

**Enclosure 7**

Supplement 3 to Attachment 3.1-A

**State of Colorado  
PACE State Plan Amendment Pre-Print**

Name and address of State Administering Agency, if different from the State Medicaid Agency.

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**I. Eligibility**

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. \_\_\_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. \_\_\_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

**Regular Post Eligibility**

1. \_\_\_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

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(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. \_\_\_ The following standard included under the State plan (check one):

- (a) \_\_\_ SSI
- (b) \_\_\_ Medically Needy
- (c) \_\_\_ The special income level for the institutionalized
- (d) \_\_\_ Percent of the Federal Poverty Level: \_\_\_%
- (e) \_\_\_ Other (specify): \_\_\_\_\_

2. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

3. \_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

- 1. \_\_\_ SSI Standard
- 2. \_\_\_ Optional State Supplement Standard
- 3. \_\_\_ Medically Needy Income Standard
- 4. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

5. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_% of \_\_\_\_\_ standard.

6. \_\_\_ The amount is determined using the following formula:

\_\_\_\_\_  
\_\_\_\_\_

7. \_\_\_ Not applicable (N/A)

(C.) Family (check one):

- 1. \_\_\_ AFDC need standard
- 2. \_\_\_ Medically needy income standard

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The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

- 3. \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
- 4. \_\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of \_\_\_\_\_ standard.
- 5. \_\_\_\_\_ The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
- 6. \_\_\_\_\_ Other
- 7. \_\_\_\_\_ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

### Regular Post Eligibility

- 2. \_\_\_\_\_ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

- 1. Allowances for the needs of the:
  - (A.) Individual (check one)
    - 1. \_\_\_ The following standard included under the State plan (check one):
      - (a) \_\_\_ SSI
      - (b) \_\_\_ Medically Needy
      - (c) \_\_\_ The special income level for the institutionalized
      - (d) \_\_\_ Percent of the Federal Poverty Level: \_\_\_\_\_%
      - (e) \_\_\_ Other (specify): \_\_\_\_\_
  - 2. \_\_\_ The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
  - 3. \_\_\_ The following formula is used to determine the needs allowance:  
\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

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(B.) Spouse only (check one):

1.  The following standard under 42 CFR 435.121:  
\_\_\_\_\_
2.  The Medically needy income standard  
\_\_\_\_\_
3.  The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.
5.  The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
6.  Not applicable (N/A)

(C.) Family (check one):

1.  AFDC need standard
2.  Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.  The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.
5.  The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
6.  Other
7.  Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

**Spousal Post Eligibility**

3.  State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a

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community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). \_\_\_ The following standard included under the State plan (check one):

- 1. \_\_\_ SSI
- 2. \_\_\_ Medically Needy
- 3. X The special income level for the institutionalized
- 4. \_\_\_ Percent of the Federal Poverty Level: \_\_\_%
- 5. \_\_\_ Other (specify): \_\_\_\_\_

(B). \_\_\_ The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.

(C). \_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_  
\_\_\_\_\_

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. \_\_\_ Rates are set at a percent of fee-for-service costs

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2. \_\_\_ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. \_\_\_ Adjusted Community Rate (please describe)
4. X Other (please describe) Rates is developed as a percent of fee-for-service (FFS) historical costs separate from the development of FFS costs used to identify the Upper Payment Limit.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

### III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

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- D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

IV. Rates and Payments

- A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.  Rates are set at a percent of fee-for-service costs
2.  Experience-based (contractors/State's cost experience or encounter date)(please describe) See attachment.
3.  Adjusted Community Rate (please describe)
4.  Other (please describe)

- B.  The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

- C.  The State will submit all capitated rates to the HCFA Regional Office for prior approval.

- V. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

- A. Enrollment Process (Please describe): See attachment

- B. Enrollee Information (Please describe the information to be provided to enrollees):  
See attachment.

- C. Disenrollment Process (Please describe - voluntary and involuntary):  
See attachment.

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- D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.
- E. In the event a PACE participant disenrolls or is disenrolled from a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.
- F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.
- G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.

VI. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).

VII. Services: The following items are the medical and remedial services provided to the categorically needy and medically needy. (Please specify): See attachment.

The State assures that the state agency that administers the PACE program will regularly consult with the State Agency on Aging in overseeing the operation of the PACE program in order to avoid services duplication in the PACE service area and to assure the delivery and quality of services to the PACE participants.

VIII. Decisions that require joint HCFA/State Authority

- A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint HCFA/State agreement:
  - 1. The State will consult with HCFA to determine the feasibility of granting any waivers related to conflicts of interest of PACE organization governing board members.
  - 2. The State will consult with HCFA to determine the feasibility of granting any waivers related to the requirements that: members of the multidisciplinary team are employees of the PACE organization; and that members of the multi-disciplinary team must serve primarily PACE participants.
- B. Service Area Designations: The State will consult with HCFA on changes proposed by the PACE organization related to service area designation.

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- C. Organizational Structure: The State will consult with HCFA on changes proposed by the PACE organization related to organizational structure.
- D. Sanctions and Terminations: The State will consult with HCFA on termination and sanctions of the PACE organization.

IX. State Licensure Requirements

For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless HCFA determines that a fire and safety code imposed by State law adequately protects participants and staff.

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**Enclosure 8**

The following are the addresses for HCFA Central and Regional Offices. Please submit your application to both the Center for Medicaid and State Operations and the Center for Health Plans and Providers within Central Office, as well as to the appropriate Regional Office simultaneously.

**Central Office:**

Health Care Financing Administration  
Center for Medicaid and State Operations  
Mail Stop S2-14-26  
7500 Security Boulevard  
Baltimore, MD 21244

Health Care Financing Administration  
Center for Health Plans and Providers  
Mail Stop C4-23-07  
7500 Security Boulevard  
Baltimore, MD 21244

HCFA Region V  
233 N. Michigan Avenue, Suite 600  
Chicago, Illinois 60601-5519

HCFA Region VI  
1301 Young Street, Room 714  
Dallas, Texas 75202

HCFA Region VII  
Richard Bolling Federal Building  
601 East 12th Street, Room 235  
Kansas City, Missouri 64106-2808

**Regional Offices:**

HCFA Region I  
JFK Federal Building, Room 2325  
Boston, Massachusetts 02203-0003

HCFA Region II  
26 Federal Plaza, Room 3811  
New York, NY 10278-0063

HCFA Region III  
Suite 216, The Public Ledger Building  
150 S. Independence Mall West  
Philadelphia, PA 19106

HCFA Region IV  
Atlanta Federal Center, 4th Floor  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909

HCFA Region VIII  
Colorado State Bank Building  
1600 Broadway, Suite 700  
Denver, Colorado 80202-4367

HCFA Region IX  
75 Hawthorne Street, 4th and 5th Floors  
San Francisco, CA 94105-3901

HCFA Region X  
2201 Sixth Avenue, MS/RX 40  
Seattle, WA 98121

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IV. Rates and Payments

Rates for the PACE program are established by calculating a historical per member per month amount for a PACE comparable set of fee-for-service member months. That historical per member per month (PMPM) comparison is then adjusted, on a service category specific basis, to account for expected changes in price and utilization between the historical period and the future rate effective period.

Benefits under risk for the PACE program include all state plan services. Therefore, the above referenced PMPM figure includes consideration of all services paid on behalf of the fee-for-service comparison population, including all claims in the Medicaid Management Information System that were provided on behalf of the fee-for-service comparison population during the member months of eligibility for that population.

The fee-for-service member months that are considered in PACE rate setting include all months where Medicaid eligibles could have potentially been PACE eligible, but were fee-for-service recipients instead. Therefore the member months considered in rate setting exclude individuals under 55 years of age, exclude those who are not long-term care recipients, and include only fully eligible Medicaid eligibles, such as QMB plus and SLMB plus dual eligibles.

PMPM calculations are equal to state plan services cost incurred during the comparison fee-for-service member months divided by the number of those member months. No lump sum supplemental payments made to providers outside of fee-for-service shall be considered when determining the PMPM calculations. The PMPM calculations are segregated into rate cells. Rate cell assignment is based upon factors such as age, eligibility category, Medicaid/Medicare dual eligibility, and the presence of other third party insurance. The PMPM calculations are further separated based on the Nursing Facility (NF) and Home and Community Based Services (HCBS) populations. An incurred but not paid (IBNP) analysis is used to create a claims completion factor.

The completed historical NF and HCBS PMPMs are adjusted to the rate effective period by applying a trend. That trend is calculated to consider both utilization and changes in unit cost. Data used to calculate the trend includes primarily historical PMPM changes observed in the fee-for-service PACE comparison population but also may include observations of other state Medicaid data, commercial data or industry-wide experience.

The NF and HCBS PMPM calculations are made on a statewide basis to pool as much claims experience as possible for data smoothing purposes. That statewide calculation is adjusted by factors designed to measure the differences in cost between different regions of the state. Those factors are equal to a ratio that is regional specific PMPM average costs divided by statewide average PMPM cost. After the regional adjustment has been applied to the NF and HCBS PMPMs, they are blended together into one PMPM for each rate cell using a frailty factor.

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The PMPM result uses fee-for-service data and therefore results in a figure that is 100% of fee-for-service costs. This amount is multiplied times a percent of fee-for-service in accordance with Colorado Revised Statutes. That percent of fee-for-service is 95%. Effective July 1, 2008, that percent of fee-for-service will be less than 100%.

No less frequently than every other year, new data is collected and used to calculate updated PMPM figures from a comparison fee-for-service population that is more recent than that used during the prior rate setting calculation.

Claims experience that is used in rate setting includes payment data that is net of fee-for-service clients' patient payment as calculated through the PETI process. However, the state may not rely upon fee-for-service patient payment experience and instead must calculate PACE enrollees' specific patient payment amounts. This calculation is accomplished by adding back to the fee-for-service PMPM amount the fee-for-service patient payment amounts. The result is the total PACE rate, prior to consideration of any particular PACE enrollee's patient payment. Actual final payment to the PACE provider is that rate, less each and every PACE enrollee's client specific patient payment amount. The state may make interim estimated payments based upon expected average patient payment, but will reconcile these estimated payments to actual amounts based upon actual PACE enrollees' patient payment amounts no less frequently than quarterly.

V. Enrollment and Disenrollment

A. Enrollment Process

Interested individuals customarily begin the enrollment process through the PACE provider, who explains the program and does preliminary screening. Age, frailty and residence in the service area are verified. A preliminary home visit is made to explain how the program works and services that are available. If the individual wants to pursue enrollment, a visit is made to the Adult Day Health Center to assure the client's understanding regarding PACE. All clients who enter the program must meet the nursing home level of care criteria, as certified by the State Agency's Peer Review Organization. He or she must be approved for PACE by the multidisciplinary team to assure appropriateness for the program. An Enrollment Agreement must be signed by the participant or family representative or guardian if the client is unable to act in his or her own behalf. Since clients seeking coverage through Medicaid must be Medicaid-eligible or meet eligibility requirements, outreach staff assists those who are not Medicaid eligible with applications through the County Department of Social Services or Single

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Entry Point Agency. Clients who are already Medicaid eligible need not apply for eligibility.

B. Enrollee Information

Once enrolled, the individual is provided the following:

- A copy of the Enrollment Agreement, which includes complete information regarding PACE, as well as the Participant's Bill of Rights;
- A membership card;
- Self-adhesive informational emergency stickers that can be posted in the individual's home, explaining how to access emergency care;
- The Medicaid card is printed with the name of the provider;
- A copy of the plan of care;
- A list of the provider's employees who provide care and a current list of contracted providers.

C. Disenrollment Process

Voluntary Disenrollment

A participant may voluntarily disenroll for any cause at any time; however, 30 days notice is required in order to reinstate the individual in the Medicare and Medicaid fee-for-service systems. The participant and/or family or other representatives will meet with social work to discuss the reason for the disenrollment and explain the procedure. If the reason is dissatisfaction, a grievance form will be completed and resolution attempted prior to the disenrollment. A copy will be provided to internal quality management and the state Medicaid agency. Information will be provided to the disenrolling participant to assure services can be readily accessed in the fee-for-service systems.

Involuntary Disenrollment

A participant may be disenrolled if she/he:

1. Moves outside the provider's service area;
2. Becomes ineligible for Medicaid and is unable or unwilling to pay PACE organization privately;
3. Fails to pay or make satisfactory arrangements to pay any amount due the provider, after a 30-day grace period;
4. Is outside the provider's service area for more than 30 days without prior arrangements;
5. Is enrolled in a program that loses its contract and/or licenses;
6. Engages in disruptive or threatening behavior that jeopardizes the health or safety of him/herself or others, or, when a participant with decision-making ability refuses to comply with the plan of care or terms of the PACE agreement;
7. Is determined to no longer meet the nursing home level of care requirements;

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8. Is enrolled in a program whose program agreement with HCFA or the state agency is terminated.

Participants may not be involuntarily disenrolled due to behavioral issues unless one verbal and one written warning have been issued and the state agency approves such disenrollment. Participant rights must be protected at all times.

VII. Medical and remedial services provided to categorically needy clients who qualify for PACE are as follows:

Each PACE benefit package must include all Medicaid covered services as listed in the State Plan, and other services determined necessary by the multidisciplinary team to meet the participant's needs. At a minimum, the PACE organization must provide the following:

- Multidisciplinary assessment and treatment planning;
- Primary care services, including nursing and physician care;
- Social work services
- Restorative therapies, including physical, occupational and speech-language;
- Personal care and supportive services;
- Nutritional counseling;
- Recreational therapy;
- Transportation;
- Meals;
- Medical specialty services, including, but not limited to: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhinolaryngology, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, reconstructive surgery, rheumatology, surgery, thoracic and vascular surgery, and urology;
- Laboratory tests, x-rays and other diagnostic procedures;
- Drugs and biologicals;
- Prosthetics and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items;
- Acute inpatient care; ambulance; emergency room care and treatment room services; semi-private room and board; general medical and nursing services; medical surgical/intensive care/coronary care unit, as necessary; laboratory tests, x-rays and other diagnostic procedures; drugs and biologicals; blood and blood derivatives; surgical care, including the use of anesthesia; use of oxygen, physical, occupational, and respiratory therapies; speech-language pathology; and social services;
- Nursing facility care; semi-private room and board; physician and skilled nursing services; custodial care; personal care and assistance; drugs and biologicals; physical, occupational and recreational therapies and speech-language pathology, if necessary; social services; and medical supplies and appliances.

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