

*Colorado Department of
Health Care Policy and Financing*



Section 1915(b) Waiver
Proposal for
The Colorado Medicaid
Accountable Care Collaborative:
Primary Care Case Management and
Prepaid Inpatient Health Plan Program; Accountable
Care Collaborative: Limited Managed Care
Capitation Initiative
and
Special Connections: Postpartum Months
Three through Twelve

Submitted March 2, 2018
for
Waiver Period July 1, 2018 to June 30, 2023
Revised May 1, 2018 and May 15, 2018

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Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Factsheet

Please fill in and submit this Factsheet with each waiver proposal, renewal, or amendment request.

The **State** of Colorado requests a waiver/~~amendment~~ under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver programs** are the Accountable Care Collaborative: PCCM Entity-PIHP Program, Accountable Care Collaborative: Limited Managed Care Capitation Imitative and Special Connections: Postpartum Months Three through Twelve. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is a(n):

- Initial request for new waiver
- amendment request for existing waiver, which modifies Section/Part _____
- Replacement pages are attached for specific Section/Part being amended
- Amendment request for existing waiver. Document is replaced in full, with changes highlighted.
- Renewal request
- This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) are filled out.
- The State has used this waiver format for its previous waiver period.
- Section A is replaced in full
- carried over from previous waiver period. The State:
- assures there are no changes in the Program Description from the previous waiver period.
- assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
- Section B is replaced in full
- carried over from previous waiver period. The State:
- assures there are no changes in the Monitoring Plan from the previous waiver period.
- assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

Effective Dates: This initial request for a new waiver is requested for a period of five (5) years, effective **July 1, 2018** and ending **June 30, 2023**. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contract person for the ACC Program under this waiver is ***Susan Mathieu***, and she can be reached at (303) 866-5584 or email at susan.mathieu@state.co.us

The State contact person for the Special Connections Program under this waiver is ***Susanna Snyder*** and she can be reached by telephone at (303) 866-3154 or e-mail at susanna.snyder@hcpf.state.co.us

The State contact person for the cost effectiveness portion of this waiver is ***John Doherty*** he can be reached by telephone at (303) 866-5180 or e-mail at John.Doherty@state.co.us

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The Department of Health Care Policy and Financing (the Department) sent the new Accountable Care Collaborative PCCM-PIHP Program, Accountable Care Collaborative: MCO Payment Reforms and Special Connections Postpartum Months Three to Twelve waiver to the federally recognized tribes in Colorado for their review and comment on January 25, 2018. The recognized tribes are the Southern Ute Indian Tribe and the Ute Mountain Ute. Additional native stakeholders include Denver Indian Health and Family Services, Utah Navajo Health Systems, Four Corners Regional Health, and New Sunrise Regional Treatment Center. As of February 26, 2018, 0 comments had been received from the tribal stakeholder groups.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe, new populations added, major new features of existing program, new programs added).

Colorado Medicaid serves 1.33 million people and has an annual budget of \$9.1 billion. The Department's mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. Colorado Medicaid clients are currently served through three major programs: Accountable Care Collaborative (ACC), Community Behavioral Health Services Program, and Long Term Services and Supports Program (LTSS). Moving into the future, the Department intends to build on the successes of each program while also seeking to integrate these programs to better serve clients and effectively utilize state resources.

The ACC is currently a managed fee-for-service model operated under a State Plan Amendment with the Center for Medicare & Medicaid Services (CMS). The ACC functions as a Primary Care Case Management Entity following the applicable federal requirements in 42 CFR 438.

The ACC Program represents an innovative way to accomplish the Department's goals for Medicaid reform by investing directly in community

infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The ACC Program makes the people and organizations that actually provide the care accountable for the quality and the cost of that care.

The ACC Program provides the framework within which other health care initiatives and tools can thrive, such as the medical home, health information technology, and payment reform. The ACC Program is a hybrid model, adding the characteristics of an Accountable Care Organization to the PCCM Entity model. Certain fundamental Accountable Care Organization characteristics are essential to the success of the ACC Program. These include managing and integrating the continuum of care across different settings; having enough members to support comprehensive performance measurement; being capable of prospectively planning budget and resource needs; and having the ability to develop and organize provider networks.

Colorado was divided into seven geographic regions with each region being served by one Regional Care Collaborative Organization (RCCO). Members were assigned to a region and RCCO based upon the county within which they resided.

The ACC has demonstrated reduced costs, improved health, and improved service utilization patterns. ACC members who have been in the program for longer than six months are more likely to seek and receive preventative services and follow-up care, and less likely to receive services at an emergency room, receive high cost imaging services, or be re-admitted to the hospital. Financial analysis indicates for SFY16 the ACC program avoided \$205 million in medical costs for ACC enrollees, with net costs avoided of \$61 million in SFY2016 and total cumulative savings of \$139 million since the program began. Please see the 2016 ACC Annual Report at:

<https://www.colorado.gov/pacific/sites/default/files/Health%20Care%20Policy%20and%20Financing%20FY%202016-17%20RFI%203.pdf>

In parallel to the ACC, the Department provided behavioral health services to Medicaid members through the Community Behavioral Health Services Program. The federal Health Care Financing Administration (HCFA) originally granted the State waivers to implement a managed mental health program in 1993. These waivers covered a two-year period, beginning July 1, 1995 and ending June 30, 1997 and were extended by HCFA through March 8, 1998.

The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties, and was expanded in 1998 to the remaining 12 counties of the state. The state was divided into five (5) specific geographic areas and one contractor, the Behavioral Health Organization, administered the program in each area. In 2004, program operations were

transferred from the Department of Human Services to the Department, allowing for more cohesive management of the program.

The waiver for the Mental Health Capitation and Managed Care Program has been amended several times. A 2013 amendment, effective for waiver period January 1, 2014 through June 30, 2015 included substance use disorder services in the program and provided the authority to serve the expansion population. At this time, the name of the program was also changed to the Community Behavioral Health Services Program. In 2015, CMS approved a waiver renewal for the period January 1, 2016 to June 30, 2017. In this waiver, the Department incorporated a few new populations, including Former Foster Care Children, expansion parents, and Children age six (6) through nineteen (19) with income above 100 percent but at or below 133 percent of the Federal poverty level. In 2017, CMS approved a waiver renewal for the period July 1, 2017 to June 30, 2019.

The ACC was designed to be iterative. In this next phase, the ACC will build upon the first seven years of the Program and advance the Department's goals to improve Member health and life outcomes and to use state resources wisely.

The ACC PCCM-PIHP will focus on the following objectives:

- Join physical and behavioral health under one accountable party.*
- Strengthen coordination of services by advancing team-based care and Health Neighborhoods.*
- Promote member choice and engagement by providing information, resources, tools and involving members in their care planning.*
- Pay providers for the increased value they deliver by shifting payment within Medicaid to value-based models, including a percentage of the RAE payments distributed to providers to support the medical home and value-based care delivery and use of performance-based incentives.*
- Ensure greater accountability and transparency through robust financial and public performance reporting.*

One entity, the Regional Accountable Entity (RAE), will be responsible for promoting physical and behavioral health and the previous duties originally contracted by the Regional Care Collaborative Organizations and Behavioral Health Organizations in their region. RAEs will implement and oversee all aspects of the ACC PCCM Entity-PIHP program within each of the seven regions. The RAE will manage a network of primary care physical health providers and specialty behavioral health providers to ensure access to appropriate care for Medicaid members in their region. A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to Members. Having one entity will improve the Member experience by creating one point of contact and clear accountability for whole-person care.

The ACC is the Department's delivery system within which all payment initiatives function, including limited managed care capitation initiatives. The Department currently has contracts for two existing capitated physical health Managed Care Organizations (MCOs) that operate in ACC region 1 and ACC region 5. To support continuity of care for Members receiving care through the existing MCOs and to encourage the continued engagement of the providers participating in these MCOs, the Department will incorporate the MCOs into RAE region 1 and RAE region 5 as the ACC: Limited Managed Care Capitation Initiative (ACC: MCO). These MCOs will function as a formal part of the ACC in these 2 regions and will be operated by the RAEs. In addition, the ACC: MCOs will be held accountable for improving health outcomes and Member satisfaction, incorporating value-based payments for providers around achieving these goals, and maximizing the integration of behavioral health and physical health services within the ACC infrastructure. ACC: MCO payment reform efforts will emphasize provider value-based payments tied to quality metrics that increase care coordination between physical and behavioral health; improve patient outcomes; and improve patient experiences. Achieving a set of defined quality metrics will allow ACC: MCOs to reduce its Medical Loss Ratio by a set percentage, but not less than the federal minimum of 85%.

Special Connections History

The Department is also seeking approval of Special Connections as part of this new waiver, which is anticipated effective July 1, 2018. The Special Connections portion of the waiver extends postpartum substance use disorder benefits from sixty (60) days postpartum to twelve (12) months postpartum.

The Department previously obtained authority for the extension of these services through an amendment to the Community Mental Health Services Program waiver. This portion of the waiver was originally approved beginning January 1, 2007 and extending to Sept. 30, 2009. Subsequent renewals occurred between 2009 and 2015. The current approved waiver renewal period is Jan. 1, 2016 through June 30, 2017. In 2017, CMS approved a waiver renewal for the period July 1, 2017 to June 30, 2019.

Special Connections is jointly administered by the Colorado Department of Human Services, Office of Behavioral Health (OBH), and the Department. Since 1992, assessment, treatment and case management services have been provided to pregnant and postpartum women with substance use disorder issues. The Office of Behavioral Health contracts with licensed women's treatment programs to provide Medicaid-paid services through an Interagency Agreement (IA) with the Department.

The Special Connections portion of the waiver extends the Medicaid postpartum substance use disorder benefits from sixty days to twelve months postpartum to ensure that the mother remains drug free and able to care for her new infant. Waiver-eligible members must have participated in the Special Connections program prior to giving birth and during the 60-day postpartum period. Extending treatment for these women increases the likelihood that the mother remains drug free and able to care for her infant. The rationale is that a mother who is drug free for an additional ten months postpartum would decrease Medicaid expenditures for these infants.

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A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. **1915(b)(1)** – (*Applies to the ACC PCCM Entity-PIHP*) The State requires enrollees to obtain medical care through a primary care case management entity (PCCM Entity) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - (*Applies to the ACC PIHP and the Special Connections*) The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - (*Applies to the ACC PIHP, ACC: MCO and the Special Connections*) The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

MCO (*Applies to the ACC: MCO*)

PIHP (*Applies to the ACC PIHP*)

PAHP

PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

✓ FFS Selective Contracting Program (please describe) (*Applies to the Special Connections*)

There is an IA between the Office of Behavioral Health (OBH) and the Department (refer to attached Appendix E2 for details) for provision of Medicaid services delivered by the Special Connections network. The Special Connections network consists of providers approved by and contracted with OBH for the delivery of these specialized services, and functions as a subcontract network of OBH. OBH has oversight for prior authorization for residential benefits. Program rates are set up to be comparable with the Fee For Service selective contracting requirements as stipulated in the state plan.

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. **Section 1902(a)(1)** – State wideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. ✓ **Section 1902(a)(10)(B)** – (*Applies to the ACC PIHP and the Special Connections*) Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.
- c. ✓ **Section 1902(a)(23)** – (*Applies to the ACC PCCM Entity-PIHP*) Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM Entity.
- d. ✓ **Section 1902(a)(4)** – (*Applies to the ACC PIHP*) To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

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B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

- a. **MCO:** (*Applies to the ACC: MCO*) Risk-comprehensive contracts are fully capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP:** (*Applies to the ACC PIHP*) Prepaid Inpatient Health Plan means an entity that:
- (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
- The PIHP is paid on a risk basis.
 The PIHP is paid on a non-risk basis.
- c. **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
- The PAHP is paid on a risk basis.
 The PAHP is paid on a non-risk basis.
- d. **PCCM Entity:** (*Applies to the ACC PCCM Entity*) A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM Entity is a PAHP.
- e. **Fee-for-service (FFS) selective contracting:** (*Applies to the Special Connections*) A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

- the same as stipulated in the state plan
 different than stipulated in the state plan (please describe)

f. **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement.** The State selected the contractor in the following manner (required by 42 CFR Part 74 if contract over \$100,000). Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc.):

- Competitive** procurement process (*Applies to the ACC PCCM Entity-PIHP*) (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

One Regional Administrative Entity (RAE) will be awarded in each of seven regions and will be responsible to provide all functions associated with the ACC PCCM Entity-PIHP, including the behavioral health and physical health functions. Bidders in region 1 and region 5 had the option to propose to implement ACC: MCO.

- Open** cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement. CMS Regional Office prior approval required.

- Other** (please describe) (*Applies to the Special Connections*)

Only specialized providers can provide services to this population. The Special Connections require providers with specialty knowledge of pregnancy, gender-responsive treatment, postpartum care, trauma-informed care, and substance use disorder issues.

The remainder of this page is intentionally left blank.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

(*Applies to the ACC PCCM Entity -PIHP*) The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

The Department contracts with Regional Accountable Entities (RAEs) to administer the ACC PCCM Entity-PIHP program. The Department requires the RAE to maintain two separate provider networks throughout their service region to meet access standards. The RAE is responsible for creating a network of specialty behavioral health providers that allow members sufficient access to services and choice of providers for the ACC PIHP. Additionally, the RAE is expected to contract with existing Medicaid providers to develop a network of primary care medical providers (PCMPs) for the ACC PCCM. Although members can choose to receive physical health services from any willing Medicaid provider, the RAE will provide additional practice support and resources to contracted PCMPs, enhancing members' access to high-functioning medical homes. The Department monitors the entire ACC PCCM Entity-PIHP network of providers through reporting on network adequacy, complaints and grievances, member satisfaction surveys, and site reviews. Members are also permitted to access ACC PIHP covered services from any contracted provider network when they are outside of their home service region.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Two or more MCOs

A PCCM or one or more MCOs

Two or more PIHPs.

Two or more PAHPs.

Other: (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*) (please describe)

- ***Within the ACC PCCM Entity PIHP and ACC: MCO networks, enrollees have a choice of providers.***

To help assure that enrollees continue to have a robust choice of providers, multiple safeguards regarding access to services have been constructed, including:

- *The beneficiaries will have full freedom of choice of state plan enrolled providers for physical health care;*
- *The State has developed rigorous time and distance and related access standards;*
- *The RAE is expected to contract with existing Medicaid providers to develop a network of primary care medical providers (PCMPs) for the ACC PCCM Entity;*
- *The RAE is responsible for supporting a network of specialty behavioral health providers that provide members sufficient access to services and choice of providers for the ACC PIHP;*
- *The RAE will provide additional practice support and resources to contracted PCMPs, enhancing members' access to high-functioning medical homes;*
- *The State will monitor the entire ACC PCCM Entity-PIHP network of providers through reporting on network adequacy, complaints and grievances, member satisfaction surveys, and site reviews.*

3. **Rural Exception.**

_____ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

Beneficiaries will be limited to a single provider in their service area (please define service area).

- ✓ (Applies to Special Connections) Beneficiaries will be given a choice of providers in their service area.

The outpatient, residential, care management and health education services included in Special Connections are provided by a specialty network of providers that have expertise in substance use disorders, gender-responsive treatment, trauma-informed

care, and pregnancy/postpartum care. They are located throughout the State with no specific defined service area. The current number of residential providers is three (3) with approximately sixteen (16) beds available at each facility. Depending upon the services deemed to be clinically appropriate, one bed may be used by multiple clients over the course of a year (typically between eighty (80) and one hundred (100) statewide). In outpatient treatment, a typical counselor will carry between twenty-five (25) and fifty (50) clients of varying levels of intensity, and if enrollment increases, additional staff are hired to cover the additional work load. With a total of five (5) outpatient programs and approximately fifteen (15) dedicated outpatient counselors and case managers, the caseload could vary between zero (0) and three hundred (300) at any given time, with a greater number of clients accumulating over the course of a year.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

- Statewide -- (Applies to the ACC PCCM Entity-PIHP and Special Connections) all counties, zip codes, or regions of the State
- Less than Statewide (ACC: MCO)**

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

ACC PCCM Entity-PIHP Geographic Areas of Service

Current RAE Contract Regions	Entity Type	Entity Name	Counties Served
Region 1	PCCM Entity-PIHP	Rocky Mountain Health Plans	Archuleta, Delta, Delores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

	ACC: MCO	Rocky Mountain Health Plans/Prime	Garfield, Gunnison, Mesa, Montrose, Pitkin, Rio Blanco
Region 2	PCCM Entity-PIHP	Northeast Health Partners	Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma
Region 3	PCCM Entity-PIHP	Colorado Access	Adams, Arapahoe, Douglas, Elbert
Region 4	PCCM Entity-PIHP	Health Colorado, Inc.	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache
Region 5	PCCM Entity-PIHP	Colorado Access	Denver
	ACC: MCO	Colorado Access/Denver Health	Denver
Region 6	PCCM Entity-PIHP	Colorado Community Health Alliance	Boulder, Broomfield, Clear Creek, Gilpin, Jefferson
Region 7	PCCM Entity-PIHP	Colorado Community Health Alliance	El Paso, Park and Teller

Special Connections Geographic Areas of Service

Region/Area Served	Type of Program (PCCM, MCO, PIHP, PAHP)	Name of Entity (for MCO, PIHP, PAHP)
1. Northeast Colorado	Fee for Service	<ul style="list-style-type: none"> Centennial Mental Health Center, Sterling
2. Denver metro area	Fee for Service	<ul style="list-style-type: none"> ARTS: The Haven, Denver Mile High Behavioral Health Care, Denver
3. Pueblo, Alamosa, and surrounding areas	Fee for Service	<ul style="list-style-type: none"> Crossroads Turning Points, Alamosa Crossroads Turning Points, Pueblo

E. Populations Included in Waiver

1. **Included Populations**. The following populations are included in the Waiver Program:

- ✓ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
 - ✓ Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*). **All full benefit beneficiaries will be enrolled in the ACC PCCM Entity-PIHP. The Region 5 ACC: MCO will mandatorily enroll children**
 - ✓ Voluntary enrollment (*Applies to the Special Connections*). **Special Connections waiver services are for 12-months post-partum members; adolescents who give birth could volunteer to participate in the program.**

- ✓ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
 - ✓ Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections*)

- ✓ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
 - ✓ Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections*)

- ✓ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
 - ✓ Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections*)

Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*)
- Voluntary enrollment

Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- Mandatory enrollment (*Applies to ACC PCCM Entity-PIHP*)
- Voluntary enrollment (*Applies to the Special Connections and ACC: MCO*)

TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

- Mandatory enrollment
- Voluntary enrollment

Other (Please define):

Former Foster Care Children under twenty-six (26) years of age as described in §1902(a)(10)(A)(i)(IX) of the Social Security act.

- Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC:MCO*)
- Voluntary enrollment (*Applies to the Special Connections*)

Children age six (6) through nineteen (19) with income above 100 percent but at or below 133 percent of the Federal poverty level.

- Mandatory enrollment (*Applies to the ACC PCCM Entity-PIHP and ACC:MCO*)
- Voluntary enrollment (*Applies to the Special Connections*)

Special Connections Included Populations

- i. Medicaid Eligibility***
- ii. Pregnant***
- iii. Assessed at a high risk for a poor birth outcome due to substance use or dependence***
- iv. Willing to receive prenatal care during pregnancy***

- v. *Meet ASAM criteria for treatment as assessed and determined by Special Connections Providers*
 - 1. *Services are provided on an outpatient or residential basis depending on an assessment which is done according to ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders (2nd Ed, Revised). These placement criteria determine the level of care into which a client is placed during the course of treatment*
- vi. *In order to be eligible for Special Connections services in postpartum months three through twelve the client must:*
 - 1. *have been enrolled in and receiving Special Connections services prior to giving birth*
 - 2. *meet ASAM criteria for treatment as assessed and determined by the Special Connections providers*

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the “Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

- Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
- Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- Other Insurance**--Medicaid beneficiaries who have other health insurance.
- Reside in Nursing Facility or ICF/MR** (*Applies to the Special Connections*)--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
- Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

- ___ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- ___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- ___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
- ✓ **SCHIP Title XXI Children** (*Applies to the ACC PCCM Entity-PIHP and the Special Connections*) – Medicaid beneficiaries who receive services through the SCHIP program.
- ✓ **Retroactive Eligibility** (*Applies to the ACC PCCM Entity-PIHP*) – Medicaid beneficiaries for the period of retroactive eligibility.
- ✓ **Other** (Please define): (*Applies to the ACC PCCM Entity-PIHP*)

The following individuals are not eligible for enrollment in the ACC: MCO, ACC PCCM Entity-PIHP Program, and Special Connections:

- A. Qualified Medicare Beneficiary only (QMB-only).***
- B. Qualified Disabled and Working Individuals (QDWI)***
- C. Qualified Individuals 1 (QI 1).***
- D. Special Low Income Medicare Beneficiaries (SLMB).***
- E. Undocumented aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Federal Medicaid for care and services related to the treatment of an approved medical condition.***
- F. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).***
- G. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.***
- H. All individuals while determined presumptively eligible for Medicaid.***

F. Services

List all services to be offered under the Waiver in Appendices D2.S and D2.A of Section D, Cost Effectiveness.

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2). State plan services, as listed in Appendix D2.S of Section D, Cost Effectiveness, are:
 - *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*
 - *Behavioral health assessment*
 - *Pharmacological management*
 - *Outpatient day treatment*
 - *Emergency/crisis services*
 - *Medication Assisted Treatment (MAT)*
 - *Targeted Case Management*
 - *Psychosocial Rehabilitation*
 - *Emergency*
 - *FQHC*
 - *RHC*
 - *School-based Mental Health Services*
 - *Alcohol/drug Screen Counseling*
 - *Social/Ambulatory Detoxification*
 - *Substance Use Disorder Assessment*
 - *Pharmacy*
 - *Outpatient Lab Services*
 - *Emergency Transportation*
 - *Lab and X-ray*
 - *EPSDT Services*
 - *Family Planning Services*
 - *Medical/Surgical Dental Services*
 - *Optometrist*
 - *Other Practitioner Services*
 - *Home Health*
 - *Medical Supplies*
 - *Physical Therapy, Occupational Therapy and Speech Pathology*
 - *Clinical Services*

- *Prosthetic Devices*
 - *Eye Glasses*
 - *Pediatric or Family Nurse Practitioners*
 - *Hospice Care*
 - *Nurse-midwife Services*
 - *Nursing Facility*
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
 - Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b).

1. **Assurances.**

✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State’s alternative requirement. (See note below for limitations on requirements that may be waived).

✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable, for the period of **July 1, 2018** through **June 30, 2023**.

✓ (Applies to the Special Connections) This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

✓ (Applies to the ACC PCCM Entity and ACC:MCO) The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

- *(Applies to the Special Connections) The FFS Selective Contracting program does not cover emergency services, which are covered under the PCCM Entity-PIHP program.*

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- ___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
- ___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
- ___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
- ✓___ Other (please explain): *ACC: MCOs will be required to pay for family planning services from network providers and out-of-network providers.*
- ___ Family planning services are not included under the waiver.

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- *The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.*

- (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The program is **mandatory** and the enrollee is guaranteed a choice of at least one PIHP/PCCM Entity/MCO which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PCCM Entity that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PCCM Entity he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PCCM Entity with a participating FQHC:

Beneficiaries will have the choice of at least one FQHC within and outside the ACC PCCM Entity-PIHP region. The RAE Contractor must offer contracts to all FQHCs and RHCs that meet PCMP requirements located in the Contract Region and is also required to ensure that its networks include FQHCs.

Note: All Special Connections participants are also enrolled in the PCCM Entity program and therefore have access to FQHC services.

- The program is mandatory and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

- (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

All Special Connections Program participants are also enrolled in the PCCM Entity-PIHP programs, with some being enrolled in an ACC: MCO; therefore, the Special Connections Program population of pregnant or post-partum women who meet eligibility criteria for EPSDT have access to those services.

6. **1915(b)(3) Services.**

- (Applies to the ACC PCCM -PIHP and the Special Connections) This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each

waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

Please refer to the Cost Effectiveness Section of this waiver for expenditures specific to the (b)(3) services.

1915(b)(3) services are:

Intensive Case Management describes community-based services averaging more than one hour per week, provided to adults with serious behavioral health diagnoses 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.

Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, locally-based treatment to adults with a serious behavioral health diagnosis. 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. ACT teams provide case management, initial and ongoing behavioral health assessments, psychiatric services, employment and housing assistance, family support and education, and substance use disorder services. ACT multidisciplinary treatment teams may consist of the following providers: psychiatrists; Master's and Bachelor's level clinicians; and peer specialists.

Respite Care is temporary or short-term care of a child, 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 mental health issues.

Vocational Services are services designed to assist adults and adolescents 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, 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.

Clubhouses and drop-in center services are peer support services for people who have behavioral health disorders, provided in Clubhouses and drop-in centers. In Clubhouses, individuals (members) utilize their skills for clerical work, data input, 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, members 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 behavioral 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 behavioral health clinicians, Bachelor's level or above.

Recovery Services are designed to provide choices and opportunities for adults with serious behavioral health disorders. 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 individuals 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, National Alliance for the Mentally Ill (NAMI) courses, Wellness Recovery Action Planning (WRAP) groups, consumer and family support groups, warm lines and advocacy services. Most recovery services are provided by behavioral health peers or family members, whose qualifications are having a behavioral health diagnosis or being a family member of a person with a behavioral health disorder. Although Colorado does not currently require that peer 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.

Prevention/Early Intervention services are proactive efforts to educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote positive psychological health. Prevention and early intervention efforts include services such as behavioral 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.

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 adults and older adults whose behavioral 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.

Special Connections from three through twelve months postpartum:

1. **Case Management** – *Medically necessary case management services provided in a licensed substance abuse treatment center by a CAC II, CAC III or LAC.*
2. **Individual Counseling** – *Substance use disorder counseling and treatment services provided by a CAC II, CAC III or LAC with one consumer.*
3. **Group Counseling** – *Substance use disorder counseling and treatment services provided by a CAC II, CAC III or LAC with more than one consumer, of up to and including two hours.*

4. **Family Counseling** – Substance use disorder counseling and treatment services provided by a CAC II, CAC III or LAC with one consumer and their family of more than 30 minutes, but no more than two hours.
5. **Group Health Education** – Contact with more than one consumer, of up to and including two hours, on health education of pregnancy, postpartum issues, infant care and development, and parenting.
6. **Outpatient** – A program of care in which the consumer receives substance use disorder treatment services in an OBH licensed treatment program, but does not remain in the facility 24 hours a day.
7. **Residential** – An OBH licensed program that offers organized substance abuse treatment services with a planned regimen of care in a 24-hour residential setting geared toward substance use disorder and recovery services. Provides for a stable and safe living environment to develop recovery skills to attain and maintain drug and alcohol-free lifestyle. Room and board are not covered.

7. **Self-referrals.**

✓ (*Applies to the ACC PCCM Entity*) _ The State requires ACC PCCM Entities to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the ACC PCCM Entity contract:

The State requires ACC PCCM Entities to allow enrollees to self-refer unless the individual has been placed in the Client Over Utilization Program (COUP)

The Department allows the ACC: MCO to set their own policy on whether clients can self-refer..

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Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

(Applies to the ACC PIHP and ACC: MCO) The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver a waiver of section 1902(a)(4) of the Act, to waive compliance with of one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

(Applies to the ACC PIHP and ACC: MCO) The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services and these contracts are effective **July 1, 2018** through **June 30, 2023**.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B Capacity Standards.

2. Details for PCCM Entity-PIHP and ACC: MCO program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses to assure timely access to services.

a. **Availability Standards.** The State's PCCM Entity -PIHP and ACC: MCO Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. PCPs (please describe):

The PCMP and MCO Networks shall be robust enough to serve all clients' primary care needs, meet strict access to care standards, and allow for adequate freedom of choice for their members. The Network shall have a sufficient number of PCMPs to meet the following standards:

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Adult Primary Care Providers	30	30	45	45	60	60
Pediatric Primary Care Providers	30	30	45	45	60	60
Gynecology, OB/GYN	30	30	45	45	60	60

The Department defines rural counties as having a population of less than 100,000 and frontier counties as having less than 6 individuals per square mile.

- ***In the event that there are less than two (2) practitioners that meet the PCMP standards within the defined area for a specific Member, then the Contractor shall not be bound by the requirements of the prior paragraph for that Member.***
- ***GeoAccess or a comparable service will be used to measure the distance between the Members and the providers.***

2. ___ Specialists (please describe):

3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):

5. ___ Hospitals (please describe):

6. Mental Health (please describe):

The ACC PIHP shall ensure that its behavioral health network meets the time and distance standards described in the table below for each practitioner type listed. The Department intends to hold all entities to the same standards

Mental Health Network Time and Distance Standards

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Hospitals (acute care)	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers, for adults	30	30	60	60	90	90
Psychiatrists and other psychiatric prescribers; serving children	30	30	60	60	90	90
Mental Health Provider; serving adults	30	30	60	60	90	90
Mental Health Provider; serving children	30	30	60	60	90	90

The ACC PIHP shall ensure that its behavioral health network has a sufficient number of Providers so that each Member has their choice of at least two (2) behavioral health providers within their zip code or within the maximum distance for their county classification. For Rural and Frontier areas, the Department may adjust this requirement based on the number and location of available providers.

In the event that there are no behavioral health providers who meet the behavioral health provider standards within the defined area for a specific Member, then the ACC PIHP shall not be bound by the time and distance requirements of the prior table for that Member.

7. ___ Pharmacies (please describe):

8. Substance Abuse Treatment Providers (please describe):

The ACC PIHP shall ensure that its Substance Abuse Treatment Provider network meets the time and distance standards described in the table below for each practitioner type listed.

Substance Abuse Treatment Network Time and Distance Standards

	Urban County		Rural County		Frontier County	
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Substance Use Disorder Provider; serving adults	30	30	60	60	90	90
Substance Use Disorder Provider; serving children	30	30	60	60	90	90

The ACC PIHP shall ensure that its Substance Abuse Treatment Provider network has a sufficient number of Providers so that each Member has their choice of at least two (2) Substance Abuse Treatment Providers within their zip code or within the maximum distance for their county classification. For Rural and Frontier areas, the Department may adjust this requirement based on the number and location of available providers.

In the event that there are no Substance Abuse Treatment Providers who meet the behavioral health provider standards within the defined area for a specific Member, then the ACC PIHP shall not be bound by the time and distance requirements of the prior table for that Member.

9. ___ Other providers (please describe):

b. **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State’s PCCM Entity – PIHP Program and ACC: MCO includes established standards for appointment scheduling for waiver enrollee’s access to the following providers.

1. PCPs (please describe):

The PCMP Network and ACC: MCO networks shall be sufficient to ensure that appointments will be available to all Members:

- *Well Care Visit— within one-month after the request; unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department’s accepted Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedules.*
- *Urgent Care--Within twenty-four (24) hours after the initial identification of need.*
- *Outpatient Follow-up Appointments – within seven (7) days after discharge from a hospitalization.*
- *Non-urgent Symptomatic Care Visit – within seven (7) days of the request.*

2. ___ Specialists (please describe):

3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):

5. Mental Health (please describe):

The ACC-PIHP must also meet additional timeliness standards:

- *Emergency Behavioral Health Care – by phone within fifteen (15) minutes of the initial contact, including TTY accessibility; in person within one (1) hour of contact in Urban and suburban areas, in person within two (2) hours of contact in Rural and Frontier areas;*
- *Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days of a Member’s request*

6. Substance Abuse Treatment Providers (please describe):

The ACC-PIHP must also meet additional timeliness standards:

- *Emergency Behavioral Health Care – by phone within fifteen (15) minutes of the initial contact, including TTY accessibility, in person within one (1) hour of contact in Urban and suburban areas, in person within two (2) hours of contact in Rural and Frontier areas;*
- *Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days of a Member’s request*

7. ___ Urgent care (please describe):

8. ___ Other providers (please describe):

c. ___ **In-Office Waiting Times:** The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ___ PCPs (please describe):

2. ___ Specialists (please describe):

3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):

5. ___ Mental Health (please describe):

6. ___ Substance Abuse Treatment Providers (please describe):

7. ___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program. (*Applies to the Special Connections*)

The Office of Behavioral Health requires service standards for access and availability, and will apply these standards to the Special Connections clients. All pregnant women determined to have a substance use disorder must be able to access treatment within 48 hours of initial contact with the treatment program, or they must be provided interim services if such immediate admission is not possible. Any pregnant woman seeking treatment who is not able to be admitted to the program to which she seeks to be admitted must be referred to the Women's Treatment Coordinator at Office of Behavioral Health for more immediate placement in another program.

The Office of Behavioral Health currently serves as the monitoring agency for Special Connections. The Department requires of the Office a Behavioral Health, through the interagency agreement, quarterly and annual program reporting. The standards used to assure access to services will include yearly auditing and reporting.

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B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

✓ *(Applies to the ACC PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the ACC PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services and these contracts are effective for the period of July 1, 2018 through June 30, 2023.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM Entity program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. ___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. ___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.
- c. ___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.
- d. ___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

- e. ___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.
- f. **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

The ACC PCCM shall ensure that its Network has a sufficient number of PCMPs to maintain the following provider to client ratios:

- *Adult primary care providers: One (1) PCMP per eighteen hundred (1,800) adult Members.*
- *Mid-level adult primary care providers: One (1) PCMP per twelve hundred (1,200) adult Members.*
- *Pediatric primary care providers: One (1) PCMP per eighteen hundred (1,800) child Members.*

<i>Area(City/County/Region)</i>	<i>Adult PCMP-to-Enrollee Ratio</i>	<i>Adult Mid-level-to-Enrollee Ratio</i>	<i>Pediatric PCMP-to-Enrollee Ratio</i>
Region 1	1:1,800	1:1,200	1:1,800
Region 2	1:1,800	1:1,200	1:1,800
Region 3	1:1,800	1:1,200	1:1,800
Region 4	1:1,800	1:1,200	1:1,800
Region 5	1:1,800	1:1,200	1:1,800
Region 6	1:1,800	1:1,200	1:1,800
Region 7	1:1,800	1:1,200	1:1,800
<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	1:1,800	1:1,200	1:1,800

g. ____ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

(Applies to the Special Connections)

The current number of residential beds is sixteen (16) at the Haven, sixteen (16) at Crossroads' Turning Points and sixteen (16) at the Aspen Center. Depending upon the services deemed to be clinically appropriate, one bed may be used by multiple clients over the course of a year (typically between eighty (80) and one hundred (100) statewide). In outpatient treatment, a typical counselor will carry between twenty-five (25) and fifty (50) clients of varying levels of intensity, and if enrollment increases, additional staff are hired in order to cover the additional work load. With a total of five (5) outpatient programs and approximately fifteen (15) dedicated outpatient counselors and case managers, the caseload could vary between zero (0) and three hundred (300) at any given time, with a greater number of clients accumulating over the course of a year's time.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

✓ *(Applies to the ACC PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the ACC PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care and these contracts are effective for the period of July 1, 2018 through June 30, 2023

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ✓ *(Applies to the ACC PIHP)* The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

The ACC PIHP is limited to behavioral health services. Based on the Department's definition of Persons with Special Health Care Needs, the Department does not require the PIHP to meet the primary care requirements nor implement any additional mechanism for identifying, assessing and developing a treatment plan for Persons with Special Health Care Needs.

- b. **Identification.** (*Applies to ACC: MCO*) The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

The State requires ACC: MCOs to implement mechanisms for identifying members requiring long-term services or having special health care needs as defined by the state in 10 C.C.R. 2505-10, §8.205.9, et seq.

- c. **Assessment.** (*Applies to ACC: MCO*) Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

The ACC: MCO will develop and implement a comprehensive assessment to identify any special conditions that necessitate a special treatment and care coordination plan or regular care monitoring, pursuant to 42 CFR 438.208(c)(2). The ACC: MCO is responsible for establishing and maintaining procedures and policies to coordinate health care services for persons with Special Health Care Needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, transportation, home and community based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates.

- d. **Treatment Plans.** (*Applies to ACC: MCO*) For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3. In accord with any applicable State quality assurance and utilization review standards.

- e. **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM Entity program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. Each enrollee receives **health education/promotion** information. Please explain.

Members will have access to health education/promotion information through the Department's enrollment broker, Healthy Communities (the Department's EPSDT onboarding and navigation program), and the RAE.

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

- h. **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

Colorado is defining "care coordination" as the deliberate organization of client care activities between two or more participants (including the client and/or family members) to facilitate the appropriate delivery of physical health, behavioral health, oral health, specialty care, and other services. The ACC PCCM Entity-PIHP will assure the availability of care coordination depending on member need.

- i. **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

(Applies to the Special Connections)

Continuity and coordination of care are required components of the Special Connections. Network providers offering services to pregnant and postpartum women must make arrangements for prenatal care and monitor that pregnant women are receiving regular care. Developmental assessments for children already in the client's care must be made available, as well as parenting classes.

In order to eliminate the most common barriers experienced by women to participating in substance use disorder treatment, programs provide linkages to child care during the time the woman is in treatment, as well as transportation to and from treatment, access to mental health services for those experiencing co-occurring disorders, domestic violence treatment and family and couple's treatment.

The Department requires of the Office of Behavioral Health, through the interagency agreement, quarterly and annual program reporting. The Department will provide oversight, in conjunction with the Office of Behavioral Health, to assure continuity and coordination of care are occurring. The standards used to assure continuity and coordination of care will include yearly auditing and reporting.

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Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

- ✓ *(Applies to the ACC PCCM Entity- PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- _____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PIHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State’s alternative requirement.
- ✓ *(Applies to the ACC PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 and these contracts are effective for the period of **July 1, 2018** through **June 30, 2023**.
- ✓ *(Applies to the ACC PIHP and ACC: MCO)* Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
- ✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Activities Conducted		
	EQR study	Mandatory Activities	Optional Activities
ACC: MCO	✓	✓	
ACC PCCM	✓	✓	

Entity- PIHP			
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The Department assures that the state complies with 42 CFR Part 438 Subpart E as applicable to MCOs and PIHPs, and that the state will comply with 42 CFR 438 Subpart E (specifically §438.330(b)(2), (b)(3), (c), and (e), §438.340, and §438.350) as applicable to PCCM entities described at 42 CFR § 438.310(c)(2) by the applicability dates specified in 42 CFR 438.310(d) and 438.334(a)(3).

2. Assurances For PAHP program.

NOT APPLICABLE

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PAHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State’s alternative requirement.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, and these contracts are effective for the period ___ to ___.

3. Details for PCCM Entity program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM Entity program.

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM-Entity program. Please attach.

b. **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ___ Provide education and informal mailings to beneficiaries and PCMPs;

2. ___ Initiate telephone and/or mail inquiries and follow-up;

3. Request PCCM Entity’s response to identified problems;

4. Refer to program staff for further investigation;

5. Send warning letters to PCCM Entities;
6. Refer to State's medical staff for investigation;
7. Institute corrective action plans and follow-up;
8. Change an enrollee's PCMP;
9. Institute a restriction on the types of enrollees;
10. Further limit the number of assignments;
11. Ban new assignments;
12. Transfer some or all assignments to different PCMPs;
13. Suspend or terminate PCCM Entity or PCMP agreement;
14. Suspend or terminate as Medicaid providers; and
15. Other (explain):

c. **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM Entity administrator as a PCCM Entity. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM Entity program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

The Department has identified the following criteria for the ACC PCCM Entity's selection of providers:

- *Provider is enrolled as a Colorado Medicaid provider.*
- *Provider is licensed and able to practice in the State of Colorado.*
- *Provider holds an MD, DO, or NP provider license with additional licensing and provider type qualifications.*
- *Provider is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.*
 - *Community mental health centers and HIV/infectious disease practitioners may qualify as PCMPs with the Contractor's approval if all other PCMP criteria are met.*
- *The practice, agency, or individual provider renders services utilizing one of the following Medicaid Provider types:*
 - *Physician*
 - *Osteopath*
 - *Federally Qualified Health Center*
 - *Rural Health Clinic*
 - *School Health Clinic*
 - *Family/Pediatric Nurse Practitioner*
 - *Clinic-Practitioner Group*
 - *Non-physician Practitioner Group*
- *Provide some level of care coordination.*
- *Provide 24/7 phone coverage with access to a clinician that can triage the client's health need.*
- *Adopt and regularly use universal screening tools, uniform protocols, and guidelines/decision trees/algorithms to support clients in accessing necessary treatments.*
- *Track the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.*
- *Weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (Monday – Friday 7:30 am – 5:30 pm).*

- *Using available data (e.g. Department claims data, clinical information) to identify special patient populations who may require extra services and support for health or social reasons. The practice has procedures to proactively address the identified health needs.*
- *Collaborate with patient, family, or caregiver to develop an individual care plan for Members with complex needs.*
- *Utilize an electronic health record or are working with the RAE to share data with the Department.*

The regional ACC PCCM Entity-PIHP may enter into a written agreement with a primary care Provider to fulfill some of the specific criteria listed above on behalf of a Provider, such as the ACC PCCM Entity-PIHP provides 24/7 phone coverage for a practice or provides Care Coordination for a practice. The ACC PCCM Entity-PIHP shall partner with these providers to identify practice goals and support the providers in working toward achieving these goals.

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. ___ Initial credentialing
 - B. ___ Performance measures, including those obtained through the following (check all that apply):
 - ___ The utilization management system.
 - ___ The complaint and appeals system.
 - ___ Enrollee surveys.
 - ___ Other (Please describe).
4. Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to

ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. Other (please describe).

d. **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

(Applies to the Special Connections)

Providers for the Special Connections are selected on their ability to provide quality and innovative outpatient and residential programs to meet the needs of pregnant and postpartum women with substance use disorders. Providers for the Special Connections meet quality of care standards that are set and monitored by the Office of Behavioral Health (OBH). OBH sets provider licensure criteria and audits each program service provider on a yearly basis. Audits consist of either desk or on-site reviews. They evaluate the outcomes of the services and appropriate level of care being provided. They audit randomized cases for reduction of symptoms, recovery and improved quality of life. Cases are also reviewed for accurate assessment and identification of the problem(s).

The Department requires of OBH, through the interagency agreement, quarterly and annual program reporting. The Department will provide oversight to and in conjunction with OBH to assure service quality is occurring in the Special Connections. The standards used to assure continuity and coordination of care will include yearly auditing and reporting.

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Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM Entity administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM Entity in general) and direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

✓ _____ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ _____ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period of July 1, 2018 through June 30, 2023.

✓ _____ *(Applies to the Special Connections Substance Abuse Treatment Program)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. **Scope of Marketing**

1. _____ The State does not permit direct or indirect MCO/PIHP/PAHP or PCCM marketing.

2. ✓ _____ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State permits indirect MCO/PIHP/PAHP or PCCM Entity marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM Entity in general). Please list types of indirect marketing permitted.

The RAE must obtain prior approval from the Department for all proposed marketing materials

3. (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State permits direct MCO/PIHP/PAHP or PCCM Entity marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Direct mailing of brochures, notices, and letters. Cold call marketing is prohibited.

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.
2. The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State requires MCO/PIHP/PAHP and PCCM Entity to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

Spanish

The state and its contractors will comply with 42CFR 438.10, 42 CFR Part 92 (implementing ACA Section 1557) and all other applicable regulations. The RAEs will be responsible to provide interpretative services to beneficiaries who only speak another language.

The State has chosen these languages because (check any that apply):

- i. (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The languages comprise all prevalent languages in the MCO/PIHP/PAHP/PCCM Entity service area. Please describe the methodology for determining prevalent languages.

The Department uses the most recent data from the American Community Data Survey to determine the prevalent non-English languages spoken throughout the state. A percentage is then calculated for the identified non-English languages.

- ii. ___ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately ___ percent or more of the population.
- iii. ___ Other (please explain):

The remainder of this page is intentionally left blank.

B. Information to Potential Enrollees and Enrollees

1. Assurances.

(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for PIHPs and PAHPs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements and these contracts are effective for the period of July 1, 2018 through June 30, 2023.

(Applies to Special Connections)
This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. **Non-English Languages**

(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

Spanish

The State defines prevalent non-English languages as:
(check any that apply):

1. *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

The Department uses the most recent data from the American Community Data Survey to determine the prevalent non-English

languages spoken throughout the state. A percentage is then calculated for the identified non-English languages.

2. ___ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
3. ___ Other (please explain):

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC MCO)* Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

The ACC PCCM Entity-PIHP and ACC: MCO is responsible for providing oral translation of potential enrollee/enrollee materials to all enrollees as needed in compliance with federal requirements.

Some of the requirements that will be incorporated into the ACC PCCM Entity-PIHP and ACC: MCO Contracts are outlined below:

- *Each ACC PCCM Entity-PIHP and ACC: MCO will develop policies and procedures (as needed) on how the ACC PCCM Entity-PIHP and ACC: MCO shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in Regions where language may pose a barrier so that participating providers can: (i) conduct the appropriate assessment and treatment of non-English speaking Members (including Members with a communication disability) and (ii) promote accessibility and availability of covered services, at no cost to Members.*
- *The ACC PCCM Entity-PIHP and ACC: MCO shall provide language assistance services, including bilingual staff and interpreter services, at no cost to any Member. Language assistance shall be provided at all points of contact, in a timely manner and during all hours of operation.*
- *The Contractor shall implement appropriate technologies for language assistance services in accordance with evolving best practices in communication.*
- *The ACC PCCM Entity-PIHP and ACC: MCO shall provide interpreter services for all interactions with Members when there is no RAE staff person available who speaks a language understood by a Member.*
- *ACC PCCM Entity-PIHP's and ACC: MCO's customer service telephone functions must easily access interpreter or bilingual services.*

(Applies to ACC PCCM Entity-PIHP and ACC: MCO) The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The ACC PCCM Entity-PIHPs and ACC: MCOs are contractually responsible for having a mechanism in place to help enrollees understand the requirements and benefits of the plan. This information may be provided through the Department's enrollment broker, Healthy Communities, the ACC PCCM Entity-PIHP, ACC: MCO, or the enrollee handbook.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- contractor (please specify)

(Applies to the ACC PCCM Entity-PIHP) There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- (i) the State
- (ii) (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) State contractor (please specify): Enrollment broker

The remainder of this page is intentionally left blank.

C. Enrollment and Disenrollment

1. Assurances.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

✓ *(Applies to the ACC PCCM Entity-PIHP)* The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

42 CFR 438.56 (b) – The ACC PCCM Entity-PIHP cannot request disenrollment of an enrollee for any reason.

42 CFR 438.56 (c) – The enrollee cannot disenroll from the ACC PCCM Entity-PIHP.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56. Disenrollment requirements and these contracts are effective for the period of ***July 1, 2018*** through ***June 30, 2023***.

✓ *(Applies to Special Connections)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.** Please describe the State's enrollment process for MCOs/PIHPs/PAHP and PCCM Entities by checking the applicable items below.

a. ✓ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The Enrollment Broker, Healthy Communities, and the ACC PCCM Entity-PIHP Entity all have a role in outreaching members.

- ***The Enrollment Broker will be responsible for initial outreach to members upon determination of eligibility, including informing members of their assigned PCMP and ACC PCCM Entity-PIHP Entity,***

choice counseling of a PCMP, and how to contact the PCMP and ACC PCCM Entity-PIHP Entity.

- *Healthy Communities will be responsible for the following three essential services for children and their parents:*
 - *Outreach and onboarding to Medicaid and the ACC*
 - *Navigation of benefits and participating in a primary care medical home*
 - *Education on preventive services.*
- *The ACC PCCM Entity-PIHP Entity will assist members in connecting with a PCMP and behavioral health providers, as needed, particularly for preventative services.*

b. Administration of Enrollment Process.

✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) State staff conducts the enrollment process.

The enrollment process for the ACC PCCM Entity-PIHP is as follows:

- *The Colorado Benefits Management System (CBMS) determines eligibility*
- *CBMS sends eligibility information to the Department's Colorado interChange, the Medicaid Management Information System (MMIS)*
- *Colorado interChange reads the eligibility information and automatically enrolls the client in the ACC PCCM Entity-PIHP.*

The enrollment process for the ACC: MCO is as follows:

- *The Colorado Benefits Management System (CBMS) determines eligibility*
- *CBMS sends eligibility information to the Department's Colorado interChange, the Medicaid Management Information System (MMIS)*
- *Colorado interChange reads the eligibility information and automatically enrolls the client in the ACC PCCM Entity-PIHP and the ACC: MCO.*

✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct components of the enrollment process and related activities.

✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: To Be Determined. A new vendor will be competitively procured for a July 1, 2018 start date.

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

All program components of the ACC PCCM Entity-PIHP will be implemented statewide on July 1, 2018. The ACC: MCO will be implemented within the geographic regions on July 1, 2018.

Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. Potential enrollees will have days/month(s) to choose a plan.

ii. Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

(*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*) The State **automatically enrolls** beneficiaries

on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

(*Applies to the ACC PCCM Entity-PIHP*) on a mandatory basis into a single PCCM Entity-PIHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

There are three main components to the ACC PCCM Entity-PIHP enrollment plan:

- 1. All Medicaid enrollees will be mandatorily enrolled into the ACC;***
- 2. All ACC members will be immediately attributed or assigned to a PCMP; and***
- 3. All clients will be assigned to a RAE based upon who their PCMP is.***

Enrollment into the Program is effective on the same day that a Member's Medicaid eligibility notification is received in interChange from the Colorado Benefit Management System (CBMS). Members enrolled in Denver Health or Rocky Mountain Health Plans Prime will be automatically enrolled in the ACC: MCO for the July 1, 2018 start date. Future enrollment in the ACC: MCO will occur when the ACC: MCO enrollment drops below the contracted enrollment level in which case new Medicaid members who met the geographic and eligibility requirements will be automatically enrolled. Those individuals have a 90-day period to choose to opt out of the ACC: MCO and choose a PCMP. The members choice of a PCMP will determine the ACC: PCCM Entity-PIHP enrollment as described above.

The Member will be notified by the enrollment broker of the RAE and PCMP assignment or attribution. The notice will also inform the Member of their right to change their PCMP at any time. Members can select a PCMP by calling the enrollment broker. Changes in the PCMP may result in a change in the attributed RAE if the selected PCMP is within a different RAE region.

_____ on a voluntary basis into a single MCO, PIHP, or PAHP, and beneficiaries can opt out at any time. Please specify geographic areas where this occurs: _____

(Applies to Special Connections) The State DOES NOT automatically enroll women into the program

Enrollment is voluntary- women are not selected for the program. Women who seek services are enrolled assuming they meet enrollment criteria. Referrals are made through self-referrals, family referrals, health care providers, social services, and the criminal justice system

- ___ The State provides **guaranteed eligibility** of ___ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.
- ___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in a PIHP. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
- ✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State **automatically re-enrolls** a beneficiary with the same PIHP/MCO if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

- ✓ (Applies to the ACC PCCM Entity-PIHP) The State allows enrollees to ~~disenroll from~~/transfer between MCOs/PIHPs/PAHPs and PCCM Entities. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
 - i. ✓ Enrollee submits request to State.

If a member chooses a new PCMP who is contracting only with a different ACC PCCM Entity-PIHP, the member will be transferred to the new ACC PCCM Entity-PIHP. Members will submit choices of PCMP to the enrollment broker, who follows Department guidelines.

***RAE Reassignment Process**
Each RAE shall implement special arrangements for the reassignment of a Member from the RAE serving the Member's PCMP to the RAE serving the Member's county of residence when requested by both the Member and a care coordinator/case manager of the Member's treating Community Mental Health Center (CMHC).*

The originally assigned RAE serving the Member's PCMP shall ensure that Members considered for RAE reassignment meet all of the following criteria:

- *The Member resides in a RAE geographic region different from the RAE geographic region of the Member's PCMP.*
- *The Member is receiving an array of mental health and community support services from a CMHC.*
- *The Member has a current plan of care that features the utilization of state plan services, 1915(b)(3) community-based*

system of care services, and other state resources to support the Member's living in the community, maintaining optimal level of functioning, and achieving recovery.

- *The Member requires ongoing therapeutic and community-based services in order to live stably in the community as evidenced by a history of hospitalization for a mental health condition, utilization of the Colorado Crisis Services system, involvement with the criminal justice system, or other similar indicator of the complexity of the Member's mental health condition within the past twelve (12) months.*
- *The Member and a care coordinator/case manager from the CMHC initiate conversation with both the RAE serving the Member's PCMP and the RAE serving the Member's county of residence*

Both the RAE serving the Member's PCMP and the RAE serving the Member's county of residence shall collaborate to review each Member's request on an individual basis and determine the most appropriate RAE assignment for the Member. Both RAEs shall jointly determine the appropriate RAE assignment based on the Member's plan of care, health needs, and service utilization patterns.

The originally assigned RAE serving the Member's PCMP shall not consider the financial risk when making a reassignment determination. The RAEs shall jointly communicate to the Department's designated staff person the request to reassign a Member to a new RAE. Assignment to the new RAE will be effective on the first day of the month following the month in which the Department is notified of the request for reassignment. If a request for reassignment comes too late within a month to process the request in the Colorado interChange, the reassignment will occur the first day of the second month following the month in which the Department is notified of the request for reassignment.

The originally assigned RAE serving the Member's PCMP shall develop procedures to transition services to the new RAE to ensure that the Member's quality, quantity and timeliness of care is not affected during the transition.

- ii. Enrollee submits request to MCO/PIHP/PAHP/PCCM Entity. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii. Enrollee must seek redress through MCO/PIHP/PAHP/PCCM Entity grievance procedure before determination will be made on disenrollment request.

The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area or from a single PCCM entity.

When enrollees choose a new PCMP who is contracting only with a different RAE, they are automatically enrolled with the new RAE. The enrollee can freely change PCMP providers.

(Applies to ACC: MCO) The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

All Members enrolled in an ACC: MCO will have 90 days in which to opt out; those who do not opt out will be locked into the ACC: MCO until 60 days prior to the Member's birth month. During the lock-in period a Member can opt out of the ACC: MCO for legitimate reasons such as moving out of the geographic area.

The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

The State permits **MCOs/PIHPs/PAHPs and PCCM Entities to request disenrollment** of enrollees. Please check items below that apply:

MCO/PIHP/PAHP and PCCM Entity can request reassignment of an enrollee for the following reasons:

The beneficiary moves out of the ACC PCCM Entity-PIHP's or ACC: MCO's Service area.

i. The State reviews and approves all MCO/PIHP/PAHP/PCCM Entity-initiated requests for enrollee transfers ~~or disenrollments~~.

- ii. ✓ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the PCMP/ACC PCCM Entity-PIHP to remove the enrollee from its membership or from the PCMP's caseload.

- iii. ✓ The enrollee remains an enrollee of the PCMP/ACC PCCM Entity-PIHP until another PCMP/ACC PCCM Entity-PIHP is chosen or assigned.

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D. Enrollee rights.

1. Assurances.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM Entity contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period of **July 1, 2018** through **June 30, 2023**.

✓ *(Applies to the Special Connections)* This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

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E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM Entity programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart F, including:

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

✓ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

✓ Please describe any special processes that the State has for persons with special needs.

The Department contracts for an Ombudsman program that is available to all managed care enrollees with medical or behavioral health issues.

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart F.

✓ (Applies to the ACC PIHP and ACC: MCO) The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHPs. Please identify each regulatory requirement waived and the State's alternative requirement.

✓ (Applies to the ACC PIHP and ACC: MCO) The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, and these contracts are effective for the period of **July 1, 2018** through **June 30, 2023**.

3. **Details for MCO or PIHP programs.**

a. **Direct access to fair hearing.**

- The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
- The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

- (*Applies to the ACC PIHP and ACC: MCO*) The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days.
- The State's timeframe within which an enrollee must file a **grievance** is 20 days (may not exceed 90).

4. **Optional grievance systems for PCCM Entity and PAHP programs.** States, at their option, may operate a PCCM Entity and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM Entity and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM Entity, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM Entity or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

The State has a grievance procedure for its PCCM Entity and/or PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM Entity/PAHP grievance procedure):

- The grievance procedures are operated by:
- the State
 - the State's contractor. Please identify:
 - the PCCM Entity
 - the PAHP.

Please provide definitions the State employs for the PCCM Entity and/or PAHP grievance system (e.g. grievance, appeals)

Grievance system is the overall system that includes grievances and appeals handled at the PCCM Entity level and access to the State fair hearing process for appeals.

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

Appeal shall mean a review by a managed care organization of an adverse benefit determination.

State Fair Hearing shall mean the formal adjudication process for appeals related to:

- 1. Action, denial or failure to act with reasonable promptness regarding eligibility or services;*
- 2. Decisions regarding changes in the type or amount of services;*
- 3. Decision by a nursing facility to transfer or discharge a resident; and*
- 4. Determination with regard to the preadmission screening and annual resident review requirements.*

Has a grievance committee or staff who review and resolve grievances. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM Entity administrator function.

The PCCM Entity is responsible to receive and act on grievances.

Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

Specifies a time frame from the date of action for the enrollee to file a grievance, which is: _____

Has time frames for staff to resolve grievances for PCCM Entity/PAHP grievances. Specify the time period set:

The time period to resolve grievances must not to exceed 15 working days from the day the PCCM entity receives the grievance

Establishes and maintains an expedited grievance review process for the following reasons: _____. Specify the time frame set by the State for this process_____

- Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the grievance.
- Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.
- Other (please explain):

The remainder of this page is intentionally left blank.

F. Program Integrity

1. Assurances.

✓ *(Applies to the ACC PCCM Entity-PIHP and ACC: MCO)* The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM Entity, PIHP, or PAHP from knowingly having a relationship listed below with:

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM Entity PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM Entity's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM Entity, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM Entity's, PIHP's, or PAHP's obligations under its contract with the State.

✓ *(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections)* The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

- ✓ *(Applies to the ACC PIHP and ACC: MCO) The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.*

- ✓ *(Applies to the ACC PIHP and ACC: MCO) State payments to a MCO/PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.*

- ___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for MCOs or PIHPs. Please identify each regulatory requirement waive and the State's alternative requirement.

- ✓ *(Applies to the ACC PIHP and ACC: MCO) The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. These contracts are effective for the period of July 1, 2018 through June 30, 2023.*

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Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP Capacity, Specialty Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement, PCCM Entity Quality)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the strategies used to monitor the major areas of the waiver. The second is a detailed description of each strategy.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring strategies are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring strategies they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring strategies in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality

strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM Entity programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM Entity programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM Entity programs. State must assure access and quality in PCCM Entity waiver programs, but have the flexibility to determine how to do so and which monitoring strategies to use.

1915(b)(4) FFS Selective Contracting Programs: (Applies Special Connections) The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Answers to these questions have been addressed under Part II: Access. Section A. 3.

PART I. Summary chart

States should use the chart on the next page to summarize the strategies used to monitor major areas of the waiver program. If this waiver authorizes multiple programs, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

**For the Accountable Care Collaborative PCCM Entity-PIHP and ACC: MCO*

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information	Grievance	Timely Access	Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Accreditation for Deeming												
Accreditation for Participation												
Consumer Self-Report data							✓					✓
Data Analysis (non-claims)						✓	✓		✓			
Enrollee Hotlines												
Focused Studies												
Geographic mapping							✓					
Independent Assessment							✓					✓
Measure any Disparities by Racial or Ethnic Groups												✓
Network Adequacy Assurance by Plan							✓	✓			✓	
Ombudsman						✓						
On-Site Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information	Grievance	Timely Access	Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Performance Improvement Projects							✓	✓	✓			✓
Performance Measures							✓	✓	✓	✓		✓
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data							✓		✓			✓
Test 24/7 PCP Availability												
Utilization Review												
Other:												

For Special Connections– OBH is responsible for these monitoring activities:

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data												
Data Analysis (non-claims)							✓					
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by Plan	✓											

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Ombudsman												
On-Site Review				✓			✓	✓				✓
Performance Improvement Projects												
Performance Measures							✓					
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe) Monitoring of complaints and grievances						✓						

PART II. Monitoring Strategies

Please check each of the monitoring strategies or functions below used by the state. A number of common strategies are listed below, but the state should identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the state does not use a required strategy, it must explain why.

For each strategy, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

a. Accreditation for Deeming (i.e. the State deems compliance with certain access, structure/operation, or quality requirements for entities that are accredited)

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

b. Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

c. (*Applies to the ACC PCCM Entity-PIHP*) Consumer Self-Report data

CAHPS (please identify which one(s))

Programs: ACC PCCM Entity-PIHP

Personnel Responsible: The Department

Strategy: The Department will use CAHPS-Physical Health measures (Rating of all Health Care, Rating of Personal Doctor, Rating of specialist seen most often, Getting needed care).

The CAHPS related survey is one tool used to:

- *improve the quality of services*
- *evaluate care coordination*
- *evaluate and monitor the quality of the PCCM Entity*
- *hold providers accountable through public reporting.*

Each regional ACC PCCM Entity is required to assist the Department or its designated vendor with the annual administration of the Clinician and Group (CG) CAHPS survey for both adults and children to measure Member satisfaction with network providers. RAEs work with the department on sampling methodology, survey administration, and survey tool development and partner with the Department's Quality Team to determine the specific questions to be included in the survey and the strategies and methodologies for administration. RAEs must utilize the survey results and data to inform their Quality Improvement Plan.

Frequency: *Annual*

How it yields information about the area being monitored: *Quality of care as measured in the CAHPS surveys can correlate with aspects of clinical performance and provide comparative data. CG CAHPS survey topics include access to care and coordination of care and can be used as one indicator of quality. By obtaining patient experience about their interactions with the health care system, including with care from health plans, and providers of care the state can obtain direct information about the plans and provider performance in the target areas.*

✓ (Applies to the ACC PIHP) State-developed survey – Client Satisfaction Survey

Programs: *ACC PIHP*

Personnel Responsible: *The Department*

Strategy: *Each ACC PIHP must support the Department in administering the Experience of Care and Health Outcomes (ECHO) Survey developed by the Office of Behavioral Health among Members accessing behavioral health services at CMHCs and other contracted behavioral health providers. The ECHO survey is used to:*

- *improve the quality of services*
- *evaluate care coordination*
- *evaluate and monitor the quality of the ACC PIHP*
- *hold providers accountable through public reporting.*

Frequency: *Annual*

How it yields information about the area being monitored:

The ECHO Survey measures patient experience in areas such as:

- *Getting treatment quickly*
- *How well clinicians communicate*
- *Getting treatment and information from the plan*
- *Perceived improvement*
- *Information about treatment options*
- *Overall rating of counseling and treatment*
- *Overall rating of the health plan*

Disenrollment survey

Consumer/beneficiary focus groups

d. *(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections) Data Analysis (non-claims)*

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

PCP termination rates and reasons

Other (please describe)

Programs: ACC PCCM Entity-PIHP and ACC: MCO

Personnel Responsible: The Department and ACC PCCM Entity-PIHP and ACC: MCO

Strategy: As described in the Department's Quality Strategy, non-claims reports are utilized with other strategies including on-site reviews, performance measures and performance improvement projects to give a full picture of the ACC PCCM Entity-PIHP's and ACC: MCO's performance. The Department's Rates Section, and Quality Health & Improvement Section use a number of processes to monitor Program Integrity.

The Department's contract managers monitor the contract requirements and receive regularly scheduled reports from the ACC PCCM Entity-PIHP and ACC: MCO that provide status of their network meeting client needs and other program operations. The Department also has a Quality Strategy Team (QST) that provides additional monitoring activities on the Network and grievance and appeals reports. Deficiencies in these reports can identify areas where the ACC PCCM Entity-PIHP or ACC: MCO may not be meeting contractual

requirements. If the Department identifies any areas of concern in its review, the ACC PCCM Entity-PIHP or ACC: MCO is required to correct these issues.

Examples of the specific reports that the ACC PCCM Entity-PIHP and ACC: MCO is contractually required to submit to the Department include the following:

- *Quarterly Grievance and Appeals Report.*
 - *These reports are separated into specific categories that assist the Department with trending and follow up with the health plans. Once the grievance and appeals reports are received at the Department they are reviewed by the Department's Quality Strategy Team (QST) which consist of the ACC PIHP Contract Manager and a representative of the Quality Health and Improvement Unit. If any concerns are found during the review they are noted and included in the follow up letter sent to each plan so the health plan can research or provide for additional follow up to correct the concern.*
- *Quarterly Network report that includes, at a minimum, the following information:*
 - *Number of network providers by provider type and areas of expertise*
 - *Geographic location of network providers in relationship to where Medicaid members live*
 - *Percent of network providers accepting new Medicaid Members.*
 - *Performance meeting timeliness standards.*
- *Care Coordination Activity Report that includes the number of unique members for whom care coordination was provided by the Contractor and narrative descriptions of how care coordination is delivered throughout the network.*
- *Quarterly 1915(b)(3) Services Report to the Department. The report must list specific 1915(b)(3) Waiver services and the expenditure amounts associated with each service provided within that quarter.*
- *A quarterly Client Over-Utilization Program (COUP) Report containing information including, but not limited to, outreach attempts, health assessments, interventions, and primary care visits of Members meeting overutilization criteria.*

Frequency: *Monthly to annually as defined in the ACC PCCM Entity-PIHP and ACC: MCO contracts.*

How it yields information about the area being monitored: *The reports provide discrete pieces of information that might not otherwise be available*

to the Department in its oversight of access, choice, program integrity and other aspects of program monitoring. For example, the grievance narrative often captures input where clients request a new provider due to dissatisfaction with their current provider selection and client satisfaction with the new Provider Selection is noted in the narrative.

Programs: *Special Connections*

Personnel Responsible: *Department of Human Services, Office of Behavioral Health*

Strategy: *Timely access is monitored through the Office of Behavioral Health's CSTAT process. Providers report dates of first contact, dates of first appointment offered, and dates of admission to treatment. For any woman for whom the difference between date of first contact and date of first appointment offered is more than 3 days, the Special Connections program manager calls the provider agency to find out the reason for the discrepancy.*

Frequency: *Monthly*

How it yields information about the area being monitored: *The CSTAT information allows the Office of Behavioral Health and the Department to monitor access to services and identify barriers to access.*

- e. _____ Enrollee Hotlines operated by State
- f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
- g. _____ Geographic mapping of provider network
- h. _____ (*Applies to the ACC PCCM Entity-PIHP and ACC: MCO*) Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

Programs: *The ACC PCCM Entity-PIHP and ACC: MCO*

Personnel responsible: *The Department's contracted designee*

Strategy: *The Department contracts with an external quality review organization (EQRO) to conduct ACC PCCM Entity-PIHP and ACC: MCO compliance site reviews, to evaluate performance improvement projects and to validate performance measures. The EQRO assesses all these activities as they relate to access, quality, and timeliness and provides summarized results in an annual technical report. The data is analyzed to help determine plan compliance. If compliance problems are identified, the ACC PCCM Entity-PIHP and ACC: MCO is required to provide and implement a corrective action plan.*

Frequency: *Annually*

How it yields information about the area being monitored: *The EQRO reviews provider performance information related to various aspects of the ACC PCCM Entity-PIHPs and ACC: MCOs through document review (policies, documents, minutes, etc.) and on-site review, including interviews performed by appropriate professionals. This process compiles additional information that may not be provided by other State monitoring processes, which employ conference calls, meetings, documentation requests or periodic reports. The objective of each review is to provide information to the Department and plans regarding:*

- *the quality and timeliness of, and access to, health care furnished by the plan,*
- *possible interventions to improve the quality of the plan's services,*
- *activities to enhance performance processes.*

i. _____ Measurement of any disparities by racial or ethnic groups.

j. _____ (Applies to the ACC PIHP, ACC: MCO and Special Connections) Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

Programs: *The ACC PCCM Entity-PIHP and ACC: MCO*

Personnel responsible: *The ACC PCCM Entity-PIHP and ACC: MCO*

Strategy: *Each ACC PCCM Entity-PIHP is required to create, administer and maintain a network of PCMPs and a network of behavioral health providers in compliance with established state network adequacy standards. Each ACC: MCO is required to create, administer and maintain a network of providers in compliance with established state network adequacy standards. ACC PCCM Entity-PIHPs and ACC: MCOs must submit and annually update a Network Adequacy Plan. ACC PCCM Entity-PIHPs and ACC: MCOs must also submit a quarterly network report.*

The ACC PCCM Entity-PIHP and ACC: MCO shall notify the Department, in writing, within five (5) Business Days of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network. The notice shall include:

- *Information describing how the change will affect service delivery.*
- *Availability, or capacity of covered services.*
- *A plan to minimize disruption to the Member care and service delivery.*
- *A plan to correct any network deficiency.*

Frequency: *Annual plan and quarterly reports, unless a material change which requires notice within 5 days*

How it yields information about the area being monitored: *The Department uses this information, along with other quality measures, to fully assess the contractor’s network adequacy*

Programs: *For Special Connections*

Strategy: *The Office of Behavioral Health monitors network adequacy in terms of client choice. Special Connections services are provided at six sites serving three regions. Choice in providers is limited only by geography, and clients transition to different providers when their treatment needs change, or when they must relocate for other reasons.*

Frequency: *Monthly*

How it yields information about the area being monitored:

k. ✓ _____ (Applies to the ACC PCCM Entity-PIHP and ACC: MCO) Ombudsman

Programs: *The ACC PCCM Entity-PIHP and ACC: MCO*

Personnel responsible: *The Department*

Strategy: *The Department operates an Ombudsman for Medicaid Managed Care program. The program is utilized to inform and educate Medicaid enrollees about their existing rights and benefits. The Department monitors trends in ACC PCCM Entity-PIHP and ACC: MCO issues and outcomes through quarterly and annual reports.*

Frequency: *Quarterly and annually.*

How it yields information about the area being monitored: *This data is reviewed at least semi-annually in conjunction with other information obtained through annual site reviews, quarterly reports and consumer surveys.*

1. ✓ _____

(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections) On-site review

Programs: *The ACC PCCM Entity-PIHP and ACC: MCO*

Personnel responsible: *The Department's contracted designee*

Strategy: *The Department has contracted with an EQRO to conduct annual on-site reviews. The site review monitoring process is consistent with the CMS compliance monitoring protocol. The scope of the review includes state and federal regulations and contractual standards. The ACC PCCM Entity-PIHP and ACC: MCO must develop Department-approved corrective action plans for all areas of non-compliance. Corrective actions are monitored until the ACC PCCM Entity-PIHP and ACC: MCO is in compliance. The annual technical report for each ACC PCCM Entity-PIHP and ACC: MCO will be submitted to CMS under separate cover.*

Frequency: *Annually*

How it yields information about the area being monitored: *The EQRO reviews provide performance information related to various aspects of the plans through document review (policies, documents, minutes, etc.) and on-site review, including interviews performed by appropriate professionals. This compiles additional information that may not be provided by other State monitoring processes employing conference calls, meetings, documentation requests or periodic reports. The objective of each site review is to provide information to the Department and plans regarding:*

- *Plans' compliance with federal Medicaid managed care regulations and contract requirements in each area of review,*
- *The quality and timeliness of, and access to, health care furnished by the plan,*
- *Possible interventions to improve the quality of the plan's services,*
- *Activities to enhance performance processes.*

Some specific areas that the EQRO will review and provide information back to the Department and plans include:

- *Credentialing*
- *Information provided to beneficiaries*
- *Grievances/Appeals*
- *Timely access standards*
- *Coordination/continuity of care*
- *Coverage/authorization*
- *Quality of care*
- *Program integrity processes*
- *Information systems*

The information allows the Department to evaluate the accuracy of the performance measures reported by or on behalf of the PCCM Entity-PIHP and ACC: MCO. The validation also will determine the extent to which Medicaid specific performance measures calculated by a ACC PCCM Entity-PIHP and ACC: MCO followed specifications established by the Department.

Programs: *Special Connections:*

Personnel responsible: *Office of Behavioral Health*

Strategy:

On-site reviews are done annually by OBH to assure facilities and agencies are meeting physical plant and administrative and clinical quality assurance standards. Additionally, program integrity, timely access, coordination/continuity and quality of care are monitored via on-site review.

Frequency: *Annually*

How it yields information about the area being monitored:

The on-site reviews provide information with respect to compliance with federal and state standards and identify areas where improvement or corrections need to be made.

m. _____

(Applies to the ACC PCCM Entity-PIHP and ACC: MCO) Performance Improvement projects [Required for MCO/PIHP]

Clinical

Non-clinical

Programs: *The ACC PCCM Entity-PIHP and ACC: MCO*

Personnel responsible: *The ACC PCCM Entity-PIHP and ACC: MCO*

Strategy: *The ACC PCCM Entity-PIHPs and ACC: MCOs shall conduct Performance Improvement Projects (PIPs) that are designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The ACC PCCM Entity-PIHPs will have a minimum of two (2) PIPs chosen in collaboration with the Department: one that addresses physical health (may include behavioral health integration into physical health) and one that addresses behavioral health (may include physical health integration into behavioral health). The ACC MCOs will have a minimum of one (1) PIP chosen in collaboration with the Department. The ACC PCCM Entity-PIHPs and ACC: MCOs will conduct PIPs on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a topic. Additionally, the ACC PCCM Entity-PIHPs and ACC: MCOs must have the capacity*

to conduct up to two (2) additional PIPs upon request from CMS after Year 1 of the waiver. The PIPs will include the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

All PIPs must be submitted for validation to the Department’s External Quality Review Organization.

The ACC PCCM Entity-PIHPs and ACC: MCOs will participate in an annual Performance Improvement Project learning collaborative hosted by the Department that includes sharing of data, outcomes, and interventions.

Frequency: Annually

How it yields information about the area being monitored: Performance Improvement Projects include measurement of performance using objective quality indicators, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement, all of which will provide important and actionable information on how ACC PCCM Entity-PIHPs and ACC: MCOs are meeting performance goals.

n. ✓ _____

(Applies to the ACC PCCM Entity-PIHP, ACC: MCO and Special Connections)

Performance measures [**Required** for MCO/PIHP]

- Process
- Health status/outcomes
- Access/availability of care
- Use of services/utilization
- Health plan stability/financial/cost of care
- Health plan/provider characteristics
- Beneficiary characteristics
- Timely Access

Programs: The ACC PCCM Entity-PIHP and ACC: MCO

Personnel responsible: The Department

Strategy: The Department will establish and administer a performance system, as detailed in the Department’s Quality Strategy, encompassing the following components:

- *Key Performance Indicators (KPIs) used to evaluate service delivery and overall ACC performance as well as that of individual ACC PCCM Entity-PIHPs.*
- *Public reporting including 1) reporting of HEDIS and other clinical measures that align with SIM, CPC+, and other state and federal initiatives; and 2) reporting of broader public health type metrics where the ACC PCCM Entity-PIHP and provider play a critical but perhaps not determinative role in affecting change.*
- *Behavioral Health Incentive Payment to reward achievement on established performance targets.*

Frequency: *Annually*

How it yields information about the area being monitored: *The ACC PCCM Entity-PIHP's and ACC: MCO's performance will be evaluated based on achieving established benchmarks or for percentage improvement over previous year's performance. The performance measures are part of the ACC PCCM Entity-PIHPs' and ACC: MCOs' overall quality plans and annual reports which will help provide a complete picture of the ACC PCCM Entity-PIHPs' and ACC: MCOs' overall annual performance.*

Programs: *Special Connections*

Personnel Responsible: *Office of Behavioral Health*

Strategy: *The performance measures listed under item (n) above are monitored. Performance measures are done annually by the Office of Behavioral Health to yield information about how care is being delivered and the outcome of intervention being performed. Access to services will be monitored to assure those consumers desiring help will receive it in a timely manner.*

Clinical and fiscal oversight is performed to assure the appropriate level of care is being given meeting American Society of Addiction Medicine (ASAM) clinical criteria for the designated level of care being given. Audits focus on matching paid claim data with appropriate clinical charting and administrative billing.

Providers of care are evaluated to assure appropriate credentialing/ licensure is in place, such as the CAC (Certified Addictions Counselor) credential. The CAC is designated at three levels of clinical practice: Levels I, II and III and is under the oversight of the Department of Regulatory Agencies (DORA) for the State of Colorado.

Special Connections providers must also have appropriate LAC (Licensed Addiction Counselor) credentials.

Frequency: *Annually*

How it yields information about the area being monitored: Performance measures are utilized to yield information about how care is being delivered, the outcome of the interventions being performed, and to assure the appropriate level of care is being given.

- o. ____ Periodic comparison of number and types of Medicaid providers before and after waiver
- p. ____ Profile utilization by provider caseload (looking for outliers)
- q. Provider Self-report data
 - ____ Survey of providers
 - ____ Focus groups

Programs: The ACC PCCM Entity-PIHP

Personnel responsible: The Department

Strategy: The ACC PCCM Entity-PIHP s shall assess each PCMP in their network on chosen structural criteria using provider self-report data in the following 6 domains: Continuous Quality Improvement, Team-Based Care, Access, Care Management, Care Coordination and Providing Self-Management Support. The ACC PCCM Entity-PIHP s shall submit summary details to the Department on each PCMP's rating within the structural criteria.

Frequency: Annually

How it yields information about the area being monitored: The practice characteristics that are captured in the provider self-report data will be used to assess the ACC PCCM Entity-PIHPs' ability to improve the delivery of services by its network providers. The provider self-report data, in combination with performance measures and consumer self-report data, will also help the Department assess whether changes in provider practices are resulting in improved outcomes and member experience.

- r. ____ Test 24 hours/7 days a week PCP availability
- s. ____ Utilization review (e.g. ER, non-authorized specialist requests)
- t. Other: (please describe) Grievances

Programs: Special Connections

Personnel responsible: Department of Human Services, Office of Behavioral Health

Strategy: Grievances are monitored as a part of the Office of Behavioral Health's licensing and contracting process, with the quality assurance staff member assigned to each program being responsible for responding to them. Almost all grievances are resolved informally. The low number of women served through the Special Connections program, together with the significant amount of attention that each receives, explains the overall low number of grievances received.

Frequency: Ad hoc

How it yields information about the area being monitored: Grievances provide information with respect to compliance with federal and state standards and identify areas where improvement or corrections need to be made.

The remainder of this page is intentionally left blank.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State’s Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring strategies described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request. The State provides below the results of monitoring strategies conducted during the previous waiver.

This is an amendment request.

For each of the strategies checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each strategy. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each strategy identified in Section B:

Strategy:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State’s CMS Regional Office.

Part I: State Completion Section

A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
 - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State’s waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
 - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State’s submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:
 _____John Doherty_____

c. Telephone Number:___(303) 866-5180_____

d. E-mail:___John.Doherty@state.co.us_____

e. The State is choosing to report waiver expenditures based on
 ___ date of payment.
 ___x___ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

The use of a new MMIS system beginning on March 1, 2017 has prevented accurate reporting for the March – June 2017 timeframe. Because of the consistency of the SFY 2017 data prior to the system go-live on March 1, 2017, the State felt confident with the integrity of the SFY 2016 data. Therefore, the State decided to proxy for SFY 2017 program costs by using SFY 2016 costs, in conjunction with trends provided by the State’s Actuary.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

- a. ___ The State provides additional services under 1915(b)(3) authority.
- b. ___ The State makes enhanced payments to contractors or providers.
- c. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver.
- d. ___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services,*

enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b.**

- a. MCO
- b. PIHP
- c. PAHP
- d. Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

- 1. First Year: \$15.50 per member per month fee
- 2. Second Year: \$15.50 per member per month fee
- 3. Third Year: \$15.50 per member per month fee
- 4. Fourth Year: \$15.50 per member per month fee
- 5. Fifth Year: \$15.50 per member per month fee

b. Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not

exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d._√_ Other reimbursement method/amount. _\$4.00 of the \$15.50 is withheld into a pool and is awarded to the PCCMEs based on their performance metrics in the prior State Fiscal Year. Please explain the State's rationale for determining this method or amount.

The cost effectiveness sections of this application are composed of 4 parts:

I. Behavioral Health component

II. PCCME component

III. MCO component

IV. Consolidated Waiver

In order to provide the most recent complete base for the cost effectiveness analysis, the State used SFY 2017 (July 1st, 2016 – June 30th, 2017) as a base. In using the CMS-64 reports as a source, several issues were found with the base period. The costs associated with part I – III of this application all appear to have under-reported SFY 2017 Q3 (January – March 2017) by a significant amount, and have no reporting on SFY17 Q4 (April 2017 – June 2017). In researching the issue, the use of a new MMIS system beginning on March 1, 2017 has prevented accurate reporting for the March – June 2017 timeframe. Arraying the quarterly program costs over time, the first 2 quarters of SFY 2017 appear consistent with the level and the trend from SFY 2016.

Because of the consistency of the SFY 2017 data prior to the system go-live on March 1, 2017, the State felt confident with the integrity of the SFY 2016 data. Therefore, the State decided to proxy for SFY 2017 program costs by using SFY 2016 costs, in conjunction with trends provided by the State's Actuary. For consistency, the State used the SFY 2016 member months, trended by the State Budget Section's enrollment projections.

In contrast with program costs, administrative costs appear throughout SFY 2017, although slightly lower than in SFY 2016. However, it is possible that these costs appear lower because the pace of deliverables associated with the new MMIS has slowed as the system became operational. At the same time, other administrative costs seem unlikely to have declined. To avoid skewing administrative costs in either direction, the State chose to average the quarterly administrative spend over the past 3 years as a proxy for SFY 2017 administrative costs.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a. ___ Population in the base year data

1. Base year data is from the same population as to be included in the waiver.

2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

1915b – Consolidated Waiver Cost Effectiveness spreadsheet:

The Department projects the member months in the waiver by applying the Department’s most up-to-date Budget enrollment trends. The components of the waiver, PCCME, BH and MCO, are detailed in the 1915b – PCCME Component, 1915b – Behavioral Health Component, and 1915b – MCO Component spreadsheets. Member months, as well as costs are segregated appropriate to the Component, to avoid duplication or omission of costs.

The member months in this waiver include members who receive services under HCBS waivers, as those members will receive Behavioral Health services, Primary Care Case Management, and physical health services within this waiver. However, the costs associated with the HCBS waivers have been carved out from this waiver application to avoid duplication of costs. Thus, on a per member per month (PMPM) basis, portions of this waiver application will under-represent the total client costs.

Populations in MEG 1 include: individuals who are aged 65 and older, blind or disabled and receive Supplemental Security Income; working adults and children participating in the Medicaid Buy-In program for individuals with disabilities; parents/caretakers and children previously eligible under section 1931 of the federal Medicaid statute; participants of the Breast and Cervical Cancer Treatment Program; foster care and former foster care children; and pregnant adults.

Populations in MEG 2 include: Affordable Care Act (ACA) expansion adults without dependent children; and Affordable Care Act (ACA) expansion parents/caretakers with incomes between 68-133%.

SFY17 – 10,329,816 MEG1, 5,386,884 MEG2 member months

Trends – Trending BY to 1st quarter of P1 – 4.7% for MEG1, 8.9% for MEG2

Aggregate trends – P1 – 4.6% annualized, P2 – 1.9%, P3 – 1.9%, P4 – 1.9%, P5 – 1.9%

SFY19 – 10,893,612 MEG1, 5,906,544 MEG2 member months
SFY20 – 11,072,232 MEG1, 6,049,728 MEG2 member months
SFY21 – 11,257,140 MEG1, 6,196,740 MEG2 member months
SFY22 – 11,445,132 MEG1, 6,347,316 MEG2 member months
SFY23 – 11,636,268 MEG1, 6,501,552 MEG2 member months

***Note on use of member month quarterly MEG1 and MEG2 totals:
the PCCME Component overcounts the cost, per member per month, because it contains all the same member month projections as the BH component except the exact number of member months contained in the MCO component. To prevent overcounting on the Consolidated Waiver, the Quality Incentive PMPM in column AD of the tab D5 of the MCO Component contains the negative amounts of incentive contained in column AD of the tab D5 of the PCCME Component. In this way, the Consolidated Waiver spreadsheet uses the member month counts of the components to have accurate annual projections. This distortion to each projection year of the MCO costs on tab D5 is corrected by adding back in \$4 PMPM to column H.***

c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: All changes in member month projections are a result of applying the State Budget Section Projections.

d. [Required] Explain any other variance in eligible member months from BY to P2:

e. [Required] List the year(s) being used by the State as a base year: SFY 2017. If multiple years are being used, please explain: Only SFY2017 is being used

f. [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period SFY.

g. [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data: Yes, explained above Section E

For Conversion or Renewal Waivers:

a. [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: _____

d. [Required] Explain any other variance in eligible member months from BY/R1 to P2: _____

e. [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a. [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

HCBS Waiver costs, costs of the PACE program, plus costs associated with members without full TXIX Medicaid benefits were excluded from the cost-effectiveness analysis.

In particular, the PCCME Component spreadsheet D3. Actual Waiver Cost, column G, contains Fee-For-Service costs associated with the member months, except for all HCBS Waiver costs, which are significant, and have been carved out. This results in Base Year PMPMs of \$202.61 PMPM for MEG1, and \$212.26 for MEG2. However, these PMPMs do not represent the total per member per month costs of clients on this waiver application. Instead, it represents only the non-HCBS waiver costs PMPM on this waiver application.

For Conversion or Renewal Waivers:

a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

b. [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _____

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
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(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2
Total	Appendix D5 should reflect this.		Appendix D5 should reflect this.

The three tables on pages 101 – 103 provide the requested information this table captures.

The allocation method for either initial or renewal waivers is explained below:

- a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. ___ Other (Please explain).

The administrative costs detailed in D2.A. of the Cost Effectiveness spreadsheet are an attempt to count all costs associated with the three components, without double-counting, or failing to account for costs in the base. The instructions note that estimating Administrative costs as a percentage of total Medicaid costs are appropriate for PIHPs. Since the Behavioral Health PIHP represents 9.356% of Medicaid costs in the base year, and Behavioral Health distribution of costs reported in the BH Component worksheet D2.A is the result.

The instructions note that allocating by the member would be appropriate for the MCO and PCCME components. However, given that portions of any per member estimation would contain Behavioral Health costs and other Waiver costs, combining any per member estimate to the BH component would double count costs. To avoid this issue, the State chose to extrapolate the BH Administrative cost methodology to the MCO (6.291%) and PCCME (45.045%) components. Given the structure of the State’s costs, this method was deemed the most accurate way to estimate total Administrative Cost. Thus, the Behavioral Health distribution of costs were used for D2.A in the Consolidated CE spreadsheet, but applied as 60.693% of Medicaid costs, to represent the sum of the components.

The Behavioral Health component represented 9.356% of total Medicaid non-Administrative cost, the PCCM component represented 45.045% of total Medicaid non-Administrative cost,

and the MCO component represented 6.291% of total Medicaid non-Administrative cost. The proposed waiver represents 60.093% of total Medicaid non-Administrative cost.

H. Appendix D3 – Actual Waiver Cost

a. The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

In response to the Colorado Legislative Request For Information (LRFI), the State estimated that the PCCM program spent an additional \$5,235,463 on administrative costs in FY17 and estimated \$26,804,230 in associated savings, as the program grew. On a PMPM basis, the additional costs came to \$.45 and the associated savings to \$2.32. Using this ratio as an estimate of savings to management cost, we find a ratio of \$5.12 FFS savings per additional \$1 of management cost. In recognition of diminishing returns, the State chooses to apply only 3/4 this ratio, or \$3.84 in FFS savings per additional \$1 of management cost. The additional spending on PCCME capitations is chosen from column N of tab D5. Waiver Cost Projection. For MEG1, the additional investment in the program is \$3.70 for MEG1, and \$6.38 for MEG2, for a weighted average of \$4.62 across both populations.

However, this estimate is problematic, as it is reasonable to assume that much of the FFS savings realized are actually the result of the expansion of primary care management in the previous year, FY16. The additional cost will be immediate in the first month of P1 (FY19), but it is reasonable to assume that there will not be any resulting savings in that first month. At the same time, it is reasonable to assume that savings will be realized by the end of the first year. Therefore, the estimate of savings will only be applied to 1/2 of P1 (SFY19); this results in 103.98% inflation of savings in P2 (3.98% secular inflation + 100% increase to apply savings assumption to all of P2, from a base of P1).

Costs associated with the PCCME member months are trending at the State Plan adjustment rate, based on assumption that savings will primarily come in non-HCBS FFS costs associated with this waiver application. The additional management costs for each MEG are captured in the D5. Waiver Cos Projection of the 1915b – PCCME Component spreadsheet, cells N13 and N14. For MEG1, that represents \$2.71 in additional costs for P1, and for MEG2, an additional \$3.33. In MEG1 in the Base Year, 71.2% of the FFS associated costs were non-HCBS costs, so the expected savings in the projection years are multiplied by 71.2%. In MEG2

in the Base Year, 99.7% of FFS associated costs were non-HCBS, so the expected savings in the projection years are multiplied by 99.7%.

Given the limitation of growth to the State Plan trend, the State amended the savings estimates over time to fit the regulation. In order to preserve the estimated new savings associated with the change to mandatory PCCME enrollment, the initial estimate above was pasted into the “Savings” tab under the heading of “Initial Annual Savings estimates”. The State totals the estimated savings in column H. Then in the “Savings Adjusted to fit SP trend” table, the State state projects the same amount of savings in the previous table, but at the growth of the State Plan.

Chart: Mandatory Enrollment 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation Projected	Amount projected to be spent in Prospective Period
<i>Savings in FFS costs associated with additional spending on primary care case management.</i>	<i>\$9.25 PMPM savings in P1 \$9.25 PMPM savings in P2 \$9.39 PMPM savings in P3 \$9.55 PMPM savings in P4 \$9.70 PMPM savings in P5</i>	<i>10.2% inflation from BY to P1 2.3% inflation in P2 3.4% inflation in P3 3.5% inflation in P4 3.5% inflation in P5</i>	
Total	<i>\$155,367,874.72 in P1 \$158,385,131.03 in P2 \$163,930,847.45 in P3 \$169,836,260.72 in P4 \$175,914,124.39 in P5</i>		

Chart: Continuation of established 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in	Inflation Projected	Amount projected to be spent in Prospective Period

	State Plan Services		
<i>Savings associated with continuation of established (b)(3) services into the projection period (Residential, Assertive Community Treatment, Intensive Case Management, Respite Care, Vocational Services, Clubhouses/Drop-in Centers, Recovery Services, Prevention/Early Intervention).</i>	<i>\$.17 PMPM savings in P1 \$.18 PMPM savings in P2 \$.18 PMPM savings in P3 \$.19 PMPM savings in P4 \$.20 PMPM savings in P5</i>	<i>10.2% inflation from BY to P1 2.3% inflation in P2 3.4% inflation in P3 3.5% inflation in P4 3.5% inflation in P5</i>	
Total Note: as these established services have historically been offered together, differentially assigning savings to services is not possible, so the State has estimated on a basket of services.	<i>\$2,931,232.15 in P1 \$3,053,151.13 in P2 \$3,219,683.35 in P3 \$3,398,643.60 in P4 \$3,586,982.67 in P5</i>		

Chart: Total of established and new 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation Projected	Amount projected to be spent in Prospective Period
	<i>\$9.42 PMPM savings in P1 \$9.43 PMPM savings in P2 \$9.58 PMPM savings in P3 \$9.74 PMPM savings in P4 \$9.90 PMPM savings in P5</i>	<i>10.2% inflation from BY to P1 2.3% inflation in P2 3.4% inflation in P3 3.5% inflation in P4 3.5% inflation in P5</i>	<i>\$7.64 PMPM savings in P1 \$7.81 PMPM savings in P2 \$8.07 PMPM savings in P3 \$8.36 PMPM savings in P4 \$8.65 PMPM savings in P5</i>

Total	\$158,299,106.87 in P1		\$128,299,583.23 in P1
	\$161,438,282.16 in P2		\$133,678,899.09 in P2
	\$167,150,530.80 in P3		\$140,925,075.89 in P3
	\$173,234,904.32 in P4		\$148,709,158.89 in P4
	\$179,501,107.06 in P5		\$156,899,123.81 in P5

The cost estimates in the “Amount projected to be spent in Prospective Period” column above are derived from moving the average PCCME cost from \$8.58 PMPM, up to the proposed average cost of \$15.50. These calculations are shown on the “Savings” tab, in the “Waiver PMPM expenses” and “Waiver dollar expenses” tables.

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

b. ___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2. ___ The State provides stop/loss protection (please describe):

The State requires contractors to be licensed as either a Health Maintenance Organization or Limited Service Licensed Provider Network with the Colorado Division of Insurance.

d. ___ ✓ ___ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. ___ ✓ ___ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

Behavioral Health Quality Incentive program:

The Department will allow the ACC: PIHP to receive incentive payments for the improvement of key performance indicators. The implementation of the Pay for Performance Program is contingent on the availability of funds as well as state and federal approval.

Under the Pay for Performance Program, the overall incentive funds available to the ACC: PIHP are proportionally contingent on the ACC: PIHP's performance as it relates to the following three (3) minimum participation performance requirements:

1. ***All corrective action plan submissions and activities will be in accordance with the provisions of the Contract, for the duration of the Contract term.***
 - ***25% of the overall incentive funds are allocated to this participation measure.***
 - ***To qualify for the portion of overall incentive funds allocated for this participation measure, the Contractor shall demonstrate 100% compliance.***
2. ***Encounter data is submitted monthly in accordance with the provisions of the Contract, for the duration of the Contract term.***
 - ***25% of the overall incentive funds are allocated to this participation measure.***
 - ***To qualify for 100% of the portion of overall incentive funds allocated for this participation measure, the Contractor shall submit flat file data***

that is 100% accurate for a minimum of ten (10) months for the duration of the Contract term.

- *In the event of a submission beyond the due date, up to two (2) months, the Contractor shall remain eligible for participation in the performance incentive program at a 10% reduction for each month beyond the due date. Inaccurate flat file submissions will be rejected by the Department and the Contractor shall continue to resubmit until the data is accurate.*
3. *The Contractor shall demonstrate documentation accuracy in the 2018 Contractor reported 411 audit.*
- *50% of the overall incentive funds are allocated to this participation measure.*
 - *The portion of overall incentive funds allocated for this participation measure is adjusted based on the average percentage of compliance achieved by the Contractor for the following six (6) documentation categories:*
 - *Procedure Code*
 - *Diagnosis Code*
 - *Place Service*
 - *Service Program Category*
 - *Units*
 - *Staff Requirements*
 - *The percentage of total incentive payments for which the Contractor qualifies is determined by the accuracy of the above six (6) measures as follows:*
 - *90% accuracy qualifies the Contractor for 100% of the portion of overall incentive funds allocated for this participation measure;*
 - *85% accuracy qualifies the Contractor for 90% of the portion of overall incentive funds allocated for this participation measure;*
 - *80% accuracy qualifies the Contractor for 80% of the portion of overall incentive funds allocated for this participation measure.*

After meeting minimum program performance requirements, the ACC: PIHP can qualify for incentive payments by achieving minimum improvement in incentive performance measures and by percentage of compliance with incentive process measures.

Minimum improvement for each incentive performance measure is defined as the ACC: PIHP “closing their performance gap by 10%” from a Department Goal (based on FY 16-17 rates) and Fiscal Year 2017-2018 performance. The table below lists the intended initial behavioral health performance measures; the actual measures will be included in the contracts to be reviewed by CMS annually. The Department will work with the ACC: PIHP to negotiate what the appropriate baselines will be.

Indicator	Incentive Performance Measure	Percentage of Funding Allocated for Measure
1	Engagement in Outpatient Substance Use Disorder (SUD) Treatment	20%
2	Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition	20%
3	Behavioral Health Screen or Assessment for Foster Care Children	20%
4	Follow-up after a Positive Depression Screen	20%
5	Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	20%

In accordance with 42 CFR 438.6(b)(2) incentive payments may not provide for payment in excess of 105% of the approved capitation payments. Incentive payments must be considered when determining the cost effectiveness of the ACC: PIHP.

The incentive arrangements specified in the Performance Incentive Program are necessary to support program initiatives as specified in the state's behavioral health quality strategy, in accordance with 42 CFR 438.6(b)(2)(v).

Incentive payments may only be available for a fixed period of time and incentive performance must be measured during the rating period under the contract in which the performance incentive program is applied, in accordance with 42 CFR 438.6(b)(2)(i). The Department must remit qualifying incentive payments earned during the performance period on July 1, 2018 and June 30, 2019 to the Contractor between July 1, 2019 and December 31, 2019.

In accordance with 42 CFR 438.6(b)(2)(ii) - (iv) Performance Incentive Program arrangements:

- *Are not renewed automatically.*
- *Are made available to both public and private contractors under the same terms of performance.*
- *Are not conditioned on the Contractor entering into or adhering to intergovernmental transfer agreements.*

2. For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)

- i. Document the criteria for awarding the incentive payments.
- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

The Department accounts for this incentive on the Behavior Health component of the waiver in tab D5. Waiver Cost Projection, column AD: Incentive Cost Projection.

PCCME Component incentive withhold arrangement:

The Department is setting aside four dollars (\$4.00) PMPM through a withhold arrangement, to be distributed to the PCCMEs based on the results of a set Key Performance Indicators (KPI). The ACC: PCCM Entity may earn up to \$4.00 PMPM in a KPI Incentive Program for meeting established performance goals on up to nine (9) KPIs.

The KPI incentive payment will be set and paid as follows:

- ***The Department will determine the proportion of funds associated with each individual KPI so that the total incentive payment the ACC: PCCM Entity may earn equals four dollars (\$4.00) PMPM.***
- ***The Department will pay an incentive payment to the ACC: PCCM Entity for each individual KPI that the ACC: PCCM Entity meets or exceeds the established performance goal.***
- ***The Department will remit all payments on KPIs to the ACC: PCCM Entity within 180 days from the last day of the quarter in which the KPI incentive payments were earned. The Department will calculate the KPI incentive payment as of the end of each quarter based off the ACC: PCCM Entity's performance from the prior 12 months.***

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and

method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The Department utilized the following adjustments on the 1915b – Consolidated Waiver Cost Effectiveness worksheet: State Plan Trend (column J), Administrative Cost Adjustment (column Y), FFS Cost (not in cap payment) Adjustment (column Q), and Quality Incentive Plan Adjustment (column AD). The Department also used the 1915(b)(3) Service Trend Adjustment to account for the estimate of savings associated with additional PCCME management costs, as directed by the instructions.

In order to produce a mathematically accurate Consolidated worksheet, and combine the 3 component projections on a consistent basis, the Department avoided using the State Plan Programmatic/Policy/Pricing changes Adjustment (column L) on the Consolidated Worksheet, since the column L Adjustment compounds the column J Adjustment.

The PCCME worksheet contains a State Plan Programmatic/Policy/Pricing change Adjustment (column L), which is detailed in that worksheet, but those Adjustments are included in the Consolidated worksheet, column J Adjustment, for the aforementioned reason.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.I_√_ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e.*, *trending from 1999 to present*) The actual trend rate used is: See below 3. for description. Please document how that trend was calculated:

The State BY was SFY 2016-2017. P1 is SFY 2018-2019. As a result the State is using actual cost to develop a moving three (3) year average trend. The State Plan Adjustment (tab D5. Waiver Cost Projection, column J) in the 1915b – Consolidated spreadsheet is the aggregation of the State Plan Trends (column J) from the component spreadsheets, as well as the Program

Adjustment Trend (column L of tab D5. Waiver Cost Projection of the PCCME Component spreadsheet).

Use of the Program Adjustment Trend in the Consolidated spreadsheet would have compounded costs associated with the State Plan Adjustments. In order to avoid that distortion to the State Plan Trends associated with the MCO and Behavioral Health Components, the Department aggregated the trends in the “MEG1 consolidation” and “MEG2 consolidation” tabs.

2. [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) (*i.e., trending from present into the future*).

i. State historical cost increases. Please indicate the years on which the rates are based: base years 3 year moving average of the trends derived from State Actuary trends in their rate model, for that year. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used _____. Please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

The State aggregated the PMPM trends (combining utilization and unit cost trends) from the actuarial models used in rate-setting to MEG1 and MEG2, combining the FY17-18 and FY18-19 into one PMPM adjustment for FY17-FY19 (midpoint-to-midpoint). In order to project beyond the actual PMPM trends, the moving 3 year average was used.

The state plan trend adjustment for the waiver cost projection of the Consolidated Cost Effectiveness spreadsheet:

BY to P1 – 10.19% in MEG1 (composed of a 30.83% PCCME component, 8.09% BH, 6.12% MCO, weighted by the applicable member months), and 10.28% in MEG2, based on 40.78% PCCME component, 8.09% BH, 6.24% MCO, again, weighted by the applicable member months. Detail found in “MEG1 consolidation” and “MEG2 consolidation” tabs.

P2 – 3.11% for MEG1 (composed of 0% PCCME, 4.15% BH, and 2.94% MCO), .72% for MEG2 (composed of 0% PCCME, 4.15% for BH, 3.03% for MCO)

P3 – 3.09% for MEG1 (composed of 0% PCCME, 4.03% BH, and 2.99% MCO) , 3.94% for MEG2 (composed of 0% PCCME, 4.03% for BH, 3.06% for MCO)

P4 – 3.17% for MEG1 (composed of 0% PCCME, 4.16% BH, and 2.98% MCO), 4.06% for MEG2 (composed of 0% PCCME, 4.16% for BH, 3.03% for MCO)

P5 – 3.16% for MEG1 (composed of 0% PCCME, 4.11% BH, and 2.97% MCO), 4.02% for MEG2 (composed of 0% PCCME, 4.11% for BH, 3.03% for MCO)

The state plan trend adjustment for the waiver cost projection of the Behavioral Health Cost Effectiveness spreadsheet:

BY to P1 – 8.09% (composed of 3.23% to FY18 and 4.22% to FY19), P2 – 4.15%, P3 – 4.16%, P4 – 4.2%, P5 – 4.11%

To see the detail of how these trends were consolidated, please see the MEG1 and MEG 2 Consolidation tabs on the Consolidated CE spreadsheet.

b. **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:

- i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ *Determine adjustment for Medicare Part D dual eligibles.***
 - E. ___ Other (please describe):
- ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ Changes brought about by legal action (please describe):

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- iv. ___ Changes in legislation (please describe):

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. Other (please describe):

Applies only to PCCM-Entity portion of the waiver

The ACC PCCM Entity was initially approved under a State Plan Amendment(SPA); that SPA is being replaced by this waiver.

For PCCM, the State Plan Services Programmatic/Policy/Pricing Change Adjustment (column L on tab D5. Waiver Costs Projection of the 1915b – PCCME Component, from BY to P1 are:

MEG1 – 30.83%, MEG2 – 40.78%, aggregate of 34.14%

This increase in costs of the PCCM program is composed of 2 parts:

A 33.78% increase in MEG1, and a 40.12% increase in MEG2, due to mandatory enrollment. Base Year PCCME costs are diluted, as they are spread across member months of the current population, which included a significant number of members opting-out of the current PCCM program.

A 2.20% decrease in MEG1 costs, and a .47% decrease to MEG2 costs, of the current PCCME program, to end the current incentive programs. These programs are withheld from the current PCCM capitations, but the money in the pool is partially paid out, so this adjustment is designed to bring the total PMPM to \$11.50, to make room for a new, more effective incentive program, which is delivered through a withhold arrangement, bringing the total possible payment to \$15.50.

All subsequent trends for P2-P5 are 0%

c. ___ **Administrative Cost Adjustment***: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ___ No adjustment was necessary and no change is anticipated.

2. An administrative adjustment was made.

i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ___ Other (please describe):

ii. ___ FFS cost increases were accounted for.

A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ___ Other (please describe):

iii. [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years 5 year moving PMPM trend. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

The trends applied within the 1915b – Consolidated spreadsheet are aggregated in the “MEG1 consolidation” and “MEG2 consolidation” tabs. The increased cost inherent in this application is driven by the increased investment into the PCCME component. Attributing that additional investment in the PCCME component would have resulted in a 23.48% MEG1 Administrative Adjustment from BY to P1, and a 31.25% adjustment for MEG2 (found in column G of the “MEG1 consolidation” and “MEG2 consolidation” tabs, respectively.

To avoid overestimating the Administrative Adjustment, the Department chose to use the 5 year moving average PMPM trend found in column F of the “MEG1 consolidation” and “MEG2 consolidation” tabs, based on the Base Year level of Administration for the 3 components.

Administrative trends:

FY17-19: MEG1 - 6.83%, MEG2 – 4.07%, aggregate 5.6%

FY19-20: MEG1 - 7.53%, MEG2 – 6.70%, aggregate 7.2%

FY20-21 – MEG1 - 5.74%, MEG2 – 4.95%, aggregate 5.4%

FY21-22 – MEG1 - 4.36%, MEG2 – 3.58%, aggregate 4.0%

FY22-23 – MEG1 - 6.92%, MEG2 – 6.13%, aggregate 6.6%

Effect of trending Administrative PMPMs, by year:

BY: \$12.22 for MEG1, \$18.72 for MEG2

P1: \$.83 for MEG1, \$.76 for MEG2, aggregate of \$.81

P2: \$.98 for MEG1, \$1.31 for MEG2, aggregate of \$1.09

P3: \$.81 for MEG1, \$1.03 for MEG2, aggregate of \$.88

P4: \$.65 for MEG1, \$.78 for MEG2, aggregate of \$.69

P5: \$1.07 for MEG1, \$1.38 for MEG2, aggregate of \$1.18

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. [Required, if the State’s BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: 1.2%. Please provide documentation.

2. [Required, when the State’s BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State’s trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above

_____.

Behavioral Health component – b3 costs currently under the Community Mental Health Services Program Waiver were included in the State Plan for this application, to follow the directions provided for initial waiver applications, while accounting for all costs in the program. Instead, this section was used to estimate savings for the additional 1915(b)(3) services.

For a thorough explanation of the savings estimates used in column T of tab D5. Waiver Cost Projection, see section H of this document. The P1-P5 estimates of savings provided in column W of tab D5. Waiver Cost Projection are the result of the initial savings estimates in column T, trended forward in column U, by the FFS cost trend associated with the PCCME Component, since the expected savings are driven by reductions in those FFS costs. The FFS cost trends for all components of the waiver can be found in the “MEG1 consolidation” and “MEG2 consolidation” tabs, in column E.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a.** __see below _____
2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
3. Explain any differences:

Because there are Fee-For-Service costs associated with each component of the waiver, but not included in the capitation, the State converted this section “Incentives (not in capitated payment) Inflation Adjustment” columns to “FFS Cost Inflation Adjustment”.

In the Behavioral Health component, these costs are primarily FFS Drug costs, so the State trended these costs by a moving average of the PMPM % change in historical FFS Behavioral Health Drug costs.

The FY17-19 (BY to P1) trend applied to MEG1 was -4.06%, which results from a -2.73% projection in FY17-18 costs and a -1.37% projection in FY18-19 costs.

The FY17-19 trend applied to MEG2 was .67%, which results from a .06% projection in FY17-18 costs and a .61% projection in FY18-19 costs.

Trends for P2: .53% for MEG1, 2.67% for MEG2, aggregate of 1.7%

Trends for P3: .53% for MEG1, 3.74% for MEG2, aggregate of 2.3%

Trends for P4: .53% for MEG1, 3.74% for MEG2, aggregate of 2.3%

Trends for P5: .53% for MEG1, 3.74% for MEG2, aggregate of 2.3%

Effect of applying BH FFS Drug cost trends:

P1: $-\$.14$ for MEG1, $\$.05$ for MEG2, $-\$.08$ in aggregate

P2: $\$.02$ for MEG1, $\$.21$ for MEG2, $\$.08$ in aggregate

P3: $\$.02$ for MEG1, $\$.30$ for MEG2, $\$.11$ in aggregate

P4: $\$.02$ for MEG1, $\$.31$ for MEG2, $\$.12$ in aggregate

P5: $\$.02$ for MEG1, $\$.32$ for MEG2, $\$.12$ in aggregate

In the PCCM component of the waiver, associated costs are a mix of physical health services and drug costs, with the mix closely resembling the MCO cost mix. For that reason, the State chose the State Plan MCO aggregate moving average trends developed from the MCO rate models.

Therefore, in the MCO and PCCME components of the waiver, the PMPM trends from the actuarial models were aggregated to the MEG1 and MEG2 levels in the years of rate-setting. The moving 3 year average of these trends was used to project the trends into the projection period.

FY17-19 (BY to P1) – 6.12% for MEG1, 6.24% for MEG2, aggregate of 6.16%, from FY17-18 of 3.02% for MEG1, 3.15% for MEG2,

FY18-19 of 3.00% for MEG1, 2.99% for MEG2

P2 – 2.94% for MEG1, 3.03% for MEG2
P3 – 2.99% for MEG1, 3.06% for MEG2
P4 – 2.98% for MEG1, 3.03% for MEG2
P5 – 2.97% for MEG1, 3.04% for MEG2

Effect of applying PCCM FFS cost trends:

P1: \$12.39 for MEG1, \$13.24 for MEG2, \$12.68 in aggregate
P2: \$6.33 for MEG1, \$6.84 for MEG2, \$6.51 in aggregate
P3: \$6.62 for MEG1, \$7.11 for MEG2, \$6.78 in aggregate
P4: \$6.79 for MEG1, \$7.25 for MEG2, \$6.95 in aggregate
P5: \$6.97 for MEG1, \$7.50 for MEG2, \$7.15 in aggregate

Effect of applying MCO FFS cost trends:

P1: \$5.89 for MEG1, \$.93 for MEG2, \$4.05 in aggregate
P2: \$3.01 for MEG1, \$.48 for MEG2, \$2.07 in aggregate
P3: \$3.14 for MEG1, \$.50 for MEG2, \$2.17 in aggregate
P4: \$3.23 for MEG1, \$.51 for MEG2, \$2.22 in aggregate
P5: \$3.31 for MEG1, \$.53 for MEG2, \$2.28 in aggregate

The 1915b - Consolidated spreadsheet FFS cost trends are the result of a weighted blending of the component trends in the “MEG1 consolidated” and “MEG2 consolidation” tabs on the spreadsheet.

BY to P1: 5.71% for MEG1, 6.04% for MEG2, aggregate of 5.8%
Trends for P2: 2.91% for MEG1, 3.00% for MEG2, aggregate of 2.9%
Trends for P3: 2.95% for MEG1, 3.36% for MEG2, aggregate of 3.1%
Trends for P4: 2.94% for MEG1, 3.40% for MEG2, aggregate of 3.1%
Trends for P5: 2.94% for MEG1, 3.40% for MEG2, aggregate of 3.1%

Effect of applying Consolidated FFS cost trends:

P1: \$12.22 for MEG1, \$13.38 for MEG2, \$12.61 in aggregate
P2: \$6.58 for MEG1, \$7.04 for MEG2, \$6.74 in aggregate
P3: \$6.88 for MEG1, \$8.11 for MEG2, \$7.30 in aggregate
P4: \$7.06 for MEG1, \$8.49 for MEG2, \$7.55 in aggregate
P5: \$7.25 for MEG1, \$8.79 for MEG2, \$7.78 in aggregate

f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. We assure CMS that GME payments are included from base year data.

2. We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3. ___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. ___ GME adjustment was made.
 - i. ___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii. ___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. ___ No adjustment was necessary and no change is anticipated.

Method:

1. ___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine GME adjustment based on a pending SPA.
3. ___ Determine GME adjustment based on currently approved GME SPA.
4. ___ Other (please describe):

- g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.

1. Payments outside of the MMIS were made. Those payments include (please describe):

In the Transitional Medicaid Reconciliation, clients were identified as having been paid the Expansion Parent rate, where the true eligibility was non-Expansion Adult through Transitional Medicaid eligibility. BHO's and MCOs were paid the value of those non-Expansion member months through this reconciliation. In the SSI Children Reconciliation, clients were identified that had been errantly paid the Disabled rate instead of the Childrens' rate. BHO's were paid the value of those Children member months through this reconciliation. These payments were all included in the base data.

2. Recoupments outside of the MMIS were made. Those recoupments include (please describe):

In the Transitional Medicaid Reconciliation, BHO's and MCOs were recouped the value of the errantly-paid Expansion Parent member months through this reconciliation. In the SSI Children Reconciliation, BHO's were recouped the value of those errantly-paid Disabled member months through this reconciliation. In the Expansion Parent Overpayment reconciliation, overpayments to Expansion Parent member months were recouped. The prior MMIS system (retired 2/28/2017) failed to identify Expansion Parent member months, which resulted in paying the higher AwDC rate. This reconciliation recouped all these capitations down to the correct Expansion Parent rate.

These recoupments were all included in the base data.

3. ___ The State had no recoupments/payments outside of the MMIS.

- h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1. ___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine copayment adjustment based on pending SPA.
3. ___ Determine copayment adjustment based on currently approved copayment SPA.
4. ___ Other (please describe):

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. No adjustment was necessary
 2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.
 3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
 4. ___ The State made this adjustment:*
- i. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5**.
 - ii. ___ Other (please describe):

- j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. Other (please describe):

Pharmacy claims for the Base Year did not reflect Rebates from drug manufacturers. However, the State's Data Section calculates average Rebate percentages by quarter, by MEG. These percentages were removed from the raw Pharmacy claims totals to provide a net-of-rebate estimate of Pharmacy costs. These net-of-rebate estimates are the only Pharmacy costs included in the waiver.

- k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.
1. We assure CMS that DSH payments are excluded from base year data.
 2. We assure CMS that DSH payments are excluded from the base year data using an adjustment.
 3. Other (please describe):

- l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs

significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. This adjustment was made:
 - a. Potential Selection bias was measured in the following manner:
 - b. The base year costs were adjusted in the following manner:
- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
 1. We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
 2. We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
 3. *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
 4. Other (please describe):
- n. **Quality Incentive Program Adjustment:** *The State waiver application proposes a Behavioral Health quality incentive program and a PCCM Entity incentive program. The changes in cost are accounted for in column AD. For a detailed explanation of the two quality incentive programs, see section H.d. above.*

The Quality Incentive costs for each projection year are calculated in the “MEG1 consolidation” and “MEG2 consolidation” tabs of the 1915b – Consolidated Waiver spreadsheet.

The PCCME Component of the waiver offers up to \$4 PMPM for Quality Incentive. However, there are members within the waiver, whose care would be managed under the MCO Component of the waiver, so the MCO Component includes -\$4 in the Quality Incentive to correct for the overcounting of the PCCME Component. Finally, the Behavioral Health Component offers up to 5% above the capitation for achievement on performance measures in that Quality Incentive program.

Increases in Total Cost due to Quality Incentive Programs

P1: \$5.57 for MEG1, \$6.01 for MEG2, \$5.72 in aggregate
P2: \$5.64 for MEG1, \$6.08 for MEG2, \$5.79 in aggregate
P3: \$5.72 for MEG1, \$6.18 for MEG2, \$5.88 in aggregate
P4: \$5.81 for MEG1, \$6.29 for MEG2, \$5.97 in aggregate
P5: \$5.90 for MEG1, \$6.41 for MEG2, \$6.07 in aggregate

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b. ___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness

Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation:

Adjustment	Capitated Program	PCCM Program
	costs from the PCCM With Waiver Calculations -- See the next column)	PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

- o. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*
 - 1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
 - 2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 - 3. ___ Other (please describe):

- p. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
 - 1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 - 2. ___ This adjustment was made in the following manner:

- q. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wraparound. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how

utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:

2. ___ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) (*i.e., trending from present into the future*).

i. ___ State historical cost increases. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ___ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will

occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
 - Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
 - Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ___ An adjustment was necessary and is listed and described below:

i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ___ Determine adjustment for Medicare Part D dual eligibles.

E. ___ Other (please describe):

ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv. ___ Changes brought about by legal action (please describe):

For each change, please report the following:

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ___ Other (please describe):

v. ___ Changes in legislation (please describe):

For each change, please report the following:

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ___ Other (please describe):

vi. ___ Other (please describe):

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ___ Other (please describe):

c. ___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed

care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ An administrative adjustment was made.
 - i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - ii. ___ Cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. ___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D. ___ Other (please describe):

iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.

2. ___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years _____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) costeffectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness

calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wraparound. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.

2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor’s providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.

3. ___ Other (please describe):

1. ___ No adjustment was made.

2. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:
2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:
3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.