DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR 3 0 2012

Ms. Suzanne Brennan
State Medicaid Director
Colorado Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Brennan:

We are pleased to inform you that Colorado's request for a new Medicaid section 1115(a) Demonstration, entitled "Colorado Adults without Dependent Children (AwDC) Demonstration" (Project Number 11-W-00280/8), has been approved for the period starting April 1, 2012, through December 31, 2013.

Colorado's new section 1115 Demonstration expands Medicaid eligibility to provide adults without dependent children, who have family income at or below 10 percent of the Federal poverty level (FPL) with Medicaid State plan benefits and enhanced mental health services. These adults will receive coverage through the State's Accountable Care Collaborative, which will help coordinate care and improve health outcomes while ensuring the cost-effective provision of care. The State is granted the flexibility, as State funding allows, to increase enrollment and increase the State-established income standard up to 60 percent of the FPL without amending the Demonstration, pursuant to requirements outlined in Special Terms and Conditions (STCs). The State will also evaluate beneficiary needs, provider capacity and care delivery to inform its implementation of the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). We commend the State on taking steps to expand comprehensive and coordinated care for some of the most vulnerable Coloradans.

As of the date of this letter, the Demonstration is authorized through December 31, 2013, upon which date, unless reauthorized, all authorities granted to operate this Demonstration will expire. Our approval of this Demonstration project is subject to the limitations specified in the attached expenditure authorities, and title XIX requirements not applicable. The State may deviate from Medicaid State plan requirements only to the extent that those requirements have been specifically granted expenditure authority or specified as title XIX requirements not applicable.

The approval is also conditioned upon the State's compliance with the enclosed STCs defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receipt of your written acknowledgement of the award, and acceptance of the STCs and expenditure authorities within 30 days from the date of this letter.

Your project officer for this Demonstration is Ms. Rebecca Burch Mack. She is available to answer any questions concerning your section 1115 Demonstration, and may be contacted as follows:

Ms. Rebecca Burch Mack
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
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Email: Rebecca.BurchMack@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Burch Mack and Mr. Richard Allen, Associate Regional Administrator in our Denver Regional Office. Mr. Allen's address is:

Mr. Richard Allen
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
1600 Broadway, Suite 700
Denver, CO 80202

We extend our congratulations to you on this award, and we appreciate your collaboration through the review process. If you have any questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Centers for Medicaid and CHIP Services, (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Marilyn Tavenner
Acting Administrator

Enclosures

cc: Richard Allen, Associate Regional Administrator, Denver Regional Office
Diana Dunstan-Murphy, State Representative for Colorado, Denver Regional Office
Rebecca Burch Mack, Project Officer, Centers for Medicaid and CHIP Services

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00280/8**

TITLE: **Colorado Adults without Dependent Children (AwDC) Demonstration**

AWARDEE: **Colorado Department of Health Care Policy and Financing**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Colorado for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration beginning April 1, 2012, through December 31, 2013, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STCs) shall enable the State to operate its section 1115 Medicaid AwDC Demonstration.

I. **Demonstration Population Expenditures.** Expenditures to provide coverage to the following Demonstration population that are not covered under the Medicaid State plan:

Colorado Adults without Dependent Children (AwDC) Demonstration Population. Expenditures for health care-related costs for adults, ages 19 through 64 years, who are not pregnant, who do not have a Medicaid-eligible dependent child living in the household, who are not otherwise eligible under the Medicaid State plan, Medicare or the Children's Health Insurance Program (CHIP), and who have family income at or below a State-established standard that shall not be lower than 10 percent of the Federal poverty level (FPL), and may increase to 60 percent of the FPL pursuant to the procedure set out at STC 17.

II. **Behavioral Health Service-Related Expenditures.** Expenditures for benefits specified in STC 25(c) and Attachment B to the extent not available under the Medicaid State plan for eligible enrollees.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Population beginning April 1, 2012, through December 31, 2013.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. Prepaid Insurance Health Plan (PIHP) Enrollment **Section 1902(a)(4)**

To the extent necessary to permit the State to limit disenrollment from a Prepaid Insurance

Health Plan (PIHP) providing behavioral health services in the region in which the eligible individual lives.

2. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable the State to limit enrollment for the Demonstration-eligible population and maintain a waiting list for applicants as outlined in STC 18, and to delay enrollment to the first day of the month in which a position becomes available and enrollment is offered.

3. Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable the State to provide mental health services to eligible individuals as outlined in STC 25(c) that may not be available to all categorically needy individuals under the Medicaid State plan, or to all individuals in a statutory eligibility group or all Demonstration-eligible individuals, and to the extent necessary to enable the State to impose a limit on the number of such individuals participating in the Demonstration.

4. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment, as outlined in Sections V and VII of the STCs, in the Accountable Care Collaborative program and the one Regional Care Collaborative Organization (RCCO) serving the region in which the Demonstration-enrolled individual lives, and in the one PIHP serving the region in which the Demonstration-enrolled individual lives.

5. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to enable the State to not extend eligibility to individuals prior to the first day of the month in which a position becomes available within any applicable enrollment cap and eligibility is offered.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00280/8**

TITLE: **Colorado AwDC Demonstration**

AWARDEE: **Colorado Department of Health Care Policy and Financing**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Colorado's section 1115(a) Medicaid Adults without Dependent Children (AwDC) Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Colorado Department of Health Care Policy and Financing (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective as of April 1, 2012, through December 31, 2013, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits
VI. Cost Sharing
VII. Delivery Systems
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Monitoring Budget Neutrality
XI. Evaluation of the Demonstration
XII. Schedule of State Deliverables During the Demonstration Extension Period
Attachment A. Quarterly Report Content and Format
Attachment B. Mental Health Benefits and Service Definitions
Attachment C. Covered Mental Health Diagnoses

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Colorado AwDC Medicaid section 1115 demonstration provides comprehensive health care benefits to adults, ages 19 through 64 years, who are not pregnant, who do not have a Medicaid-eligible dependent child living in the household, who have family income at or below 10 percent of the Federal poverty level (FPL), and who are not otherwise eligible under the Medicaid State plan, the Children's Health Insurance Program (CHIP) or Medicare. Upon initial implementation of the

Demonstration, the State-established income eligibility standard is set at 10 percent of the FPL. As State funding allows, the State may choose to expand income eligibility up to 60 percent of the FPL and/or increase enrollment as outlined below in Section IV of the STCs.

The Demonstration population will receive health care benefits through mandatory enrollment in the State's Accountable Care Collaborative (ACC). As part of the ACC, clients are mandatorily enrolled into a Regional Care Coordination Organization (RCCO) serving the region in which the Demonstration-enrolled individual lives. The RCCO is charged with assisting individuals in coordinating care and in improving health outcomes. Through the Demonstration, eligible individuals also receive mental health services through mandatory enrollment into the one Prepaid Insurance Health Plan (PIHP) serving the region in which the Demonstration-enrolled individual lives. Demonstration enrollees with co-occurring mental health and substance use disorders may receive treatment for both conditions provided under the PIHP contract.

The State's goals under the Demonstration are to:

- Provide health care coverage to 10,000 currently uninsured Coloradans, or more if available funding is sufficient to cover additional individuals;
- Ensure that services are provided in an effective and coordinated fashion through an accountable care structure that will ensure that appropriate services are provided in a cost-effective manner for this population;
- Provide comprehensive coverage for individuals who were previously uninsured and served through the Colorado Indigent Care Program, a State-only program that provides low-cost health care services to low-income individuals who are not eligible for Medicaid or CHIP; and
- Study trends in beneficiary needs, provider capacity, and care delivery to assist in preparations for the implementation of provisions of the Affordable Care Act in 2014, including the coverage for the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65, regardless of disability status, with income at or below 133 percent of the FPL.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy**. The State must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy statement affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly identified as not

applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the Demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX State plan amendments (SPAs) for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility (except as permissible pursuant to STCs 17 and 18), enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    An explanation of the public process used by the State, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;

    a. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures,

as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX State plan amendment, if necessary; and

c. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of STC 9.

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in STC 14, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives. The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met.

   b. Special Terms and Conditions. The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   c. Quality. The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO), State quality assurance monitoring and quality improvement activities, and any other documentation of the quality of care provided under the demonstration.

   d. Compliance with the Budget Neutrality Cap. The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

   e. Interim Evaluation Report. The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements**.**

    a. Notification of Suspension or Termination. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

    b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

    c. Phase-out Plan Requirements. The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    d. Phase-out Procedures. The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    e. FFP. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 Demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

    In States with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)).The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY

16. **Eligibility Criteria.** Demonstration eligibles are individuals who:
    a. Are adults age 19 through 64 years who are not pregnant and do not have a Medicaid-dependent child living in the household;
    b. Are not eligible for Medicaid under the State plan, Medicare, or CHIP; and

c. Have family income at or below the State-established income eligibility standard referenced in STC 17 not to exceed 60 percent of the FPL, as determined in accordance with STC 19.

17. **State-Established Income Eligibility Standard.** Upon initial implementation of the Demonstration, the State-established income eligibility standard is set at 10 percent of the FPL. As State funding allows, the State has the flexibility to expand income eligibility up to 60 percent of the FPL based on the criteria outlined below. Additionally, an adjustment to increase the State-established income eligibility standard will not require an amendment to the Demonstration pursuant to STC 6.

    a. Minimum Income Eligibility Standard. The State must not decrease the income eligibility standard below 10 percent of the FPL. The State is prohibited from reducing the income eligibility standard below this minimum level without an amendment to the Demonstration pursuant to STC 6.

    b. Enrollment off the Waiting List. Prior to increasing the income eligibility for the Demonstration, the State must ensure that any individual on a waiting list at the current State-established income eligibility standard is enrolled into the Demonstration.

    c. Notice for Changing the Income Eligibility Standard. Before adjusting the income eligibility standard, the State must notify CMS at least 60 calendar days in advance of implementation. This notice must include updated budget neutrality spreadsheets, State estimates on the number of uninsured that meet the proposed income standard and projected enrollment estimates, including any enrollment limit, and a proposed process for maintaining a wait list. The State must also provide public notice as outlined in State rules.

    d. Non-Federal Share. Prior to implementation of any increase in the income eligibility standard, the State must identify an allowable non-Federal share, which must be approved by CMS.

18. **Enrollment.** Upon initial implementation of the Demonstration, the State will limit enrollment to 10,000 individuals. The State will have flexibility to increase enrollment in accordance with the criteria outlined below. An adjustment to increase enrollment will not require an amendment to the Demonstration pursuant to STC 6.

    a. Minimum Enrollment. The State must not decrease enrollment below 10,000 individuals in the Demonstration. The State is prohibited from reducing enrollment below this minimum level without an amendment to the Demonstration pursuant to STC 6.

    b. Notice. Before adjusting or removing this limit, the State must notify CMS at least 30 calendar days in advance of implementation and provide public notice. This notice must include updated budget neutrality spreadsheets, projected enrollment estimates, and proposed enrollment limit. The State must also provide public notice as outlined in State rules.

c. Non-Federal Share. Prior to implementation of any increase in enrollment or removing the limit, the State must identify an allowable non-Federal share, which must be approved by CMS.

d. Attrition. If the State chooses to reduce enrollment once it is increased above the minimum enrollment limit, individuals enrolled at that time must be able to maintain coverage, and enrollment may only be reduced by attrition.

e. Implementing Enrollment.
A Demonstration eligible individual may be placed on a waiting list for enrollment in the program if current enrollment in the program meets the current enrollment limit, if applicable. If a waiting list is in place, the State will enroll individuals from the waiting list based on a randomized member selection enrollment process as outlined below.

i. Initial Implementation. Initial enrollment into the Demonstration will be 10,000 positions. Initial implementation must adhere to the following 3 actions:
   1. Allocation of these positions will be distributed between the 7 RCCO regions utilized in the ACC program. Allocation will be based on State estimates of uninsured individuals residing within each region and is outlined in Table A.
   2. The State will accept and process applications for the Demonstration for a minimum of 45 calendar days. All applicants determined eligible during this initial processing period will receive notification that they are eligible, but that benefits will only be provided to some eligible applicants. Each eligible applicant will be placed into a regional pool of applicants based on county of residence.
   3. After the initial processing period for Demonstration applications, the State will conduct 7 regional randomized member selections to enroll individuals into the available enrollment positions allocated by region.

Table A. Initial Allocation of Enrollment Positions by RCCO

ACC Region	Counties in RCCO	Demonstration Allocation
RCCO 1	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit	1,704
RCCO 2	Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	631
RCCO 3	Adams, Arapahoe, Douglas	2,377
RCCO 4	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache	909
RCCO 5	Denver	1,658
RCCO 6	Boulder, Broomfield, Clear Creek, Gilpin, Jefferson	1,439

RCCO 7	El Paso, Elbert, Park, Teller	1,282
Total		10,000

ii. On-going Implementation. Following utilization of this initial regional randomized member selection processes, the State will conduct monthly randomized member selections on a statewide basis to enroll people into coverage positions available within the current enrollment limit or as the enrollment limit is increased. Changes to the waiting list operational policy that affect the Demonstration must be submitted to CMS for approval prior to implementation.

iii. Notification. When applicants are placed on a waiting list, they will receive notification of waiting list status. When applicants are selected through the process outlined above, they will receive notification of enrollment into Demonstration coverage.

19. **Eligibility Determinations.** Eligibility determinations for the Demonstration-eligible population are determined based on an application by the beneficiary. Demonstration-eligible individuals may apply for the Demonstration at any of the 64 County Agencies, a Medical Assistance Site, or through the State's designated eligibility and enrollment vendor. If found eligible and there is no waiting list in place, the individual will be enrolled into the Demonstration and offered coverage as outlined below in Sections V and VII of the STCs. If found eligible but there is a waiting list in place, the individual will be notified of placement on the waiting list pursuant to STC 18.

    For income calculations, the State will consider the Demonstration applicant's gross income and the spouse's gross income (if applicable). The State will apply the Family Medicaid earned income disregard standard and the Adult Medicaid unearned income disregard as described in the approved Medicaid State plan. Assets are not included in determining eligibility.

    The State must ensure that Demonstration applicants that meet the categorical requirements for Medicaid under the State plan or CHIP will be processed and enrolled in Medicaid or CHIP as these populations are ineligible for Demonstration eligibility.

20. **Retroactive Eligibility.** Demonstration eligibles must be enrolled effective the first day of the month in which a position is available within any applicable enrollment limitpursuant to STCs 18 and 19, and eligibility is offered. Retroactive eligibility prior to the date of application as provided for under the approved Medicaid State plan does not apply to Demonstration eligibles.

21. **Eligibility Redeterminations.** Individuals enrolled in the Demonstration must have an eligibility redetermination at least once every 12 months.
    a. Each redetermination must include a reassessment of the individual's eligibility for Medicaid and CHIP.
    b. A Demonstration enrollee may apply for eligibility under Medicaid or CHIP at any time for any reason. The State must determine eligibility for Medicaid and CHIP and enroll individuals in programs for which they are found eligible.
    c. A Demonstration enrollee who fails to complete the redetermination process in a timely manner may lose eligibility for the program and, upon reapplication, be placed on a

waiting list if the State enrollment limit has been reached, as described in STC 18.

d. Demonstration enrollees and those on the waiting list, if applicable, are required to report changes in circumstances in accordance with Medicaid law and policy.

22. **Disenrollment.** Demonstration enrollees will be disenrolled when circumstances change in accordance with Medicaid law and policy. Prior to disenrollment from the Demonstration, the State must determine if an individual is eligible on any other basis/existing Medicaid category.

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V. BENEFITS

23. **Benefits.** Demonstration enrollees must receive all mandatory and optional services pursuant to the Medicaid State plan, which are paid for by the State on a fee-for-service (FFS) basis. Additionally, eligible Demonstration enrollees receive mental health benefits pursuant to STC 25(c), which are capitated to a Prepaid Inpatient Health Plan (PIHP) providing mental health benefits. Demonstration enrollees with co-occurring mental health and substance use disorders may receive treatment for both conditions under the PIHP contract.

24. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The State must meet its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions) for eligible individuals, ages 19 and 20, within the Demonstration.

25. **Seamless Coordination of Benefits.** Benefits available through the Demonstration are coordinated through the ACC program, the RCCOs and a PIHP providing mental health benefits as outlined below.

    a. Accountable Care Collaborative (ACC). The following benefits are coordinated through the RCCOs and the Primary Care Medical Providers (PCMPs):
        i. Physician services
        ii. Dental care
        iii. Prescription medicines
        iv. Durable medical equipment
        v. EPSDT for Demonstration enrollees through age 20
        vi. Family Planning (pursuant to freedom of choice of provider as specified in 42 CFR 431.51(a)(5))
        vii. Medically-related transportation
        viii. Laboratory and radiological services
        ix. Ambulatory surgery (independent facility)
        x. Vision and eye glasses following eye surgery
        xi. Podiatry services (not routine care)
        xii. Prosthetics and orthotics
        xiii. Independent clinic services
        xiv. Speech, occupational, and physical therapies
        xv. Hospital services, including inpatient, outpatient and emergency
        xvi. Hospice

xvii. Home health
xviii. Private duty nursing
xix. Outpatient substance abuse treatment
xx. Skilled nursing facilities

b. Care Management Services. The RCCO will also provide Demonstration enrollees with care management and coordination services to assist individuals in accessing the health care delivery system and improving health outcomes.

c. Mental Health Benefits. Demonstration enrollees receive State plan mental health services as well as enhanced services (consistent with the services covered under the State's Community Mental Health Services Program (CMHSP) authorized under Colorado's section 1915(b) demonstration program for state plan populations) as defined in Attachment B, that are delivered through regional Prepaid Inpatient Health Plans (PIHPs). Individuals eligible for these enhanced services must have a confirmed mental health diagnosis as outlined in Attachment C. The State may amend the enhanced services and list of covered mental health diagnoses consistent with any amendments made to the State's CMHSP waiver without an amendment to the Demonstration as outlined in STC 6; however it must notify CMS at least 30 days prior to implementation of the change, provide an updated Attachment B and/or C, and follow reporting requirements pursuant to STCs 40, 41 and 42.

d. The RCCOs and PIHPs will work collaboratively to coordinate and integrate care for medical and behavioral health care services.

VI. COST SHARING

26. **Cost Sharing.** All Demonstration enrollees will be subject only to nominal cost-sharing, as stipulated in 42 C.F.R 447.54. Standard Medicaid exemptions from cost-sharing, such as family planning services, as stipulated in 42 C.F.R. 447(b) apply to the Demonstration.

VII. DELIVERY SYSTEMS

27. **Mandatory Enrollment.** The State may mandatorily enroll individuals served through this Demonstration into the RCCO and the PIHP providing mental health benefits within the region in which an individual resides to receive benefits. In order to effectuate mandatory enrollment, the State shall prioritize capacity within the RCCOs for the Demonstration enrollees before voluntary enrollment of individuals eligible under the State plan.

28. **Role of the ACC/RCCOs.** The RCCO is charged with assisting individuals in coordinating care, improving health outcomes, and in assisting enrollees in finding a Primary Care Medical Provider (PCMP). In the ACC, the RCCOs manage the primary care provider network and are required to contract with the PCMPs to serve as medical homes. In addition to managing a network of PCMPs, the RCCOs are required to establish a virtual informal network of specialists and ancillary providers. ACC members can see any Medicaid specialist as specialists are not required to be contracted with the RCCOs in order to serve Demonstration enrollees; however, referrals are required for some services as specified in the approved Medicaid State plan.

29. **Provider Reimbursement.** PCMPs, specialists, and ancillary providers must be enrolled Medicaid providers, and they will be paid on a FFS basis consistent with the rates under the approved State plan. In addition, PCMPs and RCCOs receive a monthly per-member, per-month case management fee as referenced in the PCMP and RCCO contracts. Each PIHP providing mental health services will be paid an actuarially sound capitation rate consistent with the requirements of 42 CFR 438.6.

30. **Managed Care Requirements.** The State must comply with the managed care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan and behavioral health services used in the rate development process.

31. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the Demonstration, until the contract compliance requirement is met.

32. **Public Contracts**. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

33. **Network Requirements.** The State must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the PIHP network must be sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed. Each PIHP must provide Demonstration populations with all Demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the State.

34. **Demonstrating Network Adequacy**. Annually, each RCCO and PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate network of (PCMPs) or mental health providers.

    a. The State must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the Demonstration as well as the number of network providers accepting the new Demonstration population;

    b. Each RCCO is also required to report on the assignment of new enrollees to a PCMP and its virtual/informal network of specialists as part of the quarterly reports pursuant to STC 41 and Attachment A; and

    c. The State must develop a plan outlining the role of the State's Data Analytics Contractor

(SDAC) in monitoring and reporting associated with ensuring an adequate provider network and related to health outcomes in the networks.

35. **Readiness Review Requirements.** The State shall conduct a readiness review of each RCCO and PIHP at least 30 days prior to program implementation.

    a. Readiness reviews shall address each RCCO and PIHP's capacity to serve the Demonstration enrollees, including, but not limited to, adequate network capacity and operational readiness to provide the intensive level of support and care management to this population;

    b. Prior to the State's planned implementation date for the Demonstration, the State must submit to CMS for review proposed ACC and PIHP contracts or contract amendments, as needed, to implement the Demonstration and a contingency plan for addressing insufficient network issues if they arise.

    c. CMS reserves the right to request additional documentation and impose additional milestones on the Demonstration in light of findings from the readiness review activities.

36. **Revision of the State Quality Strategy.** To the extent necessary, the State must update the Quality Strategy for mental health services provided by the PIHPs to reflect the addition of the Demonstration population to its managed care mental health program and submit it to CMS for approval within 90 days from the approval date of the Demonstration. The revised Quality Strategy shall continue to comply with the requirements of 42 CFR 438 Subpart D.

VIII. GENERAL REPORTING REQUIREMENTS

37. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in Section IX of these STCs.

38. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

39. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section X of these STCs.

40. **Quarterly Calls.** The State must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, ACC/RCCO/PIHP operations (such as network adequacy, assignment of a PCMP, contract amendments, and rate certifications), health care delivery, enrollment, proposed or implemented changes to the enrollment limit and/or State-specified income eligibility standard, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, ACC/PIHP financial performance that is relevant to the Demonstration, role of the State's Data Analytics Contractor, progress on evaluations, State legislative developments, any

Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

41. **Quarterly Reports.** The State must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, ACC/RCCO/PIHP operations (such as network adequacy, assignment of a PCMP, contract amendments and rate certifications); approval and contracting with new plans; health care delivery; benefits; enrollment; grievances; quality of care; access; proposed changes to payment rates; proposed or implemented changes to the enrollment limit and/or State-specified income eligibility standard; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;

    c. Action plans for addressing any policy and administrative issues identified;

    d. Quarterly enrollment reports that include the member months, in addition to end of quarter and point-in-time enrollment for each Demonstration population and other statistical reports listed in Attachment A;

    e. Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;

    f. Progress updates to the Transition Plan as specified in STC 43, including how the State will reduce the time that the Expansion Population must wait before receiving benefits;

    g. Evaluation activities and interim findings.

42. **Annual Report.** The annual report must include, at a minimum, include the requirements outlined below. The State must submit the draft annual report no later 120 days after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

    a. All items included in the quarterly report pursuant to STC 41 must be summarized to reflect the operation/activities throughout the DY;

    b. Total annual expenditures for the Demonstration population for each DY, with

administrative costs reported separately; and

c. Yearly enrollment reports for Demonstration enrollees for each DY (enrollees include all individuals enrolled in the Demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement.

43. **Transition Plan.** The State is required to prepare, and incrementally revise a Transition Plan, consistent with the provisions of the Affordable Care Act, for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of enrolled individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. By November 1, 2012, the State must submit to CMS for review and approval an initial Transition Plan, consistent with the provisions of the Affordable Care Act, for all individuals enrolled in the Demonstration. The State must include progress updates on the transition plan in each quarterly and annual report thereafter. The State will revise the Transition Plan as needed. The plan must outline how the State will initiate transition activities beginning July 1, 2013, and contain the required elements and milestones described in subparagraphs (a)-(d) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

a. Seamless Transitions. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
    i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
    ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
    iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid eligibility.
    iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.
    v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b. Provider Participation. The State must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

c. Adequate Provider Supply. The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of service delivery. The report must separately address each of the following provider types:

i. Primary care providers;
ii. Specialty providers;
iii. Mental Health services;
iv. Substance Use Services; and
v. Dental

d. Systems Development or Remediation. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include:

i. Tracking out-of-pocket charges in order to implement a 5 percent aggregate family cost-sharing cap for low-income population coverage options; and
ii. Replacing manual administrative controls with automated processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

e. Progress Updates. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

f. Implementation.

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

44. **Final Report.** Within 120 days following the end of the Demonstration, the State must submit a draft final report to CMS for comments. The State must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

IX. GENERAL FINANCIAL REQUIREMENTS

45. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including

those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of the STCs.

46. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a. Tracking Expenditures. In order to track expenditures under this Demonstration, Colorado must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

    b. Cost Settlements. For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

    c. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

    d. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.

    e. Use of Waiver Forms. For each Demonstration year, a separate Form CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name ”AwDC” to report expenditures for the Demonstration population. The waiver name “AwDC” must be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiverxpenditures should be allocated to these forms based on the guidance found below.

47. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures related to the Demonstration benefit package described in Section V of the STCs provided to individuals who are enrolled in this Demonstration as described in Section IV of the STCs. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

48. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

49. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

50. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

    a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 41, the actual number of eligible member months for the Demonstration population. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

       To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

    b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

51. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Colorado must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

52. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal

matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section X of the STCs:

a. Administrative costs, including those associated with the administration of the Demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

c. Net medical assistance expenditures made under section 1115 Demonstration authority under the DSHP.

53. **Sources of Non-Federal Share.** The State must certify that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

54. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local)

used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

55. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

56. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

X. MONITORING BUDGET NEUTRALITY

57. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

58. **Risk.** Colorado shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles. Because CMS provides FFP for all Demonstration eligibles, Colorado shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Colorado at risk for the per capita costs for current eligibles, CMS assures that the federal Demonstration expenditures do not exceed the level of expenditures had there been no Demonstration.

59. **Demonstration Population Used to Calculate the Budget Neutrality Expenditure Cap.** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

a. For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group (EG) described as follows:
    i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under STC 50 for the Demonstration population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below.
    ii. The PMPM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility group subject to the budget neutrality agreement under this Demonstration are specified below. The Demonstration Year is consistent with the State fiscal year (July 1 – June 30). A PMPM was constructed based on State historical expenditure data. The trend rate and PMPM amounts for the Demonstration population are shown below. The Demonstration population is a "pass-through" or "hypothetical" population. Therefore, the State may not derive savings from this population.

Eligibility Group	Growth Rate	DY 1 SFY 2012 PMPM	DY 2 SFY 2013 PMPM	DY 3 SFY 2014 PMPM
AwDC	4.00%	$738.42	$767.54	$798.24

    iii. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of the projected annual expenditure cap for the Demonstration population calculated in subparagraph (i) above.

b. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual Demonstration expenditures during the extension approval period, as reported on the forms listed in STC 46(e) above, by total computable Demonstration expenditures for the same period as reported on the same forms. Should the Demonstration be terminated prior to the end of the extension approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the Demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

c. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration population described in STC 46(e) during the Demonstration period reported in accordance with STC 46.

60. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the Demonstration.

61. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Demonstration Year	Cumulative Expenditure Cap Definition	Percentage
Year 1	Budget neutrality expenditure cap plus	1 percent
Years 1 and 2	Combined budget neutrality expenditure caps plus	0 percent

62. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

63. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 calendar days from the award of the Demonstration extension a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

    a. Domain of Focus. The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the Demonstration as outlined in Section I of the STCs. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
        i. The number of uninsured in the State;
        ii. The number of Demonstration-enrolled individuals accessing health care services in comparison to the number of Demonstration eligibles in need of services;
        iii. The decrease in uncompensated care provided by hospitals and federally qualified health centers (FQHCs) serving individuals who would have received discounted medical services through the Colorado Indigent Care Program (CICP) in the absence of the Demonstration;
        iv. The number of Demonstration-enrolled individuals who would have received discounted medical services through CICP participating hospitals and FQHCs in the absence of the Demonstration;
        v. The cost-effectiveness and efficiency of the ACC program in ensuring that appropriate health care services are provided in an effective and coordinated

fashion;

vi. Provider network capacity to serve the health care needs of the Demonstration population;

vii. Identify trends in beneficiary needs for the Demonstration population to aid in preparation for coverage expansions pursuant to the Affordable Care Act; and

viii. Identify limitations, challenges, opportunities and best practices in provider capacity and care delivery for the Demonstration population to aid in preparation for coverage expansions pursuant to the Affordable Care Act.

64. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of its request for each subsequent renewal.

65. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design described in STC 63 within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

66. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration; the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The State is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	**Deliverable**	**STC Reference**
30 days prior to implementation	Submit Readiness Review	STC 35
90 days from the date of the award letter	Submit Quality Strategy	STC 36
120 days from date of award letter	Submit Draft Evaluation Plan	STC 63
60 days of receipt of CMS comments	Submit Final Evaluation Plan	STC 65
11/01/2012	Submit Draft Transition Plan	STC 43
Annually	**Deliverable**	**STC Reference**
120 days after the close of the DY	Draft Annual Report	STC 42

30 days following receipt of CMS comments	Final Annual Report	STC 42
Each Quarter	**Deliverable**	**STC Reference**
60 days after the close of the quarter	Quarterly Operational Reports	STC 41
	CMS-64 Reports	STC 46

ATTACHMENT A

Quarterly Report Content and Format

Under STC 41, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Colorado Adults without Dependent Children Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (04/1/2012 – 06/30/2012)
Federal Fiscal Quarter: 1 (4/2012 – 06/2012)

I. Introduction

Information describing the goals of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

II. Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

A. Enrollment Counts

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
AwDC		

B. Enrollment Limit/Wait List

Summarize what the current enrollment limit within the Demonstration is and the number of individual currently on a wait list. Also identify any proposed changes to the enrollment limit.

C. State-Established Income Eligibility Standard

Summary the current State-established income eligibility standard and any proposed changes to this standard.

D. Collection and Verification of Encounter Data and Enrollment Data
Summarize any issues, activities or findings related to the collection and verification of encounter and enrollment data.

III. Benefits Information

Discuss any changes or anticipated changes in populations served and benefits, including any implemented or proposed changes to the State plan benefits or covered mental health diagnosis for eligible individuals to receive behavioral health services.

IV. Assignment of a Primary Care Medical Provider and Virtual Network

Summarize RCCO activities related to assignment of new enrollees to a PCMP and the RCCOs' virtual/informal network of specialists and complete the following chart:

Demonstration Populations	New Enrollees for the Quarter	New Enrollees Assigned a PCMP
AwDC		

V. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

VI. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, ACC/RCCO/PIHP operations (such as network adequacy, assignment of a PCMP, contract amendments and rate certifications); approval and contracting with new plans; health care delivery; benefits; enrollment; grievances; quality of care; access; proposed changes to payment rates; proposed or implemented changes to the enrollment limit and/or State-specified income eligibility standard; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues.

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VII. Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

VIII. Budget Neutrality

ATTACHMENT A

Quarterly Report Content and Format

A. Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

B. Member Month Reporting
Enter the member months for each of the EGs for the quarter.

i. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
AwDC				

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures *(Member months multiplied by PMPM)*
AwDC			

IX. Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the MCARP and other consumer groups.

X. Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

XI. Demonstration Evaluation
Discuss progress of evaluation design and planning.

XII. Transition Plan
Pursuant to STC 43, provide updates on the State's work related to the transition plan consistent with the provisions of the Affordable Care Act, for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of enrolled individuals to a coverage option.

XIII. Additional Information

A. Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

B. State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

C. Date Submitted to CMS

ATTACHMENT B

Mental Health Benefits and Service Definitions

The benefits provided by PIHPs for individuals eligible for mental health services include both State plan services as well as enhanced services as described below:

State Plan Services

- Inpatient Hospital (includes psych)
- Under 21 Psychiatric
- 65 and Over Psychiatric
- Outpatient Hospital (includes psych)
- Physician Services (includes psych)
- Rehabilitative Services
- Individual psychotherapy
- Individual brief psychotherapy
- Family psychotherapy
- Group psychotherapy
- Mental health assessment
- Pharmacological management
- Outpatient day treatment
  Emergency/crisis services
- Clinic Services, Case Management
- Pharmacy
- FQHC
- RHC
- School-based Mental Health Services

Enhanced Services

Mental Health Service	**Service Definition**
Assertive Community Treatment	A service-delivery model that provides comprehensive, locally-based treatment to adult members with serious mental illnesses. Services are highly individualized and are available 24 hours a day, seven days a week, 365 days a year to clients who need significant assistance and support to overcome the barriers and obstacles that confront them as a result of their mental illnesses. ACT teams provide case management, initial and ongoing mental health assessments, psychiatric services, employment and housing assistance, family support and education, and substance abuse services to individuals with co-occurring diagnoses of SA and MI. ACT multidisciplinary treatment teams may consist of the following providers: psychiatrist, Masters level licensed mental health professionals, Bachelor's level mental health professionals, and peer specialists.
Clubhouse and Drop-in Centers	Peer support services for members who have mental illnesses, provided in Clubhouses and drop-in centers. In Clubhouses, individuals (members) utilize their skills for clerical work, data input,

ATTACHMENT B

Mental Health Benefits and Service Definitions

Mental Health Service	Service Definition
	meal preparation, providing resource information or reaching out to fellow members. Staff and members work side by side, in a unique partnership. In drop-in centers, individuals with mental illnesses plan and conduct programs and activities in a club-like setting. There are planned activities and opportunities for individuals to interact with social groups. Clubhouse and drop-in centers are staffed by mental health consumers in recovery. Many of them are trained as peer specialists and some have degrees in mental health or other professions. Clubhouses may also be staffed by mental health clinicians, Bachelor's level or above.
Intensive Case Management	Community-based services averaging more than one hour per week, provided to adult members with serious mental illnesses (SMI) who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning. Services are designed to provide adequate supports to ensure community living. Services are assessment, care plan development, multi-system referrals, assistance with obtaining wraparound services and supportive living services, monitoring and follow-up. Intensive case management services are provided by Bachelors level or Masters level mental health professionals.
Prevention/Early Intervention Services	Proactive efforts to educate and empower members to choose and maintain healthy life behaviors and lifestyles that promote mental health. Prevention and early intervention efforts include services such as mental health screenings, the Nurturing Parent Program, educational programs promoting safe and stable families, senior workshops related to common aging disorders, and Love and Logic classes for healthy parenting skills. These services and programs are provided by Master's level licensed mental health providers.
Recovery Services	Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, and rights protection. They also provide social supports and a lifeline for members who have difficulties developing and maintaining relationships. These services can be provided at schools, churches or other community locations. Recovery services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring for children and adolescents, Bipolar Education and Skills Training (BEST) courses, NAMI courses, Wellness Recovery Action Planning (WRAP) groups, consumer and family support groups, warm lines and advocacy services. Most recovery services are provided by mental health peers or family members, whose qualifications are having a diagnosis of mental illness or being a family member of a person with mental illness. Although Colorado does not currently require that peer

ATTACHMENT B

Mental Health Benefits and Service Definitions

Mental Health Service	**Service Definition**
	support specialists be licensed, the Department has developed a set of guidelines or "core competencies" for peer support specialists to promote consistent standards across the State. Occasionally, programs such as the BEST courses may be co-facilitated by Masters level licensed mental health providers, as well.
Residential Services	Residential services are defined as twenty-four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, and are appropriate for adult and older adult members whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Residential services are a variety of clinical interventions that, individually, may appear to be similar to traditional state plan services. By virtue of being provided in a setting where the client is living, in real-time (i.e. with immediate intervention possible), residential service become a unique and valuable service in its own right that cannot be duplicated in a non-structured community setting. These clinical interventions, coupled together, in real-time, in the setting where a client is living, become a tool for treating individuals in the most cost-effective manner and in the least restrictive setting. Clinical interventions provided in this setting are: assessment and monitoring of mental and physical health status; assessment and monitoring of safety, including suicidal ideation and other behavioral health issues; assessment of level and quality of social interactions; assessment of/support for motivation for treatment; assessment of ability to provide for daily living needs; observation and assessment of group interactions; behavioral interventions to build effective social behaviors and coping strategies; behavioral interventions to reduce social withdrawal and inappropriate behavior or thought processes; individual therapy; group therapy; family therapy; and medication management. Residential services are provided by Bachelors and Masters level clinicians, psychologists, and psychiatrists; medical services may be provided by MDs, NPs, RNs, depending on the service location.
Respite Services	Temporary or short-term care of a youth or adult client that is provided by adults other than the birth parents, foster parents, adoptive parents, family members or caregivers that the client normally resides with, that is designed to give the parents, family members or caregivers some time away from the client, to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges. Respite care provider backgrounds range from some college to advanced degrees in mental health. All respite providers receive extensive training to serve clients with

ATTACHMENT B

Mental Health Benefits and Service Definitions

Mental Health Service	Service Definition
	mental health issues.
Vocational Services	Services designed to assist adults and adolescent members who are ineligible for state vocational rehabilitation services and require long-term services and supports in developing skills consistent with employment and/or in obtaining employment. Services are skill and support development interventions, educational services (GED, college prep skills), vocational assessment and job coaching. Credentials of vocational providers vary from Bachelor's level staff to Masters level licensed behavioral health staff. Some vocational services are provided by peer specialists.

ATTACHMENT C

Covered Mental Health Diagnoses

295 - 298.9	
295	**Schizophrenic disorders**
	(the following fifth-digit sub-classification is for use with category 295)
0	unspecified
1	subchronic
2	chronic
3	subchronic with acute exacerbation
4	chronic with acute exacerbation
5	in remission
295.0	Simple type
295.1	Disorganized type
295.2	Catatonic type
295.3	Paranoid type
295.4	Acute schizophrenic episode
295.5	Latent schizophrenia
295.6	Residual type
295.7	Schizoaffective disorder
295.8	Other specified types of schizophrenia
295.9	Unspecified schizophrenia
296	**Episodic mood disorders**
	(the following fifth-digit subclassification is for use with categories 296.0-296.6)
0	unspecified
1	mild
2	moderate
3	severe, without mention of psychotic behavior
4	severe, specified as with psychotic behavior
5	in partial or unspecified remission
6	in full remission
296.0	Bipolar I disorder, single manic episode
296.1	Manic disorder, recurrent episode
296.2	Major depressive disorder, single episode
296.3	Major depressive disorder, recurrent episode
296.4	Bipolar I disorder, most recent episode (or current) manic
296.5	Bipolar I disorder, most recent episode (or current) depressed
296.6	Bipolar I disorder, most recent episode (or current) mixed
296.7	Bipolar I disorder, most recent episode (or current) unspecified

296.8	Other and unspecified bipolar disorders
296.80	Bipolar disorder, unspecified
296.81	Atypical manic disorder
296.82	Atypical depressive disorder
296.89	Other
296.9	Other and unspecified episodic mood disorder
296.90	Unspecified episodic mood disorder
296.99	Other specified episodic mood disorder
297	**Delusional disorders**
297.0	Paranoid state, simple
297.1	Delusional disorder
297.2	Paraphrenia
297.3	Shared psychotic disorder
297.8	Other specified paranoid states
297.9	Unspecified paranoid state
298	**Other nonorganic psychoses**
298.0	Depressive type psychosis
298.1	Excitative type psychosis
298.2	Reactive confusion
298.3	Acute paranoid reaction
298.4	Psychogenic paranoid psychosis
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
300 - 301.99	
300	**Anxiety, dissociative and somatoform disorders**
300.0	Anxiety states
300.00	Anxiety state, unspecified
300.01	Panic disorder without agoraphobia
300.02	Generalized anxiety disorder
300.09	Other
300.1	Dissociative, conversion and factitious disorders
300.10	Hysteria, unspecified
300.11	Conversion disorder
300.12	Dissociative amnesia
300.13	Dissociative fugue
300.14	Dissociative identity disorder
300.15	Dissociative disorder or reaction, unspecified

ATTACHMENT C

Covered Mental Health Diagnoses

300.16	Factitious illness with predominantly psychological signs and symptoms
300.19	Other and unspecified factitious illness
300.2	Phobic disorders
300.20	Phobia, unspecified
300.21	Agoraphobia with panic attacks
300.22	Agoraphobia without mention of panic attacks
300.23	Social phobia
300.29	Other isolated or specific phobias
300.3	Obsessive-compulsive disorders
300.4	Dysthymic disorder
300.5	Neurasthenia
300.6	Depersonalization disorder
300.7	Hypochondriasis
300.8	Somatoform disorders
300.81	Somatization disorder
300.82	Undifferentiated somatoform disorder
300.89	Other Somatoform disorder
300.9	Unspecified nonpsychotic mental disorder
301	**Personality disorders**
301.0	Paranoid personality disorder
301.1	Affective personality disorder
301.10	Affective personality disorder, unspecified
301.11	Chronic hypomanic personality disorder
301.12	Chronic depressive personality disorder
301.13	Cyclothymic disorder
301.2	Schizoid personality disorder
301.20	Schizoid personality disorder, unspecified
301.21	Introverted personality
301.22	Schizotypal personality disorder
301.3	Explosive personality disorder
301.4	Obsessive-compulsive personality disorder
301.5	Histrionic personality disorder
301.50	Histrionic personality disorder, unspecified
301.51	Chronic factitious illness with physical symptoms
301.59	Other histrionic personality disorder
301.6	Dependent personality disorder
301.7	Antisocial personality disorder

ATTACHMENT C

Covered Mental Health Diagnoses

301.8	Other personality disorders
301.81	Narcissistic personality disorder
301.82	Avoidant personality disorder
301.83	Borderline personality disorder
301.84	Passive-aggressive personality
301.89	Other
301.9	Unspecified personality disorder
307.1 - 309.99	
307	**Special symptoms or syndromes, not elsewhere classified**
307.1	Anorexia nervosa
307.2	Tics
307.20	Tic disorder, unspecified
307.21	Transient tic disorder
307.22	Chronic motor or vocal tic disorder
307.23	Tourette's disorder
307.3	Stereotypic movement disorder
307.4	Specific disorders of sleep of nonorganic origin
307.40	Nonorganic sleep disorder, unspecified
307.41	Transient disorder of initiating or maintaining sleep
307.42	Persistent disorder of initiating or maintaining sleep
307.43	Transient disorder of initiating or maintaining wakefulness
307.44	Persistent disorder of initiating or maintaining wakefulness
307.45	Circadian rhythm sleep disorder of nonorganic origin
307.46	Sleep arousal disorder
307.47	Other dysfunctions of sleep stages or arousal from sleep
307.48	Repetitive intrusions of sleep
307.49	Other
307.5	Other and unspecified disorders of eating
307.50	Eating disorder, unspecified
307.51	Bulimia nervosa
307.52	Pica
307.53	Rumination disorder
307.54	Psychogenic vomiting
307.59	Other
307.6	Enuresis
307.7	Encopresis
307.8	Pain disorders related to psychological factors

ATTACHMENT C

Covered Mental Health Diagnoses

307.80	Psychogenic pain, site unspecified
307.81	Tension headache
307.89	Other
307.9	Other and unspecified special symptoms or syndromes, not elsewhere classified
308	**Acute reaction to stress**
308.0	Predominant disturbance of emotions
308.1	Predominant disturbance of consciousness
308.2	Predominant psychomotor disturbance
308.3	Other acute reactions to stress
308.4	Mixed disorders as reactions to stress
308.9	Unspecified acute reaction to stress
309	**Adjustment reaction**
309.0	Adjustment disorder with depressed mood
309.1	Prolonged depressive reaction
309.2	With predominant disturbance of other emotions
309.21	Separation anxiety disorder
309.22	Emancipation disorder of adolescence and early adult life
309.23	Specific academic or work inhibition
309.24	Adjustment disorder with anxiety
309.28	Adjustment disorder with mixed anxiety and depressed mood
309.29	Other
309.3	Adjustment disorder with disturbance of conduct
309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.8	Other specified adjustment reactions
309.81	Post-traumatic stress disorder
309.82	Adjustment reaction with physical symptoms
309.83	Adjustment reaction with withdrawal
309.89	Other
309.9	Unspecified adjustment reaction
311 - 314.9	
311	**Depressive disorder, not elsewhere classified**
312	**Disturbance of conduct, not elsewhere classified**
	(the following fifth-digit sub-classification is for use with categories 312.0-312.2)
0	unspecified
1	mild
2	moderate
3	severe

ATTACHMENT C

Covered Mental Health Diagnoses

312.0	Undersocialized conduct disorder, aggressive type
312.1	Undersocialized conduct disorder, unaggressive type
312.2	Socialized conduct disorder
312.3	Disorders of impulse control, not elsewhere classified
312.30	Impulse control disorder, unspecified
312.31	Pathological gambling
312.32	Kleptomania
312.33	Pyromania
312.34	Intermittent explosive disorder
312.35	Isolated explosive disorder
312.39	Other
312.4	Mixed disturbance of conduct and emotions
312.8	Other specified disturbance of conduct, not elsewhere classified
312.81	Conduct disorder, childhood onset type
312.82	Conduct disorder, adolescent onset type
312.89	Other conduct disorder
312.9	Unspecified disturbance of conduct
313	**Disturbance of emotions specific to childhood and adolescence**
313.0	Overanxious disorder
313.1	Misery and unhappiness disorder
313.2	Sensitivity, shyness, and social withdrawal disorder
313.21	Shyness disorder of childhood
313.22	Introverted disorder of childhood
313.23	Selective mutism
313.3	Relationship problems
313.8	Other or mixed emotional disturbances of childhood or adolescence
313.81	Oppositional defiant disorder
313.82	Identity disorder
313.83	Academic underachievement disorder
313.89	Other
313.9	Unspecified emotional disturbance of childhood or adolescence
314	**Hyperkinetic syndrome of childhood**
314.0	Attention deficit disorder
314.00	Without mention of hyperactivity
314.01	With hyperactivity
314.1	Hyperkinesis with developmental delay
314.2	Hyperkinetic conduct disorder

314.8	Other specified manifestations of hyperkinetic syndrome
314.9	Unspecified hyperkinetic syndrome