

*Colorado Department of
Health Care Policy and Financing*



Section 1915(b) Waiver Renewal
Proposal for
The Colorado Medicaid
Community Behavioral Health Services Program
and
The Special Connections Substance Abuse Treatment
Program Postpartum Months
Three through Twelve

Submitted on **October 22,** 2015
for
Waiver Period January 1, 2016 to June 30, 2017

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Instructions – see separate document

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

Facesheet

Please fill in and submit this Facesheet 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 Colorado Medicaid Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program 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 renewal is requested for a period of two (2) years, effective January 1, 2016 and ending June 30, 2017. The Department has extended the current contracts for an additional year via a renewal that became effective July 1, 2015. The

Department has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019. (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 contact person for the *Community Behavioral Health Services Program* under this waiver is *Lenya Robinson*, and she can be reached at 303-866-6387 or email at *lenya.robinson@state.co.us*.

The State contact person for the *Special Connections Substance Abuse Treatment Program* under this waiver is *Lenya Robinson* and she can be reached by telephone at (303) 866-6387 or e-mail at *lenya.robinson@state.co.us*.

The State contact person for the cost effectiveness portion of this waiver is Sarah Campbell and she can be reached by telephone at (303) 866-2083, or fax at (303) 866-2370, or e-mail at *sarah.campbell@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 Community Behavioral Health Services Program and Substance Abuse Treatment Program Postpartum Months Three to Twelve renewal waiver to identified stakeholders and the federally recognized tribes in Colorado for their review and comment on January 7, 2015. The recognized tribes are the Northern Navajo, Southern Ute 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. Please see Appendix A.I. for a list of identified stakeholders. As of March 31, 2015 no comments had been received from the native 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).

Community Behavioral Health Services Program History

The Colorado Medicaid Program is administered by the Department, the single state agency authorized to administer the Colorado Medicaid Program.

Prior to 1995, most Medicaid beneficiaries in Colorado received mental health benefits through a fee-for-service system. Medicaid beneficiaries who were not enrolled in Health Maintenance Organizations (HMOs) received mental health services from a variety of Medicaid-enrolled providers, such as Community Mental Health Centers (CMHCs), clinics, hospitals, psychiatrists, psychologists and social workers. These health care providers billed the Medicaid Program for each covered service provided to Medicaid beneficiaries. There was no central gatekeeper determining the need for services and no single clinician or case manager coordinating all aspects of an individual's mental health care. Medicaid beneficiaries were free to seek services from any Medicaid-enrolled provider.

Medicaid beneficiaries who were enrolled in HMOs received a limited amount of inpatient and outpatient mental health services through these HMOs. Once a beneficiary received the maximum mental health benefits available through the

HMO, she/he received any additional necessary mental health services through the Medicaid fee-for-service system described above.

In 1992, the Colorado General Assembly passed House Bill 92-1306, authorizing the Department of Human Services and the Department to implement a two-year pilot program to provide comprehensive mental health services to Medicaid beneficiaries through a capitated managed care system. In 1995, shortly before the start of the pilot program, the General Assembly passed Senate Bill 95-78, revising the reporting and termination dates of the pilot program and directing the Departments to implement a statewide mental health managed care program.

The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties, and in 1998 in the remaining 12 counties of the state. From 1998 through 2004, eight contractors operated the Program. In 2005, the Department reconfigured the counties into five (5) geographic service areas (please see Section A. Part I. D. 2.). Each contractor operates the Program in a specific geographic area..

In 1993, the federal Health Care Financing Administration (HCFA) granted the State waivers under Section 1915(b) and Section 1902(a) of Title XIX of the Social Security Act. These waivers allowed the State to implement a managed mental health program for a two-year period, beginning July 1, 1995 and ending June 30, 1997. These initial waivers were subsequently extended by HCFA through March 8, 1998.

In 1998, HCFA renewed Colorado's waivers for an additional two years, beginning March 9, 1998 and ending March 8, 2000. These waivers were subsequently extended by HCFA through April 9, 2001. In 2001, HCFA renewed the waivers for an additional two years beginning April 10, 2001 through April 9, 2003. This waiver was extended until July 8, 2003 to allow time for approval of the subsequent renewal waiver, which was approved for the waiver period of May 5, 2003 through May 4, 2005 and later extended to June 30, 2005.

Legislation that passed April 6, 2004 transferred the program operations from the Department of Human Services to the Department, allowing for more cohesive management of the program, since the Department possesses the authority for the Program's management and the Department manages the entire continuum of Medicaid services and administrative contracts. This shift also allows the Department to be more aware of gaps between physical and mental health care and to better serve Medicaid beneficiaries by having one administrative agency responsible for the provision of their Medicaid services.

In 2005, the Centers for Medicare and Medicaid Services (CMS) renewed Colorado's waivers for the waiver period of July 1, 2005 through June 30, 2007. In 2007, CMS again renewed Colorado's waivers for the waiver period of July 1, 2007 through September 30, 2009. In 2009, CMS renewed Colorado's waivers for

*the waiver period of October 1, 2009 through June 30, 2011. On June 15, 2011 CMS approved the renewal of Colorado's waivers for the period of July 1, 2011 through June 30, 2013. On May 29, 2013, CMS approved a two-year waiver extension effective for waiver period July 1, 2013 through June 30, 2015. In early 2013, the Colorado General Assembly approved funding for substance use disorder services (SUD) to be incorporated into the Community Behavioral Health Services program. On January 1, 2014 the Department implemented these changes with authority provided by the approved waiver. On December 26, 2013, CMS approved an amendment of the current waiver, effective for waiver period January 1, 2014 through June 30, 2015. The State requested and was granted a temporary extension of the waiver through **December 31, 2015**. The amendment also included authority to serve the Expansion Population*, and to change the name of the program from the Community Mental Health Services Program, to the Community Behavioral Health Services Program.*

** Beginning January 1, 2014, individuals that earned up to 133% of the Federal Poverty Level (FPL) may be eligible for Medicaid coverage. For 2013, this equated to about \$15,000/year for an individual or \$30,000/year for a family of four.*

In this waiver renewal, several changes have occurred. First, the Department incorporated the expansion parents into MEG 2. During the last waiver renewal, only the AwDC population was included in MEG 2. After the waiver was approved, the Department and CMS discussed MEG 2 further and determined that the expansion parents should also be included in MEG 2 so that MEG 2 represents the costs for the expansion population. To comply with that request, the expansion parents were included in this waiver renewal.

Second, there are two new populations covered under the waiver. Specifically, 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 (the Act) and Children age six (6) through nineteen (19) with income above 100 percent but at or below 133 percent of the Federal poverty level. The Former Foster Care Children population is being added to conform with the requirements set forth in the Act. Children age six (6) through nineteen (19) with income above 100 percent but at or below 133 percent of the Federal poverty level are being added because this population falls within the State's CHIP program Medicaid expansion population. The children that are not part of the expansion population will continue to receive services through the CHIP program.

Third, in order to provide clear conformance to State managed care rules, the Department has added children in the custody of the Division of Youth Corrections who are placed in a Psychiatric Residential Treatment Facility or a Residential Child Care Facility to the excluded populations section of this waiver.

Lastly, the current waiver application is for an eighteen (18) month period rather than a twenty-four (24) month period. The change in the effective period relates to the Department's need to receive a temporary extension on the CMS approved waiver, which is effective until December 31, 2105. Therefore, the projected member months and costs included in this waiver application are for an eighteen (18) month period rather than the historical twenty-four month period.

Special Connections Substance Abuse Treatment Program History

On September 29, 2006, the Department submitted an amendment to the Community Mental Health Services Program waiver to include the Colorado Special Connections Substance Abuse Treatment Program Postpartum Months Three to Twelve (hereafter referred to as the Special Connections Substance Abuse Treatment Program). This portion of the waiver was approved for the periods of January 1, 2007 through June 30, 2007, for July 1, 2007 through September 30, 2009, for October 1, 2009 through June 30, 2011, for July 1, 2011 through June 30, 2013, and for July 1, 2013 through June 30, 2015. Additionally, an amendment was approved for January 2014 through June 30, 2015. A temporary extension of the waiver was granted through December 31, 2015. The Department is currently seeking renewal of this waiver amendment, which is anticipated to be effective January 1, 2016 through June 30, 2017, with no proposed changes. The Special Connections Substance Abuse Treatment Program portion of the waiver extended the postpartum substance use disorder benefits for Special Connections participants from three months postpartum to twelve months postpartum.

Special Connections is a substance use disorder treatment program jointly administered by the Colorado Department of Human Services (DHS), Office of Behavioral Health (OBH), formerly the Alcohol and Drug Abuse Division (ADAD)¹, and the Department's Medicaid Program Division, formerly the Health Benefits Division² (Appendix E1). Since 1992, the Special Connections Substance Abuse Treatment Program has provided substance use disorder treatment and case management services to pregnant and postpartum women with substance use disorder issues. OBH contracts with licensed women's treatment programs to provide Medicaid-paid services through an Interagency Agreement (IA) (Appendix E2) with the Department.

Legislation authorizing the Special Connections Substance Abuse Treatment Program was passed in 1991, as Senate Bill 91-56. Rationale for this legislation was that Colorado would benefit from early identification and intervention with pregnant women who had substance use disorders and therefore were at risk of delivering low birth weight babies with other health complications, such as fetal alcohol spectrum disorders, withdrawal complications and neurological,

¹ ADAD became part of the Division of Behavioral Health in late 2008.

² The Health Benefits Division name was changed to the Medicaid Program Division in late 2008.

cognitive and physiological deficits. Funding for both residential (room and board excluded) and outpatient treatment was approved at that time.

The initial enrollment in the Special Connections Substance Abuse Treatment Program was small, serving 42 clients in 1992. The phase-in of the program focused first on OBH contracting with licensed providers with specialized skill in treating pregnant women with substance use disorders and then working with referral sources throughout the State to make them aware of the services offered. Special Connections providers have worked to educate communities about the program and increase the number of collaborators and partners who can refer clients to the program. OBH currently works with the Department, the Colorado Department of Public Health and Environment, the local county departments of human/social services, DHS Child Welfare Division, the State Court Administrator's Office and the Division of Probation Services.

In 2004, the Colorado legislature enacted HB04-1075 to extend the Medicaid postpartum substance use disorder benefits from two months to twelve months postpartum. The legislature reasoned that Medicaid expenditures for care of these infants would decrease as there was a greater likelihood that the mother would remain free from substance abuse if treatment were extended. The intent of the legislation was to expand the eligibility period to provide substance use disorder treatment services to Special Connections clients who deliver in the program. The original legislation was interpreted and applied in that fashion since implementation in 1992. The Special Connections Substance Abuse Treatment Program portion of the waiver provides an additional period of substance use disorder treatment to ensure that the mother remains drug free and able to care for her new infant.

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 Community Behavioral Health Services Program*) The State requires enrollees to obtain medical care through a primary care case management (PCCM) 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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program*) 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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program*) 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

PIHP (*Applies to the Community Behavioral Health Services Program*)

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 Substance Abuse Treatment Program*)
All Special Connections Substance Abuse Treatment Programs are currently licensed by OBH. There is an IA between 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 Special Connections 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)** - Statewideness--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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program*) 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 Community Behavioral Health Services Program*) 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.

- d. **Section 1902(a)(4)** – (*Applies to the Community Behavioral Health Services Program*) 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:** 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 Community Behavioral Health Services Program*)
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:** 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 is a PAHP.
- e. **Fee-for-service (FFS) selective contracting:** (*Applies to the Special Connections Substance Abuse Treatment Program*) 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 Community Behavioral Health Services Program*) (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- 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 Substance Abuse Treatment Program*)

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

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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 Community Behavioral Health Services Program) 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 contract requires PIHPs to maintain an adequate provider network throughout their service regions to meet access standards. The Department monitors this through reporting on network adequacy, complaints and grievances, member satisfaction surveys and site reviews. Members are also permitted to access 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
- ___ Two or more primary care providers within one PCCM system.
- ___ A PCCM or one or more MCOs
- ___ Two or more PIHPs.
- ___ Two or more PAHPs.
- Other: *(Applies to the Community Behavioral Health Services Program)* (please describe)

Within the PIHP network, enrollees have a choice of providers.

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 the Special Connections Substance Abuse Treatment Program*) Beneficiaries will be given a choice of providers in their service area.

Under the Special Connections Substance Abuse Treatment Program, the outpatient, residential, care management and health education services 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. In the Denver metro area, there are several different providers that are defined by specific services they offer rather than service area.

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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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program*) all counties, zip codes, or regions of the State

Less than Statewide

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.

Community Behavioral Health Services Program Geographic Areas of Service and PIHPs

| Current PIHP Contractors | Counties Served |
|--|---|
| Colorado Access (dba Access Behavioral Care) | Cheyenne, Elbert, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma |
| Colorado Access (dba Access Behavioral Care) | Denver |
| Behavioral Healthcare, Inc. | Adams, Arapahoe, Douglas |
| Foothills Behavioral Health Partners, LLC | Boulder, Broomfield, Clear Creek, Gilpin, Jefferson |
| Colorado Health Partnerships, LLC | Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Otero, Ouray, Park, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, Teller |

The Department completed a re-procurement for the Community Behavioral Health Services Program and awarded contracts to four out of five of the same contractors that had previously managed the program. Colorado Access won the bid to manage the northeast region of the state, previously managed by Northeast Behavioral Health Partners. The contractor names in the table above reflect present contractor names and

regions. The new contracts began on July 1, 2014 and are effective for one year, with four possible renewals.

Special Connections Substance Abuse Treatment Program 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: Women’s Connection, Denver ARTS: The Haven, Denver Arapahoe House: Aspen Center, Denver Arapahoe House Case Management Services, Thornton |
| 3. Pueblo, Alamosa, and surrounding areas | Fee for Service | <ul style="list-style-type: none"> Crossroads Turning Points, Alamosa Crossroads Turning Points, Pueblo |
| 4. Boulder county and surrounding areas | Fee for Service | <ul style="list-style-type: none"> Mental Health Partners |

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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 Community Behavioral Health Services Program*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment 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 Community Behavioral Health Services Program*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

- ✓ **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 Community Behavioral Health Services Program*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

- ✓ **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 Community Behavioral Health Services Program*)
 - ✓ Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

- ✓ **Aged and Related Populations** (*Applies to the Community Behavioral Health Services Program only*) 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 Community Behavioral Health Services Program*)
- 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 the Community Health Services Program*)
- Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

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 Community Health Services Program*)
- Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

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 Community Health Services Program*)
- Voluntary enrollment (*Applies to the Special Connections Substance Abuse Treatment Program*)

Special Connections Substance Abuse Treatment Program

- 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 Substance Abuse Treatment Program*)--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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program*) – Medicaid beneficiaries who receive services through the SCHIP program.
- ___ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- ✓ **Other** (Please define): (*Applies to the Community Behavioral Health Services Program*)

The following individuals are not eligible for enrollment in the Community Behavioral Health Services Program:

- 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 who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan who are:*
 - *Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI);*
 - *Found by a criminal court to be Incompetent to Proceed (ITP); or*

- *Ordered by a criminal court to a State Institute for Mental Disease (IMD) for evaluation (e.g. Competency to proceed, sanity, conditional release revocation, pre-sentencing).*
- H. *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.*
- I. *Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Behavioral Health Services program while they are on TPR. TPR individuals remain under the control and care of the Institute.*
- J. *Classes of individuals determined by the Department to require exclusion from the Community Behavioral Health Services program, defined as individuals residing in State Regional Centers for people with developmental disabilities and associated satellite residences for more than 90 days.*
- K. *Individuals who receive an individual exemption as set forth at 10 CCR 2505-10, §8.212.2 and further described in Section A Part IV.C.2.c of this waiver.*
- L. *Individuals while determined presumptively eligible for Medicaid.*
- M. *Children or youth in the custody of the Colorado Department of Human Services - Division of Child Welfare or Division of Youth Corrections who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF) as defined in C.R.S. 25.5-4-103 or a Residential Child Care Facility (RCCF) as defined in C.R.S. 26-6-102.*

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F. Services

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

1. Assurances.

✓ (Applies to the Community Behavioral Health Services Program) The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- 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*
 - *Home-Based Services for Children and Adolescents*
 - *Specialized Services for Addressing Adoption issues*
 - *Social/Ambulatory Detoxification*
 - *Substance Use Disorder Assessment*
- 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).

- ✓ 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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program) Family planning services are not included under the waiver.

- ✓ *(Applies to the Community Behavioral Health Services Program)* 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, 2014 through June 30, 2015. *The Department has extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*

- ✓ *(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. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

- 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 Substance Abuse Treatment Program)*
The FFS Selective Contracting program does not cover emergency services.

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):

- (Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* 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:

- (Applies to the Special Connections Substance Abuse Treatment Program)*
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.

This is a FFS waiver request and therefore “enrollment” and “disenrollment” are not applicable terms. Clients have the right to obtain FQHC services through the regular Medicaid Program while receiving Special Connections services.

- The program is **mandatory** and the enrollee is guaranteed a choice of at least one ~~MCO/PIHP/PAHP/PCCM~~ which has at least one FQHC as a participating provider. If the enrollee elects not to select a ~~MCO/PIHP/PAHP/PCCM~~ 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/PAHP/PCCM~~ 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/PAHP/PCCM~~ with a participating FQHC:

✓ *(Applies to the Community Behavioral Health Services Program)* The program is mandatory and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.

Pursuant to C.R.S. 25.5-8-110(4)(b) the PIHPs shall offer contracts to essential community providers in their region. An FQHC is an essential community provider. All members have access to FQHC services such as physical health and dental services through the regular Medicaid program. However, the waiver and BHO contracts with FQHCs are limited to behavioral health services. All of the BHOs have contracts with FQHCs in their networks and in those instances members may also access behavioral health services at the FQHC.

5. **EPSDT Requirements.**

✓ *(Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* 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.

Please see the State's note below regarding changes to (b)(3) services provided to children/youth under EPSDT.

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

✓ *(Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* 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.

For the Community Behavioral Health Service Program

During one of the previous waiver periods, the State worked with CMS to move most (b)(3) services provided to children/youth under EPSDT to an appropriate location in the State Plan and to develop an appropriate methodology for these services. Services for children/youth that remain (b)(3) services are respite and vocational rehabilitation.

1915(b)(3) services that are provided by each PIHP 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, educational services (GED, college prep skills),

vocational assessment and job coaching. Credentials of vocational providers vary from Bachelor's level staff to Masters level licensed behavioral health staff. Some vocational services are provided by peer specialists.

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.

For the Special Connections Substance Abuse Treatment Program:

The Special Connections Substance Abuse Treatment Program provides substance use disorder treatment to women during pregnancy and 60 days postpartum. The waiver extends the benefit to include three through twelve months postpartum. The program provides risk assessments; individual, group and family counseling; case management services; and group health education. These services may be provided on an outpatient or residential basis depending upon the severity of the substance use disorder and level of need.

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)³. These placement criteria determine the level of care into which a client is placed during the course of treatment. Service definitions for Special Connections include:

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.

___The State requires MCOs/PIHPs/PAHPs/PCCMs 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 MCO/PIHP/PAHP/PCCM contract:

³ Copyright 1995-2004 American Society of Addiction Medicine

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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 Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* 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, 2014 through June 30, 2015. *The Department expects to extend the current contracts for an additional year via an amendment that will become effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*

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

2. Details for PCCM 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.

NOT APPLICABLE

a. ___ **Availability Standards.** The State's PCCM 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):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
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 Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

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. ___ 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 Substance Abuse Treatment Program*)

OBH 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 OBH for more immediate placement in another program.

OBH currently serves as the monitoring agency for the Special Connections Substance Abuse Treatment Program. The Department requires of OBH, through the IA, 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 Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*

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 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.

NOT APPLICABLE

- 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.

| Area(City/County/Region) | PCCM-to-Enrollee Ratio |
|--|------------------------|
| | |
| | |
| | |
| | |
| Statewide Average: (e.g. 1:500 and 1:1,000) | |

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 Substance Abuse Treatment Program)

The current number of residential slots (or beds) is sixteen (16) at the Haven, sixteen (16) at Crossroads’ Turning Points and sixteen (16) at the Aspen Center. The remaining four (4) beds were lost when one contractor decided to expand its program to twenty-four (24) beds, thus putting them out of compliance with the Institutes for Mental Diseases exclusion and thereby decreasing the number of beds available overall for Special Connections. 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, the number of “slots” is dependent upon the number of staff employed at the treatment agency. 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. As with residential treatment, as clients cycle in and out of a program, the number of clients served overall varies considerably. 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 Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* 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, 2014* through *June 30, 2015*. *The Department extended the current contracts for an additional year via an amendment that will become effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*

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

The following items are required.

a. ✓ *(Applies to the Community Behavioral Health Services Program)*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 scope of this contract is limited to behavioral health services; primary care is not included. Under the Community Behavioral Health Program, PIHPs are required to coordinate with primary care providers, who are tasked with developing a treatment plan, and maintain a treatment plan for all enrollees receiving services, as all enrollees have a special health care need.

Based on the Department's definition of Persons with Special Health Care Needs, the scope of the PIHPs' services and the organization of the managed care delivery system, the Department decided not to require PIHPs to meet the primary care requirements nor implement an additional

mechanism for identifying, assessing and developing a treatment plan for Persons with Special Health Care Needs.

- b. ___ **Identification.** 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.
 - c. ___ **Assessment.** 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.
 - d. ___ **Treatment Plans.** 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 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.

NOT APPLICABLE

- 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 is receives **health education/promotion** information.
Please explain.
- 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).
- 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 Substance Abuse Treatment Program)

Continuity and coordination of care are required components of the Special Connections Substance Abuse Treatment Program. Providers under Special Connections 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 couples treatment.

The Department requires of OBH, through the IA, quarterly and annual program reporting. The Department will provide oversight to and in conjunction with OBH 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 Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*
- ✓ *(Applies to the Community Behavioral Health Services Program)* 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. The State was working with CMS staff to finalize the 2012 Quality Strategy, but that strategy was not approved. The Department continues to work with CMS to approve the 2015 draft Quality Strategy and is planning to submit the draft to CMS in **January 2016**. Significant changes have been made to the Quality Strategy as a result of several reform initiatives happening within the state, as well as changes in managed care quality efforts being conducted by MCOs and PIHPs.
- ✓ *(Applies to the Community Behavioral Health Services Program)* 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 | Name of Organization | Activities Conducted | | |
|---------|---------------------------------------|----------------------|----------------------|---------------------|
| | | EQR study | Mandatory Activities | Optional Activities |
| MCO | | | | |
| PIHP | <i>Health Services Advisory Group</i> | ✓ | ✓ | |

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 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 program.

NOT APPLICABLE

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM 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 PCCMs;

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

3. ___ Request PCCM's response to identified problems;
4. ___ Refer to program staff for further investigation;
5. ___ Send warning letters to PCCMs;
6. ___ Refer to State's medical staff for investigation;
7. ___ Institute corrective action plans and follow-up;
8. ___ Change an enrollee's PCCM;
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 PCCMs;
13. ___ Suspend or terminate PCCM 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 administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM 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).
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 Substance Abuse Treatment Program)

Providers for the Special Connections Substance Abuse Treatment Program 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 Substance Abuse Treatment Program meet quality of care standards that are set and monitored by 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 IA, 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 Substance Abuse Treatment Program. 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 administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

(Applies to the Community Behavioral Health Services Program) 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 Community Behavioral Health Services Program) The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*

(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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State permits indirect MCO/PIHP/PAHP or PCCM marketing (e.g., radio and

TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

For the Community Behavioral Health Services Program:

The PIHP must obtain prior approval from the Department for all proposed marketing materials. Since all beneficiaries within the PIHP region are automatically enrolled, there has not been a need to develop any marketing materials.

For the Special Connections Substance Abuse Treatment Program:

Brochures, presentations, trainings presented by OBH.

3. ___ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* The State requires MCO/PIHP/PAHP and PCCM 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 has chosen these languages because (check any that apply):

- i. *(Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* The languages comprise all prevalent languages in the MCO/PIHP/PAHP/PCCM 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 Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*
- (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. **Non-English Languages**

- (Applies to the Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program) Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

Each PIHP is responsible for providing oral translation services to all enrollees as needed. The PIHP must inform enrollees of the availability of and instructions on how to access oral translation.

(Applies to the Community Behavioral Health Services Program) The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The PIHPs 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 in the enrollee handbook. The enrollee may also receive this information by contacting the PIHP Office of Member and Family Affairs (formerly the Office of Consumer and Family Affairs).

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- ___ State
- ___ contractor (please specify) _____

(Applies to the Community Behavioral Health Services Program) 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) ___ State contractor (please specify): _____
- (ii) (Applies to the Community Behavioral Health Services Program)

C. Enrollment and Disenrollment

1. Assurances.

- (Applies to the Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* 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 PIHP cannot request disenrollment of an enrollee for any reason.*
- 42 CFR 438.56 (B) – The enrollee cannot disenroll from the PIHP unless an individual exemption is made. Individual exemptions are made on a case-by-case basis.*
- (Applies to the Community Behavioral Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*
- (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.** Please describe the State's enrollment process for MCOs/PIHPs/PAHP and PCCMs 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:

b. Administration of Enrollment Process.

(Applies to the Community Behavioral Health Services Program) State staff conducts the enrollment process.

The enrollment process for the Community Behavioral Health Services Program is as follows:

- *The Colorado Benefits Management System (CBMS) determines eligibility*
- *CBMS sends eligibility information to the Department's Medicaid Management Information System (MMIS)*
- *MMIS reads the eligibility information and automatically enrolls the client in the Community Behavioral Health Services program*

The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

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: _____

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.):

This is an existing program that will be **expanded** during the renewal period. 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 Community Behavioral Health Services Program) 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 Community Behavioral Health Services Program) on a mandatory basis into a single PIHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
- Once determined eligible for Medicaid, a beneficiary is automatically enrolled with the PIHP based on the beneficiary's county of residence. Foster care beneficiaries are enrolled in the PIHP based on the county that manages the care.*
- ___ 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 Substance Abuse Treatment Services) 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.
- ✓ (Applies to the Community Behavioral Health Services Program) 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:

Individual exemptions are addressed in Department regulations found in 10 CCR 2505-10 8.212.2, presented below:

8.212.2 INDIVIDUAL EXEMPTIONS

1. *A client may request to be exempt from enrollment in the Community Behavioral Health Services Program if:*
 - a. *The client has a clinical relationship with a provider of mental health services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area; or*
 - b. *The client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.*
2. *If the client requests an exemption based on Section 8.212.2.1.a:*
 - a. *The client shall notify the behavioral health organization of his/her request to receive necessary mental health services from the provider with whom the client has established a clinical relationship.*
 - b. *Within fourteen (14) calendar days of receiving notice from the client, the behavioral health organization shall determine whether it can contract with the client's chosen provider to provide necessary mental health services to the client and provide written notice to the client and the client's provider of that determination.*
 - c. *If the behavioral health organization is unable to approve the client's request, the notice shall:*
 - i. *Identify one or more providers within the behavioral health organization's network who can appropriately meet the client's mental health needs;*
 - ii. *Include information on the client's right to request an exemption, the process for requesting an exemption and assistance available to the client.*
 - d. *The client may request an exemption with the Department within fourteen (14) calendar days of the date of the notice from the behavioral health organization disapproving the client's request.*
 - e. *Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.*
3. *If the client requests an exemption based on Section 8.212.2.1.b:*
 - a. *The client shall request an exemption from the Department.*

- b. *Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.*
- 4. *A client whose request for exemption has been denied by the Department has the right to appeal the determination pursuant to Section 8.057.*
- 5. *A newly Medicaid eligible client who requests an exemption shall be enrolled in the Community Behavioral Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.*
- 6. *A client who is enrolled in the Community Behavioral Health Services program and is requesting an exemption shall continue to be enrolled in the Community Behavioral Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.*
- 7. *A client who wants to reenroll in the Community Behavioral Health Services program shall notify the Department. The client will be reenrolled within thirty (30) calendar days of receipt of the client's request. The Department shall notify the client and the behavioral health organization of the reenrollment prior to the effective date of reenrollment.*

(Applies to the Community Behavioral Health Services Program) The State **automatically re-enrolls** a beneficiary with the same PIHP/ if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. 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.
- ii. Enrollee submits request to MCO/PIHP/PAHP/PCCM. 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 grievance procedure before determination will be made on disenrollment request.

(Applies to the Community Behavioral Health Services Program) 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.

Enrollees may request an exemption from the program as described in Section(c), Enrollment, above.

When enrollees move from one region to another, they are automatically enrolled with the PIHP in that region following official notification of address change.

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ___ 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):

___ 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 PCCMs to request disenrollment** of enrollees. Please check items below that apply:

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

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

iii. ___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM’s caseload.

iv. ___ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

- ✓ *(Applies to the Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program)* The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*
- ✓ *(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.
- ✓ *(Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* 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 programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, 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 Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* 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.

(Applies to the Community Behavioral Health Services Program)

The Department currently contracts with Maximus, Inc. to operate an Ombudsman program that is available to all managed care enrollees with medical or behavioral health issues pursuant to C.R.S 25.5-5-406 III.(b).:

“The state department shall establish the position of ombudsman for Medicaid managed care. It is the intent of the general assembly that the ombudsman for Medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for Medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCO. The process for expedited reviews shall provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act in an emergency situation that immediately impacts the enrollee's access to quality health care services, treatments, or providers. An enrollee shall be entitled to designate a representative, including but not limited to an attorney, the ombudsman for Medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee.”

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 H.

✓ (Applies to the Community Behavioral Health Services Program) 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 Community Behavioral Health Services Program) 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, 2014 through June 30, 2015. The Department extended the current contracts for an additional year via an amendment that became effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.

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.

✓ (Applies to the Community Behavioral Health Services Program) 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 Community Behavioral Health Services Program) The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 30 days. (This timeframe was changed to 30 days in 2010 to align with the appeal timeframe for Fee for Service Medicaid.)

✓ (Applies to the Community Behavioral Health Services Program) 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 and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly

voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

NOT APPLICABLE

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

___ The grievance procedure is operated by:

- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

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

___ 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 administrator function.

___ 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/PAHP grievances. Specify the time period set: _____

___ 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):

F. Program Integrity

1. Assurances.

- ✓ *(Applies to the Community Behavioral Health Services Program)* 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, 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, PIHP, or PAHP;
 - (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
 - (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

- ✓ *(Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program)* 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 excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

- ✓ *(Applies to the Community Behavioral Health Services Program)* 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 Community Behavioral Health Services Program) State payments to a 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 Community Behavioral Health Services Program) 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, 2014 through June 30, 2015. *The Department extended the current contracts for an additional year via an amendment that will become effective July 1, 2015. The State has the option to extend the existing contract for four additional 12 month periods from July 1, 2015 through June 30, 2019.*

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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 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 programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM 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 to the Special Connections Substance Abuse Treatment Program*) 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 Community Behavioral Health Services Program:*

| 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 the Special Connections Substance Abuse Treatment Program – 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 | ✓ | | | | | | | | | | | |
| Ombudsman | | | | | | | | | | | | |

| 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 |
| 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 Community Behavioral Health Services Program*) Consumer Self-Report data

- CAHPS (please identify which one(s))
- (*Applies to the Community Behavioral Services Program*) State-developed survey – Client Satisfaction Survey

For the Community Behavioral Health Services Program:

NOTE: The Department uses client satisfaction surveys; however, these surveys are not State-developed. These surveys are adaptations of nationally used surveys.

Each PIHP must participate in a Department approved annual enrollee satisfaction survey administered according to survey guidelines. The PIHP is to incorporate the results of the survey into its overall quality plan. The

current consumer satisfaction surveys being used is the Experience of Care and Health Outcomes (ECHO) Survey. The ECHO survey includes various questions to assist the Department with understand care and services provided to the client. For example, in regards to timely access the adult survey question #4 ask “in the last 12 months, did you need counseling or treatment right away? In regards to gaining insight for possible grievances a client may have the child survey question #14 ask if ”...counseling or treatment show respect for what you had to say?” In regards to quality of care the adult survey question #30 ask “...how would you rate your overall mental health now?”

- Disenrollment survey
- Consumer/beneficiary focus groups

d. (Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program) 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)

For the Community Behavioral Health Services Program

The Department uses a number of processes to monitor PIHP Program Integrity and has an official Program Integrity Section which helps in this effort. Other Sections and Units within the Department like Rates and Quality Health & Improvement assist with monitoring Program Integrity through Compliance Site Audits which review BBA Program Integrity requirements and at times review contractual requirements and 411 encounter data. Another non-claim processes which reviews and analyzes submitted data includes review of quarterly reports. By contract the PIHP is task with ensuring their provider network is adequate for their covered population. In other words the PIHP determines their Specialist Capacity. Client Provider Selection is controlled by the appointment scheduling staff of each PIHP (continue reading for additional input on Provider Selection). The Department’s PIHP Contract manager monitors the contract requirements and receives annual reports from the PIHP that provide status of their network meeting client needs. The Department’s Quality Strategy Team (QST) provides additional monitoring activities on the quarterly Network Adequacy report. The QST is responsible for reviewing three of the quarterly reports mentioned in this section (grievance and appeals, network adequacy,

access to care) and follow up is similar for all reports (continue reading for additional QST processes). The Department receives quarterly reports on access to care, which provide information on the total number of Medicaid mental health members served by the PIHP and reflect timely access to emergent, urgent and routine care throughout the fiscal year. To understand integrity concerns in PIHP networks the Department reviews Network Adequacy reports which list the number of providers/specialist by county. For example, in quarterly one of FY 14/15 review of the required Network Adequacy report of one PIHP found no indication for telemedicine providers(PIHP may use mechanisms like telemedicine to address geographic barriers). Follow up with the PIHP found that the PIHP had omitted telemedicine providers in error. Other deficiencies in these reports can identify areas where the PIHP may not be meeting contractual requirements. The Department receives a separate quarterly report on telephone access that includes statistics on call response, call wait time, and rate of call abandonment. If the Department identifies any areas of concern in its review, the PIHP is required to correct these issues. These reports are utilized with other strategies including on-site reviews, enrollee satisfaction surveys, performance measures and performance improvement projects to give a full picture of the PIHP's performance. Each health plan submits a grievance and appeals quarterly report to the Department. 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 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. If no concerns are identified a follow up letter is still sent to the PIHP noting no additional follow up is needed. The grievance narrative for these reports 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.

For the Special Connections Substance Abuse Treatment Program

Timely access is monitored through CDHS/OBH'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.

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 Community Behavioral Health Services Program*) Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

The Department contracts with an external quality review organization (EQRO) to conduct PIHP compliance site reviews, to evaluate performance improvement projects and to validate performance measures. The EQRO assesses of all these activities as related to access, quality and timeliness and summarizes results in an annual technical report.

i. _____ (*Applies to the Community Behavioral Health Services Program*) Measurement of any disparities by racial or ethnic groups.

Effective 2008, BHOs measure penetration rate by race. Rates for BHO plans in the Community Behavioral Health Services Program were last calculated in FY 13/14 for American Indian, Asian, Black, Native Hawaiian/other Pacific Island, White, Spanish American, Unknown and the Other race category. The Department also works with sister agencies to gather additional data that can be used to measure disparities and include that data into a single report. The “Measuring Behavioral Health: Fulfilling Colorado’s Commitment to Become the Healthiest State” publication was noted on page 72.n. The “Measuring Child Health: Fulfilling Colorado’s Commitment to Become the Healthiest State” publication is expected to be cleared for release in May 2015. The Colorado Opportunity Project is another initiative where State agencies are aligning efforts to look more deeply into poverty in the State.

j. _____ (*Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program*) Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

For the Community Behavioral Health Services Program

The Contractor shall notify the Department, in writing, within five (5) Business Days of Contractor’s knowledge of an expected, 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 for clinical team meetings with the affected Member's to discuss the available options and to revise the service plan to address any changes in services or service providers.

*A plan to correct any network deficiency.

DELIVERABLE: Network Change and Deficiency Notifications DUE: Within five (5) Business Days of Contractor becoming aware of the change or deficiency.

The Department requires the PIHPs to submit Access to Service reports on a quarterly basis.

- *These reports address the following contract standards for service timeliness: Emergency services shall be available by phone within fifteen (15) minutes of the initial contact, 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;*
- *Urgent care shall be available within twenty-four (24) hours; and*
- *Routine services shall be available within seven (7) calendar days.*

PIHPs also submit quarterly network adequacy reports. The Department uses this information, along with other quality measures, to fully assess the contractor's network adequacy. Questions or concerns are addressed with the PIHP to the Department's satisfaction. PIHPs also integrate network adequacy information into their overall quality improvement plans, which are reported to the Department annually. Section d notes that Client Provider Selection is controlled by the appointment scheduling staff of each PIHP and that grievance reporting often provides insight on Provider Selection for clients(see section d for that input).

For the Special Connections Substance Abuse Treatment Program

OBH monitors network adequacy in terms of client choice. Special Connections services are provided at 13 locations by 5 different provider agencies. 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. Provider agencies continue to report difficulties in finding supervising providers due to the providers' lack of time to work closely enough with the programs they would supervise.

k. ✓ _____ (*Applies to the Community Behavioral Health Services Program*) Ombudsman

The Department operates an Ombudsman for Medicaid Managed Care program pursuant to C.R.S. 25.5-5-406(1)(b), (2006). The program is utilized to inform and educate Medicaid enrollees about their existing rights and benefits. The Department monitors trends in PIHP issues and outcomes through quarterly and annual reports.

This data is reviewed at least semi-annually in conjunction with other information obtained through annual site reviews, PIHP quarterly reports and consumer surveys.

1. ✓ _____ (Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program) On-site review

For the Community Behavioral Health Services Program:

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 PIHPs must develop Department-approved corrective action plans for all areas of non-compliance. Corrective actions are monitored until the PIHP is in compliance. The annual technical report for each BHO will be submitted to CMS under separate cover.

For the Special Connections Substance Abuse Treatment Program:

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.

- m. ✓ _____ (Applies to the Community Behavioral Services Program) Performance Improvement projects [**Required** for MCO/PIHP]

✓ _____ Clinical

✓ _____ Non-clinical

Starting in fiscal year FY 14/15 PIHPs are responsible for having one Performance Improvement Project (PIPs) related to care transitions. This PIP will be validated annually by the Department's EQRO pursuant to 42 C.F.R. Section 438 Subpart E. PIPs that cannot be validated must be revised so that validation can occur. The PIPs are validated by the Department's External Quality Review Organization who works with the Department's PIP specialist to monitor progress on the PIP. In addition to direct contact with health plans to monitor PIP status the Department also discusses PIP topics and receive status updates in two quality committee meetings (MQuIC and BQuIC) that are attended by the Department, MCO and PIHP, and the Department's EQRO. Some PIP topics selected for the current Transition of care include: "All members with a confirmed date of eligibility within 7 business days of release from Jefferson and Boulder county jails for whom FBHP has received a "yes" documentation of a behavioral health issue, as defined by the county jail screening process," "Adolescent Depression Screening and Transition to a Behavioral Health Provider," "Depression Screening and Engagement for Adolescents," "Transitions of care from the jail setting to the community - connecting Medicaid Members to behavioral health services once released from jail."

These PIP topics are intended to improve areas of care that fall under the categories noted on the Section B Part I chart.

n. ✓ _____

(Applies to the Community Behavioral Health Services Program and the Special Connections Substance Abuse Treatment Program) 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

For the Community Behavioral Health Services Program:

The Department's EQRO validates performance measures annually pursuant to 42 C.F.R. Section 438, Subpart E. The performance measures are part of the PIHPs' overall quality plans and annual reports.

The following BHO performance measures were validated in FY 13/14:

1. *Follow-up After Hospitalization for Mental Illness, 7- and 30-day follow-up)*
2. *Emergency Department Utilization*
3. *Hospital Recidivism*
4. *Overall Penetration Rates*
5. *Penetration Rates by Medicaid Eligibility Category*
6. *Percent of Members with SMI with a Focal Point of Behavioral Health Care*
7. *Inpatient Utilization*
8. *Hospital Average Length of Stay*
9. *Penetration Rates by Service Category*
10. *Penetration Rates by Age Category*
11. *Improving Physical Healthcare Access Reviewed MHSIP, YSS-F, and YSS surveys*

The following BHO performance measures were validated in FY 14/15:

1. *Follow-up After Hospitalization for Mental Illness, 7- and 30-day follow-up)*
2. *Emergency Department Utilization*
3. *Hospital Recidivism (State and non-State Hospitals)*
4. *Overall Penetration Rates*
5. *Inpatient Utilization*
6. *Hospital Average Length of Stay*
7. *Behavioral Health Engagement*
8. *Penetration Rates by Age Category*

9. *Percent of Member with Serious Mental Illness with a focal point of behavioral health care*
10. *Improving Physical Health Access*

The performance measures listed under item (n) above are monitored. Performance measures are calculated annually by the Department and the PIHPs to yield information about how care is being delivered and the outcome of interventions being performed. Validation of these performance measures not only provides the Department with assurance that measures are calculated accurately per the specifications approved by the Department, but the validation also provides trending information of the rates over a period of years. Technical reports completed each year provide an analysis of the calculated rates that were previously validated and that EQRO input is used by the Department to monitor and improve performance. For example, emergency utilization has been validated for a number of years and validation and technical reports trend the rates which help understand if the health plans are increasing emergency utilization, or decreasing utilization. In addition health plans discuss and follow up on their performance measure analysis in the Department MQuIC and BQuIC meetings each year. This process is the same for all required measures. For example, readmission/quality of care, Follow Up/coordination of care, Inpatient Utilization/coverage authorization, or penetration/timely access.

For the Special Connections Substance Abuse Treatment Program:

The performance measures listed under item (n) above are monitored. Performance measures are done annually by OBH 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 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.

- 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
- 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
(Applies to the Special Connections Substance Abuse Treatment Program)

Grievances are monitored as a part of OBH'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.

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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)

The following results apply to the Special Connections Substance Abuse Treatment Program:

For FY 13/14 there were no monitoring problems identified with the Special Connections Substance Abuse Treatment Program. In particular, timely access is represented by the amount of time that lapses between the date of a woman's first contact with the Special Connections treatment program and the date she is admitted to the program. Both best practice and OBH rules, as well as subcontracts with Special Connections providers, require treatment admission within 48 hours of contact with the program or provision of interim services (in the case of residential treatment) to keep the woman engaged pending admission and to link her with prenatal care immediately. Data is pulled monthly from OBH's DACODS system, and these data elements are analyzed to identify all cases of pregnant women being admitted to treatment outside of the allowed time limit. Statewide, 19 of such records were identified for the past fiscal year, and none of these were Special Connections clients. Based upon the monthly results of this process, it appears that all Special Connections clients were admitted to treatment within the required window of time.

For FY 13/14 no grievances were received from any Special Connections clients in the past year regarding any services that they did or did not receive.

For FY13/14 program monitoring was conducted at Boulder Health Department (who closed their addiction treatment program in January, 2015) and no quality of care issues were identified. That contract was transferred to Mental Health Partners, and many of the same staff transferred over from Boulder Health, including the staff who were dedicated to the Special Connections program. As a result there has been no break in services and no change in quality of care.

In FY13/14 provider agencies were reviewed as to program integrity (review of case files and billings), coordination/continuity of care (audits of types and appropriateness of services provided) and quality of care (assuring continuity between assessments, treatment plans, services provided and identified gaps in services). No patterns of problems on a system-wide basis were noted.

In the current CMS approved waiver the State had indicated that both Enroll/Disenroll and member materials were monitored activities. However, both of foregoing activities were checked erroneously. Therefore, the monitoring activities were not performed and there are no results to report.

The following monitoring results apply to the *Community Behavioral Health Services Program*:

For FY 13/14 9% of all FY 13/14 appeals were overturned after BHO/State Fair Hearing review. More grievances and appeals were filed for adult clients than children. Two hundred seventy eight (278) of clients who submitted a grievances agreed with the BHO's outcome, and 38 clients withdrew their grievance (61 clients not happy with outcome). Appeal categories with the most reporting include Denial of limited authorization of a requested service, and Reduction suspension or termination of a previously authorized service. Grievance categories with the most

reporting include Coordination/continuity of care, Facility issues, Medication issues, Rude treatment by clinical staff, and other. For FY 14/15 PIHPs have submitted reports for the first three quarters of this fiscal year. The Department followed up in writing with each PIHP concerning their submitted reports to clarify concerns noted. PIHPs have authority to require corrective action plans (CAP) for their providers and in quarter three one plan reported implementing a CAP to address scheduling a client service. Additional analysis for FY 14/15 quarterly reports will be completed after the fiscal year ends. No system level program changes were made. The Department analyzes additional PIHP quarterly reports (example, Network Adequacy and Access to Care) to identify issues, trends, adequate analysis by plan, evidence of appropriate investigations and follow up in regards to grievances, timely access and specialty capacity. PIHPs received follow up letters for each quarterly submission to clarify concerns noted in their submitted reports. No system level program changes were made.

For FY 13/14 the Experience of Care & Health Outcomes (ECHO) survey is used to assess the level of satisfaction enrollees have with the PIHPs. The Department provides results of this survey to all PIHPs for use in their quality programs. The ECHO survey is administered to Medicaid and Indigent adults and children who have had at least one Behavioral Health service at any of the five BHOs in the previous year in order to measure the consumer experience. The summer of 2015 will mark the second year of administering this survey so trending cannot yet to be reported. Some highlights of the 2014 survey: 85% indicated Clinicians Communicated Well, 55% Received Timely Treatment, 43% indicated Mental Health Status as Fair to Poor, 42% Highly Rated their Counseling or Treatment. No CAP or system level program changes were made for the FY 13/14 ECHO survey. The FY 14/15 ECHO survey is still in process and no data is available at this time.

Analysis of Program Integrity data and other standards is conducted when a report of potential abuse or fraud is reported to the Department by a Managed Care Organization (MCO) or Behavioral Health Organization (BHO/PIHP), and during site reviews. For fiscal year 2013/2014 the Department's EQRO conducted site reviews for all PIHPs and reviewed the Coverage and Authorization of Services and the Access & Availability standards. Two of the five PIHPs submitted corrective actions for this fiscal audit to address deficiencies.

One PIHP encountered a problem with the Access and Availability standard insofar as neither the provider manual nor the provider contract included a requirement that the provider maintain hours of operation for Medicaid members that are no less than the hours of operation for commercial members. As of September 2014 the PIHP has revised its provider manual to include language that specifies that hours of office operation for PIHP members must be no less than hours of operation offered to commercial members.

Another PIHP had multiple deficiencies in the Coverage and Authorization of Services standard. In one (1) instance one (1) of fifteen (15) denial records reviewed on-site did not include documentation that the member was notified of the PIHP's denial for continued inpatient care. The PIHP had only notified the requesting provider. In October 2013, the PIHP began sending all Notice of Action (NOA) letters to its members via certified mail. This allows the PIHP to document proof that each member was mailed a copy of the Notice of Action. As of June 2014, the UM-810 NOA policy has been updated to reflect this change.

In the second instance the provider manual stated that expedited decisions are made within three (3) calendar days. The UM Program Description stated that standard authorization decisions are made within 7 calendar days. While these statements are not out of compliance, they are inconsistent with the PIHP's policy statements and were revised for consistency. Additionally, the PIHP did not send out the NOA within the required ten-day time frame and did not file an extension of the authorization time frame for two (2) of the fifteen (15) denial records review on site. In January 2014, the PIHP implemented a new mechanism for tracking authorization timeframes and extensions. As of August 2014 the PIHP had completed these corrective actions.

In the third instance a sample English version of the NOA contained a statement in Spanish informing the member how to request a copy in Spanish, and it also stated that the member may request large print or audio tape. Denial record reviews included NOAs that were written in easy-to-understand language in all cases. However, the revised NOA template letter contained language citing specific rules and regulations by number and State or federal guideline references in the body of the letter. During on-site interviews, staff members confirmed that the NOA had been revised in late 2013 and explained that the regulatory references had been added to the letter based on advice from administrative law judges during State fair hearings. As of June 2014 the PIHP had moved all citations from the body to the footnotes.

In the fourth instance the PIHP's NOA policy described processes for the community mental health centers (CMHCs) to extend the authorization time frames. In addition, the policy stated that the CMHCs may request an extension "to allow adequate time for [the PIHP] to conduct its clinical review." Denial record reviews included five cases of extensions granted on or near the date of the initial request for authorization, and the reason described in the member extension notification referred to allowing enough time for the PIHP to process the request. During on-site discussions, staff members stated that these extensions were processed by the CMHCs prior to the date of de-delegation of UM. As of August 2014, the PIHP has removed information about authorization decision timeframes from UM-810 Notice of Action. UM-815 Utilization Management Decision Timeframes has been updated (A3, B3, C3, and D3). In addition, the PIHP de-delegated authorization decisions from the Community Mental Health Centers in October 2013.

In the fifth instance the PIHP's UM Decision Timelines policy stated that the member will be notified in writing of the decision to extend either a standard or expedited authorization, and that such notice will include the reason for the extension and the member's right to file an appeal if he or she disagrees with the extension decision. The extension of the authorization timeline is not an action; therefore, the member has no right to appeal in this circumstance but may file a grievance. Denial records reviewed on-site included five cases with extensions in which the member's written notice did not inform the member of the right to file a grievance. As of June 2014, the PIHP updated their UM-815 Utilization Management Decision Timeframes (A3b, B3b, C3b, and D3b) and the Extension Letter Template to reflect the aforementioned language.

In the last instance that PIHP's Admission and Continued Stay Authorizations and Census Tracking policy stated that when a member presents at a hospital emergency facility, the facility contacts BHI and an emergency services clinician is dispatched to evaluate the member and may

authorize inpatient hospitalization (poststabilization care). The policy states that, “If there is a disagreement after-hours, the emergency department may choose to admit the patient with the hope that BHI will retro-authorize the next day or may choose to place the patient in observation status with BHI review in the morning.” This process is not in compliance with regulations. As of August 2014, the PIHP had discontinued its UM-802 Admission and Continued Stay Authorizations and Census Tracking policy.

For fiscal year 2014/2015 the Department’s EQRO conducted site reviews for all PIHPs and reviewed the Member Information, Grievance System, Provider Participation and Program Integrity and Subcontracts and Delegation. All five PIHPs submitted corrective actions for this audit to address deficiencies in the Member Information and Grievance System standards. No system level program changes were made.

For one of the PIHPs neither the member handbooks nor the website included information to help members understand the information concerning the Child Mental Health Treatment Act. (CMHTA). The PIHP is currently working to provide this information via its website and in applicable member materials to include the Member Handbook. The updated member handbook will be sent to all new members as part of the new member packet. Member Partnership letters will include how members can find information on CMHTA. Additionally, during on-site interviews, PIHP staff stated that the provider manual refers to the member handbook as a source of information on the required elements. However, providers do not distribute member handbooks. Moreover, the staff confirmed that there are no PIHP policies or other provider directives that communicate the expectation that providers will distribute the required information, nor are there any PIHP-defined mechanisms to assist providers in doing so. Currently, the PIHP is working on adding language to the provider manual which states that they are required to provide these member materials to their members to include but not limited to: Member rights, grievances, appeals, available services, access to care standards, and the role of the contractor. The PIHP will also provider materials in the Provider manual as an attachment and post in the Provider Toolkit on its website, as well as include this information in subcontractors’ contracts as they are amended. At this time the PIHP has updated its member handbook and website to provide with the applicable language and has trained key case management staff regarding CMHTA. **As of October 2015, the PIHP has completed the corrective action.**

The PIHP also experienced three (3) deficiencies with its grievance system. In the first instance the grievance resolution letter template included a section for the results of the resolution process and the date resolved. However, the record reviews for the PHIP included two resolution letters in which the description of the results either did not provide evidence that the grievance was adequately resolved or did not provide enough information that the member would fully understand how the grievance was resolved. By November 2015 the PIHP had updated the Grievance Resolution Letter Template to explicitly state the explanation and train staff on how to state this explanation that members can understand without using convoluted medical terminology. **As of October 2015, the PIHP has completed the corrective action.**

In the second instance the State fair hearing policy stated that, “[e]xcept for Actions that involve the suspension, termination, or reduction of services, members may request a State fair hearing... within 30 calendar days of the Notice of Action (NOA).” Similarly, the PIHP’s member handbook’s stated that the member may request a State Fair Hearing within 30 calendar days “if your request is about a treatment that has not been approved” and specified that “if your request is about treatment that has been approved before,” the member must make the request within 10 calendar days from the date on the NOA or before the effective date of the termination or change in services, whichever is later. As of September 2015 the PIHP has revised its State Fair Hearing policy as well as its website and member handbook with proper language, as well as continuing to provide appropriate staff trainings.

In the third instance its grievance system the professional agreement template required providers to comply with all grievances and appeal processes; however, the PIHP’s provider manual did not include detailed information on grievance and appeal policies and procedures, as specified in the requirement. The Website also did not include detailed information on grievance and appeals procedures. As of September 2015, the PIHP has included the grievance and appeal policy and procedure information in the Provider Manual, as well as on the PIHP’s website and in the Provider toolkit.

Another PHIP provided evidence that it sends an annual member letter, which notified members that privacy practices could be found in the member handbook and on the website; however, the PIHP did not enclose the privacy practices with the annual letter. The PIHP will now send the Notice of Privacy Practices to members annually. This will be included with the Annual Enrollee Letter that goes out to all members in December of each year.

The PIHP also had eight (8) deficiencies with its grievance system. In the first instance the PIHP’s policies accurately defined “action”; however, in response to the statement found in Standard VI, Requirement 2 of the contract, “the failure to act within the time frames for grievances and appeals,” the PIHP stated in its member handbook, “when we do not provide information to you within timelines required by the State.” This statement in the handbook does not accurately inform members of the situation in which they may file an appeal (i.e., the BHO’s failure to meet the time frame for resolution of grievances and appeals), and it also inaccurately alludes that members may file an appeal when no appeal right exists (e.g., when the time frame for sending the member handbook or an annual letter is not met). The PIHP has updated its Member and Family Handbook with language that members may file an appeal when the PIHP fails to meet grievance and appeal resolution time frames.

In the second instance, the PIHP’s notice of action letters accurately informed members of the time frames for filing appeals; however, the Appeal Procedure policy stated that for concurrent appeals (defined in the policy as requests to change actions that terminate a previously authorized course of treatment, typically associated with inpatient or residential services), the time frame for filing is 10 calendar days prior to the effective date of the action. The PIHP will be updating its UM-804 policy to reflect correct language regarding concurrent reviews and appeal time frames. The PIHP has updated its Member and Family Handbook to reflect the correct language.

In the third instance the PIHP's policies and its member handbook accurately stated that the PIHP will send an acknowledgement letter within two working days of the receipt of the appeal. During the on-site record review, HSAG found that five out of seven standard appeal records included documentation that a written acknowledgement was sent to the member within the two-working-day time frame. The PIHP is now implementing more training of Utilization Management staff on the appeal process. In another instance, the PIHP's policy stated, "post-service appeals, typically being claims appeals, are always processed in a 30-day timeframe," regardless of whether they are considered member or provider appeals. The PIHP has updated the UM-815 policy on Decision Time Frames and UM-804 policy to reflect that member initiated appeals will be resolved within 10 working days.

In the fourth instance, Appeal Resolution letters included the required continuation of benefits language; however, this language was confusing and inaccurate, as it addressed continuation of services during the "appeal or State fair hearing." The information also stated that the member must file the appeal within 30 calendar days of the notice of action letter if the PIHP denies or limits services and 10 calendar days of the letter if the PIHP reduces, suspends, or terminates a service the member was already receiving. During the on-site record review, HSAG found that for one of the three expedited appeals, the PIHP did not send a written notice of resolution. One standard resolution letter was sent to the facility only (and not to the member), and two standard resolution letters did not include the date the resolution was completed (nor was the letter dated). Therefore, six of 10 records reviewed met the requirements for resolution notices containing the required content. In addition, four resolution letters reviewed did not meet the requirement that their content be easy to understand. The member-specific reason for the decision used words or phrases that were clearly above the sixth-grade reading level. **The Department and its EQRO contractor have approved the changes, which are now complete.**

In the fifth appeals record reviewed on-site, the ERQO contractor was unable to determine who made the final appeal decision; therefore, the ERQO contractor was unable to determine whether or not the individual who made the decision was involved in any previous level of review or had the appropriate clinical expertise to treat the member's condition. The PIHP has updated the Appeal Resolution Letter template to include the full credentials for the appeal reviewer (to show clinical expertise) and an attestation will be added to the Appeal Resolution Letter to reflect that the appeal reviewed did not have any prior decision making authority in the member's care.

In the sixth instance the PIHP's provider manual contained incomplete and inaccurate information regarding the grievance system requirements. The manual stated (1) if members are unhappy with the results of a grievance, they may request a State fair hearing; (2) member claims denials are resolved in 30 days (rather than 10 working days required by Colorado regulation); (3) concurrent appeals must be filed within 10 calendar days prior to the effective date of the action; and (4) an expedited appeal is a request to change a denial for urgent care. The section of the manual titled "Member Billing" stated, "A member may have to pay for services rendered if his/her appeal of a denial made by the PIHP is upheld through a local appeal or through a State Fair Hearing." In addition, the manual did not address the member's right to a State fair hearing following or concurrent with an appeal or the filing and representation rules for State fair hearings. The provider manual was also missing the toll-free number for filing grievances and appeals, the availability of assistance from the PIHP in filing grievances and appeals, and

continuation of benefits information. The State and its EQRO contractor have approved the revisions to Provider Manual to reflect the correct language regarding grievances and appeals.

In the seventh instance the PIHP's credentialing policy stated that its credentialing delegate conducted a monthly review of Medicare and Medicaid sanctions and exclusions, and Colorado State sanctions and limitations on licensure for its providers. This policy also indicated that the PIHP reviewed member grievances processed by the Office of Member and Family Affairs, and reviewed critical incident reports and quality of care concerns processed by the Quality Improvement Department. These types of monitoring activities appeared to only examine providers that fall outside the specific performance expectations, as identified by outside sources, rather than via proactive monitoring on the PIHP's part. The site visit discussions suggested that the PIHP monitors providers for over- and underutilization; however, the reports provided to substantiate that activity did not include metrics that are indicators of provider over- or underutilization or any other provider-specific performance indicators. Based on the policies and procedures discussed and documentation provided, there was not adequate evidence of effective oversight protocols in place to ensure comprehensive monitoring for compliance with contract requirements and agreements. The PIHP created a plan to monitor provider performance with contractual requirements that includes review of access to care standards, timely and accurate claims filing, submission of reports, utilization management data, review of grievances and quality of care concerns, and compliance with BHI's corporate compliance plan. Prior to recredentialing, a "Provider Profile" will be created using all accessible data sources to determine if the provider is meeting contractual requirements. **As of August 2015, the PIHP has completed all steps to correct the deficiencies noted above.**

In the eighth instance the PIHP's corporate compliance policy required that all employees and contractors abide by the PIHP's Corporate Compliance Program Plan. The PIHP's Corporate Compliance Program Plan sufficiently addressed the seven elements of an effective compliance plan (written policies and procedures, governance, training and education, lines of communication, internal monitoring and auditing, enforcing standards, and responding promptly and taking action). While the PIHP's policy provided for the identification and reporting of fraud, waste, and abuse, past training on the corporate compliance plan focused more on educating employees and contractors on what corporate compliance is without in-depth and focused training on recognizing and reporting suspected incidents of fraud, waste, and abuse. Site visit discussions and review of the Q4 SFY 14 Contract Performance Summary report submitted was also inconclusive in determining if there were effective mechanisms to identify and report suspected incidences of upcoding, unbundling of services, and identifying services that were never rendered or billed at an inflated rate. As a result, the PIHP will be creating four new Corporate Compliance Policies including Compliance Hotline Policy, Training and Education on Corporate Compliance Policy, Effective Lines of Communication Policy, and an Auditing and Monitoring Policy. The PIHP will also update its training on Corporate Compliance and Fraud, Waste, and Abuse training to include identifying and reporting suspected upcoding, unbundling of services, and services that were never rendered or billed at an inflated rate. Examples of each will be added to the training as well as employee expectations. The PIHP has also developed a provider profiling system to proactively identify providers that will be monitored for Fraud, Waste, and Abuse. **As of August 2015, the PIHP has completed all steps to correct the deficiencies noted above.**

Another PIHP experienced six (6) deficiencies with its grievance system. In one instance, the grievance policy and member and provider communications stated that a grievance will be resolved and letter sent to the member within 15 working days. However, two (2) of ten (10) (20%) of the grievance records reviewed did not have a grievance resolution letter sent within the required time frame. The grievances that were out of compliance were handled by the community mental health centers. The PIHP plans two interventions. First, the PIHP will provide grievance training to all community mental health center staff who handles grievances. Second, the PIHP will monitor the letters, sent by the community mental health centers. Four grievances will be randomly selected from across the PIHP each quarter, and review to ensure compliance. If deficiencies are found, the PIHP will work further with the mental health center staff up to and including a corrective action plan.

In the second instance, three (3) out of ten (10) grievance records reviewed were not compliant with the required content of the resolution letter, because the letter did not include the description of the resolution and did not adequately address the member's full complaint. The grievances that were out of compliance were handled by the community mental health centers. The interventions are the same. The PIHP will do two interventions. First, the PIHP will provide grievance training to all community mental health center staff who handles grievances. Second, the PIHP will monitor the letters, sent by the community mental health centers. The PIHP will randomly select four (4) grievances from across the PIHP each quarter, and review to ensure that all letters include a full description of the grievance and fully address the resolution. The PIHP will pay particular attention to situations where an extension will enable a complete resolution. If deficiencies are found, the PIHP will work further with the mental health center staff, up to and including a corrective action plan.

In the third instance the provider manual inaccurately stated that an appeal of reduction, suspension, or termination of previously approved services must be filed in ten (10) days. The reduced ten (10) day time frame for filing an appeal applies only when the member is requesting continuation of previously approved services during the appeal. **As of August 2015 PIHP has made the necessary corrections in the provider manual.**

In the fourth instance, during on-site interviews, staff members confirmed that the PIHP applies the three-calendar-day rather than three-working-day standard for resolution of expedited appeals. However, the grievances and appeals (G&A) brochure stated that expedited appeals would be resolved in three (3) working days. In addition, for two (2) of ten (10) appeal records reviewed, the appeal resolution letters were not sent within the required ten (10) working-day time frame for standard appeals. Reviewers also noted several cases in which the appeal resolution letter was sent to the DCR but not copied to the member. The member, as a party to the appeal (10 CCR 2505—10, Section 8.209.4.I), must also be notified in writing of the outcome of an appeal. The PIHP intends to revise its Grievance and Appeals Brochure; revise workflows for clinical staff and OMFA staff to include a process where members are copied on all letters sent to the provider, including extension letters and resolution letters. **As of August 2015 the PIHP has trained clinical and customer service staff on the new workflows.**

In the fifth instance the State Fair Hearing (SFH) section of the member handbook, the Grievance & Appeals brochure, and the provider manual (Appeal of Termination, Suspension or Reduction of Previously Authorized Services section) inaccurately stated that SFH appeals related to the reduction, suspension, or termination of previously authorized services must be requested within 10 calendar days. (This definition of timely filing only applies when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.) The PIHP will Revise documents that describe “previously authorized services” to make the distinction between an appeal, which would go by the 30 day time frame, and when the member is requesting a continuation of benefits, which goes by the 10 day time frame. Documents include member handbook, grievance and appeal brochure and provider manual. **As of November 2015, the PIHP is still working on resolving the abovementioned issues.**

In the sixth instance the appeal policy, provider manual, and member handbook all accurately define (per requirement) how the member may request continuation of previously authorized services during an appeal or SFH and how long they will last. However, all three documents incorrectly stated that when members are requesting continuation of benefits, members must file an appeal within 10 days of the NOA or within 10 days before the intended date of the action. As outlined in the requirement, the member must file an appeal or SFH request within 10 days of the NOA or before the intended effective date of the proposed action, whichever is later (not 10 days before the intended effective date). The PIHP will revise the appeal policy, provider manual and member handbook to include the correct language. **As of November 2015, the PIHP is still working on resolving the abovementioned issues.**

Another PIHP indicated six (6) deficiencies with its grievance system. In the first instance the Grievance and Appeal policy, member handbook, provider manual, and Grievance and Appeal Guide described an action, an appeal, and the 30-calendar-day time frame for filing. However, all documents also inaccurately stated that an appeal of reduction, suspension, or termination of previously approved services must be filed in 10 days. The reduced 10-day time frame for filing an appeal applies only when the member is requesting continuation of previously approved services during the appeal. The PIHP will make necessary changes to relevant OMFA documents (Grievance and Appeal Policy, member handbook and Grievance and Appeal Guide) and train OMFA staff on when to apply the reduced 10 day time frame for filing. The PIHP will also make necessary changes to its Provider Manual and train appropriate staff. The edits will indicate that the reduced 10 day time frame for filing an appeal only applies if the member is requesting continuation of services. **As of October 2015, the PIHP has satisfied this requirement.**

In the second instance the Grievance and Appeal policy, member handbook, and Grievance and Appeal Guide all accurately address this process. The Appeal Acknowledgement letter included the date the appeal was received. Six out of eight appeal records reviewed (75 percent) included an acknowledgement letter sent within the required time frame. The OMFA Director has redoubled her efforts to ensure that acknowledgment letters are sent within required time frame and has cross-trained the Grievance Coordinator in this process, to ensure timely acknowledgement letters are sent in the absence of the OMFA Director.

In the third instance seven (7) out of eight (8) appeal records reviewed included an appeal disposition letter sent within the required time frame. The record that was out of compliance with required time frames for resolution appeared to have been processed only after receipt of the written appeal, which was received more than one month after the member's verbal appeal. The Grievance and Appeal policy will be revised to require a follow-up phone call and letter to a member who files a verbal appeal but fails to send in required written appeal in a timely manner. Policy will also be revised to require that, in the event that OMFA is not successful in contacting the member prior to the appeal decision due date, OMFA will notify the member in writing by the due date that appeal is considered to be withdrawn. **As of October 2015, the PIHP has satisfied this requirement.**

In the fourth instance a letter did not inform the member of the right to continue benefits during a state fair hearing (SFH) and the potential financial implications for doing so. All appeal resolution letter templates for appeals not resolved wholly in favor of the member will be reviewed for the appropriate language and the language will be added where needed to notify members of their right to continue previously approved benefits during a SFH and that member may be held liable for the cost of these benefits if the hearing decision upholds the contractor's action. **As of October 2015, the PIHP has satisfied this requirement.**

In the fifth instance the Decision on Appeal of Previously Authorized Services letter, the member handbook, the provider manual, and the Grievance and Appeal Guide all inaccurately communicated the time frame for requesting a SFH for reduction, suspension, or termination of previously authorized services as 10 days. (The 10-day filing requirement applies only when the member is requesting continuation of previously authorized services pending outcome of the SFH.) The PIHP will revise the letter and provide training to the appropriate staff. **As of October 2015, the PIHP has satisfied this requirement.**

In the sixth instance the provider manual stated that when members are requesting continuation of benefits, members must file an appeal within 10 days of the notice of action or *within 10 days before* the intended date of the action. As outlined in the requirement, the member must file an appeal or SFH request within 10 days of the notice of action or the intended effective date of the proposed action (not 10 days before), whichever is later. The PIHP will revise its Provider Manual to clarify the requirement to notify members to request continuation of benefits on or before the later of 10 days after mailing the notice of action or the intended effective date of the action. **As of October 2015, the PIHP has satisfied this requirement.**

Annual Technical Reports for FY2012-13, FY 2013-14 have been submitted to CMS.

The Department uses Compliance Site Reviews to monitor a number of BBA requirements like enrollment, provider selection and marketing. In FY 13/14 438.206 was audited which included elements of enrollment and in FY 12/13 438.242.a was reviewed which included elements of disenrollment. Participation and Program Integrity was reviewed in FY 14/15 compliance audit and this audit looked at provider selection (438.12). Member information was audited in FY 14/15 and evaluated the type of material (marketing) PIHPs provide to members. Two of the PIHPs submitted CAPs for the Member Information standard reviewed.

The Ombudsman collects information to facilitate accurate reporting of issues, resolutions and referrals. A summary of the issues is reported to the Department on a quarterly and annual basis. The quarterly report summarizes the monthly case activity, services provided and trends in care issues. The annual report is a complete summary of care issues and trends, Ombudsman mediation, intervention and care coordination. No problems were identified.

The Department is also working with additional State agencies to align performance measure reporting methods for PIHPs, Community Mental Health Centers (CMHCs), and indigent care populations. The ECHO survey is one outcome of this initiative. Additional PIHP performance measures (example, readmissions, engagement) are being researched to understand the best way to align efforts.

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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 the State's waiver cost projection if the assumptions in its projects stay true.
 - 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:
Sarah Campbell
- c. Telephone Number: 303-866-2083
- d. E-mail: Sarah.Campbell@state.co.us
- e. The State is choosing to report waiver expenditures based on
 date of payment.
 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.

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 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: \$_____ per member per month fee
 - 2. Second Year: \$_____ per member per month fee
 - 3. Third Year: \$_____ per member per month fee
 - 4. Fourth Year: \$_____ 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. \$_____ Please explain the State's rationale for determining this method or amount.

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.
- 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 to P2:

- e. ___ [Required] List the year(s) being used by the State as a base year: _____. If multiple years are being used, please explain: _____
- f. ___ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g. ___ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

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 estimated up to six (6) months of enrollment data for R2 of the previous waiver period. Note the length of time estimated:
6 months.
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

On January 1, 2014, the State expanded Medicaid eligibility to individuals earning up to 133% of the FPL. During the last waiver amendment, the State created two MEGs. The MEGs cover the following individuals:

MEG 1: MEG 1 represents the projected member months and costs of the non-expansion individuals. These individuals are:

- Elderly (OAP-A)
- Disabled (OAP/B-SSI, AND/AB-SSI)
- Non-expansion parents (AFDC-A, BCKC-A)
- Children (AFDC-C, BCKC-C)
- Foster Care.

MEG 2: MEG 2 represents the projected member months and costs of the following individuals:

- Modified Adjusted Gross Income (MAGI)
- Expansion Parents

For the MEG 1 population:

*This waiver submission covers the projected period of January – June 2016 (P1) and FY17 (P2). In order to appropriately calculate the member months for P1 and P2, the State used FY14 (R1) actual member months of 8,749,327 and FY15 Q1 and Q2 (R2) actual member months of 4,825,735. Projected member months were calculated using the State Budget Section’s Medicaid Executive Caseload forecast for FY15 – FY17. The State applied the annual Budget projection of 16.96% to calculate the FY15 projected member months of 10,233,240. Next, the State applied the Budget projection of 7.89% to calculate the FY16 projected member months. The total FY16 projected member months are 11,040,849 (10,233,240*1.0789). However, the waiver is effective for two quarters in FY16. To calculate the projected member months for FY16 Projected Q1 (January – March 2016) and FY16 Projected Q2 (April – June 2016), the State reverse-calculated the quarterly member months from the yearly member months. The State applied a consistent increase in member months each quarter to determine Projected Q1 and Q2. FY17’s member months are projected to be 11,761,764 (11,040,849*1.0653). See tab ‘Member Months’ in Appendix H and D1 in Appendix D 1-7 for detail.*

For the MEG 2 population:

This waiver submission covers the projected period of January – June 2016 (P1) and FY17 (P2). In order to appropriately calculate the member months for P1 and P2, the State used FY14 (R1) actual member months of 1,436,346 and FY15 Q1 and Q2 (R2) actual member months of 1,705,723. Please note that FY14’s figure includes a full year of Member Months, including the AwDC population under the Federal 1115 Demonstration waiver. A full year of Member Months is used only for projecting FY16 and FY17 Member Months because the growth rates from the Medicaid Executive Caseload represent a full year. The calculation of the PMPM includes the actual Member Months and costs for the expansion population from January – June 2014.

Projected member months were calculated using the State Budget Section’s Medicaid Executive Caseload forecast for FY15 – FY17. The State applied the annual Budget projection of 131.72% to calculate the FY15 projected member months of 3,328,345. 131.72% represents the Department’s February 2015 forecasted growth (the most recent public forecast at the time of waiver submission) for the expansion adult caseload. Specifically, 131.72% is the projected growth rate of the aggregate caseload of expansion adults without dependent children and parents with income above 68% FPL from FY 2013-14 to FY 2014-15. A detailed explanation of the forecasts for these populations can be found on pages MC-51 through MC-58 at the following link: <https://www.colorado.gov/pacific/sites/default/files/2015-02%20Medicaid%20Caseload%20Narrative.pdf>. Next, the State applied the Budget projection of 19.69% to calculate the FY16 projected member

months. The 19.69% caseload was calculated due to the State's expectations that there would be additional enrollment as members became more aware of the health care options and the insurance mandate from the ACA. The FY 2015-16 growth rate is taken from the same source listed above; please see the narrative in the link for additional detail regarding the forecast. The total FY16 projected member months are 3,983,701 (3,328,345*1.1969). However, the waiver is effective for two quarters in FY16. To calculate the projected member months for FY16 Projected Q1 (January – March 2016) and FY16 Projected Q2 (April – June 2016), the State reverse-calculated the quarterly member months from the yearly member months. The State applied a consistent increase in member months each quarter to determine Projected Q1 and Q2. FY17's member months are projected to be 4,179,534 (3,983,701*1.0492). See tab 'Member Months' in Appendix H and D1 in Appendix D 1-7 for detail.

- 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: SFY

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.

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**: No differences exist between the two appendices.
- 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: No exclusions have been made.

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. The allocation method 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.*

Overall, the State allocates the administrative costs based upon the BHO program costs as a percentage of the total Medicaid budget. In FY14, the total cost of the mental health services was \$462,514,824 and the total cost of Medicaid services was \$5,715,550,404. The mental health service are 8.09% of the total cost of Medicaid services (\$462,514,824/\$5,715,550,404). The 8.09% was then applied to the total administrative cost for FY14 and FY15. Using this calculation, the mental health administrative cost for FY14 was \$23,363,983 and \$10,777,798 for FY15. This calculation is appropriate because the MH waiver is for a statewide PIHP program.

After identifying the total mental health administrative cost for FY14 and FY15, the total was distributed among the two MEGs based on total mental health expenditures for each MEG. MEG 1's total expenditures for FY14 were \$366,493,617 while MEG 2's total expenditures were \$96,021,206. MEG 1's total expenditures make up 79% of the total mental health expenditures (366,493,617/462,514,824) and MEG 2's total expenditures make up 21% of the total mental health expenditures (96,021,206/462,514,824). Using this calculation the mental health administrative cost for MEG 1 in FY14 is \$18,521,430 and the mental health administrative cost for MEG 2 is \$4,850,521. For FY15, MEG 1's total expenditures were \$201,143,736 while MEG 2's total expenditures were \$97,526,587. MEG 1's total expenditures make up 67% of the total mental health expenditures (201,143,736/298,670,322) and MEG 2's total expenditures make up 33% of the total mental health expenditures (97,526,587/298,670,322). Using this calculation the mental health administrative cost for MEG 1 in FY15 is \$7,258,460 and the mental health administrative cost for MEG 2 is \$3,519,338. The total for each MEG was then allocated among the CMS 64 lines that are affected by the MH waiver. 8.09% was applied to the total administrative cost for four lines related to the MMIS:

Line 2A: Design Development or Installation of MMIS, Line 2B: Design Development or Installation of MMIS – Private Sector, Line 4A: Operation of an Approved MMIS – In-house Activities, and Line 4B: Operation of an Approved MMIS – Private Sector. The lines listed above are applicable to the MH waiver because the MMIS is responsible for processing and paying the BHO capitations, paying and rebating the mental health FFS drug claims, processing the BHO encounter data, and denying FFS claims that are the responsibility of the BHO. The administrative costs of maintaining these functions for the State employees and the State's fiscal agent are captured in these lines.

50% of the total administrative cost for line 17, external review, was applied to calculate the MH administrative cost. After reviewing the deliverables submitted by the State’s external quality review contractor, Health Services Advisory Group, it was determined that allocating 50% of the total cost was appropriate for mental health program.

The remainder of the mental health administrative cost was assigned to line 49, Other Financial Participation. This line represents the salaries of the State’s employees that manage the mental health program and salaries of private sector employees.

For more information about the administrative costs, please see Appendix F, Explanation of Administrative Lines.

c. ___ Other (Please explain).

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 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 (See details in the attached support worksheet, tab 7 – B3 Costs)

Below are the projected 1915(b) (3) expenses for MEG 1 and MEG 2. Please note that during FY15, the CMHCs for one BHO were transitioning to a new EHR. As a result, the BHO did not receive encounters until FY15 Q3. Since the (b)(3) expenditures are reported by paid date, the BHO reported a small amount for FY15 Q1 and Q2. To account for this, (b)(3) expenditures from the same region for FY14 Q3 and Q4 were trended forward to FY15 Q1 and Q2, and then inflated for P1 and P2.

MEG 1:

| 1915(b)(3) Service | Amount Spent in R1 year SFY14 (PMPM) | Amount Spent in R2 SFY15Q1 & Q2 | Amount Projected for P1 | Inflation Projected for P1= 2.40% | Amount projected for P2 | Inflation Projected for P2=2.57% |
|---|---|--|--------------------------------|--|--------------------------------|---|
| <i>Residential</i> | \$ 1.73 | \$ 1.34 | \$ 1.37 | 2.40% | \$ 1.41 | 2.57% |
| <i>Assertive Community Treatment(ACT)</i> | \$ 0.30 | \$ 0.18 | \$ 0.18 | 2.40% | \$ 0.18 | 2.57% |
| <i>Intensive Case</i> | \$ | \$ | \$ | 2.40% | \$ | 2.57% |

| | | | | | | |
|--------------------------------------|------------|------------|------------|--------------|------------|-------|
| <i>Management</i> | 0.59 | 0.88 | 0.90 | | 0.92 | |
| <i>Respite Care</i> | \$ 0.04 | \$ 0.02 | \$ 0.02 | 2.40% | \$ 0.03 | 2.57% |
| <i>Vocational Services</i> | \$ 0.44 | \$ 0.35 | \$ 0.35 | 2.40% | \$ 0.36 | 2.57% |
| <i>Clubhouses/Drop-In Centers</i> | \$ 1.30 | \$ 0.81 | \$ 0.83 | 2.40% | \$ 0.85 | 2.57% |
| <i>Recovery Services</i> | \$ 0.16 | \$ 0.14 | \$ 0.15 | 2.40% | \$ 0.15 | 2.57% |
| <i>Prevention/Early Intervention</i> | \$ 1.49 | \$ 0.69 | \$ 0.71 | 2.40% | \$ 0.72 | 2.57% |
| <i>Special Connections</i> | \$ 0.02 | \$ 0.01 | \$ 0.01 | 2.40% | \$ 0.01 | 2.57% |
| Total | \$ 6.06 | \$ 4.42 | \$ 4.52 | 2.40% | \$ 4.64 | 2.57% |

MEG 2:

| 1915(b)(3) Service | Amount Spent in R1 year SFY14 (PMPM) | Amount Spent in R2 SFY15Q1 & Q2 | Amount Projected for P1 | Inflation Projected for P1= 2.40% | Amount projected for P2 | Inflation Projected for P2=2.57% |
|---|---|--|--------------------------------|--|--------------------------------|---|
| <i>Residential</i> | \$2.09 | \$ 2.37 | \$ 2.43 | 2.40% | \$ 2.49 | 2.57% |
| <i>Assertive Community Treatment(ACT)</i> | \$0.15 | \$ 0.17 | \$ 0.17 | 2.40% | \$ 0.18 | 2.57% |
| <i>Intensive Case Management</i> | \$0.46 | \$ 0.66 | \$ 0.67 | 2.40% | \$ 0.69 | 2.57% |
| <i>Respite Care</i> | \$0.00 | \$ 0.00 | \$ 0.00 | 2.40% | \$ 0.01 | 2.57% |
| <i>Vocational Services</i> | \$0.54 | \$ 0.94 | \$ 0.96 | 2.40% | \$ 0.99 | 2.57% |
| <i>Clubhouses/Drop-In Centers</i> | \$0.84 | \$ 1.02 | \$ 1.05 | 2.40% | \$ 1.07 | 2.57% |
| <i>Recovery Services</i> | \$0.08 | \$ 0.11 | \$ 0.12 | 2.40% | \$ 0.12 | 2.57% |
| <i>Prevention/Early Intervention</i> | \$1.17 | \$ 0.81 | \$ 0.83 | 2.40% | \$ 0.85 | 2.57% |
| Total | \$5.33 | \$ 6.08 | \$ 6.23 | 2.40% | \$ 6.39 | 2.57% |

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):

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.
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.

I. 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: 0% Please document how that trend was calculated: *The trending from the first half year's rate to the second half year's rate is considered as 0%. All trend adjustments are accounted for below in Section D Part I.Ia.2.*
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 SFY13, SFY14, and SFY15. 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.

The cost increase for SFY16 and SFY17 are calculated separately. The moving average method is used to calculate the cost trend rate for both MEG 1 and MEG 2. It results in the 2.40% (cell J13 on D5 of our conversion waiver MS Excel spreadsheet) as our annual trend rate for the state plan trend adjustment to get to P1 (SFY16 Projected Q1 and Q2).

The mathematical method used to calculate the trend for both MEG 1 and MEG 2 for the P2 (SFY17) is the moving average of previous years.

*The base mental health cost for MEG 1 for SFY16 Projected Q1 and Q2 is \$192,844,117 after the trend has been applied. The projected cost based on the projected member month of 11,761,764 for SFY17 is \$402,894,506. The cost trend rate for SFY17 is 2.57%. The total State Plan capitation cost for SFY17 is \$413,235,465 = \$402,894,506 * (1 + 2.57%).*

*The base mental health cost for MEG 2 for SFY16 Projected Q1 and Q2 is \$88,871,189 after the trend has been applied. The projected cost based on the projected member month of 4,179,534 for SFY17 is \$184,642,755. The cost trend rate for SFY17 is 2.57%. The total State Plan capitation cost for SFY17 is \$189,381,919 = \$184,642,755 * (1 + 2.57%).*

- 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. ___ 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):
- 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.
 - D. ___ Other (please describe):
- vi. ___ Other (please describe):
PMPM size of adjustment _____
 - A. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - B. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - C. ___
 - 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: 8.49% for FY16 Projected Q1 and Q2 and 9.18% for FY17 for MEG 1 and 2.

Please document how that trend was calculated:

The mathematical method used to calculate the trend for the P1 (SFY16 Projected Q1 and Q2) administrative cost is the average of the administrative cost change for the last seven years SFY09, SFY10, SFY11, SFY12, SFY13, SFY14, and SFY15. The numbers for the seven years are 3.86%, 0.62%, -4.58%, 14.18%, 26.21%, 13.20%, and 9.47% correspondingly. The P2 (SFY17) administrative cost is the average of the administrative cost change for SFY10, SFY11, SFY12, SFY13, SFY14, SFY15 and SFY16. Please see the tab labeled "Admin" in the support worksheet for details.

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. Q1 and Q2 of SFY15 to Q3 and Q4 of SFY15*). The actual documented trends are 0%.

Since an average of 3.40% annual trend rate applied to the capitation rate for Q1 and Q2 of SFY15, the trend rate from Q1 and Q2 of SFY15 to Q3 and Q4 is 0%.

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. *The trend for the State Plan Services and the historical 1915(b)(3) services is the same; therefore, the trend used is the lower trend.*

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

1. Please indicate the years on which the rates are based: base years SFY13, SFY14 and SFY15
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

The State estimates the 1915(b) (3) services for the combined Mental Health capitation program and Special Connection services will have the trend rates of 2.40% for P1 and 2.57% for P2. This trend is applied to both MEG 1 and MEG 2 1915 b(3) services. See the support worksheet tab labeled "Summary" for calculations.

ii. State Plan Service Trend

Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above 2.40% for SFY16 Projected Q1 and Q2 and 2.57% for SFY17.
This trend is applied to both MEG 1 and MEG 2 State Plan Services.

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) 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 wrap-around. 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. Please account for this adjustment in **Appendix D5**.

*For MEG 1, a decrease of \$3,804,819 or -9.02% in the Mental Health drug cost is projected for SFY16 based on previous four years SFY12, SFY13, SFY14 and SFY15. The Mental Health Drugs for SFY17 will decrease by \$3,990,805 that is calculated based on the average of SFY13, SFY14, SFY15 and SFY16's numbers. The percentage decrease for this adjustment is $-9.76\% = -\$3,990,805 / 40,890,672 * 100$. See the details in the attached support worksheet tab labeled "Summary" and the tab labeled 'Rx Forecast'.*

For MEG 2, the pharmacy adjustment is set at 0% for FY16 Projected Q1 and Q2 and FY17 because the State does not have enough historical data to calculate a pharmacy adjustment for MEG 2.

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.
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**.

J. 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.

K. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

L. 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 Colu.**
 - 4. **mn 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

Please see attached Excel spreadsheets.

| | |
|------------------|---|
| Appendix A.I. | List of Stakeholders Solicited for Input |
| Appendix A.III | Quality Strategy |
| Appendices D 1-7 | Cost Effectiveness |
| Appendix E1 | Organization Charts |
| Appendix E2 | Interagency Agreement for Special Connections |
| Appendix F | Explanation of Administrative Lines |
| Appendix G | Explanation for Over Expenditures |
| Appendix H | Cost Effectiveness Support Worksheet |