not x implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___ / voluntary ___ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

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	ii. county/counties (voluntary) _____
	iii. area/areas (mandatory) _____
	iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

- | | |
|---|--|
| <p>1932(a)(1)(A)(i)(1)
1903(m)
42 CFR 438.50(c)(1)</p> | <p>1. <u> </u> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p> |
| <p>1932(a)(1)(A)(i)(1)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)</p> | <p>2. <u> x </u> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 438.50(c)(3)</p> | <p>3. <u> x </u> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)</p> | <p>4. <u> x </u> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)</p> | <p>5. <u> x </u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)</p> | <p>6. <u> </u> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.</p> |
| <p>1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)</p> | <p>7. <u> x </u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.</p> |
| <p>45 CFR 74.40</p> | <p>8. <u> x </u> The state assures that all applicable requirements of 45 CFR 92.36 for</p> |

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procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

None.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups:

1932(a)(2)(B)
42 CFR 438(d)(1)

i. Recipients who are also eligible for Medicare. Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

1932(a)(2)(A)(i)
42 CFR-438.50(d)(3)(i)

iii. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

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Citation	Condition or Requirement
	<p>Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.</p>
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. <u>x</u> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. <p>Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.</p>
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. <u>x</u> Children under the age of 19 years who are in foster care or other out-of-the-home placement. <p>Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.</p>
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <u>x</u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. <p>Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.</p>
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <u>x</u> Children under the age of 19 years who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. <p>Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.</p>

Citation	Condition or Requirement
	<p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p>Eligibility database.</p>
<p>1932(a)(2) 42 CFR 438.50(d)</p>	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i></p> <p>Not applicable. Enrollment is not mandatory.</p>
<p>1932(a)(2) 42 CFR 438.50(d)</p>	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system; self-identification)</i></p> <p>Not applicable. Enrollment is not mandatory.</p> <p>i. Recipients who are also eligible for Medicare.</p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p>
<p>42 CFR 438.50</p>	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u></p> <p>Not applicable. Enrollment is not mandatory.</p>
<p>42 CFR 438.50</p>	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p>In accordance with the signed and approved MOU between CMS and the State, individuals eligible for this Demonstration are those meeting the following criteria:</p> <ol style="list-style-type: none"> 1. are enrolled in Medicare Parts A and B and eligible for Part D; 2. receive physical health Medicaid benefits under Fee-for-Service (FFS) arrangements;

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	<p>3. receive behavioral health Medicaid benefits under capitated arrangements; and</p> <p>4. have no other private or public health insurance; and are a resident of the State.</p> <p>H. <u>Enrollment process.</u></p> <p>1. Definitions</p> <p>i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.</p> <p>ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.</p> <p>2. State process for enrollment by default.</p> <p>Describe how the state's default enrollment process will preserve:</p> <p>i. the existing provider-recipient relationship (as defined in H.1.i).</p> <p>Clients enrolled in the program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider they already have a relationship with. If that provider is not part of the ACC program, the PCCM entity (Regional Care Collaborative Organization) will request that the provider enroll. The State will initially identify a PCMP based on which provider was the main source of primary care for the client during the previous year.</p> <p>ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</p> <p>The Regional Care Collaborative Organizations work with the State to recruit providers that have traditionally served Medicare-Medicaid beneficiaries to be a part of the ACC program. These providers have been involved as stakeholders since program planning began.</p> <p>iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)).</p>

1932(a)(4)
42 CFR 438.50

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42 CFR 438.50

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and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)

The State's enrollment process does not preserve the equitable distribution of Medicare-Medicaid beneficiaries among PCMPs because enrollment is voluntary. Clients may choose from among available MCOs and PCCMs in their geographic areas. A list of available options is included in the enrollment letter and packet sent to Medicare-Medicaid beneficiaries who are passively enrolled into the program.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will ___/will not X use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be:

Medicare-Medicaid beneficiaries are notified of the State's intent to enroll them into the program 30 days before they are enrolled. This letter also describes other options available, including managed care plans, the fee-for-service option, and any other available program.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)

The State's enrollment broker sends the Medicare-Medicaid beneficiary a letter notifying them of the State's intent to enroll them into the program.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.)

The letter sent by the State's enrollment broker to notify a Medicare-Medicaid beneficiary of the State's intent to enroll the beneficiary in the ACC program also includes instructions for disenrolling.

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	<p>v. Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</p> <p>Enrollment is based on geographic service areas. The program enrolls full benefit Medicare-Medicaid beneficiaries receiving fee-for-service Medicaid and will not affect the number of clients passively enrolled into other managed care plans.</p>
	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS); monthly reports generated by the enrollment broker)</p> <p>The State monitors rates of enrollment through monthly reports generated by the enrollment broker.</p>

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.
2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).
3. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.
 This provision is not applicable to this 1932 State Plan Amendment.
4. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act, and the recipient has a choice of at least two primary care providers within the entity. (California only.)

This provision is not applicable to this 1932 State Plan Amendment.

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	<p>5. <u>x</u> The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.</p> <p><u> </u> This provision is not applicable to this 1932 State Plan Amendment.</p>
1932(a)(4) 42 CFR 438.50	<p>J. <u>Disenrollment</u></p> <p>1. The state will <u> </u> /will not <u>x</u> use lock-in for managed care.</p> <p>2. The lock-in will apply for <u> </u> months (up to 12 months).</p> <p>3. Place a check mark to affirm state compliance.</p> <p><u> </u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p>4. Describe any additional circumstances of "cause" for disenrollment (if any).</p> <p>K. <u>Information requirements for beneficiaries</u></p> <p>Place a check mark to affirm state compliance.</p> <p><u> </u> The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)</p> <p>42 CFR 438.10(i) does not apply ("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.</p> <p>The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CFR 438.10(f) and other applicable requirements of 42 CFR 438.10.</p>
1932(a)(5)(D) 1905(t)	<p>L. <u>List all services that are excluded for each model (MCO & PCCM)</u></p> <p>All Medicaid services are included in the program.</p>
1932 (a)(1)(A)(ii)	<p>M. <u>Selective contracting under a 1932 state plan option</u></p>

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To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will /will not intentionally limit the number of entities it contracts under a 1932 state plan option.
2. The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*
The State limits the number of PCCM entities that serve as Regional Care Collaborative Organizations (RCCOs). To maximize collaboration, the program is designed to have one RCCO in each area of the State. RCCO selection was done as a competitive procurement. The criteria for selection are extensive, and are included in the Request for Proposals.
4. The selective contracting provision is not applicable to this state plan.

N. PCCM Contracts

1. PCCM contracts for Regional Care Collaborative Organizations and Primary Care Medical Providers set forth all payments (except for fee-for-service reimbursements) to these PCCM entities, including the per-member-per-month fee and any incentive payments. These contracts also describe the services rendered in exchange for the payments.
2. The State shall submit all PCCM provider contracts to CMS for review and approval

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